Report 08-15
December 2008

An Evaluation

Medical Assistance Program Integrity

Department of Health Services

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Janice Mueller
State Auditor

December 11, 2008

Senator Jim Sullivan and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Sullivan and Representative Jeskewitz:

We have completed an evaluation of the efforts of the Department of Health Services (DHS), formerly the Department of Health and Family Services, to ensure the integrity of Wisconsin's Medical Assistance program, including its certification of providers and audits of provider payments. In fiscal year (FY) 2006-07, expenditures for DHS's program integrity activities, excluding payments made to contractors that assist DHS in these activities, totaled $3.2 million.

Most providers must be certified by the State to receive Medical Assistance reimbursement for services rendered. We found that the initial certifications are generally processed on a timely basis. Some provider recertifications, which are generally required every three years, have not been completed since at least 2002, in part because of delays DHS has encountered in implementing its new Medicaid Management Information System. Delays in recertification increase the risk that unallowable payments will be made because some providers no longer meet certification requirements.

From FY 2002-03 through FY 2006-07, DHS conducted 8,517 audits of Medical Assistance providers and recovered $31.8 million, which was used to offset state and federally funded Medical Assistance expenditures. We independently analyzed 9.4 million claims paid to four types of providers during one year—FY 2005-06—and found an additional $268,000 in payments for provider claims that appear to be unallowable. We make several recommendations to improve the audit process, including seeking recovery of the payments we identified, imposing sanctions on providers found to repeatedly violate program rules, and charging interest to providers that fail to promptly return unallowable claims payments.

We also reviewed the role of the Department of Justice (DOJ) in prosecuting cases of Medical Assistance fraud. From FY 2002-03 through FY 2006-07, DOJ obtained 34 criminal convictions and negotiated 16 civil settlements between the State and Medical Assistance providers. During that period, courts ordered convicted providers to pay a total of $2.9 million, and the State received $11.7 million from civil settlements.

We appreciate the courtesy and cooperation extended to us by DHS and DOJ staff. A response from DHS follows our report.

Respectfully submitted,

Janice Mueller
State Auditor

JM/PS/ss

Report Highlights ■

Delays in implementing a new computer system have delayed some provider recertifications.

From FY 2002-03 through FY 2006-07, DHS recovered $31.8 million from Medical Assistance providers.

We identified an estimated $268,000 in unallowable provider claims paid in FY 2005-06.

The Department of Justice investigates and prosecutes allegations of fraud by Medical Assistance providers.

Wisconsin's Medical Assistance program, also known as Medicaid, funds health care services for eligible low-income, elderly, blind, and disabled individuals. The program includes medical and dental services and long-term care. Its expenditures totaled $4.9 billion in fiscal year (FY) 2007-08, including $1.7 billion in general purpose revenue (GPR).

The Department of Health Services (DHS), formerly the Department of Health and Family Services, is responsible for certifying that providers such as physicians, dentists, and nursing homes meet basic standards to participate in the program. It also is responsible for ensuring that payments for these services are consistent with federal and state program rules.

We evaluated the efforts of DHS to ensure the integrity of the Medical Assistance program by:

- certifying that providers meet licensing and other program requirements, and decertifying those that do not;
- auditing provider claims to identify overpayments and payments for services that are not allowed under program rules; and
- recovering unallowable payments.

This evaluation focuses on services provided on a fee-for-service basis. Fee-for-service providers accounted for 52.1 percent of program spending in FY 2007-08.

Provider Certification

Wisconsin's administrative rules require that virtually all providers be certified in order to participate in the Medical Assistance program. DHS contracts with Electronic Data Systems (EDS) to approve providers' requests for certification and recertification, as well as to decertify providers when rules are violated. Providers must generally be certified before any claims are paid.

From FY 2002-03 through FY 2006-07, virtually all provider certification applications were approved. EDS processed most provider applications within ten business days, as required under its contract with DHS. DHS policy requires certain providers, including physicians, dentists, and chiropractors, to be recertified every three years. However, not all recertifications have occurred when required, in part because of delays in implementing the new Medicaid Management Information System, which cost approximately $44.0 million to complete. Regular and timely recertification helps to ensure that provider information is current and accurate. Outdated and inaccurate information increases the risk that individuals who are not eligible to bill for services can obtain payment fraudulently.

We identified strategies DHS could use to improve the certification and monitoring of Medical Assistance providers, including conducting criminal background checks and promptly decertifying providers that violate program rules.

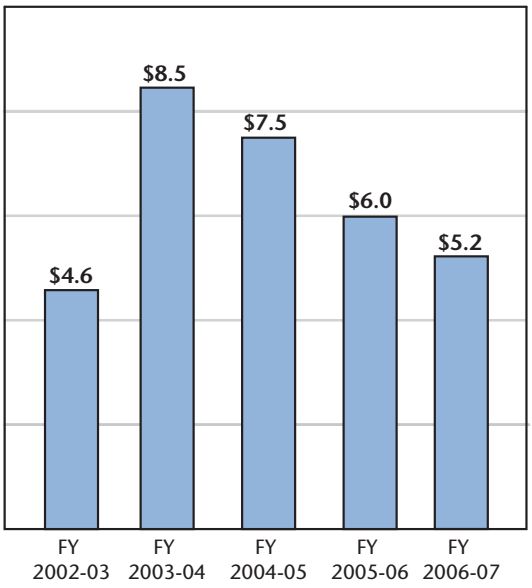
Preventing and Recovering Unallowable Payments

DHS is authorized to audit claims submitted by Medical Assistance providers and to recover payments for claims it determines to be unallowable. From FY 2002-03 through FY 2006-07, it conducted 8,517 audits of 3,050 providers. During that time, 140 providers were audited ten or more times.

As shown in Figure 1, DHS recovered a total of $31.8 million based on its provider audits, including $10.5 million from hospitals and $9.0 million from pharmacies.

Figure 1

Financial Recoveries from DHS Audits
(in millions)



While DHS has generally been successful in identifying and recovering unallowable payments, we found that it does not typically use all of its authority to recover unallowable payments. For example, it has rarely used its authority to conduct "extrapolation audits," which analyze a sample of paid claims and project the amount that is potentially recoverable from all claims.

In addition, DHS has not charged interest to providers that have not promptly repaid unallowable claims, even though statutes require that it promulgate rules to do so. DHS also has not used its statutory authority to charge providers up to $1,000 or 200 percent of the cost of unallowable claims, or to decertify or suspend those that knowingly engage in conduct that results in repeated unallowable claims.

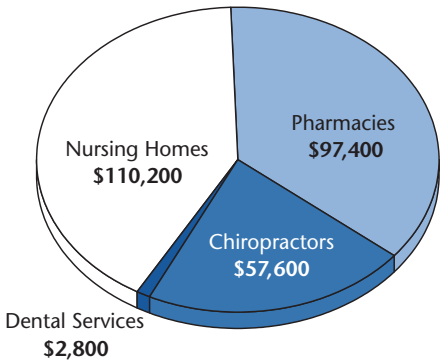
Identifying Additional Unallowable Claims

We independently analyzed 9.4 million claims from nursing homes, pharmacies, chiropractors, and dental services providers that were paid in FY 2005-06. We identified an estimated $268,000 in payments for claims that appear to be unallowable. That amount represents 4.5 percent of financial recoveries from DHS audits during FY 2005-06.

The potentially unallowable claims we identified include an estimated $108,700 paid to 65 nursing homes for transportation services, including $1,507 to transport a program participant one mile and $250 to transport a program participant five miles. In addition, three nursing homes were paid an estimated $1,500 to reserve beds for longer than allowed under program rules. As shown in Figure 2, we also found that pharmacies were paid an estimated $97,400 for 2,620 claims for controlled substances that were missing authorization numbers issued by the Drug Enforcement Administration.

Figure 2

Estimated Payments for Unallowable Claims
FY 2005-06



Medicaid Fraud Control Unit

From FY 2002-03 through FY 2006-07, the Department of Justice (DOJ) prosecuted 36 Medical Assistance providers. During the same period, 34 providers were convicted of fraud and theft-related crimes. Courts ordered convicted providers to pay a total of $2.9 million in restitution, fines, and fees. In addition, 16 civil settlements were negotiated between the State and Medical Assistance providers, pharmaceutical manufacturers, and companies that provide medical equipment or services. The courts ordered the providers and companies to pay the State a total of $11.7 million, including $8.2 million in restitution for its share of the unallowable Medical Assistance payments they received.

Recommendations

Our report includes a recommendation for DHS to:

☑ determine whether any claims we identified were unallowable and recover payments related to those that are (*p. 41*).

We also include recommendations for DHS to report to the Joint Legislative Audit Committee by April 1, 2009, on:

☑ its efforts to improve the certification and monitoring of Medical Assistance providers by:

- ensuring that providers are recertified on a timely basis (*p. 21*);
- conducting criminal background checks as part of the provider certification process (*p. 24*);
- ensuring that providers whose professional licenses are restricted, suspended, or revoked are decertified on a timely basis (*p. 24*);
- promulgating rules, as required by statute, which would allow the suspension of providers pending a decertification hearing and require providers to obtain surety bonds as a condition of certification *(p. 24);*
- ensuring that all current providers who are delinquent in making court-ordered child or family support payments or fail to comply with subpoenas or warrants related to paternity or child support proceedings are decertified or denied certification (*p. 24*); and

☑ its efforts to enhance the prevention and recovery of unallowable payments, including:

- how it plans to use its authority to sanction providers that repeatedly commit the same violations (*p. 37*);
- the extent to which it plans to use extrapolation audits to identify and recover additional unallowable payments (*p. 37*);
- the date by which it will promulgate rules to charge interest to providers that fail to promptly or entirely reimburse the State for unallowable payments (*p. 37);* and
- how it intends to improve audits of claims for controlled substances in the future (*p. 41*).

■ ■ ■ ■

Introduction ■

Ensuring the integrity of Medical Assistance program payments is difficult because of the number of fee-for-service providers; the range of services delivered, such as inpatient surgery, psychological counseling, and transportation to medically necessary services; and because delivered services can vary considerably based on participants' medical conditions, which involve diagnoses about which medical professionals can disagree.

During our fieldwork we found no reliable estimates of unallowable or fraudulent payments to providers nationwide. However, there has been an increase in the number of high-profile cases of Medical Assistance fraud involving large health care providers and drug manufacturers. The Government Accountability Office placed Medical Assistance on its list of high-risk programs in 2003 because of what it viewed as limited federal oversight, as well as inadequate fiscal management and poor oversight by some states.

DHS's audit efforts are designed to ensure that providers meet all applicable program requirements, and its auditing efforts have generally been well-regarded by past federal reviews of its procedures. To further evaluate these efforts we:

- reviewed the staffing and expenditures associated with the DHS Bureau of Program Integrity, as well as the responsibilities of four contractors that assist DHS in its program integrity efforts;

- analyzed the timeliness and outcomes of provider certification decisions from FY 2002-03 through FY 2006-07;

- analyzed the number and types of audits completed by DHS from FY 2002-03 through FY 2006-07, as well as amounts it recovered; and

- reviewed the outcomes of criminal and civil cases of Medical Assistance fraud prosecuted by DOJ's Medicaid Fraud Control Unit.

In addition, we independently analyzed 9.4 million fee-for-service claims paid in FY 2005-06 for potentially unallowable payments. We also contacted Medical Assistance staff in four other midwestern states—Illinois, Iowa, Michigan, and Minnesota—to obtain information on their program integrity functions.

Medical Assistance Program Expenditures

As shown in Table 1, Medical Assistance program expenditures increased from $3.8 billion in FY 2002-03 to $4.9 billion in FY 2007-08.

Table 1

Medical Assistance Program Expenditures
(in millions)

	Expenditures	Percentage Change
FY 2002-03	$3,756.9	–
FY 2003-04	4,119.8	9.7%
FY 2004-05	4,196.4	1.9
FY 2005-06	4,227.0	0.7
FY 2006-07	4,477.7	5.9
FY 2007-08	4,945.3	10.4

As shown in Table 2, federal revenue accounted for $3.0 billion of total Medical Assistance expenditures in FY 2007-08. GPR accounted for $1.7 billion, and segregated revenue from the Medical Assistance Trust Fund accounted for the remainder.

Table 2

Medical Assistance Program Expenditures by Revenue Source
(in millions)

	FY 2007-08	Percentage of Total
Federal Revenue	$3,012.0	60.9%
GPR	1,721.2	34.8
Segregated Revenue	212.1	4.3
Total	**$4,945.3**	**100.0%**

Payments to fee-for-service providers were $2.6 billion of total Medical Assistance expenditures in FY 2007-08.

As shown in Table 3, payments to fee-for-service providers were $2.6 billion, or 52.1 percent of total Medical Assistance expenditures in FY 2007-08. In that year, payments to institutional providers totaled $1.4 billion, including $921.4 million to nursing homes and long-term care facilities and $435.7 million to inpatient and outpatient hospitals. Payments to non-institutional providers totaled $1.2 billion. There are 6 types of institutional providers and 50 types of non-institutional providers, such as physicians, pharmacies, chiropractors, and dentists.

Table 3

Medical Assistance Program Expenditures by Type
(in millions)

	FY 2007-08	Percentage of Total
Payments to Fee-for-Service Providers[1]		
Institutional Fee-for-Service Providers	$1,357.1	27.4%
Non-Institutional Fee-for-Service Providers	1,221.3	24.7
Subtotal	2,578.4	52.1
Other Expenditures[2]	2,350.4	47.6
Fee-for-Service Payments to HMOs[3]	16.5	0.3
Total	**$4,945.3**	**100.0%**

[1] Excludes payments for administrative costs that providers can receive under the Medical Assistance program.

[2] Includes capitated payments to HMOs, payments for certain programs operated under federal waivers, and administrative costs.

[3] Includes only those payments to HMOs above standard capitation rates, including neo-natal intensive care, HIV/AIDS-related services, and services for ventilator-assisted individuals.

Prescription drug costs totaled $471.6 million in FY 2007-08 and represented 38.6 percent of all payments to non-institutional fee-for-service providers. As with other health care costs, prescription drug costs under the fee-for-service program are expected to increase in the future because of the increasing costs of prescription drugs. In addition, there has been an increase in the number of individuals who obtain prescription drugs on a fee-for-service basis, including participants in the State's SeniorCare program, a prescription drug payment program for those who are 65 years of age or older, and those Medical Assistance participants who previously obtained prescription drugs from HMOs.

The number of certified providers delivering Medical Assistance services increased from FY 2002-03 through FY 2007-08.

The number of certified fee-for-service providers delivering Medical Assistance services increased from 31,009 in FY 2002-03 to 34,125 in FY 2007-08, or by 10.0 percent. As shown in Table 4, the number of physicians and the clinics they operate increased from 18,671 to 20,206. The number of providers of therapy services, such as physical therapists, psychotherapists, and respiratory therapists, increased from 3,745 to 4,679.

Table 4

Fee-for-Service Providers[1]

Provider Type	FY 2002-03	FY 2007-08	Percentage Change
Institutional Fee-for-Service Providers			
Inpatient and Outpatient Hospitals	722	823	14.0%
Nursing Homes and Long-Term Care Facilities	441	405	(8.2)
Non-Institutional Fee-for-Service Providers			
Physicians and Clinics	18,671	20,206	8.2
Therapy Services	3,745	4,679	24.9
Other[2]	2,521	2,923	15.9
Dental Services	1,401	1,250	(10.8)
Pharmacies	1,234	1,195	(3.2)
Nursing Services	1,018	1,107	8.7
Medical Equipment and Supplies	373	494	32.4
School Based Services	200	397	98.5
Personal Care and Home Health	215	218	1.4
Specialized Medical Vehicles	211	157	(25.6)
Case Management	125	116	(7.2)
Community Assistance	79	94	19.0
Hospice	57	62	8.8

[1] Providers who deliver more than one type of service are counted only once in these data.

[2] Includes ambulance providers, chiropractors, end-stage renal disease service providers, federally qualified health centers, HealthCheck providers, laboratory and x-ray services, opticians, optometrists, prenatal care services, and rural health clinic providers.

Program Integrity Expenditures and Staffing

The Bureau of Program Integrity is responsible for auditing fee-for-service provider payments.

Within DHS, the Bureau of Program Integrity is responsible for overseeing the certification of Medical Assistance providers and auditing fee-for-service provider payments. As shown in Table 5, expenditures for DHS's program integrity efforts increased from $2.9 million in FY 2002-03 to $3.2 million in FY 2006-07. Most of these expenditures were for staff salaries and benefits, which represented 88.0 percent of FY 2006-07 expenditures. Expenditures for data processing increased in FY 2006-07 because of purchases for services and computer equipment related to program integrity operations.

Table 5

Expenditures for Medical Assistance Program Integrity[1]

	FY 2002-03	FY 2006-07	Percentage Change
Staffing			
Salaries and Fringe Benefits	$2,482,100	$2,811,300	13.3%
Limited-Term Employee Salaries	0	32,200	–
Subtotal	2,482,100	2,843,500	14.6
Administration			
Maintenance and Utilities	136,500	153,700	12.6
Data Processing	71,900	108,000	50.2
Supplies and Services	64,900	73,200	12.8
Travel and Training	36,700	36,500	(0.5)
Indirect Cost Charges[2]	84,500	0	–
Other	11,600	14,700	26.7
Subtotal	406,100	386,100	(4.9)
Total	**$2,888,200**	**$3,229,600**	11.8

[1] Excludes payments to contractors.

[2] Includes salary costs that were later reimbursed by federal revenue. DHS changed the method for billing these indirect costs in FY 2004-05.

As part of the Bureau's fee-for-service audit functions, program audit staff review paid claims to determine whether services such as trips in specialized medical vehicles or prescription drugs have been delivered and are adequately documented, allowable, and appropriate.

Payments identified as unallowable are recovered from providers. In addition, the Bureau monitors whether providers are certified in a timely manner and decertified in accordance with federal and state law.

In FY 2006-07, the Bureau's medical audit staff included 8.0 full-time equivalent (FTE) registered nurses who compare paid claims information with medical records and determine whether services are medically necessary, adequately documented, allowable, and appropriate. 2007 Wisconsin Act 20, the 2007-09 Biennial Budget Act, provided $750,500 for 5.0 additional FTE medical audit positions. It reduced Medical Assistance funding by $2.4 million during the biennium because of an anticipated increase in audit recoveries resulting from the efforts of the additional staff.

DHS did not hire additional medical audit staff as directed by 2007 Wisconsin Act 20.

We note DHS chose not to hire additional medical audit staff as directed by 2007 Wisconsin Act 20, but instead used its authority to hire an additional 5.0 FTE staff in its Division of Health Care Access and Accountability to process applications for state health services programs, such as BadgerCare Plus and Family Care. Because the positions were budgeted in DHS's general operations for the administration of the Medical Assistance program, the agency used its discretion to create positions that were believed necessary to meet the expected influx of applicants. DHS could not document whether an additional $2.4 million was recovered to offset the reduction.

Another segment of the Bureau's staff—quality assurance and appropriateness reviewers—is primarily responsible for establishing prior authorization guidelines and reviewing and approving prior authorization requests. To help control program costs and safeguard against unnecessary or inappropriate care, DHS requires providers to obtain prior authorization before delivering certain services. Approximately 4.0 percent of all services covered under the Medical Assistance program require prior authorization. In addition, quality assurance and appropriateness review staff provide technical assistance to Wisconsin's federally mandated Drug Utilization Review Board, which consists of nine medical professionals who make recommendations to DHS about the prescription drugs paid for under the Medical Assistance program.

From June 2003 through June 2007, the Bureau's total program integrity staffing declined from 39.5 to 36.5 FTE positions.

As shown in Table 6, the Bureau's total program integrity staffing declined from 39.5 FTE positions in June 2003 to 36.5 FTE positions in June 2007. During the same period, program audit staffing declined from 16.0 FTE positions to 13.5 FTE positions, in part because the number of authorized positions was reduced by DHS to meet other program needs.

Table 6

Medical Assistance Program Integrity Staffing
(Filled FTE Positions)

Position Type	June 2003	June 2007
Program Audit	16.0	13.5
Quality Assurance and Appropriateness Review	10.5	12.0
Medical Audit	8.0	8.0
Managerial and Support	5.0	3.0
Total	**39.5**	**36.5**

Contractual Services

Four contractors have assisted DHS in its program integrity activities.

Four contractors have assisted DHS in its program integrity activities. EDS processes applications for provider certifications and recertifications, processes Medical Assistance provider claims for payment, and assists DHS in detecting potential fraud or unallowable payments by conducting data analyses at the direction of DHS audit staff. In FY 2006-07, EDS was paid $37.5 million to provide various Medical Assistance–related services. We were unable to determine the amount DHS paid EDS solely for program integrity activities because these costs are not tracked separately. However, DHS staff indicated it is likely that only a very small percentage of payments made to EDS were related to program integrity activities.

As required by federal law, DHS has also contracted for independent reviews of the quality of the medical records and health care services delivered by fee-for-service providers and HMOs. Since January 1982, MetaStar, Inc., a firm headquartered in Madison, has supplemented the Bureau of Program Integrity's medical audit efforts by determining whether the medical diagnosis and treatment codes used in a sample of paid claims are appropriate and based on information contained in medical records. In addition, MetaStar reviews inpatient hospital admissions and the paid claims for certain medical and surgical procedures, mental health services, substance abuse treatment programs, and certain outpatient treatment programs to determine whether services are medically necessary, adequately documented, and appropriate. In FY 2006-07, MetaStar was paid $1.1 million for its efforts.

In addition, DHS has contracted since March 2005 with the Public Consulting Group, a firm headquartered in Boston, for assistance in conducting credit balance audits of hospitals and nursing homes. Credit balances typically occur when payments to a provider for services exceed the amounts requested, such as when a provider receives a duplicate payment for the same service from DHS and a third-party payer. In FY 2006-07, DHS reported paying the Public Consulting Group $27,553 for its services. Under its contract with DHS, the Public Consulting Group is paid a contingency fee of 9.9 percent of the excess balances it identifies and recovers. The fee is paid from the State's share of the amounts recovered.

Finally, since April 2006, DHS has contracted with HWT, Inc., a firm headquartered in Portland, Maine, which audits certain claims paid to physicians, clinics, and laboratories. 2003 Wisconsin Act 33, the 2003-05 Biennial Budget Act, required DHS to contract with a vendor to help it identify and recover unallowable payments made to these providers. Under its contract with DHS, HWT was to have been paid a contingency fee of 11.5 percent of the amount DHS recovered from the unallowable payments HWT identified. Payments would come from the State's share of recoveries. DHS officials stated that HWT will be paid a fee of $47,800 for services it provided through June 2008.

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Certifying and Monitoring Providers ■

Providers are required by administrative rule to be certified before any claims are paid, except claims for emergency medical services. DHS's contract with EDS requires EDS to apply certification requirements in approving providers' requests for certification and recertification, as well as decertify providers when program rules are violated. To be effective, certification requirements must be adequate and applied in a timely and consistent manner.

Certification Requirements

Virtually all providers must be certified to participate in the Medical Assistance program.

Virtually all providers must be certified to participate in the Medical Assistance program, as required by Wisconsin's administrative rules. Only medical technicians and certain support staff, such as dental hygienists and laboratory technicians, are not required to be certified.

To be certified, providers must submit an application to EDS containing:

- a current and valid professional license, such as those obtained by physicians and dentists from their respective license examining boards, and credentials, such as those issued by state agencies or professional associations;

- the names and addresses of all medical businesses in which the provider has a controlling interest, as well as the individuals and providers with a controlling interest in the provider's business, including whether those persons are a spouse, parent, child, sibling, or other immediate family member;

- a statement affirming that neither the provider nor any parties with whom a controlling interest relationship exists have been convicted of certain crimes related to or have been excluded from participation in federally or state-funded medical programs; and

- a disclosure of any past criminal convictions or sanctions related to the Medical Assistance program, such as Medical Assistance fraud, in Wisconsin or in other states.

EDS then processes the application by ensuring that the provider has supplied all required information and, if approved, certifies the provider to receive payment for delivered services. Additional certification requirements vary by provider type. For example, DHS visits the offices of specialized medical vehicle providers that apply for certification to ensure the availability of equipment necessary to deliver adequate services, such as properly running vans and buses. No other provider types are visited by DHS staff before certification.

All providers approved by EDS to receive payment for services delivered under the Medical Assistance program are certified for up to one year, and certification can be extended if both DHS and the provider agree to do so, as allowed under s. HFS 105.02(8), Wis. Adm. Code. DHS policies do not require institutional providers to be recertified. However, DHS ensures that these providers continue to retain valid credentials for the operation of their facilities and decertifies those with credentials that have been revoked. DHS policies require that non-institutional providers be recertified every three years, except for specialized medical vehicle providers, which are recertified annually. To be recertified, non-institutional providers must resubmit certification applications to EDS. DHS has authorized EDS to decertify providers that do not resubmit certification applications when they are required to do so.

DHS has the authority to suspend or decertify providers from program participation.

DHS has the authority to suspend or decertify providers from participating in the Medical Assistance program. For example, after providing due notice and hearing and determining that suspension or decertification would not result in participants being unable to obtain services, DHS may direct EDS to decertify providers for:

- failing to follow Medical Assistance program rules;
- failing to maintain active professional licenses and credentials;
- delivering inappropriate, unnecessary, or substandard care;
- failing to retain appropriate medical records related to the scope of need for services delivered; and
- submitting unallowable claims or refusing to repay unallowable claims identified by DHS.

In FY 2006-07, 16 providers in Wisconsin were permanently excluded from the Medical Assistance program.

In addition, providers may be decertified if they appear on a national list maintained by the federal Department of Health and Human Services, which contains information on providers that have been excluded from participating in federally or state-funded medical programs. Providers may be excluded for several reasons, such as felony or misdemeanor health care fraud convictions, failure to meet professionally recognized standards, or defaulting on student loans. In FY 2006-07, 16 providers in Wisconsin were permanently excluded for violations such as felony fraud convictions. Providers with expired licenses or credentials may also be decertified.

Adequacy of Certification Efforts

Since FY 2002-03, 99.0 percent of all provider certification applications have been approved.

As shown in Table 7, 99.0 percent of all provider certification applications were approved during our review period. Most denials were for out-of-state providers. To be eligible for certification, an out-of-state provider must demonstrate that it is necessary for Wisconsin Medical Assistance participants to obtain non-emergency medical services in the provider's locality, although out-of-state providers can be reimbursed for providing emergency services without having first been certified.

Table 7

Disposition of Certification Applications
FY 2002-03 through FY 2006-07

	Applications[1]	Percentage of Total
Certification Approved	22,421	99.0%
Certification Denied		
Out-of-State Provider	167	0.7
Provider Not Licensed to Practice	29	0.1
Other[2]	54	0.2
Subtotal	250	1.0
Total	**22,671**	**100.0%**

[1] Includes both initial and recertification applications.

[2] Includes various reasons for denial, such as not having the necessary credentials.

Administrative rules require DHS to approve or deny certification applications within 60 days. However, under its contract with DHS, EDS is required to approve or deny all certification applications within ten business days. As shown in Table 8, EDS approved or denied 97.0 percent of applications within ten business days. Of the 477 applications that took longer than ten business days to approve or deny, 463 were approved and 14 were denied. EDS's application tracking database contained insufficient information to calculate the time taken to approve 7,252 applications. As a result, our analysis was limited because we could not calculate the timeliness of all applications received during our review period.

Twenty-seven types of non-institutional providers were not recertified every three years, the period specified by DHS policy.

Efforts to recertify providers have not been consistently successful. For our review period, DHS correctly required EDS to annually recertify specialized medical vehicle providers. However, we found that since at least 2002, EDS did not recertify 27 types of non-institutional providers every three years, the period specified by DHS policy. As a result, providers such as physicians, dentists, chiropractors, and home health aides were not recertified on a timely basis, in part because of delays DHS has encountered in implementing the new Medicaid Management Information System. DHS initially projected that the system would be completed in May 2007, but it was not completed until November 2008 at a cost of approximately $44.0 million. DHS officials anticipate that they will begin recertifying all non-institutional providers, except for specialized medical vehicle providers, at least once every three years starting in 2010. Specialized medical vehicle providers will continue to be recertified annually.

Table 8

Business Days Taken to Approve or Deny Certification[1]
FY 2002-03 through FY 2006-07

Business Days	Applications	Percentage of Total
1 to 10	14,942	97.0%
11 to 20	254	1.6
21 to 30	116	0.8
31 to 40	31	0.2
41 to 50	16	0.1
51 to 60	7	<0.1
More than 60	53	0.3
Total	**15,419**	**100.0%**

[1] Does not include 7,252 applications for which the date of approval was not known.

Outdated information increases the risk that individuals who are not eligible to bill for services can obtain payment fraudulently.

Delays in recertification can increase the risk that unallowable payments will be made because providers no longer meet certification requirements. For example, requiring that providers be regularly recertified is recommended by the federal Department of Health and Human Services' Office of Inspector General and by the Government Accountability Office. Regular and timely recertification of providers also helps ensure that DHS's provider information is current and accurate and can help to prevent inappropriate activity. Outdated information increases the risk that individuals who are not eligible to bill for services can obtain payment fraudulently. For example, a clinic employee could continue receiving unallowable payments for services that were never provided by using the provider information of a recently deceased physician.

☑ Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by April 1, 2009, on the steps it has taken to ensure that all non-institutional providers are recertified on a timely basis, according to its written policies.

Enhancing Program Integrity

We identified five strategies that DHS could use to further enhance program integrity through its certification process.

We identified five strategies that DHS could use to further enhance its efforts to prevent the certification of providers that do not meet Medical Assistance program rules and to decertify providers that violate those rules. Three of the five strategies reduce the risk of making unallowable payments.

First, DHS could better ensure that it promptly notifies EDS to decertify those providers holding professional licenses that are restricted, suspended, or revoked because of disciplinary action or violations of Medical Assistance program rules. Providers with restricted licenses may typically continue to deliver certain services under greater supervision, to ensure that they are conducting their jobs appropriately. Providers with suspended licenses are prohibited from delivering services for a specified period of time or until they meet the requirements set by the Department of Regulation and Licensing (DRL), such as attending alcohol or drug counseling, taking additional academic courses in their field, or paying a fine. Providers with revoked licenses are ineligible to deliver services.

Seven of the 110 providers were not decertified on a timely basis.

We reviewed 110 certified providers whose professional licenses had been restricted, suspended, or revoked by DRL in FY 2006-07. DHS generally ensured that EDS decertified these providers on a timely basis. However, 7 of the 110 providers were not decertified on a timely basis, including:

- a registered nurse whose license was restricted beginning in November 2006, due in part to a conviction of felony Medical Assistance fraud under s. 49.49(1)(a)1, Wis. Stats., but who was not decertified until January 2008;

- a dentist whose license was suspended from January 2007 through May 2007 for using controlled substances while continuing to deliver services to patients and diverting prescriptions made in the names of clinic staff and family members to himself, but who was never decertified during the time his license was suspended;

- a chiropractor whose license was suspended in September 2006 for a conviction of pointing a firearm at a person and disorderly conduct, but who was not decertified until March 2007; and

- a psychologist whose license was suspended in October 2006 for violating restrictions placed on it because of multiple alcohol-related offenses and other unprofessional conduct, but who was not decertified until February 2007.

Although none of the seven providers obtained unallowable payments while their licenses were restricted, suspended, or revoked, the potential for them to have done so represents an internal weakness in existing payment controls.

A second strategy would be for DHS to require additional background checks. Statutes require background checks for certain providers, such as registered nurses and employees of home health agencies. However, DHS does not require EDS to conduct additional criminal or other background checks, and EDS relies solely on self-disclosure of past criminal convictions. Performing criminal background checks could help ensure that providers with criminal histories are prevented from being certified or that providers already certified can be decertified, if appropriate. Three midwestern states require background checks for specific provider types. Illinois conducts background checks of specialized medical vehicle providers, while Iowa and Minnesota conduct background checks of personal care providers.

A third strategy would be for DHS to promulgate administrative rules that would allow it, before the decertification process is complete, to suspend providers whose participation in the Medical Assistance program would lead to an "irretrievable loss of public funds." The promulgation of such rules has been required since August 2001 by s. 49.45(2)(a)12, Wis. Stats., which would, for example, prevent providers from receiving payments while a decertification decision was being appealed. However, DHS has chosen not to promulgate the required rules because it does not believe that suspending providers is effective. Instead, it prefers to withhold payment, which it may do only if it has reliable evidence of fraud committed by a provider, as allowed under s. HFS 108.02(9)(d), Wis. Adm. Code. In FY 2007-08, DHS issued orders to withhold payments to four providers. However, the rule under which that action was taken applies only when there is reliable evidence of fraud. Without additional administrative rules, DHS may not be able to take action against providers that should be suspended pending a decertification hearing for reasons other than fraud.

A fourth strategy for DHS would be to require that certain providers obtain surety bonds as a condition of certification. Surety bonds could provide additional protection against financial losses to the Medical Assistance program by ensuring that DHS can recover payments that are later identified as unallowable. Section 49.45(2)(b)7, Wis. Stats., requires DHS to promulgate

administrative rules concerning surety bonds, but DHS has neither done so nor required any provider to obtain a surety bond as a condition of certification because it believes that doing so will be unpopular among providers and the groups that represent them and could potentially limit its own ability to conduct audits and obtain recoveries. However, we note several larger states require surety bonds, such as California, Florida, Illinois, and Washington.

Finally, DHS is required by s. 49.48(3), Wis. Stats., to decertify or deny certification if a provider is delinquent in making court-ordered child or family support payments or fails to comply with subpoenas or warrants related to child or paternity support proceedings. DHS provided the Department of Workforce Development (DWD) with information on certified providers in July 1999, which was to be compared to the information on individuals who were delinquent in making payments or failing to comply with warrants and subpoenas maintained by DWD. DHS officials stated that they have not received any information from DWD that any of the providers were delinquent in payments or failed to comply with subpoenas or warrants. The available data did not allow us to determine the number of providers that would be affected if this requirement were enforced.

☑ Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by April 1, 2009, on its progress in conducting criminal background checks of providers as part of its certification process, and on the steps it has taken to:

- *ensure that providers whose professional licenses are restricted, suspended, or revoked are decertified on a timely basis;*

- *promulgate rules, as required by statute, which would allow it to suspend providers from participating in the Medical Assistance program pending a decertification hearing and require providers to obtain surety bonds as a condition of certification; and*

- *ensure that all current providers who are delinquent in making court-ordered child or family support payments or fail to comply with subpoenas or warrants related to paternity or child support proceedings are decertified or are denied certification if they are seeking it.*

■ ■ ■ ■

Preventing and Recovering Unallowable Payments ■

Preventing unallowable claims from being paid to fee-for-service providers is an important component of DHS's program integrity efforts. An electronic claims processing system administered by EDS has been designed, in part, to prevent unallowable claims payments, including duplicate claims and claims not covered by Medical Assistance. DHS also audits claims submitted by providers and recovers unallowable payments that should not have been paid under program rules. DHS appropriately addresses many concerns with unallowable payments to providers, and its efforts have been commended by federal reviewers. However, DHS does not sanction providers that fail to make required repayments or that repeatedly violate program rules. In addition, we have identified strategies for identifying additional unallowable claims payments that DHS could pursue in the future.

Preventing Unallowable Provider Payments

An electronic claims processing system prevents paying claims that are likely unallowable.

DHS uses two principal strategies to prevent unallowable payments. First, it uses an electronic claims processing system maintained by its claims processing contractor, EDS. The system is designed to prevent paying claims that are likely unallowable by ensuring that:

- the service recipient is enrolled in the Medical Assistance program;
- the provider is certified to deliver services;

- the claim is complete, is for a service covered under the program, and is not a duplicate claim for the same service; and

- the recipient remains eligible to receive certain services.

DHS staff and contractors routinely conduct audits of paid claims.

Second, DHS staff and contractors also audit paid claims to ensure that services have actually been delivered and are allowable, medically necessary, and adequately documented. In determining which providers' claims to audit, DHS electronically analyzes claims data to identify certain types of providers or certain claims, such as payments associated with trips in specialized medical vehicles or to address emerging concerns, such as incomplete deliveries of durable medical equipment. DHS also regularly analyzes whether certain providers were paid for delivering more than 24 hours of care within a day or for providing more of a service than was allowed under Medical Assistance program rules. DHS annually performs tests to determine whether the dates of service for which providers bill occurred after participants died, but it does not use the electronic claims processing system to analyze whether information for providers that have died is being used to obtain unallowable payments.

DHS audits some providers because their payments increased significantly over time, which may indicate inappropriate activity. Others are audited because DHS has received complaints from program participants through a toll-free number it maintains—1-800-642-6552—or through either its online complaint intake system, EDS, or other state agencies, including DOJ and DRL. DHS also uses information from fraud alerts issued by the federal Department of Health and Human Services' Office of Inspector General, other federal agencies, program integrity and fraud prevention professional groups, EDS, and DOJ's Medicaid Fraud Control Unit to develop new analyses to detect unallowable claims. Finally, some claims are audited at random so that every paid claim has the potential to be reviewed by auditors. DHS is not required by statutes or administrative rules to audit certain providers, and it does not typically conduct audits unless the projected amount to be recovered is estimated to be more than $50.

As shown in Table 9, DHS audited 3,050 individual providers from FY 2002-03 through FY 2006-07. Pharmacies accounted for 35.0 percent of all providers audited. Physicians, clinics, and services provided by licensed practical nurses, registered nurses, and other nurses represented an additional 28.6 percent.

Table 9

Medical Assistance Providers Audited by DHS
FY 2002-03 through FY 2006-07

Provider Type	Providers	Percentage of Total
Institutional Fee-for-Service Providers		
Inpatient and Outpatient Hospitals	173	5.7%
Nursing Home and Long-Term Care Facilities	75	2.5
Subtotal	248	8.2
Non-Institutional Fee-for-Service Providers		
Pharmacies	1,071	35.0
Physicians and Clinics	514	16.9
Nursing Services	358	11.7
Specialized Medical Vehicles	263	8.6
Personal Care and Home Health	168	5.5
Medical Equipment and Supplies	97	3.2
Therapy Services	81	2.7
Other[1]	58	1.9
End-Stage Renal Disease	38	1.2
Laboratory and X-Ray	32	1.0
Chiropractors	29	1.0
Case Management	15	0.5
Community Assistance	12	0.4
Hospice	11	0.4
Dental Services	6	0.2
Subtotal	2,753	90.2
HMOs[2]	33	1.1
Unknown	16	0.5
Total	**3,050**	**100.0%**

[1] Includes ambulance providers, HealthCheck providers, opticians, optometrists, prenatal care providers, and only those federally qualified health centers and rural health clinics for which an audit resulted in a finding of unallowable payments.

[2] Includes HMOs that received extra payment for providing neo-natal intensive care services, HIV/AIDS-related services, and services for ventilator-assisted individuals under a fee-for-service arrangement.

DHS considers specialized medical vehicle providers to be "high risk" because of widespread problems in the industry and the large number of payments in Wisconsin that are later determined to be

unallowable, such as payments for trips that were never provided or for mileage above allowable distance limits for a trip. Since FY 2000-01, new specialized medical vehicle providers have been required to submit claims using paper forms, rather than electronically. Paper forms are processed more slowly, which allows DHS time to identify initial unallowable claims before other claims are processed and paid. Providers are allowed to submit claims electronically after DHS has both audited claims for 60 trips and determined that program rules are being followed.

Claims from providers that deliver services with limited supervision inside participants' homes, such as home health aides, private-duty nurses, and personal care providers, have also come under increased scrutiny because of the increased potential for fraud, particularly as the use of these services increases. The 2007-09 Biennial Budget Act authorized DHS to create an automated monitoring system that would require home health providers to report their arrivals and departures by telephone and would be used to match paid claim information with actual dates and hours of service provided. However, this project was not initiated because DHS lapsed FY 2007-08 funding for it to the General Fund as part of the agency's required lapse under 2007 Wisconsin Act 20. DHS has not yet determined whether it will make funding available for the system in FY 2008-09.

From FY 2002-03 through FY 2006-07, DHS conducted 8,517 audits, of which 87.0 percent were desk audits.

From FY 2002-03 through FY 2006-07, DHS conducted 8,517 audits of the 3,050 providers shown in Table 9. Of these, 7,409, or 87.0 percent, were "desk audits," which are relatively short in duration and are generally limited to a single issue, such as determining whether durable medical equipment providers received proper prior authorization to deliver equipment or whether providers submitted and were paid for multiple claims for the same service. An additional 686 audits were conducted at providers' places of business. DHS's audit tracking system did not contain information about whether the remaining 422 audits were desk audits or took place at providers' places of business.

As shown in Table 10, more than one-half of the audits conducted by DHS were of pharmacies, in part because unallowable claims such as early refills, dispensing more of a drug than allowed, and pricing irregularities can be easily identified electronically. In contrast, DHS conducted only 90 audits of nursing homes and long-term care facilities, although these providers typically receive approximately $1.0 billion per year, or nearly 40 percent of all fee-for-service expenditures. In addition, DHS conducted only eight audits of dental providers because of concerns that audits could discourage participation in the Medical Assistance program, which has a limited number of dental providers. We noted concerns about the declining number of dentists in our April 2008 report on dental services for Medical Assistance participants.

Table 10

DHS Audits by Provider Type
FY 2002-03 through FY 2006-07

Provider Type	Audits	Percentage of Total
Institutional Fee-for-Service Providers		
Inpatient and Outpatient Hospitals	833	9.8%
Nursing Home and Long-Term Care Facilities	90	1.1
Subtotal	923	10.9
Non-Institutional Fee-for-Service Providers		
Pharmacies	4,508	52.8
Physicians and Clinics	944	11.1
Specialized Medical Vehicles	545	6.4
Nursing Services	441	5.2
Personal Care and Home Health	347	4.1
Medical Equipment and Supplies	175	2.1
Therapy Services	129	1.5
Other[1]	120	1.4
Laboratory and X-Ray	63	0.7
End-Stage Renal Disease	59	0.7
Chiropractors	32	0.4
Case Management	26	0.3
Community Assistance	16	0.2
Hospice	15	0.2
Dental Services	8	0.1
Subtotal	7,428	87.2
HMOs[2]	145	1.7
Unknown	21	0.2
Total	**8,517**	**100.0%**

[1] Includes ambulance providers, HealthCheck providers, opticians, optometrists, prenatal care providers, and only those federally qualified health centers and rural health clinics for which an audit resulted in a finding of unallowable payments.

[2] Includes HMOs that received extra payment for providing neo-natal intensive care services, HIV/AIDS-related services, and services for ventilator-assisted individuals under a fee-for-service arrangement.

From FY 2002-03 through FY 2006-07, 1,663 providers were audited multiple times.

From FY 2002-03 through FY 2006-07, 1,663 providers were audited multiple times, including:

- 1,167 that were each audited two to four times;
- 356 that were each audited five to nine times; and
- 140 that were each audited ten or more times.

DHS typically notifies providers of audits in advance and requests them to send specific medical records and other documents if it is conducting a desk audit, or to make records available at a certain date and time for onsite audits. For some audits conducted using only electronic paid claims data, DHS does not contact providers until its auditors have prepared a preliminary report of audit findings for discussion. In these cases, auditors review relevant paid claims data to determine whether the provider has complied with Medical Assistance program rules. If DHS finds that a provider has violated Medical Assistance program rules, it sends the provider a preliminary report identifying its audit findings and the associated amount it intends to recover.

DHS allows providers 30 days to submit additional documentation to rebut audit findings, and it can amend findings based on this information. After DHS reviews all additional documentation and determines whether it will make any additional changes to its findings, it issues notice to the provider specifying the final dollar amount it is seeking to recover.

As shown in Table 11, 2,660 of 6,888 audit findings involved providers receiving payments for delivering more of a service than is allowed or for delivering a service different from what was claimed. An additional 1,408 audit findings involved services that were not covered under the Medical Assistance program.

Table 11

Findings in DHS's Audits
FY 2002-03 through FY 2006-07

Finding	Findings[1]	Percentage of Total
Incorrect Procedure Code or Incorrect Quantity of Service	2,660	38.6%
Services Not Covered by Medical Assistance	1,408	20.4
Insufficient Documentation	961	14.0
Invalid Specialized Medical Vehicle Trip	740	10.7
Duplicate Payment	731	10.6
Claim Not Submitted to Medicare or Third-Party Insurer as Required[2]	142	2.1
No Medical Order for Service	94	1.4
Provider Lacked or Exceeded Prior Authorization	78	1.1
No Certificate of Need for Psychiatric or for Certain Substance Abuse Services	58	0.8
Provider Did Not Perform Service	12	0.2
Finding Unknown	4	0.1
Total	**6,888**	**100.0%**

[1] Does not include findings from audits that were in progress as of June 30, 2007.

[2] Providers must submit certain claims to Medicare or a participant's third-party insurers for payment before submitting claims to the Medical Assistance program.

Seventy-four providers had repeat audit findings during our review period.

As shown in Table 12, 74 providers had repeat audit findings during our review period.

Table 12

Providers with Repeat Findings in at Least Five Audits
FY 2002-03 through FY 2006-07

Provider Type	Providers[1]
Pharmacies	36
Physicians and Clinics	14
Inpatient and Outpatient Hospitals	11
HMOs	9
Medical Equipment and Supplies	3
Specialized Medical Vehicles	1
Total	**74**

[1] Does not include findings from audits that were in progress as of June 30, 2007.

We could not readily identify any sanctions imposed from FY 2002-03 through FY 2006-07.

DHS is authorized to sanction or decertify providers with repeat audit findings for violations of the same program rules or procedures for submitting claims, but it has chosen not to do so. Section 49.45(2)(b)9, Wis. Stats., authorizes DHS to charge an assessment of up to $1,000 or 200 percent of the cost of unallowable payments to providers that have had multiple recoveries due to repeated failure to follow similar program rules or procedures for submitting claims. Statutes require that the assessment be used to defray audit costs. Administrative rules also allow DHS to decertify or suspend providers that knowingly engage in conduct that results in repeated recoveries of unallowable payments. However, we could not readily identify any sanctions imposed under s. 49.45(2)(b)9, Wis. Stats., from FY 2002-03 through FY 2006-07.

As shown in Table 13, financial recoveries from DHS audits conducted from FY 2002-03 through FY 2006-07 were projected to total $44.2 million. Not all amounts are actually recovered because claims may be supported with additional information or providers may successfully appeal to pay lesser amounts or to not make payments.

Table 13

Projected Financial Recoveries from DHS Audits
FY 2002-03 through FY 2006-07

Provider Type	Audits	Projected Recovery	Percentage of Total Projected Recoveries
Institutional Fee-for-Service Providers			
Inpatient and Outpatient Hospitals	780	$12,600,800	28.5%
Nursing Home and Long-Term Care Facilities	71	303,600	0.7
Subtotal	851	12,904,400	29.2
Non-Institutional Fee-for-Service Providers			
Pharmacies	3,007	13,036,200	29.6
End-Stage Renal Disease	49	4,123,000	9.3
Physicians and Clinics	849	3,804,300	8.6
Specialized Medical Vehicles	485	2,547,200	5.8
Medical Equipment and Supplies	137	1,204,300	2.7
Personal Care and Home Health	168	880,700	2.0
Nursing Services	156	370,800	0.8
Other[1]	86	242,500	0.5
Laboratory and X-Ray	47	188,600	0.4
Therapy Services	102	167,200	0.4
Chiropractors	28	130,500	0.3
Case Management	24	126,300	0.3
Dental Services	2	28,400	0.1
Hospice	12	16,100	< 0.1
Community Assistance	13	1,700	< 0.1
Subtotal	5,165	26,867,800	60.8
HMOs[2]	122	4,366,700	9.9
Unknown	16	33,000	0.1
Total	**6,154**	**$44,171,900**	**100.0%**

[1] Includes federally qualified health centers, HealthCheck providers, opticians, optometrists, prenatal care providers, and rural health clinics.

[2] Includes HMOs that received extra payment for providing neo-natal intensive care services, HIV/AIDS-related services, and services for ventilator-assisted individuals under a fee-for-service arrangement.

DHS's audit recoveries totaled $31.8 million from FY 2002-03 through FY 2006-07.

As shown in Table 14, DHS's audit recoveries from FY 2002-03 through FY 2006-07 totaled $31.8 million, which includes some amounts identified before FY 2002-03. Recoveries increased significantly in FY 2003-04 because DHS recovered $5.2 million from institutional providers based on audits conducted by its contractor, MetaStar. They remained high in FY 2004-05 largely because one institutional provider self-identified and returned a total of $2.0 million it had mistakenly claimed for anesthesia services.

Table 14

Audit Recoveries[1]
FY 2002-03 through FY 2006-07

Fiscal Year	Amount	Percentage Change
2002-03	$ 4,573,500	–
2003-04	8,452,200	84.8%
2004-05	7,494,200	(11.3)
2005-06	5,982,400	(20.2)
2006-07	5,248,900	(12.3)
Total	**$31,751,200**	

[1] Includes $2.2 million in unallowable payments that providers self-identified and reported to DHS.

We contacted other state program integrity offices to determine the amounts they were able to recover in FY 2006-07 and found that two had reported recovering substantially less. Illinois recovered $19.8 million during that fiscal year, while Minnesota recovered $3.6 million and Iowa recovered $1.1 million.

DHS recovers unallowable payments by requiring either remittance in full, installment payments under a settlement agreed to by DHS and the provider, or retention of a portion of future claims payments. Because the Medical Assistance program is funded with a combination of state and federal funds, Wisconsin must return to the federal government a share of all recoveries that is equal to the percentage of program expenditures paid by the federal government. From FY 2002-03 through FY 2006-07, approximately 57.0 percent of all recoveries, or $18.1 million, was paid to the federal government, while the State retained the remaining $13.7 million to offset its Medical Assistance costs.

As shown in Table 15, DHS recovered $10.5 million from hospitals and an additional $9.0 million from pharmacies from FY 2002-03 through FY 2006-07.

Table 15

Audit Recoveries by Provider Type[1]
FY 2002-03 through FY 2006-07

Provider Type	Amount Recovered	Percentage of Total
Institutional Fee-for-Service Providers		
Inpatient and Outpatient Hospitals	$10,503,100	33.1%
Nursing Home and Long-Term Care Facilities	41,000	0.1
Subtotal	10,544,100	33.2
Non-Institutional Fee-for-Service Providers		
Pharmacies	9,030,300	28.5
Physicians and Clinics	3,888,400	12.2
Personal Care and Home Health	1,699,000	5.4
Specialized Medical Vehicles	1,514,400	4.8
Therapy Services	802,000	2.5
End-Stage Renal Disease	767,700	2.4
Medical Equipment and Supplies	766,900	2.4
Nursing Services	239,000	0.8
Laboratory and X-Ray	203,500	0.6
Chiropractors	197,100	0.6
Case Management	145,900	0.5
Other[2]	131,100	0.4
Dental Services	43,500	0.1
Hospice	9,000	<0.1
Community Assistance	1,700	<0.1
Subtotal	19,439,500	61.2
HMOs[3]	1,743,500	5.5
Unknown	24,100	0.1
Total	**$31,751,200**	**100.0%**

[1] Includes $2.2 million in unallowable payments that providers self-identified and reported to DHS.

[2] Includes federally qualified health centers, HealthCheck providers, opticians, optometrists, prenatal care providers, and rural health clinics.

[3] Includes HMOs that received extra payment for providing neo-natal intensive care services, HIV/AIDS-related services, and services for ventilator-assisted individuals under a fee-for-service arrangement.

DHS does not typically use all of its authority to recover additional payments for unallowable provider claims.

While DHS has been successful in identifying and recovering unallowable payments, we found that it does not typically use all of its authority to recover unallowable payments. For example, under s. HFS 105.01(3)(f), Wis. Adm. Code, DHS can conduct extrapolation audits, which analyze a sample of paid claims, determine how many are unallowable and the amount to be recovered, and project the amount that would have been recoverable if DHS had analyzed all claims. Administrative code requires DHS to define the statistical methods used to conduct these analyses. Extrapolation audits are used by the federal Department of Health and Human Services' Office of Inspector General when it audits states' Medical Assistance programs. In addition, three of the states we interviewed—Illinois, Iowa, and Minnesota—have the authority to use this methodology, and Illinois regularly does so.

While extrapolation auditing may not be appropriate in all circumstances, this approach can significantly increase recoverable amounts when it is practical to audit only a sample of claims because of their high volume, such as claims made by hospitals and physicians. To date, DHS has used extrapolation audits in rare cases when there is strong evidence that a provider has been paid for fraudulent claims. DHS prefers to change provider behavior and provide training on Medical Assistance program rules, which it believes may prevent unallowable claims in the future, rather than to recover the maximum unallowable amounts providers have been paid.

In addition, DHS does not charge interest to providers that fail to make all required installment payments in the time allowed under their settlements. Since August 2001, s. 49.45(2)(a)10, Wis. Stats., has required the promulgation of administrative rules that would authorize DHS to charge 1.0 percent per month or fraction of a month, or 12.0 percent per year, on any amount left unpaid by the payment deadline. DHS has not promulgated these required rules because it believes that doing so will be unpopular among providers and the groups that represent them, which it believes may limit its ability to conduct audits and obtain recoveries. We cannot determine the number of providers that have not made all required installment payments because EDS neither records the date on which all recoverable amounts must be paid nor tracks provider payments in a way that would allow us to determine payment deadlines. All that is recorded are the dates on which payments were made and the amounts of any existing unpaid balances.

Although DHS must balance its efforts to ensure that providers adhere to Medical Assistance program rules, to provide sufficient flexibility so that providers continue to participate in the program, and to comply with gubernatorial and legislative intent, we believe it

could make better use of both its sanctioning authority, particularly when providers repeatedly fail to comply with program rules, and of audit methods that can increase recoveries of unallowable payments.

☑ Recommendation

We recommend the Department of Health Services report to the Joint Legislative Audit Committee by April 1, 2009, on:

- *its efforts to sanction providers that repeatedly commit the same violations;*
- *its plans for using extrapolation audits to identify and recover additional unallowable payments; and*
- *the date by which it will promulgate rules to charge interest to providers that fail to promptly and entirely reimburse the State for unallowable payments.*

Improving Claims Auditing

We independently analyzed 9.4 million claims from nursing homes, pharmacies, chiropractors, and dental services providers.

We independently analyzed 9.4 million claims that were submitted by nursing homes, pharmacies, chiropractors, and dental services providers and paid in FY 2005-06. These provider types were selected following discussions with DHS audit staff and our review of the types of providers audited by DHS. The provider types we chose either were not frequently audited by DHS or were paid large amounts under the Medical Assistance program. This time period chosen for our analysis allowed sufficient time for providers to submit claims and for DHS to pay the claims and conduct its own audits.

In assessing the appropriateness of the claims, we reviewed allowable services under Medical Assistance program rules contained in administrative code and Medical Assistance provider handbooks, and we spoke with DHS staff to determine whether we had correctly interpreted program rules. We questioned payments for claims that appeared to be in violation of program rules or that were higher than would generally be considered reasonable.

We identified an estimated $268,000 in payments for claims that appear to be unallowable.

As shown in Table 16, we identified an estimated $268,000 in payments for claims that appear to be unallowable. That amount is 4.5 percent of DHS's total recoveries in FY 2005-06. DHS had not previously identified these payments because it did not conduct the

same analyses we performed, or it performed the analyses differently. It should be noted that in some cases our estimates may be overstated because additional information that supports claims is not contained in the electronic claims data. In other cases, our estimates may be understated because we examined only one fiscal year, and additional unallowable claims might be identified over a longer time period. While it is unlikely that the EDS electronic claims processing system could have prevented most of these payments from being made, DHS auditors could, in the future, use electronic claims data to easily identify these types of unallowable payments.

Table 16

Estimated Payments for Potentially Unallowable Claims
FY 2005-06

Provider Type	Potentially Unallowable Amounts
Nursing Homes	$110,200
Pharmacies	97,400
Chiropractors	57,600
Dental Services	2,800
Total	**$268,000**

Nursing Homes

In our independent review, we identified two types of paid claims from nursing home providers that appear unallowable. First, the Medical Assistance program allows nursing homes to provide transportation for medically necessary purposes and to receive payment for the actual cost of transportation, including costs associated with buses or taxis used for transporting residents. However, DHS has not established a standard payment amount for transportation services provided by nursing homes, which prevents it from analyzing these payments in a meaningful way.

Sixty-five nursing homes were paid an estimated $108,700 for what appear to be unallowable transportation costs.

In assessing the amounts paid to nursing home providers for transportation services, we used the Medical Assistance standard established in October 2003 for the maximum amounts payable to specialized medical vehicle transportation providers, which is $11.87 for the first five miles of a trip and $1.25 for each additional mile. When we applied this standard, we found that 65 nursing homes

were paid an estimated $108,700 for transportation costs that appear unallowable, including an estimated $1,700 for which the electronic paid claims data did not show any corresponding medical service or hospital visit. Some of the payments were clearly excessive. For example:

- one provider was paid $1,507 for transporting a program participant one mile;
- one provider was paid $250 for transporting a program participant five miles; and
- one provider was paid $186 for transporting a program participant ten miles.

Second, we found that three nursing homes were paid an estimated $1,500 to reserve three nursing home beds longer than the 15 days allowed under Medical Assistance program rules. Nursing homes may reserve beds if, for example, program participants require short-term care or hospitalization in another facility. Payments on these claims were initially denied by the EDS electronic claims processing system. However, the denials were overridden by EDS staff. Information on the circumstances that led to EDS allowing the claims to be paid was unavailable, but federal and state program rules do not specify exceptions for this particular rule.

Pharmacists

To prevent the illegal dispensing of drugs and other controlled substances, prescribing providers such as physicians and dentists must first obtain an authorization number issued by the federal Drug Enforcement Administration. Before May 2008, Medical Assistance program rules required pharmacists to obtain a prescribing provider's authorization number and include it with all claims for payment related to controlled substances.

In FY 2005-06, pharmacists were paid an estimated $97,400 for controlled substance claims that included invalid authorization numbers.

We found that pharmacists were paid an estimated $97,400 for 2,620 claims for controlled substances that included invalid authorization numbers. Most were alternate authorization numbers that are not issued by the Drug Enforcement Administration but may be used when pharmacists submit claims for non-controlled substances. While EDS's electronic claims processing system conducts a test to ensure that only claims with valid authorization numbers are paid, the system cannot distinguish between valid authorization numbers and alternate numbers. DHS did not conduct audits of this particular issue and, therefore, was unaware of the problem until we raised it.

Since May 2008, DHS has been prohibited by s. 146.87, Wis. Stats., from requiring pharmacists to submit authorization numbers with claims for controlled substances. The prohibition was enacted as part of 2003 Wisconsin Act 272, in order to comply with federal law related to the creation and use of a single national unique identifier for all health care providers. Prescribing providers continue to include authorization numbers on prescription orders for controlled substances. However, pharmacists may retain that information electronically or in paper files. Because DHS no longer obtains this information electronically, and the information may not be maintained in a form that can be analyzed quickly, it will be difficult to determine which future claims for controlled substances should be paid.

Chiropractors

We found three types of paid claims from chiropractors that appear unallowable. First, we identified problems with payments for multiple initial office visits. During an initial office visit, a chiropractor assesses whether chiropractic treatment is required and, if so, the type and expected number of treatment sessions. Although program rules do not limit the number of initial office visits, DHS staff stated that more than three initial office visits for the same program participant within a year would likely be unnecessary, because it is unlikely that changes in medical condition would require more frequent reassessment.

We found that 185 chiropractors were paid an estimated $51,200 for providing four or more initial office visits.

We found that 185 chiropractors were paid an estimated $51,200 for providing four or more initial office visits to program participants during FY 2005-06. For example, one provider was paid $1,000 for providing 57 initial office visits to the same program participant in that year. We also found that at least 6 of the 185 providers were paid an estimated total of $100 for providing multiple office visits to the same program participants in a single day, which is prohibited under Medical Assistance program rules.

Although DHS does audit chiropractors based on large numbers of initial office visits, it does not select chiropractors based on a large number of initial office visits involving the same program participant. By refining its reviews to include these cases, DHS could better identify which providers to audit and which specific claims to examine.

Second, we found that at least 100 chiropractors were paid an estimated total of $3,600 for multiple chiropractic treatment sessions is a single day, which is prohibited by program rules.

Third, we found that 18 chiropractors were paid an estimated total of $2,800 for supplies or procedures that are not eligible for reimbursement under the Medical Assistance program, such as ultrasounds and supplies for performing electrical stimulation. Most of these claims were submitted by one chiropractor, who was paid an estimated $2,600 for 562 claims for electrical stimulation supplies.

Dental Services

We identified three types of paid claims for dental services that appear unallowable. First, Medical Assistance program rules allow dentists to be paid for certain oral evaluations, including comprehensive evaluations of overall dental health or of specific problems, once per participant over a three-year period. We found that 15 dentists were paid an estimated total of $1,500 for evaluations provided more frequently than allowed.

Second, 18 dentists were paid an estimated total of $700 for performing the same procedures on the same patient twice on the same day. Program rules allow payment for the specific procedures to be performed only once per participant per day. For example, three dentists were paid for applying fluoride to the teeth of the same participant twice on the same day.

Ten dentists were paid an estimated total of $600 for performing procedures on teeth that had already been removed.

Third, ten dentists were paid an estimated total of $600 for performing procedures on teeth that, according to other paid claims information, had already been removed. For example, one dentist was paid for applying sealant to a tooth that another provider had been paid for extracting four months earlier. In another instance, a dentist was paid for extracting the root of the same tooth twice within seven days.

☑ Recommendation

We recommend the Department of Health Services:

- *determine whether the payments we identified were made based on unallowable provider claims;*
- *recover payments for any claims or services that are found to be unallowable; and*
- *report to the Joint Legislative Audit Committee by April 1, 2009, on how it plans to audit for the presence of valid registration numbers for controlled substances claims.*

■ ■ ■ ■

Controlling Medical Assistance Fraud ■

Wisconsin's Medicaid Fraud Control Unit is operated by DOJ.

Federal law requires states to operate Medicaid fraud control units that investigate allegations of fraud and patient abuse and neglect in health care facilities that receive Medical Assistance payments and prosecute those providers believed to have committed crimes. Wisconsin's Medicaid Fraud Control Unit is operated by DOJ. Federal funds support 75.0 percent of DOJ's fraud control activities, and the State funds the remaining 25.0 percent. We reviewed staffing and expenditures related to DOJ's efforts to investigate and prosecute allegations of provider fraud.

Fraud Control Expenditures and Staffing

As shown in Table 17, DOJ's fraud control expenditures increased from $939,200 in FY 2002-03 to $1.2 million in FY 2006-07, primarily because of increased expenditures for staff salaries and fringe benefits. Spending for travel and training and for professional and contractual services increased significantly, primarily because of a lawsuit against several pharmaceutical companies that DOJ filed on behalf of the State in June 2004. DOJ staff travel frequently on matters related to this case, which is ongoing, and DOJ has contracted with a paralegal for additional services.

Table 17

Medicaid Fraud Control Unit Expenditures

Type	FY 2002-03	FY 2006-07	Percentage Change
Salaries and Fringe Benefits	$750,200	$ 896,000	19.4%
Indirect Costs	85,900	118,300	37.7
Rent and Lease	44,600	56,500	26.7
Travel and Training	27,100	49,100	81.2
Professional and Contractual Services	8,100	40,200	396.3
Other Supplies and Services[1]	14,200	20,600	45.1
Dues and Memberships	4,100	8,100	97.6
Telecommunications	5,000	6,100	22.0
Total	**$939,200**	**$1,194,900**	27.2

[1] Includes postage, maintenance and repairs, and insurance.

DOJ was authorized 11.0 FTE fraud control positions in each year from FY 2002-03 through FY 2006-07, including three attorneys, three consumer protection investigators, three auditors, and two support staff. 2007 Wisconsin Act 20 provided DOJ with an additional $340,800 during the 2007-09 biennium to fund an additional 2.0 FTE auditor positions, and DOJ has filled those positions.

Referrals, Investigations, and Prosecutions

DOJ received 182 referrals of suspected provider fraud from FY 2002-03 through FY 2006-07.

As shown in Table 18, DOJ received 182 referrals of suspected provider fraud from FY 2002-03 through FY 2006-07, including 163 from DHS. Other referral sources are the federal Department of Health and Human Services' Office of Inspector General, which also operates a toll-free number—1-800-447-8477—to report Medicaid fraud; a licensing board; other state agencies; private citizens; and provider associations. DOJ also receives reports of suspected fraud through its general telephone number, but it has not published the toll-free telephone number—1-800-488-3780—for the Medicaid Fraud Control Unit on its Web site to facilitate referrals.

When a referral is received, DOJ reviews it and determines whether it will investigate. If DOJ decides not to investigate a referral, it may forward the referral to another state agency to determine whether other sanctions or penalties are necessary.

Table 18

Referrals of Suspected Fraud Received by DOJ

Referral Source	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	Total	Percentage of Total
DHS	31	30	30	40	32	163	89.6%
Other[1]	9	6	0	1	3	19	10.4
Total	**40**	**36**	**30**	**41**	**35**	**182**	**100.0%**

[1] Includes referrals from the federal Department of Health and Human Services' Office of Inspector General, a licensing board, other state agencies, private citizens, and provider associations.

As shown in Table 19, DOJ opened 141 investigations of provider fraud from FY 2002-03 through FY 2006-07, including 66 investigations of transportation services providers such as specialized medical vehicles and ambulances.

Table 19

Fraud Investigations Opened by DOJ

Provider Type	FY 2002-03	FY 2003-04	FY 2004-05	FY 2005-06	FY 2006-07	Total
Ambulances and Specialized Medical Vehicles	20	11	10	14	11	66
Medical Support[1]	4	4	2	7	10	27
Pharmacies	7	2	1	1	1	12
Other[2]	1	1	2	2	4	10
Physicians	0	1	0	3	2	6
Chiropractors	0	1	0	1	3	5
Home Health Aides	0	0	2	2	1	5
Dental Services	0	0	1	2	0	3
Medical Equipment	0	1	1	0	1	3
Nursing Homes and Long-Term Care Facilities	0	0	1	1	0	2
Hospitals	0	1	0	0	0	1
Therapy Services	0	0	0	0	1	1
Total	**32**	**22**	**20**	**33**	**34**	**141**

[1] Includes certified nursing assistants, group home employees, and medical facility administrators.

[2] Includes case management providers and funeral homes.

DOJ assigns an auditor and an attorney to review referrals accepted for investigation. During an investigation, auditors typically contact DHS or EDS to obtain paid claims data related to the alleged fraud. Upon completion of the initial investigation, the attorney recommends whether charges should be filed against the provider and, if so, which charges to file. The director of the Medicaid Fraud Control Unit and the Administrator of the Division of Legal Services must approve the attorney's recommendation before charges may be filed.

From FY 2002-03 through FY 2006-07, DOJ filed criminal charges against 36 providers.

DOJ filed criminal charges against 36 providers from FY 2002-03 through FY 2006-07. During the same time period, 34 providers were convicted of fraud and theft-related charges and 2 were acquitted. As shown in Table 20, courts ordered convicted providers to pay a total of $2.9 million, including $2.0 million in restitution, $898,900 in fines, and $1,200 to reimburse the cost of DOJ's investigations.

Table 20

Court-Ordered Payments from Criminal Convictions

Fiscal Year	Restitution	Fines	Investigative Costs	Total
2002-03	$ 470,400	$595,000	$ 0	$1,065,400
2003-04	89,100	10,000	0	99,100
2004-05	795,900	263,500	0	1,059,400
2005-06	580,300	29,900	0	610,200
2006-07	62,500	500	1,200	64,200
Total	**$1,998,200**	**$898,900**	**$1,200**	**$2,898,300**

Restitution payments reimburse the State and the federal government for their shares of the unallowable Medical Assistance payments made to the provider. Fines are deposited into the Common School Fund, and amounts received for investigative costs are deposited into a program revenue appropriation to help support DOJ's investigation and prosecution activities.

DOJ may also prosecute alleged violations of Medical Assistance program rules in civil court. Such prosecutions may be preferable in some cases because the evidence standards in civil court are lower than the standards in criminal court, and DOJ may avoid the cost of a trial by reaching a settlement.

From FY 2002-03 through FY 2006-07, 16 civil settlements were negotiated between the State and Medical Assistance providers, pharmaceutical manufacturers, and companies that deliver medical equipment or services. As shown in Table 21, courts ordered providers and companies to pay the State a total of $11.7 million, which includes $8.2 million in restitution payments for only the State's share of unallowable Medical Assistance payments. Forfeitures are deposited into the Common School Fund, and amounts received for investigative costs are deposited into a program revenue appropriation for DOJ's investigation and prosecution activities.

Table 21

Court-Ordered Payments Received from Civil Cases

Fiscal Year	Restitution	Forfeitures	Investigative Costs	Total
2002-03	$ 166,100	$ 223,400	$ 0	$ 389,500
2003-04	1,680,200	1,530,000	0	3,210,200
2004-05	4,075,100	1,108,900	0	5,184,000
2005-06	205,500	378,600	207,800	791,900
2006-07	2,084,800	0	0	2,084,800
Total	**$8,211,700**	**$3,240,900**	**$207,800**	**$11,660,400**

Fourteen of the settlements were negotiated by the National Association of Medicaid Fraud Control Units on behalf of multiple states, including Wisconsin, and typically involved pharmaceutical manufacturing companies. DOJ also negotiated settlements in two cases that it initiated, including one case against a dentist in FY 2003-04 and another against a nursing home in FY 2004-05.

False Claims Law

The federal Deficit Reduction Act of 2005 provided states with a financial incentive to pursue more civil fraud cases against Medical Assistance providers.

The federal Deficit Reduction Act of 2005 provided states with a financial incentive to pursue more civil fraud cases against Medical Assistance providers. To obtain this incentive, states are required to enact a false claims law that establishes civil liabilities and penalties for submitting false or fraudulent claims to a Medical Assistance program. If a state's law is approved by the federal Department of Health and Human Services' Office of Inspector General, that state is entitled to a 10.0 percentage point increase in its share of any recoveries obtained from successful settlements.

To obtain the additional share of recoveries, 2007 Wisconsin Act 20 contained a provision that:

- establishes civil liability for individuals or entities that submit false or fraudulent claims to the Medical Assistance program;

- requires civil penalties of three times the amount of damages sustained by the State, and assessments of at least $5,000 but no more than $10,000 for each violation; and

- rewards individuals who bring a case to civil court on the State's behalf against another person or entity for making a false or fraudulent claim for Medical Assistance, including rewards of at least 15.0 percent but not more than 30.0 percent of any proceeds of the action or settlement of the claim.

DOJ did not submit the State's false claims provisions for federal approval until March 2008.

In addition, Act 20 reduced funding for the Medical Assistance program by $443,300 during the 2007-09 biennium, based on an estimate of the increased share of the State's recoveries to be retained. However, we note that DOJ did not submit the State's false claims provisions to the Office of Inspector General for federal approval until March 2008, after we informed DOJ that it was required to do so. In November 2008, the Office of Inspector General determined that Wisconsin's law met all federal requirements and qualifies the State to retain an increased share of Medical Assistance recoveries.

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State of Wisconsin
Department of Health Services

Jim Doyle, Governor
Karen E. Timberlake, Secretary

December 5, 2008

Janice Mueller, State Auditor
Wisconsin Legislative Audit Bureau
22 East Mifflin Street, Suite 500
Madison, WI 53703

Dear Ms. Mueller:

This letter is in response to the Legislative Audit Bureau's (LAB) review of the Department of Health Services (DHS) Bureau of Program Integrity (BPI) and of the Bureau's effectiveness in preventing and detecting provider fraud and abuse in Wisconsin's Medical Assistance Program.

Our department is deeply committed to ensuring the Medicaid program demonstrates excellence in achieving the goal of providing access to quality health care for eligible state residents in need of support. An important part of this effort is having an active and effective program integrity program to ensure that payments to Medicaid providers are reasonable, appropriate and properly documented.

To successfully perform its fiduciary duty to Wisconsin tax payers, BPI conducts audits, enforces reasonable standards for the certification of providers, uses current technology to identify aberrant provider practices, and establishes effective working relationships with the provider community and with their state and federal partners. The Department has spent considerable time and effort in assuring the accuracy and the fairness of its program integrity processes.

Overall, I am quite pleased with the results of the LAB review and appreciate the confidence LAB demonstrates in the Department's current program integrity efforts. We also appreciate the suggestions contained in the review. The Department will evaluate the report and its suggestions and, by April 1, 2009, report back to the Joint Legislative Audit Committee on how we will use the LAB review to enhance and improve our oversight of provider activity.

As the review indicates, calculating the effectiveness of a State's program integrity efforts is complex and needs to consider several indicators. One measure is the number of audits conducted, another is the amount of inappropriate funds recovered and a third is the ability to maintain a provider network that meets the access requirements of our recipients. As LAB accurately notes, successful Medicaid program integrity efforts require a balance between its efforts to prevent fraud and abuse and the need to maintain a provider network that is adequate to assure services for Medicaid recipients.

In addition, although the review notes there is no national estimate of unallowable or fraudulent payments to providers, the federal Centers for Medicare and Medicaid Services (CMS) have recently published results from CMS' Payment Error Rate Measurement program (PERM). The year's findings of that program (published in the November 2008 HHS Performance and Accountability Report) found that the national improper payment rate for state Medicaid programs is 4.7%, while the rate for Wisconsin is 2.2%, or more than one-half below the national average. This measure clearly points to the success of our Program Integrity efforts.

I was also pleased that LAB acknowledged the high regard in which Wisconsin's program integrity unit is held by other states and by federal agencies. Wisconsin has been recognized and commended by federal CMS, the Government Accountability Office and the U.S. Department of Health and Human Services' Office of the Inspector General in several reports and publications for its efforts to prevent Medicaid fraud and abuse. BPI is often called upon by these agencies for assistance and advice.

With the successful implementation of a new Medicaid Management Information System, interChange, Wisconsin has improved the tools it uses to track our program integrity efforts and has new technologies to assist in the detection of aberrant billing practices. This will allow Wisconsin to continue to place itself as a leader nationally in its program integrity efforts.

As to the recommendations themselves, most if not all were included in 2001 Wisconsin Act 16, along with other measures to provide DHS (then DHFS) with additional program integrity resources. The provisions had been requested as a part of the Department's Biennial Budget request, and subsequently enacted into law, with the caveat that they be put into effect through the Administrative Rule process. At the time of their enactment there had been considerable opposition both from providers who feared that they were unnecessary and potentially harmful, but also from recipients who felt that implementation would have a negative effect on access to services.

The Department views these provisions as potential tools to utilize as the need arises. We are committed to enact any or all of these provisions, but only as it becomes necessary to do so. In some cases, the Department utilizes other means already within our authority to achieve these goals. Based on the adequate level of current financial recoveries, the safeguards already in place, the overall honesty of our provider network, the low number of provider sanctions, and Wisconsin's very low Medicaid error rate, we believe that the department's overall approach to program integrity has been very successful.

Of course, opportunities often exist to improve any process, and department staff will evaluate the audit's recommendations and make needed improvements. We will also evaluate the recommendations proposing that we seek additional authority and determine which options will make program integrity efforts more effective without materially harming provider relations and access to services. We will report back to the committee before April 1, 2009, on the results of our analysis and which of the new safeguards we believe will add value and should be codified. Please see the attached pages for our comments on specific audit recommendations.

In closing, I would like to express the Department's gratitude to the Legislative Audit Bureau management and staff for the diligence of their efforts and for their suggestions for improving our performance as stewards of the Medicaid program.

Sincerely,

Mark Thomas

Mark Thomas
Deputy Secretary

Attachment

Response to Legislative Audit Bureau's Recommendations
Related to Medicaid Program Integrity

LAB Recommendation #1
We recommend the DHS report to the Joint Legislative Audit Committee by April 1, 2009, on the steps it has taken to ensure that all non-institutional providers are recertified on a timely basis, according to its written policies.

DHS Response: *We agree that the installation of the new MMIS delayed the re-certification of some provider types. However, we do not believe the delay was as great or significant as the report states. Our records indicate that there was only a one year delay in the schedule. Nevertheless, it is our intention to review the process and determine the impact that any delay may have caused. By April 1, 2009, we will report to the Committee the length on any delay and the Department's proposal to ensure compliance with our schedule.*

LAB Recommendation #2
We recommend that DHS report to the Joint Legislative Audit Committee by April 1, 2009 on its progress in conducting criminal background checks of providers as part of its certification process, and on the steps it has taken to:

- Ensure that providers whose professional licenses are restricted, suspended, or revoked are decertified on a timely basis;
- Promulgate rules, as required by statute, which would allow it to suspend providers from participating in the Medical Assistance program pending a decertification hearing and require providers to obtain surety bonds as a condition of certification: and
- Ensure that all current providers that are delinquent in making court-ordered child or family support payments or failing to comply with subpoenas or warrants related to paternity or child support proceedings are decertified or are denied certification if they are seeking it.

DHS Response:
Criminal Background Checks -- DHS does not have the staff or funding resources to conduct for criminal background checks. One background check by outside contractor services could cost $20-$30 per review. However, DHS will investigate to determine if there are opportunities to do limited checks without an increase in staff or state funding.

Restriction/Suspension -- DHS will review this recommendation with the assistance of the Office of Legal Counsel to determine the feasibility and practical application of this recommendation. (It should be noted however, that when a provider's license is restricted, Administrative Code does not necessarily require de-certification).

Surety Bonds -- DHS will examine and report to the Committee options for implementing this proposal. However, it should be noted that this has been a controversial requirement, in part because of the costs and risks especially for small business providers. In 1998, CMS (then HCFA) implemented a requirement that all Home Health agencies and Durable Medical Equipment providers who sought Medicaid and Medicare certification be required to post a surety bond (based on the Florida and Louisiana models). Congress later delayed the authority to implement this requirement, and that authority has never been restored.

Delinquent Providers -- When this statutory provision was first enacted, DHS (then DHFS) made provisions to comply with its requirements. That included obtaining a list of delinquent providers from DWD. At that time, DHFS was informed that DWD was not prepared to comply and that they would

inform us of when they were. We are not aware of any further communication related to that issue. Therefore, at this time we do not have a list of individuals who might be subject to this provision. However, DHS will work closely with the Department of Children and Families on this matter, and we will report on our progress before April 1.

LAB Recommendation #3

We recommend that DHS report to the Joint Legislative Audit Committee by April 1, 2009 on:

- Its efforts to sanction providers that repeatedly commit the same violations,
- Its plans to begin to use extrapolation audits to identify and recover additional unallowable payments; and
- The date by which it will promulgate rules changes to charge interest to providers that fail to promptly and entirely reimburse the State for unallowable payments.

DHS Response:

Sanctions -- BPI has used its sanction authority during the period covered by the LAB Report. The decision not to expand that authority was based on the legal opinion that in order to be successful in taking such actions, DHS would need to provide evidence that the provider's violations were committed both repeatedly and knowingly as indicated in Administrative Code. BPI does not have the ability or the resources to meet that burden of proof.

As an alternative, BPI began informing repeat offenders that the program would not be authorizing approval of their requests for re-certification. This allows providers to dis-enroll without the need and costs of litigation.

Extrapolation -- BPI uses extrapolation in a very limited number of audits. BPI does not have unfettered access to the legal and statistical resources that would be needed to implement this practice, and routinely utilizing extrapolation would be a major change in our oversight philosophy toward providers. Nevertheless, we will look closely to see if there are opportunities to employ audit extrapolation techniques that will enhance the effectiveness of the program integrity function without adversely impacting provider participation in the Medicaid program.

Charging Interest -- Again, there is the issue of the availability of legal and other resources to implement this recommendation. However, we will review the benefits and downsides of incorporating this practice in the State's Medicaid program.

LAB Recommendation #4 regarding the LAB conducted audits

We recommend that DHS:

- Determine whether the payments we (LAB) identified were made based on unallowable provider claims;
- Recover payments for any claims or services that are found to be unallowable;
- Report to the Joint Audit Committee by April 1, 2009 on how it plans to audit for the presence of valid registration numbers for controlled substance claims.

DHS Response:

LAB Audit of Providers -- BPI has just recently been given these findings and the limited information related to them, and we have not been able to complete our evaluation of the information and plan next steps. LAB performed important initial data mining work, but as the audit notes, additional audit steps are needed, such as contacting the individual providers involved to provide them an opportunity to submit supporting documentation. BPI will need to review the audit work conducted so far, contact all providers identified by LAB to request they submit documentation to support their payments, and have audit staff

(including clinical audit staff) review the documentation to determine whether these claims are unallowable. At that time, BPI will be in a position to determine whether the payments identified by LAB can be recovered.

DEA Numbers -- Use of DEA numbers has come up as a minor part of other pharmacy audits, but BPI does not have an audit protocol specifically focused on the presence of a DEA number. BPI will examine the feasibility of creating an audit protocol and algorithms related to this issue and report their progress to the Committee by April 1, 2009.