REPORT TO THE SUBCOMMITTEE ON HEALTH SENATE COMMITTEE ON FINANCE

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Investigations Of Medicare And Medicaid Fraud And Abuse-- Improvements Needed

Department of Health, Education, and Welfare

Investigations of Medicare fraud and abuse were weak in that:

--Some fraud complaints were closed prematurely because of inadequate investigations.

--Sampling procedures and monitoring of regional office and contractor investigations were inadequate.

Federal action against Medicaid fraud and abuse has been minimal. Medicare and Medicaid fraud and abuse investigations were not well coordinated. Recent organizational changes in HEW should change the extent and direction of its fraud and abuse investigations.

HRD-77-19

MAY 23, 1977

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

B-164031(4)

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

Dear Mr. Chairman:

Pursuant to your request of February 18, 1975, this report describes the Department of Health, Education, and Welfare's investigations of Medicare and Medicaid fraud and abuse. It alsc discusses prosecution activities of the Department of Justice, and State Medicaid fraud and abuse investigations in California and Missouri.

As agreed with your office, we are sending copies of the report to the Chairman, Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce, and the Chairman, Subcommittee on Health, House Committee on Ways and Means.

This report contains recommendations to the Secretary of Health, Education, and Welfare which are set forth on pages 42 and 43. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriatiors with the agency's first request for appropriations made more than 60 days after the date of the report. We will be in touch with your office in the near future to arrange for release of the report so that the requirements of section 236 can be set in motion.

Sincerely yours,

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE SUBCOMMITTEE ON HEALTH SENATE COMMITTEE ON FINANCE

INVESTIGATIONS OF MEDICARE AND MEDICAID FRAUD AND ABUSE--IMPROVEMENTS NEEDED

Department of Health, Education, and Welfare

D I G E S T

MEDICARE

Medicare abuse cases--mostly involving complaints about physicians who violate agreements to accept the amount allowed by Medicare as the full charge, other improper billing practices, or unnecessary services--are usually closed when complaints are satisfactorily resolved.

Fraud cases--usually involving complaints about billings for services that were not rendered or about duplicate billings--receive further investigation if the complaints appear valid.

Medicare investigations are usually begun as the result of complaints; little work has been self-initiated.

No system setting out priorities has been developed for directing the investigations. The Bureau of Health Insurance, Department of Health, Education, and Welfare (HEW), has a system that only ranks the importance of complaints to be investigated if there is a backlog.

The Bureau recognizes the need for evaluating its work and for more self-initiated work, especially regarding fraud and abuse by hospitals, nursing homes, and home-health agencies.

A reorganization had been proposed by the Bureau to solve these problems. While some of the actions called for in the reorganization had been implemented, the reorganization had not been approved at the time of GAO's review. The major problem delaying a decision at that time was the relationship of the Bureau's responsibilities in Medicare investigations with those of HEW's Office of Investigations.

Subsequent organizational changes within HEW, including the establishment of the Office of Inspector General and the Health Care Financing Administration, will result in major changes in HEW's organizations responsible for controlling fraud and abuse. (See p. 13.)

Most fraud complaints appear to result from misunderstandings or honest mistakes. However, some fraud may have gone undetected because of inadequate investigations.

Some fraud complaints at the Bureau's San Francisco and Kansas City regional offices were closed prematurely because:

--No sampling, or inadequate sampling, was done to determine whether an improper billing was an error or was part of a pattern which could point to fraud.

--Investigations were inadequate.

--Contractors (private organizations helping to administer Medicare) tended to seek recovery of overpayments on specific complaints rather than to look for fraud. (See p. 16.)

Because the Bureau's sampling procedures do not require an adequate sample size, fraudulent practices can go undetected. A larger sample is needed. (See p. 15.)

Personnel conducting investigations generally did not have prior investigative training or experience. However, this did not appear to cause the inadequacies GAO noted. The Bureau recognizes that personnel with specialized skills would be needed to expand its fraud and abuse effort. (See p. 24.)

The administrative system for controlling and reporting complaints is unduly burdensome. Adequate control over complaints could be maintained without keeping details on all complaints at the region and headquarters. (See p. 10.)

About half of the Medicare fraud cases referred to U.S attorneys have been prosecuted--usually successfully. However, U.S. attorneys are often slow in deciding whether or not to prosecute, and some decisions appear to be based on factors other than the merits of the cases.

Medicare fraud cases usually involve elderly witnesses who may die, be ill, or forget facts by the time a trial is held. The defendants are usually respected members of the community. These factors may make U.S. attorneys reluctant to prosecute doctors for Medicare fraud. (See ch. 4.)

MEDICAID

The basic responsibility for Medicaid investigations has been left to the States. Limited reviews of Medicaid investigations in two States showed a wide variance in the emphasis placed on investigations.

California spent considerable resources on investigations; however, because of a large volume of cases and high production standards, self-initiated work was limited and recovery of overpayments, rather than prosecution, was stressed. Missouri's investigations were limited. (See ch. 5.)

Medicare and Medicaid fraud and abuse investigations were not well coordinated. Medicare and the two States visited coordinated to some extent. However, Medicare and the Social and Rehabilitation Service, responsible for Medicaid at the Federal level before March 8, 1977, generally did not. (See ch. 6.)

RECOMMENDATIONS

The Secretary of HEW should:

--Strengthen the monitoring of investigations so that complaints are not closed prematurely because of inadequate investigations.

--Establish statistical sampling procedures that will better detect fraudulent billing practices.

--Reduce the paperwork connected with investigating complaints by referring complaints directly to contractors rather than to the regional office.

--Discuss with the Department of Justice ways of obtaining more timely decisions on whether referred cases will be prosecuted and of assuring that criminal law related to Medicare is uniformly applied.

--Develop investigative priorities.

--Acquire personnel with the skills needed to investigate complex types of fraud and abuse.

--Delineate the responsibilities of the HEW organizations involved in Medicare-Medicaid investigations.

--Establish procedures for coordinating such work within HEW and between HEW and the States.

--Work with Missouri Medicaid officials to establish a more active program for investigating Medicaid fraud and abuse.

--Emphasize to top-level California Medicaid officials the importance of criminal prosecution as a deterrent to Medicaid fraud.
(See p. 42.)

AGENCY COMMENTS

HEW believed that GAO did not give an accurate or current presentation of Medicare's work...

HEW agreed with GAO's recommendations regarding Missouri, California, and the need for better monitoring of investigations. HEW said GAO's recommendation to refer complaints directly to contractors has considerable merit

and will be considered when it is satisfied that control of contractors is adequate.

Comments of HEW and the Department of Justice indicate that coordination has improved and will continue to improve between these Departments.

HEW stated that the sample size of 10 beneficiaries is not intended to be applied in all cases. Workload and staff resources are considered in determining the sample size. Since the Bureau's sampling instructions do not indicate this, GAO believes they should be revised to require larger samples when staff is available.

HEW stated that the Bureau has a priority system and that GAO did not indicate some other system would be better. The Bureau's priority system is merely a technique for determining the order in which backlogged complaints should be resolved. It does not address the allocation of resources between answering complaints and self-initiated work.

HEW did not fully address GAO's recommendations regarding delineating responsibilities within HEW, acquiring personnel with specialized skills, and establishing procedures for coordination. HEW noted, however, that recent legislation provided for an HEW Inspector General with responsibilities for recommending policies for and conducting, supervising, or coordinating activities carried out or financed by HEW regarding fraud and abuse. The Inspector General had not been appointed at the time of HEW's comments. (See p. 43.)

The Department of Justice felt some balance was needed regarding GAO's conclusions about the reluctance of U.S. attorneys to prosecute physicians and pointed to prosecutions in other parts of the country to support its view.

Justice described some of the difficulties in prosecuting cases and its recent activities directed toward combating Medicare and Medicaid fraud.

Comments of Medicaid officials in California and Missouri and Medicare contractors have been considered and incorporated in this report where appropriate.

Contents

ABBREVIATIONS

BHI	Bureau of Health Insurance
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SRS	Social and Rehabilitation Service
SSA	Social Security Administration

CHAPTER 1

INTRODUCTION

In a February 18, 1975, letter, the Chairman, Subcommittee on Health, Senate Committee on Finance, asked us to gather information about Medicare and Medicaid program integrity investigations. He asked us to (1) find out how the Medicare program integrity function is organized and (2) review program integrity activities in at least two of the Social Security Administration's (SSA's) regional offices. (See app. I.)

We were asked to develop similar data on State Medicaid programs, including a State where there appeared to be extensive program integrity activity and a State where there appeared to be little activity.

THE STATUTORY AUTHORITY

Titles XVIII and XIX of the Social Security Act established the Medicare and Medicaid programs to help eligible persons meet the costs of health-care services.

Under Medicare, eligible persons, generally 65 and over or disabled, may receive two basic forms of protection.

--Part A, hospital insurance benefits, generally financed by special social security taxes, covers inpatient hospital services and certain postrelease care in skilled nursing facilities and patients' homes.

--Part B, supplementary medical insurance benefits, is a voluntary program, financed by premiums and Federal contributions, covering physician services and many other medical and health benefits.

During fiscal year 1975, part A benefits totaling about $10.5 billion were paid for 23.7 million eligible beneficiaries and part B benefits totaling about $4 billion were paid for 23.2 million eligible beneficiaries.

Under Medicaid, a grant-in-aid program, the Federal Government shares with the States the costs of providing medical assistance to persons--regardless of age--whose income and resources are inadequate to pay for health care. Medicaid paid about $12 billion for about 22.5 million recipients in fiscal year 1975.

The Social Security Act requires State Medicaid programs to provide inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing home services, physicians' services, home health care, and certain other services. A State may also choose to include other services.

ADMINISTRATION OF THE MEDICARE AND MEDICAID PROGRAMS

The Department of Health, Education, and Welfare (HEW) has overall responsibility for administering Medicare and Medicaid. Within HEW, at the Federal level, SSA administered Medicare and the Social and Rehabilitation Service (SRS) administered Medicaid. 1/

Within SSA, the Bureau of Health Insurance (BHI) administered Medicare. To help administer Medicare benefits, HEW has contracted with public and private organizations called intermediaries and carriers. Intermediaries generally make payments under parts A and B on the basis of "reasonable cost" to institutional providers, such as hospitals, skilled nursing facilities, and home health agencies. Carriers make payments under part B on the basis of reasonable charges for the services of doctors and suppliers. HEW has contracts with about 50 carriers and about 80 intermediaries. HEW reimburses intermediaries and carriers for administrative costs.

A State is responsible for administering its Medicaid program. The nature and scope of a State's Medicaid program are contained in a plan which, after HEW approval, provides the basis for Federal grants.

The State may contract with private organizations to help administer its program. The responsibilities assigned to the contractors--referred to as fiscal agents--vary depending on the State's contractual arrangements. Some States administer the entire program through their State agencies.

During our review, SRS did not have a unit to investigate suspected Medicaid fraud and abuse or to help States develop the capability to investigate Medicaid fraud and abuse. SRS

1/On March 8, 1977, the Secretary of HEW announced the establishment of a Health Care Financing Administration which would include the functions now performed by the Bureau of Health Insurance and SRS's Medical Services Administration. This report describes the Medicare and Medicaid program integrity systems before March 8, 1977.

had since established a Division of Fraud and Abuse Control at its headquarters and planned to establish similar units in its regions. Also, effective September 23, 1976, States were required to report data on Medicaid fraud investigations to SRS. BHI has a program integrity staff, which is responsible for detecting and investigating suspected Medicare fraud.

MEDICARE PROGRAM INTEGRITY FUNCTION

Medicare program integrity investigations involve suspected fraud and program abuse. Fraud in Medicare usually involves claims for payment (1) for services which were not rendered or (2) more complicated and more costly services than actually rendered. The term abuse is used to describe incidents which, although not considered fraud, may cause financial losses to the Medicare program or to beneficiaries and their families.

The most frequently reported abuse is breach of an assignment agreement whereby a physician agrees to bill on behalf of a beneficiary and to accept as his full payment the amount a carrier determines to be reasonable. Violation of the agreement occurs when the physician requests the patient to pay the difference between his charge and the reasonable charge.

According to BHI, as of June 30, 1975, 35,962 complaints--18,002 fraud and 17,960 program abuse--had been received. The following tables show the type and status of complaints.

Fraud Complaints

Nature of complaints	Received	Closed	Pending
Services not rendered (doctor)	7,980	6,580	1,400
Services not rendered (provider)	2,827	2,383	444
Misrepresenting services	657	470	187
Altering bills	225	198	27
Duplicate billing	2,527	2,237	290
Falsifying records	277	172	105
Kickbacks	110	95	15
Embezzlements	15	14	1
False/misleading advertising	226	214	12
Forgery of checks	2,709	2,330	379
Other	449	379	70
Total	18,002	15,072	2,930

Abuse Complaints

Nature of complaints	Received	Closed	Pending
Breach of assignment agreement	9,630	9,333	297
Unnecessary services (doctor)	1,718	1,338	380
Unnecessary services (provider)	498	435	63
Improper billing practices	4,529	3,948	581
Other	1,585	1,315	270
Total	17,960	16,369	1,591

During fiscal year 1975, 3,744 fraud complaints and 1,970 abuse compliants were made.

Abuse complaints are closed when the complaint is satisfactorily resolved and, if the case involves an overpayment, when the determination of overpayment has been resolved.

Fraud complaints are closed when:

--The investigation indicates that a crime was not committed.

--The chance of obtaining enough evidence to prove fraud is remote or prosecution is barred by the statute of limitations.

--BHI decides that a valid case exists but prosecution is not desirable. (The U.S. attorney must concur in this decision.)

--A case is referred to the U.S. attorney.

As of June 30, 1975, BHI had referred 307 fraud cases for prosecution to the Department of Justice. The Department had (1) declined to prosecute 100 cases, (2) not decided on whether to prosecute 58 cases, and (3) prosecuted 149 cases involving 183 suspects. Of these suspects, 132 were convicted, 13 were acquitted, 21 were dismissed, and 17 were awaiting trial.

MEDICARE PROGRAM INTEGRITY ORGANIZATION

The two major SSA components concerned with Medicare fraud and abuse are BHI and the Office of Program Operations.

BHI is responsible for preventing, detecting, investigating and referring for prosecution or otherwise resolving instances of Medicare fraud and abuse.

The Office of Program Operations has about 1,300 district and branch offices, which are responsible for receiving Medicare complaints from beneficiaries, obtaining a statement of pertinent facts, and forwarding the statement to BHI. These offices may conduct preliminary investigative work at BHI's request.

Medicare contractors assist BHI in its program integrity efforts.

Bureau of Health Insurance

The BHI Headquarters Program Integrity Branch is responsible for:

--Developing overall plans for and coordinating Bureau program integrity activities.

--Developing Medicare fraud prevention, detection, reporting, and processing systems.

--Developing a training program for central office and regional office staffs.

--Coordinating an annual review of selected physicians.

--Improving the effectiveness of carrier, intermediary, and regional office fraud activities.

--Reviewing potential fraud cases developed by regional staff.

As of June 30, 1975, the program integrity staff consisted of about 40 professional personnel. Although the headquarters' staff does not make investigations, they monitor and advise the regional office staffs that make investigations. They also prepare the Health Insurance Regional Office Manual, which contains policies and procedures for program integrity investigations.

BHI's regional office program integrity staffs are responsible for undertaking, directing, coordinating, and controlling the development of investigations of suspected Medicare fraud and abuse violations. Specific duties and responsibilities include:

--Evaluating contractor and district office program integrity activities through onsite reviews and regional office studies.

--Helping contractors and district offices to upgrade their program integrity activities.

--Investigating or directing the investigation of program integrity complaints.

--Referring appropriate cases to the U.S. attorney for prosecution.

--Reviewing reports from carriers on selected physicians as part of the evaluation of carriers' utilization control systems.

As of June 30, 1975, BHI's regional office program integrity staff consisted of 79 program integrity and program validation specialists, 34 health insurance program specialists, and 8 other (nonclerical) personnel.

The BHI regional representative reports directly to the BHI Director in Baltimore. The regional office program integrity staff is under his control rather than under the headquarters program integrity staff.

SSA district and branch offices

The major responsibilities of the district and branch offices in Medicare program integrity matters are:

--Through beneficiary contacts, identifying situations which may constitute fraud or abuse.

--Documenting and referring such situations to the regional offices.

--Developing suspected fraud cases at the request of the regional offices.

Medicare contractors

Medicare contractors have internal control systems which can help detect fraud and abuse. These systems include utilization screens, duplicate payment screens, notices to beneficiaries of claims paid for services, followups on undeliverable checks and notices to beneficiaries, reviews and audits of cost reports and medical records from institutional

providers, and contacts with a sample of beneficiaries to verify that services were received and charges were proper.

Intermediaries and carriers are to refer to the BHI regional office program integrity staff all suspected fraud or abuse complaints that come from their claims review activities or from allegations by beneficiaries. When complaints can be resolved by reviewing in-house material, a referral to the regional office is not necessary. However, contractors are required to provide summary reports for complaints resolved internally showing the nature of the problem and its resolution. Contractors are not authorized to contact suspects or carry on program integrity investigations without the regional office's approval.

SCOPE OF REVIEW

Our review focused on investigations made of potential fraud and abuse cases that were identified from contractors' internal control systems. We did only limited work on the effectiveness of these systems as a means of preventing and detecting fraud.

We made our review at SSA headquarters in Baltimore and BHI regional offices in San Francisco and in Kansas City, Missouri. We visited four SSA district offices in California, two district offices in Missouri, and one branch office in Kansas. We also visited SRS offices in San Francisco and Kansas City, and State Medicaid offices in Sacramento, California, and Jefferson City, Missouri.

We reviewed legislation, documents, reports, records, and files, and talked to SSA and SRS officials, Medicare contractor representatives, officials of State Medicaid agencies, and local U.S. attorneys.

We made a statistical sample of complaints closed by BHI's San Francisco and Kansas City regional offices. In addition, we reviewed selected complaints closed by carriers, intermediaries, and SSA's district and branch offices.

We were not able to develop meaningful information on two areas of concern to the Chairman--the cost of investigations and the effects of regionalization. Neither BHI headquarters nor the regional offices maintained information on the cost of investigations. We could develop cost data for the SSA employees who are primarily involved in program integrity work, but it would be difficult to accurately estimate the extent of contractor and district office personnel involvement in such work.

The regionalization of BHI occurred about the time that its program integrity effort became organized as an identifiable function. Thus, little history of program integrity activities before regionalization existed.

CHAPTER 2

INVESTIGATIONS ARE BASED PRIMARILY ON COMPLAINTS

Most investigative work has been directed toward part B fraud and abuse. The investigative process is primarily directed at resolving complaints; self-initiated investigations of potential fraud and abuse have been limited.

As of June 30, 1975, about 2 percent of the complaints received had been referred to the Department of Justice for prosecution. Complaints by beneficiaries appear to be least likely to be referred. We believe that improvements are needed to reduce the administrative burden connected with beneficiary complaints.

The Health Insurance Regional Office Manual provides a priority system for program integrity work. However, this system is directed toward handling a backlog of complaints rather than assigning priorities to various types of program integrity activities. The basis for assigning priorities to complaints appears questionable, and we believe the priority system is of little value.

The Bureau of Health Insurance, recognizing that improvements are needed, has proposed a reorganization that would permit

--better oversight of regional office activities,

--better evaluation of the fraud and abuse control program and development of improvements to the program,

--improvement of systems for detecting fraud and abuse, and

--establishment of a staff with accounting, investigative, and program skills to reinforce regional office capabilities and to design and test new methods and techniques needed for seeking out program fraud and abuse.

The reorganization has not been fully implemented because of organizational changes within HEW.

MOST INVESTIGATIONS RESULT FROM COMPLAINTS

BHI's procedures for controlling fraud and abuse under the Medicare program are primarily directed at resolving complaints from outside sources. Most complaints are a result of carriers sending explanations of Medicare benefits which show amounts paid on the beneficiaries' behalf. The system requires that each complaint be resolved.

About 70 percent of all complaints received since the Medicare program began through June 30, 1975, have come from beneficiaries, their relatives, or interested third parties. About 17 percent have resulted from contractors' actions. The other 13 percent have come from other sources, such as public officials or the press.

Very few complaints result in the development of fraud cases. Of the approximately 18,000 fraud complaints received as of June 30, 1975, only 307 cases, or about 2 percent, were referred for prosecution.

According to BHI, about 60 percent of the fraud complaints are closed for reasons other than the physician billing being improper. Another 30 percent appear to be isolated instances and honest error is assumed. (See p. 15 for a discussion of the beneficiary sampling procedures used to determine whether a pattern of improper billing exists.) Only about 10 percent of the complaints go to full-scale investigation, and only about 2.5 percent result in sufficient evidence to seek prosecution.

NEED TO REDUCE ADMINISTRATIVE WORK CONNECTED WITH COMPLAINTS

Although most complaints come from beneficiaries, only about 41 percent of the cases submitted to the U.S. attorneys resulted from beneficiary complaints. About 41 percent of the cases submitted to the U.S. attorneys resulted from contractor referrals and about 18 percent resulted from referrals or complaints from other sources.

Most fraud complaints are referred to the regional offices by SSA's district and branch offices. (Abuse complaints of assignment violations are forwarded directly to contractors with a copy to the regional office, and the recording procedures described below are not followed.) A control

form is prepared and a copy is sent to headquarters, where it is entered into a computer system used for control and statistics.

The regional office forwards the complaint to the contractor, which screens the complaint to determine its validity. If the contractor determines that the complaint is not valid, it so reports to the regional office, which closes the complaint by annotating a copy of the control form. A copy of this form is sent to headquarters. Usually the form does not contain enough data to evaluate the adequacy of actions taken to resolve the complaint.

If the complaint is substantiated, a sample is taken of other claims by the physician, and beneficiaries are contacted to determine whether the improper billing was an isolated error or a regular practice. If the sampling shows other instances of improper billing, a full-scale investigation is usually started. The regional office uses either its personnel or contractor personnel to do the sampling.

The above procedures are not followed, however, if the beneficiary complains of fraud to the contractor or the contractor suspects fraud. Contractors list the complaints received and their disposition on a quarterly report to the regional office. The regional office does not record the complaint and BHI headquarters is not notified of the complaint except for cases that cannot be resolved through the contractor's in-house review. These cases are referred to the regional office, which decides the actions to be taken.

Thus, the prime factor in deciding if detailed data on a complaint should be maintained by BHI is whether the complaint was made to the contractor or an SSA field offi

We believe an approach that would reduce the administrative work involved in nonproductive fraud complaints would be to eliminate regional office and headquarters involvement during the preliminary investigation.

Beneficiary fraud complaints could be sent directly to the contractors rather than to the regional offices. Only complaints that appear valid after in-house screening would be forwarded to the regional office. This would eliminate direct BHI involvement in most complaints. The adequacy of contractor handling of complaints would have

to be monitored. However, this could be done as part of the regional office's periodic evaluations of contractor program integrity.

In commenting on our draft report, HEW said that, in comparing receipts and referrals of complaints by source, we did not consider that a portion of the contractor referrals were initiated by beneficiary complaints.

Our figures were developed from BHI case files and complaint files based on the initial source of the complaint. To the extent that these files are accurate and complete, complaints originating from beneficiaries are categorized as beneficiary complaints, even though they were later referred to BHI by a contractor.

HEW added that beneficiary complaints are not comparable to contractor referrals since the contractor's cases have been screened for error or misunderstanding before being referred.

We agree that the two types of cases are not comparable. For this reason, we believe that BHI should minimize its direct involvement in unscreened beneficiary complaints.

PRIORITY SYSTEM OF LITTLE VALUE

The program integrity part of the Health Insurance Regional Office Manual deals primarily with the procedures to be followed once a beneficiary complaint is received. The manual provides no direction for evaluating whether resources spent on complaints could be more productively employed on self-initiated work or whether alternative methods for controlling fraud and abuse are desirable or feasible.

The only priority system discussed in the manual deals with priorities for handling complaint backlogs. It categorized complaints into five priorities. The first three priorities are billings for services not rendered by a doctor--reported by (1) a contractor (priority one), (2) a beneficiary to a district office (priority two), and (3) all other sources (priority three). All other fraud complaints are priority four and all abuse complaints are priority five. The last two were to be investigated in the order received.

Neither region we visited was using the priority system. Kansas City regional officials said they did not have a backlog that would require assigning priorities. A

San Francisco regional official did not believe the system would work.

Our analysis of the basis for establishing the priorities indicates that despite the assertion in the regional office manual that "the priority system is based on the actual productivity of various types of complaints," there was no valid basis for the priorities assigned.

Contractors' referrals were given first priority because of a BHI study which stated

> "* * * our review of actual case files gave us the impression that these referrals were more valid than those referred by the district offices. This is probably due to the contractor's in house screening prior to the referral of the complaint to the regional office."

Normally, the regional office would forward a complaint of nonrendered services to the contractor for in-house screening. If the screening resolved the complaint, there would be no sampling or further investigation.

A beneficiary's complaint should not warrant a higher priority because it was received by a contractor rather than the regional office.

As previously discussed, an approach that could minimize regional office involvement in nonproductive complaints and still afford complaints equal consideration would be to have the district offices refer fraud complaints to the contractor rather than to the regional office.

PROPOSED REORGANIZATION OF BHI PROGRAM INTEGRITY

In June 1975 the Director of BHI proposed to redesignate the Program Evaluation staff as the Fraud and Abuse Control staff, which would be responsible for the national direction and conduct of BHI's efforts to control program fraud and abuse. The staff would consist of three branches--Investigations Control, Review and Monitoring, and Field Operations.

The Investigations Control Branch would be responsible for (1) directing and overseeing the regional office fraud and abuse control activities, (2) analyzing national experience in controlling program fraud and abuse, (3) originating

additional methods for improving tnat activity, and (4) coordinating the exclusion from the program of doctors and providers for misrepresentation and abuse of the program.

The Review and Monitoring Branch would control two activities. The first activity, payment review, would relate to the central office review of payments to physicians who received more than $25,000 from the program and whose patterns of practice appear aberrant. BHI plans to expand this activity to include part A payees. The second activity would be a program monitoring function to give precise data and to recommend, install, and maintain systematic methods for detecting program fraud and abuse.

The Field Operations Branch would consist of a staff with various skills (accounting, investigations, and program) to (1) reinforce regional office fraud and abuse capabilities as required to meet special circumstances and (2) design and test new methods and techniques for seeking out program fraud and abuse.

Although SSA had not approved the proposed reorganization as of August 1976, the Investigations Control Branch and the Review and Monitoring Branch, which essentially represent a strengthening of existing functions, had been established by augmenting the program integrity staff with other BHI personnel. The Field Operations Branch had not been established.

The major problem delaying a decision on the reorganization was the relationship of BHI's role in Medicare investigations to that of HEW's Office of Investigations.

In commenting on our draft report, HEW did not indicate whether BHI's proposed reorganization would be approved. On January 18, 1977, the Office of Investigations and BHI agreed that the Office would assume responsibility for investigations of cases where prosecution appears warranted and that staff would be reprogramed from BHI to the Office to support this change in responsibilities. The establishment of the Health Care Financing Administration will further change some responsibilities for Medicare program integrity.

CHAPTER 3

INVESTIGATIONS ARE OFTEN INADEQUATE

Fraud investigations by both the San Francisco and Kansas City regional offices were often inadequate, although Kansas City's investigations had improved. Investigations of abuse complaints appeared adequate. Contractors in both regions were exceeding their authority in making investigations and were improperly closing potential fraud cases. Also, our limited work at the Social Security Administration's field offices showed that some offices were investigating complaints instead of referring them to the regional office.

The major deficiency in the regional offices' investigations was their failure to take any sample or an adequate sample of claims to identify any pattern of improper billing. We also believe that the Bureau of Health Insurance's sampling procedures are inadequate in that they do not require a large enough sample.

USE OF SAMPLING IN INVESTIGATIONS

Most Medicare fraud complaints concern billings for services not rendered. To develop a fraud case, one must establish a pattern of such billings. If no pattern can be shown, the improper billing is assumed to be simply an error.

Since 1974 the Health Insurance Regional Office Manual has provided that a sample of 20 beneficiaries' bills be selected and that the beneficiaries be contacted to determine whether they received services that were billed on their behalf. Before 1974 sampling was required but the sample size was not specified. The sample size of 20 allows a

--2-percent fraud to be detected 33 percent of the time,

--5-percent fraud to be detected 64 percent of the time, and

--10-percent fraud to be detected 86 percent of the time.

For example, if a physician bills for services not rendered in 5 percent of his bills, a sample of 20 would detect another fraudulent bill in 64 out of 100 cases.

However, the manual also provides that if no fraudulent bills are detected after 10 beneficiaries are contacted, no

more beneficiaries be contacted. Thus, the manual in effect provides for a sample of 10 beneficiaries' bills. A sample size of 10 bills allows a

--2-percent fraud to be detected 18 percent of the time,

--5-percent fraud to be detected 40 percent of the time, and

--10-percent fraud to be detected 65 percent of the time.

In commenting on our draft report, HEW said that the sample is not intended to be a scientific sample and that the above discussion oversimplifies the Medicare development process by not considering many judgmental factors involved in every case. HEW cited only one factor--that if the beneficiary contacts do not develop a pattern which indicates fraud, the physician is asked to explain the irregularity. If the explanation is not satisfactory, additional beneficiaries are contacted.

We believe that the sample size should be expanded. Unless a high percentage of the provider's bills are fraudulent, a sample size of 10 is unlikely to detect fraud.

REGIONAL OFFICE INVESTIGATIONS OFTEN INADEQUATE

In the San Francisco region we analyzed 107 complaints closed between July 1972 and December 1974. The following table categorizes these complaints based on our analysis of the region's investigations.

	Fraud	Abuse	Total
Initial complaint substantiated	22	24	46
Initial complaint validity undeterminable	15	4	19
Initial complaint unsubstantiated	28	2	30
Initial complaint not program integrity related	6	6	12
Total	71	36	107

Of the 22 substantiated fraud cases, 4 were referred for possible prosecution. We believe that 8 of the 18 potential fraud cases, for which the initial complaint was substantiated, were closed before a realistic determination could be made about whether an illegal pattern of practice could be

established. We believe these cases were prematurely closed for one or more of the following reasons.

--Insufficient or no additional beneficiaries were contacted to determine whether there was a pattern of fraudulent practices after an initial complaint had been substantiated.

--The contractor placed the provider on a prepayment review which would not detect additional instances of most fraudulent and many abuse practices.

--The regional office failed to adequately review or follow up on the investigations made by its contractors.

Of the eight fraud cases involving substantiated complaints that we considered to be inadequately investigated, no sample was taken for five cases and an inadequate sample was taken for another case.

In addition to the substantiated complaints, our sample contained 15 fraud complaints for which we were unable to determine whether the initial complaint had any validity. However, the investigations appeared inadequate for 9 of the 15 cases because (1) the records reviewed by investigators were of questionable value, (2) the investigations did not consider certain reported problems or indicators of other problems, or (3) the regional office failed to adequately review or follow up on the investigations made by its contractors. Program integrity officials said that workload pressures forced a concentration on more promising cases. The following is an example of an investigation that appeared inadequate.

An anonymous employee made five allegations about a hospital: (1) deposits were not refunded, (2) the administrator's meals were paid by Medicare, (3) patients were billed for wheelchairs, (4) patients were charged for admission packs, and (5) there was double billing for food to patients in the dialysis unit. Two days after the intermediary was contacted for assistance, it advised the regional office that a finalized cost report for the previous year had been received and that a limited field audit was made. The intermediary also said that additional work would not be necessary because neither the report nor the audit substantiated the allegations. The complaint was closed. The report and the audit covered a period before the date of the allegations, and neither specifically examined the five areas questioned.

BHI's San Francisco regional office staff agreed that six of the eight fraud investigations involving substantiated complaints and eight of the nine fraud investigations in which the validity of the complaint could not be determined were not adequately investigated. We could not reach agreement on three cases, which we believe were not adequately investigated.

Most of the substantiated abuse cases related to assignment violations. Generally, the abuse cases were properly handled, although several cases appeared to warrant additional work regarding the complaint or other matters disclosed during the investigation.

In the Kansas City region, we analyzed 102 complaints closed between July 1972 and December 1974. There were 56 abuse complaints in our sample. We considered only one abuse case to have been inadequately investigated. The complaint alleged that unnecessary tests were given in a hospital. The intermediary was asked to handle the complaint and to review a sample of other claims for medical necessity. The intermediary made a review, but verified only that the services were documented. Medical necessity was not questioned.

We believe, however, that 9 of the 36 fraud cases were inadequately or incompletely investigated for the following reasons:

Reasons	Number of cases where applicable
Other claims were not sampled even though the initial fraud complaint was substantiated	6
Regional personnel did not examine any records--they relied on carrier's word	5
Neither the carrier nor regional personnel examined any records--they relied on the provider's word that services were rendered	2
Pertinent questions or issues were not resolved during investigation	3
Inadequate documentation was obtained	1
Even though the initial fraud complaint was unsubstantiated, other claims should have been sampled	2

In summary, two cases were inadequate for one reason; four cases involved two reasons; and three cases involved three reasons. The following is an example of one of the cases we considered inadequate.

An executor complained that a physician did not render services. The carrier reviewed hospital records and determined that billed services were rendered. Records were forwarded to the regional office. The regional office review of hospital records indicated that not all physician visits were documented. The regional office asked the carrier to visit the physician's office. The carrier determined that not all billed visits were documented. The physician refunded about $281. The regional office closed the complaint after a refund was obtained from the physician.

Because investigations made in 1974 appeared more thorough than those made in 1972 and 1973, we examined cases closed in 1975 to determine if the improvement had continued.

During January and Feburary 1975, the Kansas City region closed 39 cases--27 fraud and 12 abuse cases. Investigations appeared adequate for the 12 abuse cases. Of the fraud cases, two were inadequately investigated.

In addition, one case was adequately investigated but the region decided not to seek prosecution. Although the decision seemed reasonable, the case should have been referred to the U.S. attorney for authority to close it.

Overall, the cases closed in 1974 and 1975 appear to have been much more thoroughly investigated than the 1972 and 1973 cases.

MEDICARE CONTRACTORS CLOSING POTENTIAL FRAUD COMPLAINTS IN VIOLATION OF REGULATIONS

San Francisco regional office

In this region, we reviewed 28 complaints that had been closed by Blue Cross of Southern California, Occidental Life Insurance Company, and Blue Shield of California from January to June 1975. Of the complaints, 12 should have been referred to the regional office for further investigation. An analysis of these closed complaints by contractor is presented below.

Contractor	Total complaints reviewed	Possible referrals	Providers contacted
Blue Cross	8	3	5
Occidental	10	6	8
Blue Shield	10	3	5
Total	28	12	18

The contractors obtained explanations of the discrepancies by contacting providers in 64 percent of the complaints. The Health Insurance Regional Office Manual specifically prohibits contractors from contacting providers without regional office approval because such contact may prejudice any potential fraud investigation and give providers a chance to claim clerical error.

In an example of an inadequately handled case, a beneficiary's friend discovered a room rate error and a duplicate pharmacy charge on the beneficiary's bill. To assure that proper corrections were made, he wrote to the hospital and the intermediary. The intermediary requested medical and financial records from the hospital. These records showed that errors exceeding $1,300 had occurred in (1) billing for intensive care instead of a private room, (2) a duplicate 7-day pharmacy bill, and (3) two charges for services after the patient was discharged. Additional beneficiaries were not contacted to determine if there were additional instances of overcharging.

Kansas City regional office

We reviewed 23 complaints that had been closed by General American Life Insurance Company between January 1, 1974, and March 31, 1975, and 10 complaints closed by Kansas Blue Shield between April 1 and June 30, 1975. We believe 13 of the General American complaints and 7 of the Blue Shield complaints should have been referred to the regional office for further investigation. We believe that all of the 13 General American complaints that should have been referred to the regional office were inadequately investigated.

Regarding the inadequate investigations and closing of complaints by General American, a Kansas City program integrity staff official said:

--The regional program integrity staff had not spent much time reviewing the carrier's quarterly reports. He added that he was unaware that the carrier was closing potential fraud cases without regional office involvement.

--16 of the 23 cases we reviewed should be reopened for additional investigative work. In each case, the carrier was instructed to review a sample of other claims.

--A carrier official told him that he generally agrees with our observations; i.e., that many of the investigations were inadequate.

--Some (10 to 12) of the cases shown on the quarterly reports were reviewed by health insurance program specialists during an annual visit to each of the carriers.

Regarding the last matter, a regional office health insurance program specialist made a regularly scheduled program integrity visit to General American in January 1975. In his trip report, the specialist said:

"* * * In my review of actual cases, I found that they were handled appropriately and in neat order. I reviewed ten cases off the Quarterly * * * Complaint Report and found no problems with any of them."

We believe that the program integrity specialists should more carefully evaluate the results of reviews of contractors' program integrity operations by the less experienced health insurance program specialists under their supervision.

General American, in commenting on our draft report, said that its conscientious efforts in the fraud and abuse area were demonstrated by the large number of irregularities identified and referred to the BHI regional office each year. It also pointed out that because General American's investigative personnel have considerable experience, BHI has allowed it to use more judgment than other carriers in deciding whether or not a case should be referred to the regional office.

General American discussed the cases we had reviewed and said that, except for two cases in which its personnel had made clerical errors, it believed the initial investigations were adequate. It pointed out that the cases we questioned were reopened and no fraud or abuse was found.

We do not agree that the cases were adequately investigated. We believe that 13 of the 23 cases we reviewed should have been referred to BHI's regional office and we consider the investigations of these 13 cases inadequate. Some of the reasons we consider the investigations inadequate are:

--No sampling or insufficient sampling was done to identify a pattern of improper billing.

--Apparent cases of services not rendered were treated as documentation errors and the possibility of fraud was not adequately considered.

--Other matters disclosed during investigations did not appear to be adequately addressed.

--Providers were contacted without regional office approval.

General American's comments imply that, because experienced personnel conducted investigations and because followup investigations showed no improprieties, the initial investigations were adequate.

We disagree. Most suspected fraud turns out to be misunderstandings or honest errors. It is the reasonableness of the steps taken rather than the outcome that determines the adequacy of an investigation. Further, we made a limited review of the followup investigations in December 1976 at the regional office and found that some had not been completed. Several that were completed did not appear adequate.

Of the seven cases that we believe Blue Shield should have referred to the regional office, four had received inadequate investigations. For example, Blue Shield had paid bills for physician nursing home visits on August 27, September 17, and October 17, 1974. The carrier learned later that the beneficiary had died on August 6, 1974. The carrier contacted the physician's office assistant, who said that she prepared Medicare claims from visit slips given to her by the physician. Blue Shield requested a refund from the physician for the three visits. The regional office was not notified of this program integrity matter, nor was the complaint reported on the carrier's quarterly report of program integrity complaints.

As a result of our discussions with a regional office official, the regional office has directed Blue Shield to reopen the four cases for which we considered the investigations inadequate.

In commenting on our draft report, Blue Shield stated that, after our review, it acted to (1) audit records as a routine procedure when verifying that billed services were rendered, (2) refer all cases in which there is a possibility of nonrendered services to the regional office, and (3) include all potential fraud and abuse cases on its quarterly reports to the regional office. Blue Shield believes it is doing a satisfactory job regarding Medicare program integrity and says it is receiving positive feedback from the regional office.

REFERRALS OF COMPLAINTS BY DISTRICT AND BRANCH OFFICES

Our limited work relating to SSA's district and branch offices showed wide differences in the number of referrals from offices serving similar size populations. Some differences appear to be the result of the emphasis the offices placed on program integrity and the tendency of some offices to do their own investigative work and refer only what they consider valid complaints to the regional office.

We visited four district offices in the San Francisco region. According to SSA officials, the district office in Santa Ana, which had forwarded 90 program integrity complaints since Medicare began, was comparable with the district office in Van Nuys, which had forwarded 46 complaints. District offices in Riverside--30 complaints--and San Bernardino--69 complaints--were also considered comparable. The two offices with the least complaints said they did preinvestigative research, including sometimes contacting physicians, before deciding whether to forward complaints to the regional office. The other two offices said they did no preinvestigative research on complaints.

We visited three district or branch offices in the Kansas City region--two with a relatively low number of referrals and one with a relatively high number. The offices with few referrals said they did not receive many complaints. The office with relatively more referrals attributed this fact to its stress on program integrity training and to in-house publicity on the results of referrals.

Based on our visits to 7 offices, we cannot generalize on the reasons for great differences in referral rates among SSA's approximately 1,300 branch and district offices. However, we believe SSA should reemphasize to these offices that they are to refer, rather than investigate, complaints and point out that premature physician contact can hamper the development of a fraud case.

QUALIFICATIONS, TRAINING, AND SUPERVISION OF REGIONAL OFFICE PROGRAM INTEGRITY PERSONNEL

Training for regional program integrity personnel has consisted mainly of on-the-job training, although formal training sessions are provided. Formal training for program integrity personnel is divided into (1) introductory training, (2) a followup session held about 6 months later, and (3) an annual session for experienced personnel. The session for experienced personnel is a seminar at which experiences and ideas are exchanged.

Training for new personnel includes learning how to evaluate complaints, sample, plan and schedule field investigations, interview, review records, and work with U.S. attorneys. New personnel also learn about beneficiary contacts, sources of information, proof necessary to establish a violation, rules of evidence, case writeup, testifying in court, and legal nomenclature. Records showed that most regional office program integrity personnel had attended the introductory and followup training sessions.

Regional program integrity personnel are supervised by the program officer who heads the Program Evaluation Branch. Also, the San Francisco staff has two project leaders with supervisory and investigative responsibilities and the Kansas City staff has one project leader with such responsibilities.

Headquarters program integrity personnel are responsible for monitoring and evaluating the regional office work however, they do not directly supervise or control regional staffs nor do they make investigations. Generally, they did not have training or experience in investigations before being assigned to program integrity activities.

We did not evaluate the capabilities of program integrity personnel. However, the deficiencies we noted did not appear to be related to lack of training or experience. The most common deficiency was failure to sample additional bills to determine whether a charge for a service not rendered was an isolated error or a common practice. Workload considerations and the tendency of carriers to recover overpayments rather than search for fraud appeared to be the major reasons for not sampling.

Most U.S. attorneys we contacted were satisfied with the quality of the cases they received.

In our opinion, most cases handled by program integrity specialists would not require extensive training or investigative experience. A typical case involves determining whether services were rendered or whether beneficiaries were billed for more than allowed on assigned claims.

We believe that investigators would need a strong background in accounting and auditing for Medicare part A fraud and abuse, which would involve hospital and nursing home cost reports and records. However, as previously discussed, BHI recognized this in its proposed reorganization.

CHAPTER 4

PROSECUTION OF MEDICARE FRAUD

The Department of Justice has given authority to local U.S. attorneys to prosecute providers suspected of defrauding the Medicare program. Local U.S. attorneys decide whether to prosecute. Suspects are prosecuted under section 1877 of the Social Security Act (42 U.S.C. 1395nn) and section 1001 of the Federal Criminal Code (18 U.S.C. 1001). Suit must be filed within 5 years of the violation. In addition, providers may be liable for civil actions under the False Claims Act (31 U.S.C. 231). A civil suit must be filed within 6 years of the violation.

The Government does not prosecute many Medicare fraud cases, and U.S. attorneys often take a long time to decide whether they will prosecute.

As of June 30, 1975, 307 cases had been forwarded for prosecution. U.S. attorneys had declined to prosecute in 100 cases and had not decided whether to prosecute in 58 others. Convictions were usually obtained in the cases that were prosecuted.

Some reasons given for not prosecuting Medicare fraud cases were lack of recent evidence of questionable practices, disagreements on matters involving medical judgment, and problems with elderly witnesses.

In the Kansas City region, which declined most cases referred for prosecution, there appeared to be a strong reluctance to prosecute doctors considered to be providing valuable services to the community. Civil suits or out-of-court settlements were viewed as acceptable alternatives to criminal prosecution.

The U.S. attorneys we interviewed in the Kansas City region were satisfied with the quality of the cases referred to them. Two of the four attorneys we interviewed in the San Francisco region believed the quality was not adequate.

SAN FRANCISCO REGION

As of June 30, 1975, this regional office had referred 37 cases to U.S. attorneys, who had begun to prosecute in 16 cases, declined to prosecute in 13 cases, and had not decided whether to prosecute in 8 cases. The 16 cases prosecuted involved 26 suspects, of whom 22 were convicted, 2 were acquitted, and 2 had their cases dismissed.

Only 4 of our 107 sample cases were referred to U.S. attorneys. One case was successfully prosecuted, one was not prosecuted after an intent to defraud could not be established, one was not prosecuted because of extralegal factors, and one was awaiting the apprehension of the suspect.

The case where intent to defraud could not be established involved falsifying hospital records and submitting claims for services not rendered. The U.S. attorney declined prosecution on the grounds of insufficient evidence to establish criminal intent. The assistant U.S. attorney handling this case had resigned, and we could not determine why the evidence was insufficient.

As of June 30, 1975, the regional office had 14 cases pending with U.S. attorneys. Ten of these were for criminal prosecution 1/ and the other four were for civil actions. Three of these cases had been pending with the U.S. attorney for less than 6 months, four had been pending for from 7 to 12 months, and three had been pending for from 25 to 48 months.

We interviewed four assistant U.S. attorneys in the San Francisco region to obtain their views on Medicare cases. Two of them believed the cases they received from the regional office were of good quality. They said that the investigations were as good as those done by other law enforcement agencies.

One attorney believed that the Medicare case she handled was biased and that the witnesses were led to respond in a specific manner. In other words, they were advised to answer in a way which made them appear to be giving definite facts. The attorney believed this problem related to a lack of technical knowledge in the criminal justice field and a lack of training on how to write up a case for criminal prosecution. An SSA headquarters' Office of Administration investigator, rather than the regional office staff, had made the investigation.

The other attorney who was dissatisfied with the quality of Medicare cases discussed three pending cases. He said that in two cases the investigations were not complete. He

---

1/Page 26 shows that U.S. attorneys had not made a decision on eight cases. It appears that two cases (one resubmitted in March 1975 and one submitted in June 1975) were not included in the region's report to headquarters which was used in developing the statistics.

said that the third case was adequately investigated but that it was not a strong case and that when he got it, the most recent offense was almost 2 years old. He believed the investigators needed more education and training in developing and presenting cases.

The attorneys cited the following hindrances to prosecuting Medicare fraud cases:

--Elderly Medicare witnesses tend to forget facts.

--When a case involves the necessity of medical services, it is difficult to get physician agreement on the best treatment.

--Cases often do not include recent examples of continued questionable practices.

KANSAS CITY REGION

As of June 30, 1975, this regional office had referred 15 cases to U.S. attorneys for prosecution. The U.S. attorneys had prosecuted five cases, had declined to prosecute nine cases, and had one case awaiting trial. The five cases that were prosecuted resulted in three convictions and two dismissals.

Only two of the nine cases were declined in 6 months or less. In three cases, 7 to 12 months elapsed before the case was declined, and the other four took 13 to 24 months.

Of the 15 criminal referrals by the regional office staff, 4 were handled by the St. Louis U.S. attorney (Eastern District of Missouri) and 6 were handled by the Kansas City U.S. attorney (Western District of Missouri).

We examined eight cases referred for prosecution to the St. Louis and Kansas City U.S. attorneys. Two cases were prosecuted and one was awaiting trial. Criminal prosecution was declined in the other five cases.

Although there appeared to be some valid legal reasons for reluctance to prosecute, extralegal factors seemed to play a large part in the decisions to decline. For example, in one case the U.S. attorney stated:

"Our office has given careful consideration to the prosecution of the above individual, but we are declining criminal prosecution for the following reasons:

"1. A conviction, although misdemeanor, would seriously jeopardize his license to practice medicine.

"2. Defendant performs valuable services for the citizens living in rural * * *, who would otherwise be neglected.

"3. Defendant has agreed to make restitution of the overpayment and pay an additional $2,000 penalty pursuant to the False Claims Act.

"4. Defendant is also on notice of the potential for criminal prosecution for repetition of the offense.

"Thank you for your fine job of investigation and presentation."

St. Louis attorneys said that because of their limited experience, they could not generalize about the quality of Medicare cases. They highly praised the work done by one regional office staff member. The cooperation and assistance of the regional office in getting witnesses to court was also praised.

They made these general comments about fraud investigations, priorities, and the factors considered in deciding whether to prosecute:

--Typically, Medicare cases involve many small claims. When the U.S. attorney "weeds out" beneficiaries who have died, lost their memory, become too ill to travel, or moved away, the number of counts may have been greatly reduced.

--Getting elderly people to the trial site in a town some distance from their home is difficult. In addition, the U.S. attorney's office is faced with a travel problem.

--The physician's location is a consideration. He may be the only doctor in the area.

--The various considerations are not ranked, but a decision to decline criminal prosecution is based on the way all factors come together.

--Criminal cases are given priority over civil cases, but no formal priorities have been established.

In the one case in which a physician was prosecuted criminally for Medicare fraud in the Kansas City region, an assistant U.S. attorney said all factors came together favorably. Enough credible witnesses were found who were willing to testify and healthy enough to travel to the trial. The trial was held in St. Louis, thereby reducing the U.S. attorney's office's logistics problem, and enough counts to make the case worth going to trial were present. Also, because the doctor was working at a State hospital, the problem of removing him from private practice in an area where he was rendering a vital service to the community was not present.

The Kansas City U.S. attorney said that he did not know of any weaknesses in the regional office's investigations. He said fraud is difficult to prove because willful intent must be shown. His decision to prosecute a Medicare fraud case was influenced by the (1) possibility of a doctor losing his license--a penalty he considered too severe, (2) availability of medical services to the people served by the doctor, (3) quality of the doctor's treatment, and (4) reasonableness of the total money received from Medicare. He considered civil action or out-of-court settlement to be adequate deterrents.

The Kansas City assistant U.S. attorney who handled the three most recent Medicare cases said that in two cases the decision not to prosecute was based equally upon (1) the lack of credible witnesses and (2) extralegal factors. In the other case, he began criminal proceedings, but the defendant introduced conflicting medical testimony which discredited the evidence against him.

He said that the quality of investigations was generally very good; the case writeups have been complete, thorough, and well done; and regional personnel have always been cooperative. However, he thought some additional training was needed in criminal and legal proceedings and in distinguishing between criminal and civil fraud.

He said Medicare cases do not receive as much or as prompt attention as other cases because they are problematical (involve technical questions, lack credible witnesses, etc.) and require too much time. He believed that a civil consent judgment, which is legally not an admission of guilt, is just as effective as criminal prosecution and is viewed by the community as an admission of guilt. He pointed out that in the two declined cases, he obtained settlements of $14,686 and $12,000,

although the amounts allegedly obtained fraudulently were $207 and $2,900, respectively.

DEPARTMENT OF JUSTICE COMMENTS

In comments dated February 4, 1977 (see app. III), the Department of Justice stated that time lessens the prosecutability of cases, since witnesses die, become ill, move, and forget facts. Timely referrals improve the likelihood of successful prosecution, and the requirement for recent examples of fraud is often a reflection of the lengthy review process before referral.

The Department pointed out that it has been working with the Social Security Administration for 5 years to improve prosecutions. However, as long as there are shortages of investigators and prosecutors, delays in prosecutions are inevitable.

The Department believed some balance is necessary to our statements about the reluctance of some U.S. attorneys to prosecute physicians and cited some of its significant efforts in Pennsylvania, New York, California, and Illinois.

The Department stressed its concern with program integrity and discussed recent steps it has taken to combat Medicare and Medicaid fraud, including:

--Involvement of the Federal Bureau of Investigation in such fraud investigations, which has resulted in task force efforts in several cities.

--Plans to improve enforcement methods and techniques.

--Pledging all its investigators, at a recent National Conference on Medicaid Fraud and Abuse, to help State officials clean up their Medicaid programs.

Justice considered it unfortunate that the legislation proscribing Medicare and Medicaid fraud provides only for misdemeanor penalties. Although more general fraud statutes have been used, they create problems with indictments and provide an argument for defense counsel that misdemeanor penalties are all the Congress really intended.

The Congress is currently considering legislation to strengthen the penalties for Medicare and Medicaid fraud. H.R. 3 and S. 143, introduced in the 95th Congress on January 4, 1977, and January 11, 1977, respectively, provide felony penalties for certain fraudulent offenses relating to Medicare and Medicaid.

CHAPTER 5

MEDICAID PROGRAM INTEGRITY ACTIVITIES IN CALIFORNIA AND MISSOURI

As the Committee requested, we examined Medicaid program integrity data in a State where there appeared to be extensive program integrity activity and in a State where such activity appeared limited. For the State with extensive activity, we selected California, which had a program integrity staff of 47 investigators and 9 auditors as of September 1, 1975. For a State with limited activity, we selected Missouri, which did not have full-time Medicaid investigators. Its Medicaid investigations were made by personnel borrowed from other offices.

California Medi-Cal investigators, who faced a large volume of cases and production standards that limited in-depth investigations, concentrated on closing cases quickly and recovering overpayments. The investigators did little self-initiated work because of the backlogs of complaints.

Missouri's program integrity activity has been minimal. About 10 to 15 investigations have been made, but no prosecutions have resulted. There were no written procedures for making investigations.

CALIFORNIA

The Investigation Section of the Department of Health is responsible for making systematic inquiries into allegations of violations of Medi-Cal laws and regulations. The Investigation Section is divided into a headquarters office in Sacramento and six district offices. The headquarters office provides staff support services, including developing and implementing management information and control systems, developing investigative procedures, preparing budgets, managing personnel, and filing reports required by the Social and Rehabilitation Service. The chief of the Investigation Section said that each district office has the authority to open investigations, do the fieldwork, and decide the disposition of its cases.

At the headquarters office, the section chief is helped by two investigators--the chief of intelligence, who is primarily responsible for background investigations of those wishing to provide services to Medi-Cal beneficiaries, and

the chief investigator, who is responsible for investigations involving Department of Health statutes, rules, or regulations. The chief investigator is responsible for the efficient and effective handling of all investigations by the district offices. This involves monthly visits to each of the six offices.

The section chief said that, in general, the investigators were either police science majors or former police officers or had investigative experience. The auditors have either come from other State agencies or have a bachelor's degree in accounting. We verified this information at the two district offices we visited.

In 1975 the Investigation Section received almost 7,700 cases. Of these, 60 percent involved possible beneficiary fraud or abuse and 40 percent involved possible provider fraud or abuse. Medi-Cal officials said that no statistical distinction was made between fraud and abuse cases.

District offices investigate complaints

The Investigation Manual prescribes the policies, procedures, and guidelines for the effective and efficient investigation of all complaints. The manual provides that all complaints be screened by the district supervisors for investigation and subsequent disposition and be summarized in a written report.

The district supervisor is responsible for screening all complaints with a preliminary investigation. The primary purpose of this investigation is to determine whether the complaint has merit. After a complaint has been substantiated, a full investigation is made.

The section chief said that the vast number of complaints requiring investigation and the limited staff precluded self-initiated investigations. The two district office supervisors said that internally generated cases had not been developed because of the massive workload and workload standards. They said investigators were responsible for 20 to 150 cases and had little time to identify new areas of potential fraud.

The workload standards, developed by the Management Consultation Section of the Department of Health, indicate the allowable times for investigations of various types of cases. When a district office spends more time completing investigations than the standards allow, the headquarters office

warns it to either improve efficiency or face a staff reduction. This forces investigators to respond to cases quickly and not develop cases which may take longer than the established standards. The chief investigator said tnat cases were frequently not developed for criminal prosecution because the time needed to adequately develop them would exceed the standard.

Investigations directed to quick case closures

The primary emphasis in Medi-Cal investigations appeared to be placed on closing cases quickly and recouping program overpayments.

During 1975 the Investigation Section closed 1,145 provider cases and 1,917 beneficiary cases. Recovery of overpayments and the use of warning letters were among the more common dispositions. For providers and beneficiaries these actions accounted for 47 and 45 percent, respectively, of the dispositions. Only 2 percent of provider cases and 1 percent of beneficiary cases were developed for criminal prosecution.

We were told that the number of criminal cases being prosecuted by district attorneys has dropped considerably because they hesitate to become involved in cases that require a long time to prosecute. Some district attorneys are only taking cases involving $25,000 or more. Also, investigators feel that the courts are too lenient.

As a result of these factors and the pressure to close cases, the investigators concentrate on actions such as warning letters and recovering overpayments.

Although our work in this area was limited, we were able to determine that statistical sampling generally was not done. Criteria were recently inserted in the Investigation Manual concerning when to sample additional claims. However, the criteria were rarely followed because workload pressures and the workload standards prevented detailed work on many cases.

According to the Los Angeles district office supervisor, no sampling had been done since 1972 or 1973. He said that sampling was time consuming and staff was not available to analyze the results. The San Bernardino district office supervisor gave the same reasons for not sampling additional

bills. He was unable to recall when the last sampling had occurred.

We analyzed 22 Medi-Cal cases closed between April 5, 1973, and January 30, 1976. The investigations for most of these cases appeared adequate.

In a January 1976 report, the Commission on California State Government Organization and Economy noted that the Investigation Section was spending too much time identifying Medi-Cal overpayments. The report stated:

> "The Investigation Section is currently burdened with administrative duties in relation to beneficiary overpayments. This activity is apparently of a routine clerical nature which could be assigned to the county welfare departments who now complete the eligibility screening and are identifying cases of overpayment due to ineligiblity. There appears no reason that routine cases of overpayment should be handled by the Investigations unit. The unit should be assigned only responsibility for special investigative work related to fraud and abuse."

The California Health and Welfare Agency, in commenting on our draft report, said that the responsibility for beneficiary overpayments had been transferred to county welfare departments.

A Department of Health official said that the California Department of Benefit Payments' failure to recover overpayments once they were identified created a morale problem with his staff because their efforts were not successfully completed. The Department of Health identifies about $100,000 in overpayments monthly and refers these to the Department of Benefit Payments for collection.

Because of backlogs or other problems in the Department of Benefit Payments, it actually recovers only about $25,000 monthly. We did not visit this department to discuss the problems in collecting overpayments.

MISSOURI

The Bureau of Medical Services in the Division of Family Services of the Department of Social Services administers the

Medicaid program in Missouri. The bureau chief said there is no distinct program integrity unit and no full-time Medicaid investigators.

Some complaints are received directly from beneficiaries, and others come through county welfare offices. According to the chief, complaints are placed in the provider's or beneficiary's file. No logs or reports of complaints were maintained. Therefore, information on the number and source of complaints was not readily available.

The bureau chief estimated that 10 to 15 investigations excluding pharmaceutical validation work had been made. In commenting on our draft report, the Director of Missouri's Department of Social Services said we should highlight the pharmaceutical validation activity. He stated that, in addition to verifying that beneficiaries have drugs of the quantity and quality for which Medicaid is charged, the pharmaceutical consultant obtains information on physicians' services, nursing home services, and numerous other things during his investigations.

The bureau chief said written investigative procedures had not been established. The cases we reviewed showed that the individuals involved in making or supervising the investigation decided on their own what steps to take. The bureau chief said no Medicaid fraud cases had been prosecuted in Missouri although two cases had been referred to county prosecutors. The county prosecutor decided not to prosecute one case and had not yet decided on the other case.

The chief counsel, Division of Family Services, said that Medicaid fraud cases are within the jurisdiction of county prosecutors. He said Missouri does not have a civil fraud statute providing punitive damages. Therefore, when county prosecutors decide not to prosecute on criminal charges, the only recourse is to recover overpayments. The bureau chief agreed that consideration should be given to referring Medicaid cases to U.S. attorneys for civil prosecution under Federal statutes which provide for punitive damages. He said Federal civil prosecution may be the only practical way to punish Medicaid fraud perpetrators since county prosecutors were often reluctant to prosecute someone in their community on criminal charges.

In commenting on our draft report, the director of Missouri's Department of Social Services said that our report

indicated that Missouri has done nothing to control the Medicaid program. He pointed out that, since its beginning, the Missouri Medicaid program has had a number of manual and mechanized controls which enable Medicaid officials to detect problems early and usually keep them from becoming serious.

This report focuses on the investigation of fraud and abuse. No evaluation was made of the overall fraud and abuse control system, nor is any criticism of such a system intended.

The director added that the Missouri General Assembly has appropriated funds to hire investigators for the department and that a number of these investigators are being assigned full time to the Medicaid program. The director suggested that full Federal financing of Medicaid investigators would enable States to carry out this important phase of Medicaid without undue problems.

CHAPTER 6

MEDICAID-MEDICARE COORDINATION

San Francisco's and Kansas City's Bureau of Health Insurance and Social and Rehabilitation Service regional office officials said an effective system for coordinating Medicaid and Medicare fraud and abuse investigations has not been set up. In Kansas City, BHI was notifying SRS (1) when a physician was suspended from accepting assignment under the Medicare program, (2) about some investigations of Medicare fraud, and (3) about physicians receiving high Medicare reimbursement. However, BHI was not routinely notifying SRS about all investigations or giving it all available overutilization data.

On the other hand, SRS had limited information to give BHI. An SRS official said his agency had not actively participated in Medicaid's program integrity activities but that it was establishing a program integrity unit.

Because SRS had no fraud unit in San Francisco, BHI rarely contacted SRS during Medicare fraud investigations. For crossover claims involving Medicare and Medicaid, BHI program integrity specialists contacted California's Medi-Cal fraud unit.

A California Medi-Cal official said his only contact with the San Francisco SRS regional office was to submit a quarterly report of the State's investigative activities.

According to both Medi-Cal and Medicare officials, an informal but cooperative relationship existed between their investigative staffs. The agencies exchanged information readily when a claim was for a person eligible for both programs.

A Missouri Medicaid official said that numerous contacts were made with Medicare carriers regarding certain suppliers and Medicare officials were probably notified when vendors were suspended by Medicaid for failure to comply with the participation agreement. However, he added that there was not a complete exchange of information between Medicaid and Medicare concerning suppliers of medical services who were suspected of fraud, overutilization, or other noncompliance with program requirements. Also, some complaints had been referred by Medicare carriers and the BHI regional office to State Medicaid officials.

Recent actions, when implemented, should help improve the coordination of Medicare and Medicaid fraud investigations.

On July 27, 1976, HEW published in the Federal Register proposed regulations permitting the release of data on individuals or organizations being actively investigated for Medicare fraud or certain types of abuse.

Final regulations were published requiring the States to report to SRS data on Medicaid fraud cases when complete investigations are being made. SRS has established a Division of Fraud and Abuse Control at headquarters and has authorized plans to establish similar units in its regional offices. It expected these offices to be fully staffed by October 1976.

Also, it appears that Medicare and Medicaid program integrity activities will be brought together in the Health Care Financing Administration.

CHAPTER 7

CONCLUSIONS, RECOMMENDATIONS, AND HEW COMMENTS AND OUR EVALUATION

CONCLUSIONS

Medicare program integrity investigations have largely focused on complaints from beneficiaries or someone acting on their behalf. The complaints have been about equally divided between fraud and abuse. Most abuse complaints involved violations of assignment agreements, and most fraud complaints involved billing for services not rendered.

Very little program integrity work has been self-initiated, and no priority system has been developed for directing program integrity action. The Bureau of Health Insurance's only established priorities relate to investigating backlogged complaints. There appeared to be no valid basis for these priorities, and they were not being followed at the two regional offices visited.

BHI recognized the need for evaluating its program integrity work. It also recognized the need for more self-initiated work, especially regarding fraud and abuse by institutional providers. A proposed reorganization of the program integrity functions dealt with these areas. However, the reorganization has not been implemented because of organizational changes within the Department of Health, Education, and Welfare.

Program integrity specialists usually have had little prior experience or formal training in making investigations. However, the deficiencies we noted in investigations did not appear to be caused by a lack of investigative experience. BHI recognized that personnel with investigative and accounting backgrounds would be needed to expand provider fraud and other self-initiated investigations.

Most fraud complaints appeared to result from misunderstandings by beneficiaries or errors by contractors or physicians. However, some fraud may have gone undetected because of inadequate investigations of complaints.

We believe that the monitoring of contractors' and regional offices' program integrity activities needs strengthening. Special emphasis should be placed on assuring that substantiated complaints of billing for nonrendered services are

not closed without determining whether such billing is an isolated error or part of a pattern of improper billing.

The sampling procedures specified by BHI are not adequate to permit such a determination. A larger sample should be taken. We recognize that this would require more investigative work. However, if staff limitations preclude adequate sampling, we believe that larger samples should be taken when sufficient staff is available.

We believe BHI should spend less time accounting for complaints and more time evaluating the adequacy of investigations. Both BHI headquarters and the regional office maintain a file for every fraud complaint reported to the regional office. Most complaints are resolved by the contractor and require no action by BHI except to open a case, refer the complaint to the contractor, and close the case when the contractor determines that no fraud is involved.

We believe adequate control over complaints could be exercised without maintaining details on all complaints at the regional offices and headquarters. Complaints should be forwarded to the Medicare contractors for in-house investigations and only complaints that merit further investigation should be reported to the regional office.

Referring all complaints to BHI headquarters is unnecessary. The data submitted is of little value in evaluating regional performance, and the statistical needs of BHI could be met by summarized data from the regions.

About half of the Medicare fraud cases referred to U.S. attorneys have been prosecuted--usually successfully. However, U.S. attorneys often delay in deciding whether or not to prosecute, and some decisions appear to be based on factors other than the merits of the cases.

Medicare fraud cases usually involve elderly witnesses who may die, be ill, or forget facts by the time a trial is held. Defendants frequently are respected members of the community. These factors sometimes make U.S. attorneys reluctant to assign a high priority to prosecuting Medicare fraud. It appeared to us that an unwillingness to prosecute physicians on criminal charges was a major factor in the high percentage of cases for which prosecution was declined in the Kansas City region.

The Congress, as evidenced by section 1877 of the Social Security Act, intended that criminal penalties be used against

those who defraud the Medicare program. We believe that better coordination is needed between SSA, HEW, and the Department of Justice to assure that Medicare criminal fraud statutes are uniformly applied. Also, decisions on whether to accept or decline cases should be more timely to better assure the availability of witnesses and reduce the need for updating information.

Medicare-Medicaid coordination was limited. Some coordination existed between Medicare and the two States visited. However, there was essentially no coordination between Medicare and the Social and Rehabilitation Service because SRS had no program integrity units.

HEW has acted to provide a framework for better Medicare-Medicaid coordination. Final regulations have been published requiring the States to report fraud and abuse data to SRS. Proposed regulations for providing Medicare data to SRS have been published. SRS had established and was staffing a fraud and abuse control staff, and HEW had established and was staffing a central Office of Investigations.

The above actions had not been fully implemented. Therefore, we could not evaluate their impact on the coordination of Medicare and Medicaid fraud and abuse control programs.

Our reviews of Medicaid investigations in two States showed a wide variance in the emphasis placed on Medicaid program integrity. California spent considerable resources on program integrity work. However, because of a large volume of cases and high quantitative production standards, little self-initiated work was done and recovery of overpayments rather than prosecution was stressed. Missouri's program integrity investigations were limited.

RECOMMENDATIONS

We recommend that the Secretary of HEW:

--Strengthen the monitoring of regional and contractor investigations so that complaints are not closed prematurely due to inadequate investigations.

--Establish statistical sampling procedures that provide reasonable assurance of detecting fraudulent billing practices.

--Reduce the paperwork connected with the investigation of fraud complaints by referring complaints directly to contractors rather than to the regional office.

Detailed records on unscreened beneficiary complaints should not be maintained by BHI headquarters and its regional offices.

--Discuss with the Department of Justice the possibility of obtaining more timely decisions on whether referred cases will be prosecuted and assuring that Medicare's criminal sanctions are uniformly applied.

--Develop priorities for investigating fraud and abuse.

--Acquire personnel with the investigative and accounting skills necessary to investigate types of fraud and abuse that are more complex than the typical beneficiary complaints of physician billing for services not rendered.

--Delineate the responsibilities of the various HEW organizations involved in Medicare-Medicaid program integrity.

--Establish procedures for coordinating program integrity activities within HEW and between HEW and the States.

--Work with Missouri Medicaid officials to establish a more active program for investigating Medicaid fraud and abuse.

--Emphasize to top-level Medi-Cal officials the importance of criminal prosecution as a deterrent to Medicaid fraud.

HEW COMMENTS AND OUR EVALUATION

HEW's December 27, 1976, comments to our draft report (see app. II) pointed out that Public Law 94-505, approved October 15, 1976, provides for an HEW Inspector General, whose responsibilities include (1) recommending policies for and conducting, supervising, or coordinating activities carried out or financed by HEW regarding fraud and abuse and (2) keeping the Secretary and the Congress informed about these matters.

On March 8, 1977, the Secretary of HEW announced the creation of a Health Care Financing Administration that places Medicare and Medicaid under one administrator. HE stated that one benefit of this reorganization will be the launching of a more energetic program of reviews to determine

major abuses in health care financing. The HEW comments presented below are based on the organizational structure which existed in December 1976.

HEW believes that our review did not consider all the fraud and abuse controls of the Medicare administrative system, of which the program integrity staff is but one part. HEW cites a number of features of its administrative system designed to insure program integrity.

We believe that some of the administrative features cited by HEW have little relationship to the detection of fraud and abuse or that their magnitude has been overstated. HEW points out that about 16,000 surveys are made of institutional providers and independent laboratories that participate in Medicare each year. However, these surveys are primarily designed to insure that patient care is adequate and have little relevance to fraud or abuse detection.

HEW also cites the number of contractors and the staff-years expended on the Medicare program. Although this data shows the number of people employed to administer Medicare, it tells little about the efforts to detect fraud and abuse.

HEW states that about 1,400 staff-years are spent annually to audit Medicare institutional providers. However, this large effort, which is essential to the provider reimbursement process, may have little impact on the detection of fraud and abuse. Our review indicated that audits are usually not of sufficient scope to detect fraud and abuse and that intermediary auditors usually did not consider whether fraud or abuse were intended when they detected unallowable costs.

HEW also cites as an example of its self-initiated work the annual Payment Review Project, which reviews physicians with high Medicare earnings and patterns of practice that appear abnormal. It points out that since 1971 these reviews have established about 1,000 abuse cases with overpayments exceeding $5.5 million and resulted in about 250 fraud investigations.

This project was not initiated by SSA; it resulted from the efforts of the staff of the Senate Finance Committee. The staff requested data on physicians paid $25,000 or more by Medicare and Medicaid in 1968. Although complete data was not available, the data provided to the staff indicated that hundreds of physicians might be abusing the programs. With regard to Medicare, the staff recommended that each

carrier be required to regularly compile and evaluate basic payment profile information for each health care practitioner. HEW agreed with the recommendation.

We agree that SSA has an extensive system that inhibits and helps to detect fraud and abuse and that most investigations are started based on leads developed from that system. However, the system has resulted in the program integrity staff being inundated with beneficiary fraud and abuse complaints, which generally result from such causes as a contractor error rather than improper billing by providers.

HEW states that our report deals with investigations from 1972-74, cites statistics more than 18 months old, and does not reflect or acknowledge the improvements and innovations made in the fraud and abuse control effort since 1974.

HEW points out that (1) in 1974, before our review, coordination with the Department of Justice was improved, (2) central office review and monitoring has been expanded, (3) a reorganization has been partially implemented at headquarters and the regions, (4) investigations are improving, and (5) as of June 30, 1976, BHI had referred 578 fraud cases to the Department of Justice, compared to the 307 cases referred through June 30, 1975.

Our review did not indicate substantial improvements in obtaining decisions from U.S. attorneys. As of June 30, 1974, 55 percent of the cases awaiting decisions by U.S. attorneys had been with the attorneys for over 6 months. At June 30, 1975, 56 percent of the cases were over 6 months old. As of June 30, 1976, 49 percent of the cases were over 6 months old.

Some of the improved monitoring referred to by HEW had already taken place at the time of our review. However, we were not able to determine its impact. We attempted to determine the extent of headquarters review of investigations for the two regions we visited. However, BHI's records showed little data on the extent of headquarters review or actions taken based on such review. As previously discussed, significant improvements were needed in contractors' program integrity activities, although BHI had been reviewing these activities for some time.

Our review, of which the Medicare portion was made in 1975, covered cases investigated by BHI through December 31, 1974, except for Kansas City, where we examined some 1975 cases because investigations appeared improved in 1974. Most of the contractor cases we examined were investigated in 1975. Improvements may have been made since that time.

HEW said that we understated BHI's achievements because we ignored statistics showing that as of June 30, 1976, BHI had referred 573 fraud cases to the Department of Justice. Statistics for fiscal year 1976 were not published until August 1976, after the completion of our fieldwork. We used the fiscal year 1975 statistics so we could verify and analyze them during our review.

Although referrals for prosecution have no doubt increased substantially, the number of cases is well below that cited by HEW. Beginning with Septe[illegible] 30, 1975, BHI reported the number of suspects referred for [illegible]secution rather than the number of cases. In summarizing [illegible]s report, BHI pointed out this change and stated that as of September 30, 1975, 326 cases involving 423 suspects were referred. Thus, counting suspects rather than cases resulted in about a 30-percent "increase" in referrals. BHI's report on referrals as of June 30, 1976, shows that 578 suspects were referred for prosecution but does not show the number of cases involved.

HEW also said that our report gives the impression that prosecutions are the only result of its program integrity effort. HEW cited its deterrent value, the recovery of overpayments, and educational contacts to eliminate future billing problems as other benefits.

We agree that these other results are beneficial.

HEW said that we recommended an increase in sample size without considering cost and manpower limitations. It noted that an objective of assuring virtually no possibility of fraud before closing each of the thousands of cases processed would be an extravagant use of administrative funds.

HEW also said that, although not specifically stated, the report indicates that we believe BHI should not investigate all suspected incidents of fraud and abuse. HEW then disagreed with this position.

We recognize that larger samples would require more work, but we believe that larger samples should be taken in some cases even if they cannot be taken in all cases for which sampling appears warranted. Also, most fraud complaints are determined not to involve fraud during their initial development and never reach the point at which sampling appears warranted. We do not believe that HEW should virtually assure no possibility of fraud in every case. We agree that would be too costly to justify.

Nor do we advocate ignoring complaints of fraud and abuse. Rather we are recommending that BHI's involvement with fraud complaints be minimized until such complaints are screened by contractors. Once meaningful priorities for investigative effort are established, staff limitations may preclude adequate investigations of all complaints. Under such circumstances, we would consider selective investigations to be appropriate.

HEW said that it agrees with our recommendation about the need for better monitoring and that it has acted, within staff constraints, to improve the monitoring of regional offices and contractors. It believes our recommendation to refer complaints directly to contractors has considerable merit and will consider doing so when satisfied that its control of contractors is adequate.

Regarding our recommendation that better sampling procedures be established, HEW said that the sampling of 10 beneficiaries is not intended to be applied in all cases and that workload and staff resources are considered in determining the sample size. Since the program integrity manual does not indicate this, we believe the manual needs revision to require that adequate sampling is performed when staff is available.

HEW said that BHI has been working with the Department of Justice for a number of years and pointed out some of the actions it has taken. HEW also pointed out that its Office of Investigations, which has recently assumed responsibility for Medicare fraud investigations, is also working with the Department of Justice. In view of the above comments and those of the Department of Justice (see p. 31), it appears that coordination between the two Departments has improved and will continue to improve.

With regard to our recommendation for developing investigative priorities, HEW said that BHI already has a priority system and that we did not indicate that some other system would be more effective. As discussed on p. 12, BHI's priority system is merely a technique for determining the order in which to resolve backlogged complaints. The system does not address the issue of allocating resources between work done in response to complaints and self-initiated work.

HEW also cited BHI's efforts to expand its capabilities, the Office of Investigations' efforts to coordinate and delineate responsibilities, and SRS's efforts to increase coordination between SRS and the States.

HEW concurred in our recommendations regarding Missouri and California and pointed out a number of major actions being taken by SRS to enhance enforcement and prosecution activity in all States with high Medicaid expenditures, including California and Missouri. These actions include:

--Full-scale reviews planned or underway in major Medicaid States directed toward providers exhibiting a high probability of fraud. (We were advised by an SRS official on April 6, 1977, that a review is expected to begin in California in May, but one is not currently planned for Missouri.)

--Technical assistance to, and coordination with, the States.

--Evaluations of State management systems.

--Development of guidance and procedures for detecting and investigating fraud and abuse.

According to HEW, its Office of Investigations now has staff in every region and is discharging its investigative responsibilities in all HEW programs including Medicaid and Medicare. The Office is working with an Interdepartmental Task Force headed by the Deputy Attorney General. Also, the Office was in the final stages of developing a memorandum of understanding with SSA regarding the criteria for referring Medicare program integrity cases to the Office. The memorandum, which was signed after we received HEW's comments, provides that, except for beneficiary fraud, BHI will refer cases to the Office when a criminal violation is indicated and presentation to the U.S. attorney appears warranted.

HEW said that preliminary discussions have begun with SRS regarding the referral of Medicaid cases to the Office.

APPENDIX I

United States Senate
COMMITTEE ON FINANCE
WASHINGTON, D.C. 20510

February 18, 1975

B-164031(4)

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

Dear Mr. Staats:

Because of the continued attention being given to allegations of fraud and abuse under the Medicaid and Medicare programs, the Subcommittee on Health of the Committee on Finance is interested in obtaining additional information on how the Program Integrity activities under these Federally-assisted programs are being administered and managed.

With respect to the Social Security Administration's Program Integrity function for Medicare, we would appreciate your Office developing information on (1) how this function is organized, and (2) the Program Integrity activities in at least two Social Security regional offices. The review should cover the following matters:

-- The thoroughness and completeness of Social Security's investigations.

-- How priorities on investigations are established.

-- How workloads are managed and the extent of self-initiated investigations as opposed to investigations initiated through referrals and/or specific complaints.

-- Data on the costs of investigations.

-- The qualifications established for Social Security's investigative staff and the extent of supervision by the regional and central offices.

-- A comparison of the efficacy of present Program Integrity organization and activity with that which obtained prior to "regionalization."

APPENDIX I

-- The procedures for determining the disposition of investigations through referrals for civil or criminal prosecution, or for administrative action, or for closing a case.

-- The disposition of cases that have been referred to the Department of Justice with specific emphasis on any backlogs.

-- Coordination between Medicare and the Medicaid programs and between Medicare and other Federal investigative and audit agencies.

-- Social Security's procedures for making and following up on referrals to Medicaid agencies or others.

-- The extent of the involvement of intermediaries and carriers in Social Security's Program Integrity investigations.

The Committee would also appreciate similar data on selected State Medicaid programs, including a State where there appears to be extensive Program Integrity activity as well as a State where there appears to be less activity.

The significance of this request for assistance lies in the development of information as to how the effectiveness of the Program Integrity function under Medicare and Medicaid could be improved and how such a function under any national health insurance plan could best be structured, administered and managed.

Sincerely,

Herman E. Talmadge

Herman E. Talmadge
Chairman, Subcommittee on Health

cc: The Honorable Al Ullman
The Honorable Dan Rostenkowski

APPENDIX II

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF THE SECRETARY
WASHINGTON D C 20201

December 27, 1976

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Improvements Needed in Investigations of Medicare and Medicaid Fraud and Abuse." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

You will note that these comments discuss only the matters commented on in the draft report. As you know, Public Law 94-505, approved October 15, 1976 provides for an Office of Inspector General within the Department to increase our capabilities in dealing with problems of Medicare and Medicaid fraud and abuse. Under this Law, along with other responsibilities, the Inspector General is responsible for recommending policies for, and to conduct, supervise or coordinate activities carried out or financed by the Department for purposes including preventing and detecting fraud and abuse in its operations--and to keep the Secretary and the Congress informed on these matters. I believe that you may wish to recognize these factors in your final report.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

John D. Young
Assistant Secretary, Comptroller

APPENDIX II

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE COMMENTS ON GAO'S DRAFT REPORT ENTITLED, "IMPROVEMENTS NEEDED IN INVESTIGATIONS OF MEDICARE AND MEDICAID FRAUD AND ABUSE"

I. Social Security Administration (Medicare)

GENERAL

Overall, we believe that this draft report has serious shortcomings in that it does not recognize any results stemming from investigations of fraud and abuse except referrals for prosecution; does not mention significant self-initiated program integrity activity; arrives at conclusions that are based on a review of statistical records without an indepth analysis of the entire program integrity operation; criticizes a sampling technique utilized for investigative purposes without recognizing that it is a selective sample determined by other judgmental factors; and recommends an increase of sample size without considering cost and manpower limitations in work of this kind--i.e., that an objective of assuring that there is virtually no possibility of fraud before closing each of the thousands of cases processed would be an extravagant use of administrative funds.

The cover sheet of the draft report begins with statements that Medicare investigations of fraud and abuse have largely been directed to resolving beneficiaries' complaints, and that little self-initiated work has been done. In light of the overall Medicare administrative control system, these statements are inaccurate and misleading. GAO simply did not take into consideration the Medicare administrative system which is designed to assure proper payment and identify those situations which are potentially fraudulent or abusive of the program. Medicare fraud and abuse control activities conducted by the Program Integrity staff in the Bureau of Health Insurance (BHI) are but one facet of the overall effort to assure proper payments. All institutional providers--hospitals, skilled nursing facilities, and home health agencies--are periodically surveyed by State agencies under detailed Federal rules. About 16,000 surveys of providers and independent laboratories are made each year.

A provider, certified to participate in Medicare, can bill the program only for services to persons whose beneficiary status has been confirmed through careful procedures established by the program. When a provider does bill the program for services to a beneficiary, the bills are reviewed for coverage and medical necessity by intermediary organizations consisting of 81 Blue Cross plans and commercial insurers. These intermediaries annually expend in the neighborhood of 7,800 man-years carrying out program functions including provider bill reviews which employ procedures, developed under detailed Federal instructions, that are regularly and systematically monitored by BHI headquarters and regional office specialists. Final payment for a provider's bills is determined by an intermediary only after it has received, analyzed and, in many cases, field audited the provider's annual report of the costs of services to Medicare beneficiaries. Approximately 1,400 man-years are expended annually by the intermediaries or their auditors to audit, in varying degrees of intensity, the Medicare cost reports of some 13,000 providers that participate in the program.

APPENDIX II

Similar controls are in effect with respect to the bills of physicians and other suppliers of medical services. Again, bills are accepted for payment only after eligibility of the beneficiary is confirmed through careful procedures established by the program. These bills are reviewed for coverage, medical necessity, and reasonableness of charges by carrier organizations--48 Blue Shield plans and commercial insurers--who annually expend about 14,000 man-years on bill review and other Medicare functions. Here again, the bill review processes are established under Federal instructions and are systematically monitored by BHI headquarters and regional office specialists. Each bill paid generates an "Explanation of Medicare Benefits" form which is sent to the beneficiary to review and notify the carrier or the Social Security Administration if there is an error or improper charge.

All of the foregoing activities are, in essence, self-initiated sources which identify situations that give indication of attempts to defraud or abuse the Medicare program. All of these situations are addressed by the Program Integrity staff of BHI.

Concomitantly, the Program Integrity staff carries out an annual Payment Review Project which looks at those physicians who have Medicare earnings in excess of a specified amount and who have a pattern of practice which suggests certain departures from the norm. Since 1971, Program Integrity has identified 15,296 such physicians. Reviews of these physicians have established some 1,000 abuse cases with overpayments exceeding $5.5 million. In addition, approximately 250 fraud investigations have resulted from the Program Review Project.

In view of the processes and activities cited above, GAO's conclusion that little self-initiated work has been done is simply not supported by the facts.

The way the draft report is written gives the reader the impression that it represents the situation as it exists today. In fact, the report covers case investigations going back to the period 1972 to 1974, and cites statistics that are more than 18 months old. It does not reflect or acknowledge the improvements and innovations made in the fraud and abuse control effort since 1974.

In 1974, prior to GAO's review, BHI streamlined its fraud case referral procedures with the Department of Justice and established a follow-up mechanism. BHI central office role in case review and regional office monitoring have been expanded. Partial implementation of the reorganization of the fraud and abuse control activity has taken place with a resultant reprogramming of staff, both centrally and in the regions. Case investigations have improved and are continuing to improve. The draft report understates BHI achievements by ignoring the statistics that were provided to GAO--i.e., through June 30, 1976, BHI had referred 578 fraud cases to the Department of Justice for criminal prosecution. In contrast, the draft report cites the 307 cases that had been referred through June 30, 1975.

APPENDIX II

[See GAO note 1, p. 64.]

GAO RECOMMENDATIONS AND DEPARTMENT COMMENTS

GAO Recommendation

That the Secretary, HEW, direct the Commissioner of Social Security to:

APPENDIX II

--Strengthen the monitoring of regional and contractor investigations to assure that complaints are not closed prematurely due to inadequate or incomplete investigations,

--Establish statistical sampling procedures that provide reasonable assurance of detecting fraudulent billing practices,

--Reduce the paperwork connected with the investigation of fraud complaints by referring complaints directly to contractors rather than to the regional office. Detailed records on complaints which cannot be substantiated should not be maintained by BHI headquarters and its regional offices, and

--Enter into discussions with the Department of Justice directed towards obtaining more timely decisions on whether referred cases will be prosecuted and assuring that Medicare's criminal sanctions are uniformly applied, consistent with legislative intent, throughout the United States.

Department Comment

We concur with the first part of the recommendation. To the extent possible, within current staffing constraints, BHI has expanded its central office case review and monitoring activities. The regional offices also have expanded their monitoring of Medicare contractor investigations.

As to the second part of the recommendation, we would point out that the sampling of 10 beneficiaries, as suggested by BHI's operating instructions, is not intended to be applied universally in all cases. A number of factors--including workload and staff resources--are considered in determining sample size. We would also point out that a case is not closed solely on the results of a nonproductive sampling of beneficiaries. Subsequent to the sampling, the suspected individual is confronted and afforded an opportunity to explain the questionable billing which prompted the inquiry. The case is closed only if the explanation is determined to be satisfactory.

We believe that the third part of the recommendation--to refer fraud complaints directly to the contractors--has considerable merit and will be considered when we are satisfied that we have established adequate control of the carriers' handling of their existing program integrity workload.

As to the last part of the recommendation, discussions with the Department of Justice have been in progress for a number of years. In 1974 BHI, in concert with the Department of Justice, established procedures which permit early and summary referral of criminal cases. BHI also established a follow-up system to identify cases aging toward the point where they could lose prosecutive appeal. Further, the Department of Justice is notified whenever BHI disagrees with the declination of a given case by a U.S. Attorney or believes that cases are being unduly delayed.

APPENDIX II

GAO Recommendation

That the Secretary, HEW, assure that action is taken to:

--Develop priorities for investigating fraud and abuse including self-initiated efforts and more extensive effort in Part A of Medicare,

--Acquire personnel with the investigative and accounting skills that would be necessary to investigate types of fraud and abuse that are more complex than the typical beneficiary complaints of physician billing for services not rendered,

--Delineate the responsibilities of the various HEW organizations involved in Medicare-Medicaid program integrity, and

--Establish procedures for coordination of such program integrity activities within HEW and between HEW and the States.

Department Comment

BHI does have a priority system which calls for certain cases to be investigated first and others later--but all cases are investigated. Insofar as we can tell, GAO's study did not indicate that some other system of setting priorities would be more effective or productive. As the draft report indicates, BHI plans call for additional staff with accounting and investigative backgrounds, expanded studies and investigations of institutional providers, broader evaluations of the fraud and abuse control program, and improvements in the systems for detecting fraud and abuse.

The draft report notes that proposed and final regulations--permitting the release of Medicare fraud and abuse data to State and Federal agencies, and requiring the States to report Medicaid fraud data to the Social and Rehabilitation Service--together with the establishment of the Office of Investigations, offer opportunities for better coordination of Medicare and Medicaid fraud investigations in the future. We favor improvements in the coordination of fraud activities and will fully cooperate in any Department effort in this regard.

While not part of GAO's recommendations, the discussion in the report itself indicates that GAO believes BHI should not investigate all suspected incidents of fraud or abuse. We do not agree and would point out that existing policy calls for all incidents to be investigated.

APPENDIX II

OTHER MATTERS DISCUSSED IN GAO'S DRAFT REPORT

Pages 3 and 4--Under the caption "Administration of the Medicare and Medicaid programs", the report discusses the administrative mechanism for the Medicare program. It does not mention, however, the Program Integrity Staff, which is the unit responsible for investigating fraud and abuse. As a result, the reader is left with the impression that the carriers and intermediaries are responsible for this aspect of program administration. This impression is amplified by the discussion in the last paragraph of this section, page 4, on the lack of a Medicaid fraud investigative unit and SRS's plans in this regard. We suggest that a statement along the following lines be inserted after the first sentence of the second paragraph on page 3--"BHI has an organizational component, the Program Integrity Staff, which is responsible for the detection and investigation of suspected Medicare fraud."

Page 9--References in the second and third paragrephs to the "Bureau of Field Operations" should be changed to the "Office of Program Operations." In addition, the second paragraph is misleading in that it implies the responsibility for detecting, investigating, and preventing fraud and abuse is shared equally by BHI and the former Bureau of Field Operations. Actually, the district offices, under the Office of Program Operations, are the contact point for the Medicare beneficiary population and their function is to take complaints and forward them to BHI. In certain instances, the personnel in the district offices will conduct a limited investigation at the direction of the Bureau of Health Insurance. We suggest that the paragraph be changed, after the first sentence, to read "The Bureau of Health Insurance has the responsibility for preventing, detecting, investigating, and referring for prosecution or otherwise resolving instances of Medicare fraud and abuse. The district offices are responsible for receiving Medicare complaints from beneficiaries, obtaining pertinent facts via a statement and forwarding same to BHI. Upon request, district office personnel will conduct limited preliminary investigative work. This effort is assisted by the health insurance contractors."

Page 10--The following additional Program Integrity responsibilities should be shown following the first item at the top of the page:

--Development of a training program for central office and regional office staffs

--Coordinating an annual review of selected physicians

To correct the figure in the first sentence of the second paragraph, we suggest that the sentence be changed to read: "As of June 30, 1975, following the partial implementation of a reorganization plan, the staff consisted of about 40 professionals."

APPENDIX II

Page 11--The following should be included in the list of duties and responsibilities of the regional program integrity staffs; we suggest that it be shown as the second item:

--Reviewing reports from carriers on selected physicians as part of the evaluation of carriers' utilization control systems (PARE)

The figures shown in the first full paragraph on page 11 should be changed to reflect the April 1975 transfer to the program integrity effort in the regional offices of personnel formerly assigned to Program Validation. The correct figures are (1) 79 Program Integrity and Program Validation Specialists, (2) 34 Health Insurance Program Specialists, and (3) 8 other personnel. These figures do not include clerical personnel.

Page 12/13--In the first paragraph, the item dealing with provider cost reports should read: "reviews and audits cost reports and medical records from institutional providers." The second paragraph on this page is misleading in stating that no contact is necessary with the regional office on those cases resolved through a review of the contractor's inhouse material. The fact is that the intermediaries and carriers must provide the BHI regional office with a report of all cases resolved internally showing the nature of the problem and the resolution. We suggest that the second sentence be changed to read:

"When complaints can be resolved through a review of inhouse material, the intermediaries and carriers must furnish the BHI regional office with a report showing the nature of the problem and its resolution, even though a referral is not necessary."

Page 16

[See GAO note 1, p. 64.]

The last part of the second sentence of the first paragraph--stating that self-initiated investigations of potential fraud and abuse have been limited--ignores such self-initiated activities as the Payment Review Project, contractor reviews performed by Program Integrity, and the overall Medicare administrative control system described earlier.

APPENDIX II

The first sentence of the second paragraph places undue emphasis on the proportion of cases referred for prosecution, and leads the reader of the report to believe that this is the only result of the program integrity effort. The report omits any mention of positive deterrant value of this activity, of the overpayments which are recovered as a result of a complaint of alleged fraud, or of the educational contacts that are made to insure future billing problems will not occur.

The second sentence of the second paragraph states that complaints by beneficiaries appear to be least likely to be referred to the Department of Justice. This is not borne out by the statistics on page 19 of the report--showing that of the cases submitted to the U.S. Attorney, 41 percent resulted from beneficiary complaints and 41 percent from contractor referrals. In both the statement and the statistics, GAO apparently did not consider the fact that a portion of the contractor referrals were initiated by a complaint of a beneficiary to the contractor. Moreover, the two types of cases are very different; the beneficiary complaint is a "raw" complaint with no development, whereas the carrier referral is a partially developed case which has been screened for error or misunderstanding. In view of this, we believe that both the GAO statement and the statistics are misleading and suggest that they be deleted from the report.

In the last sentence of the second paragraph, GAO expresses an opinion that improvements are needed to reduce the administrative effort connected with beneficiary complaints. GAO may want to clarify this opinion since it seems to suggest that some complaints should not be investigated. BHI policy has been to appropriately investigate all complaints alleging incidents of fraud or abuse. We believe that this policy should continue.

Page 18--The third line of the third paragraph states that as of June 30, 1975, 307 cases had been referred for prosecution. More current information, shows that the number of referrals had increased to 578 by June 30, 1976. Here again, however, the reader of the report is led to believe that referral of cases for prosecution is the only benefit stemming from the program integrity effort.

Page 19--With respect to the statistics cited in the first full paragraph, we pointed out earlier that GAO apparently did not consider the fact that a portion of the contractor referrals were initiated by a complaint of a beneficiary and, moreover, that the two types of cases mentioned are not comparable; the beneficiary complaint being a "raw" complaint with no development, whereas the carrier referral is a partially developed case that has been screened for error or misunderstanding. Thus, we suggest that these statistics be deleted.

Page 20--The sentence beginning on the third line should be corrected to show that a copy of the control, Form SSA-2014, not a copy of the complaint, is sent to headquarters.

APPENDIX II

Pages 21 and 22--While the idea--mentioned in the paragraph beginning at the bottom of page 21--of reducing administrative effort on the part of the headquarters and regional offices may be desirable, we believe it should be considered when we have established adequate control of the carriers' handling of their existing program integrity workload.

Page 26--The statement made in the last paragraph of this page--that guidelines, etc. had not been issued--is not correct. In July 1976, BHI Identical Memorandum 76-93 was issued to establish interim guidelines and procedures between the Office of Investigations and Program Integrity.

Page 27--The first sentence of this page states, "Fraud investigations by both the San Francisco and Kansas City regional offices were often inadequate although Kansas City's recent investigations showed improvement." The implication is that San Francisco did not improve. However, GAO did not examine the more recent cases in San Francisco as they did in Kansas City and, thus, the question arises as to whether San Francisco too would have shown improvement if GAO had looked at the recent cases there. We think that the report should be clarified.

The second paragraph on page 27 states that the sampling procedures are inadequate and demonstrates this on page 28 with probability statistics which may not be applicable. The sample which is done is not, nor is it intended to be, a scientific sample of bills submitted by a physician. It is a biased sample whereby we select a sample of bills which are similar in character regarding the type of service billed for, and proximity in time to the bill in question. Further, we think that GAO's discussion oversimplifies the Medicare development process by not considering many judgmental factors which are involved in every case. For example, if the 10 beneficiary contacts fail to develop a pattern which indicates fraud, the physician is contacted for an explanation of the irregularities. If this explanation is not satisfactory in the judgment of the interviewer, additional beneficiaries are contacted.

Page 29--With respect to the first sentence following the table, since abuse cases are not referred for prosecution, it would be more appropriate to show the number of fraud cases only--i.e., 22--rather than combine both fraud and abuse cases. Thus, the report should show that 4 out of 22 fraud cases were referred--a considerably greater percentage.

Page 31--Earlier in these comments, we pointed out certain inaccuracies or omissions in the first two examples on this page.

The last sentence of the last paragraph on this page is intended to reflect the reason given by Program Integrity officials for the closure of some cases. To more fully and accurately reflect the reason for the closures, we suggest that the statement be modified along these lines--"Program Integrity officials said that workload pressures forced a concentration on more promising cases."

APPENDIX II

[See GAO note 1, p. 64.]

Page 44--In the last paragraph, we suggest that Kansas City staffing with respect to project leaders be shown. Kansas City has one project leader with supervisory as well as investigative responsibilities.

Page 49--The last paragraph mentions that the U.S. Attorney was dissatisfied with the quality of some Medicare cases. BHI would appreciate receiving information from GAO on those cases discussed with the U.S. Attorneys in order to determine if they were incomplete because of an early and summary contact with the U.S. Attorney designed to obtain his guidance on further development.

[See GAO note 1, p. 64.]

APPENDIX II

II. Social and Rehabilitation Service (Medicaid)

GAO Recommendation

The Secretary, HEW, should direct the Administrator, SRS, to:

--Work with the Missouri Medical officials toward establishing a more active program for investigating Medicaid fraud and abuse.

--Emphasize to top-level California Medicaid officials the importance of criminal prosecution as a deterrent to Medicaid fraud.

Department Comment

We concur. The comments below apply to both recommendations.

The Medical Services Administration (MSA) of the Department's Social and Rehabilitation Service has directed its efforts at enhancing enforcement and prosecutorial activity in all high Medicaid dollar volume States, including California and Missouri.

MSA's Division of Fraud and Abuse Control has full-scale reviews underway in 7 major Medicaid States. In this connection, field work (i) has been completed in three States (Ohio, Massachusetts, and Georgia), and (ii) is scheduled to begin (January 77) in 4 States (Texas, Oregon, Louisiana, and Idaho). The focus of these reviews is to examine claims of providers who exhibit a high probability of fraud. These reviews will accomplish four objectives: first, potential violators will be documented and referred to law enforcement, regulatory agencies, or peer review groups, as appropriate. Second, State management systems, policies and procedures will be appraised and recommendations will be made to State agencies where warranted. Third, high visibility of our review process will create a deterrent effect. And fourth, information gleaned from the review process will help in determining a realistic estimate of Medicaid fraud and abuse. During the course of the reviews, California and Missouri will be advised of the most appropriate means of improving their operations, and technical assistance will be given as needed. The Medicaid program in each State is different as are the organizations to combat fraud and abuse in each State; therefore, countermeasures for each State should be designed to conform to individual State requirements. Some States need more help than others.

This leads to another initiative, general technical assistance, which is now taking place in a variety of forms such as joint Federal-State investigations and reviews, as well as training sessions, exchange of information, provision of guidance and advice. For example, States attended a seminar in November 76 on the control of Medicaid fraud and abuse. The curriculum included identification of potential abuse, case development, referrals, prosecutions, deterrents and much more It also included workshops, panels, and presentations by highly qualified speakers.

APPENDIX II

MSA's Regional Fraud and Abuse Control Units have launched a massive program to assess State management systems and capabilities. Approximately 15 States will be studied by December 31, 1976, and the remaining 39 jurisdictions will be studied by June 30, 1977. Corrective action plans will be developed from these assessments and technical assistance, geared to each State's needs, will be offered.

Other programs in the planning stage are: development of investigatory and prosecutory handbooks; training on the use of provider review guides; development of additional guides as needed; and the development of a computer program to more definitively identify probable and potential Medicaid program violators.

Finally, the MSA Division of Fraud and Abuse Control constantly monitors existing legislation and regulations for effectiveness and appropriateness and recommends effective regulatory changes to support programmatic and operational needs. To this end, MSA has recently published regulations on reporting that will facilitate excharges of information with the Social Security Administration and regulations on factoring that will help to eliminate exploitation and profiteering.

In summary, MSA's Fraud and Abuse Control programs are designed to provide a comprehensive nationwide response to the problem.

III. Office of Investigations

The Office of Investigations (OI) now has investigative staff in each of the 10 HEW regions and has the capability to and is discharging its investigative responsibilities in all HEW programs including Medicaid and Medicare. Within the limits of staff, cases referred to OI are being investigated and indictments, prosecutions, and convictions are being obtained.

OI has successfully achieved a working agreement with the FBI regarding investigative jurisdiction in HEW cases. OI is participating in an Interdepartmental Task Force headed by the Deputy Attorney General and promulgated by the Fraud Section of the Criminal Division to set up guidelines, criteria, and procedures for the handling of HEW fraud and other "white collar crime" violations. Target areas and programs are being selected for concentrated task force type investigative effort to be coordinated by the U.S. Attorney or a special prosecutor from the Department of Justice.

Internally, OI is in the final stages of developing a memorandum of understanding with BHI, SSA, regarding the criteria for the referral of criminal fraud cases disclosed by BHI program integrity efforts to OI for investigation. The basic agreement is that when sufficient facts have been disclosed to indicate a criminal violation of law has occurred and consultation with the U.S. Attorney is indicated by the facts, the case will be referred to OI. This referral is in all cases except beneficiary fraud, which can best be handled administratively.

APPENDIX II

Preliminary discussions have begun with MSA, SRS, regarding the referral to OI of Medicaid cases when possible fraud is disclosed by the MSA Fraud and Abuse Unit or complaints of fraud are received by MSA.

GAO notes: 1. Deleted comments relate to matters discussed in the draft report which are not included in the final report.

2. Page references in this appendix may not correspond to page numbers in the final report.

APPENDIX III

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D.C. 20530

Address Reply to the Division Indicated and Refer to Initials and Number

February 4, 1977

Mr. Victor L. Lowe
Director
General Government Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Lowe:

This letter is in response to your request for comments on the draft report entitled "Improvements Needed in Investigations of Medicare and Medicaid Fraud and Abuse."

We agree with many of the report observations and recommendations. A significant number of them have been the subject of discussions over the past several years between our Criminal Division and the Department of Health, Education and Welfare (HEW), and the Bureau of Health Insurance (BHI). Among the areas of concern were the need for better coordination of Medicare and Medicaid enforcement efforts, need for larger samples to provide assurance that fraudulent practices are detected, and the need for more timely investigation and prosecution of alleged fraud cases. Certain other observations and recommendations made in the report were also of direct concern to us and warrant further comment.

Implementation of the BHI proposed reorganization discussed on page 17 and the focusing of HEW investigative resources on the detection of fraud and abuse have been hindered by several reorganizations. Now that the Inspector General legislation has been passed into law, we expect HEW will be able to improve and expand its investigative capability and better coordinate its

APPENDIX III

investigative efforts. However, we do recognize the possibility that an Inspector General may not be appointed for at least several months, thereby causing some delay before a strong, well-coordinated investigative program is underway.

In regard to the use of contractors to screen complaints as stated on page 27, it is our experience that contractors are poorly trained and motivated to uncover fraud and abuse. The contractors often employ recent graduates to audit the providers of the service. These graduates are generally unfamiliar with the regulations and have a greater interest in completing the audit in a specified time than in protecting the program. For these reasons, we would recommend either de-emphasizing the contractor's role in detecting fraud and abuse or taking steps to insure their effort is more professional and vigorous.

We agree with the basic criticism on pages 27-28 that the sample size is too small. Rather than the U.S. Attorney spending many days wrestling with material provided by the investigator that gives meager or inconclusive evidence on whether to prosecute, the Criminal Division prefers that a sample be secured which is sufficient to identify high likelihood of a sizeable fraud and then refer the matter to the U.S. Attorney. At that point, the BHI investigator can work with the prosecutor to determine what further investigative material is required. In effect, this is the approach presently employed, but because of the small sample sizes, determinations to prosecute often cannot be made without the expenditure of additional time and effort on the part of both the U.S. Attorney and the investigator. A larger sample would afford an adequate basis for the U.S. Attorney to respond to the timeliness or the appropriateness of prosecutorial actions and afford him the opportunity to immediately coordinate his needs with the investigator to develop a "solid" case.

With respect to the declination of cases, the development of fraud cases is difficult and often time-consuming. In Medicare cases, time has a deleterious effect on the prosecutability of the cases. Over time elderly Medicare witnesses die or tend to forget facts, become too ill to travel, or move away. For these reasons, the more prompt

APPENDIX III

and expeditious the referral, the chance for successful prosecution improves. The requirement by U.S. Attorneys for "recent examples" of the fraud is often a reflection of the time-consuming review process prior to referral. We have also encouraged the policy of BHI investigators working closely with the U.S. Attorneys even before the actual referral to enable a prompt and vigorous enforcement effort.

One of the recommendations on page 73 suggests that the Commissioner of Social Security "enter into discussions with the Department of Justice directed towards obtaining more timely decisions on whether referred cases will be prosecuted and assuring that Medicare's criminal sanctions are uniformly applied, consistent with legislative intent throughout the United States." This recommendation has been in effect for the past 5 years to help expedite prosecutions. However, as long as there continues to be a shortage of investigators and prosecutors, delays in prosecutions are inevitable.

In terms of prosecuting cases, we consider it unfortunate that the legislation proscribing fraud in the Medicare and Medicaid programs provides only for a misdemeanor penalty under 42 U.S.C. 1395 and 1396. As a consequence, the U.S. Attorney is forced to employ the more general fraud statutes, such as 18 U.S.C. 1001 and 1341. Although we have sustained these charges, it does create problems with the indictments and more importantly, it provides an argument for defense counsel that misdemeanor penalties are all that the Congress really intended.

The report makes reference to some reluctance on the part of U.S. Attorneys to prosecute physicians. This conclusion may simply reflect the acknowledged limitations of the audit as stated in the scope of review. To provide proper balance to the report, we consider it important to highlight some of the active prosecutions by U.S. Attorneys of physicians and others for alleged defrauding of the Medicare and Medicaid programs. Over the past 2 years, the U.S. Attorney's Office, Eastern District of Pennsylvania, has indicted 12 Medicaid/Medicare cases of which 9 cases involved doctors. The U.S. Attorney's Office, Southern District of New York, prosecuted

APPENDIX III

two chiropractors in the cases of: (1) United States v. Joseph H. Ingber and (2) United States v. Max Kavaler. During the period 1971-1975, the U.S. Attorney's Office, Central District of California, prosecuted seven Medicare fraud cases of which three were instituted against physicians. In addition, the U.S. Attorney's Office, Northern District of Illinois, has under consideration approximately 49 Medicare/Medicaid cases involving over 400 individuals and firms. Recently, convictions were obtained from four nursing home owners, whose sentences included fines totalling $700,000. The nursing homes charged in these indictments were suspended from the Medicaid program, and the projected revenue lost by the defendants is $600,000 per month.

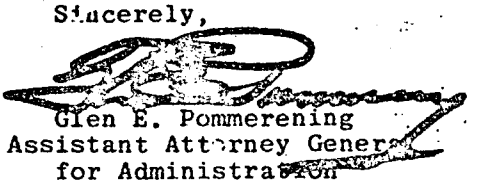
We also want to take this opportunity to point out steps being taken by the Department of Justice to improve and make more effective its enforcement efforts in Medicare and Medicaid prosecutions. In November 1976, the Federal investigative resources to combat fraud on the Medicare and Medicaid programs were sizably increased when the Federal Bureau of Investigation agreed to take on the joint investigative responsibility with HEW for these investigations. This infusion of a talented investigative resource has already had a noteworthy impact in the setting up of task force efforts in several cities. The HEW Office of Investigation has also expanded its personnel within the past year from 10 to 24, and we are encouraging its continued expansion. We expect the number to double within the next year. Finally, one of the objectives of the Attorney General's White Collar Crime Committee is to improve enforcement methods and techniques so that enforcement efforts in the Medicare and Medicaid programs will be more effective. As one of a series of steps taken in our efforts to curb suspected program fraud abuse, the Criminal Division conducted a 3-day seminar in October 1976 in which representatives of HEW and 60 Assistant U.S. Attorneys from the major offices around the country discussed the very objectives set forth in the GAO report. We believe this conference, which also included representatives of the Department of Agriculture and the Department of Housing and Urban Development, was extremely worthwhile.

APPENDIX III

One of the foremost concerns of the Department of Justice is to make an impact on the sizable amount of fraud and abuse in the Medicare and Medicaid programs. At a recent National Conference on Medicaid Fraud and Abuse, the Department pledged its full arsenal of investigators to helping State officials clean up fraud and abuse in their Medicaid programs. The U.S. Attorneys throughout the country are gravely concerned with the need to protect the integrity of programs and to prosecute violators. While there may be differences of opinion among professionals as to the merits of a particular case, we feel comfortable in assuring that the U.S. Attorneys are exercising their best professional judgment in the handling of cases presented them.

We appreciate the opportunity to comment on this draft report. Should you have any further questions, please feel free to contact us.

Sincerely,



Glen E. Pommerening
Assistant Attorney General
for Administration

GAO note: Page references in this appendix may not correspond to page numbers in the final report.