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An Evaluation:

Medical Assistance
Program Integrity

Department of Health Services

December 2008

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 longterm 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 inform ation 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

Key Facts and Findings

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.

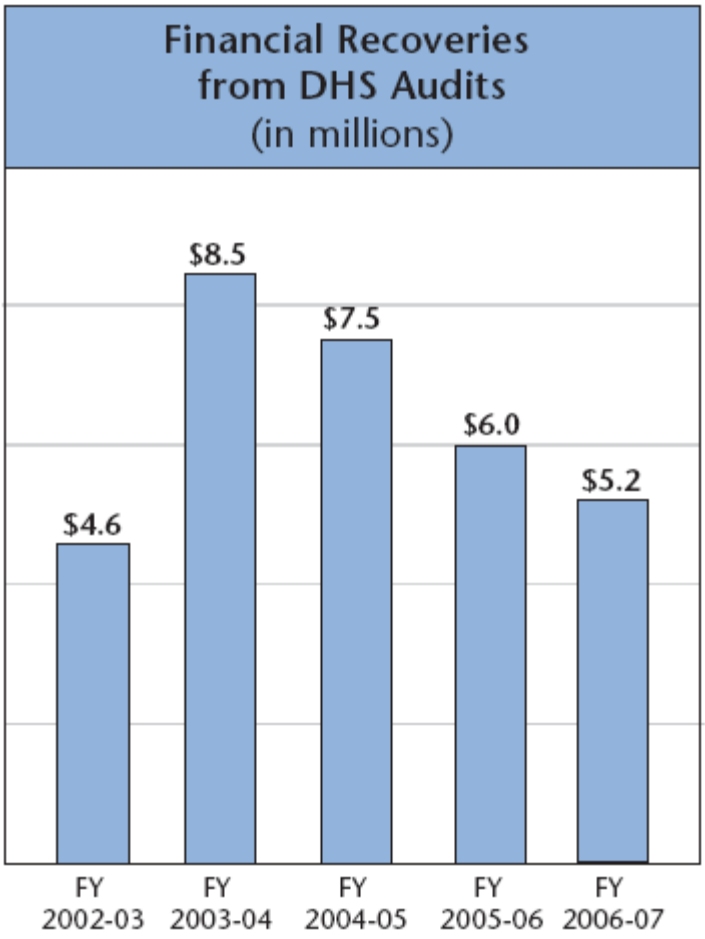
DHS recovered a total of $31.8 million based on its provider audits, including $10.5 million from hospitals and $9.0 million from pharmacies.

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

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

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

From FY 2002-03 through FY 2006-07, DHS auditors identified repeat findings in audits of 74 providers.



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

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.

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

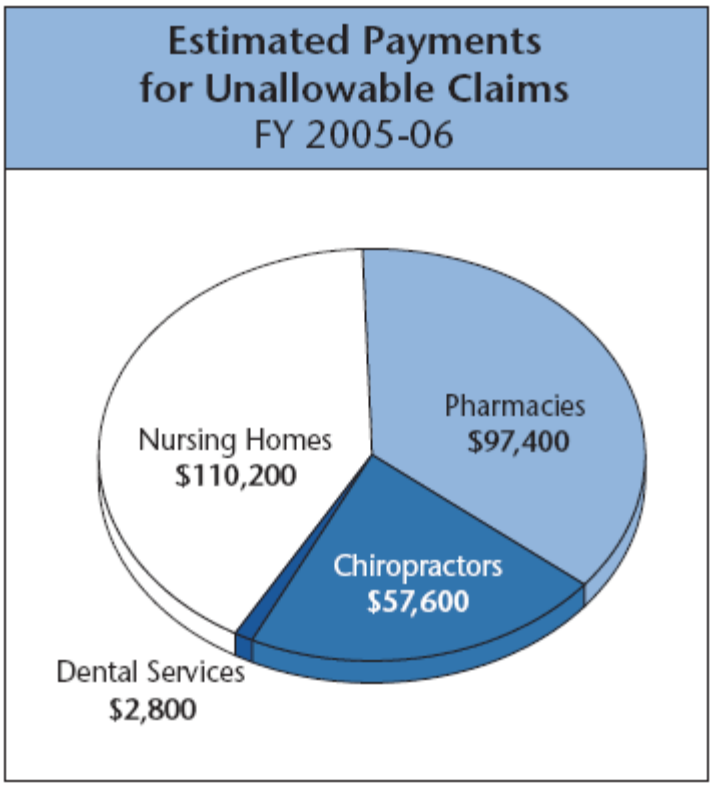
In addition, DHS has not charged interest to providers that have not promptly repaid unallowable claims, even though statutes require that it promulgate rules to do so. DHS also has not used its statutory authority to charge providers up to $1,000 or 200 percent of the cost of unallowable claims, or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

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.



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**).*

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