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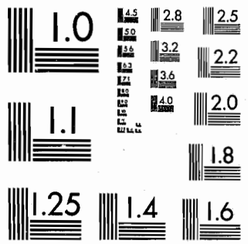

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DRAFT

The Prevention and Control of Fraud: A Case Study of the Medicaid Program

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ABSTRACT

This report presents four case studies describing the efforts in the states of California, Michigan, Vermont and Washington, to control and prevent fraud in the Medicaid program. The focus of each case study is on the information needed (1) to detect accurately patterns of misutilization of Medicaid funds by health care providers; and (2) to prosecute those cases where investigation establishes that a pattern of potentially fraudulent activity exists. This is the second of two reports that examine the need for information in the prevention and control of fraud in government benefits programs.

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EXECUTIVE SUMMARY

A. INTRODUCTION

More and more, the problem of fraud in government programs and operations has become the concern of federal, state, and local agency administrators and policymakers. To date, most anti-fraud strategies have been largely reactive-in-nature; however, attempts are now being made to move toward the development of more proactive fraud prevention strategies which are designed to identify and correct program weaknesses as well as detect the occurrence of fraud. Efforts have been initiated to develop vulnerability assessments (i.e., the identification of the susceptability of agency programs to fraud), telephone "hotlines", and computer-aided detection techniques. However, a major obstacle has been the lack of timely, accurate, and comprehensive data needed by government agencies to:

- specify the nature and extent of fraud in government programs and, thereby,
- facilitate the systematic development, implementation, operation, and evaluation of proactive strategies and techniques for the prevention and control of fraud.

B. PURPOSE OF STUDY

Recognizing that accurate and reliable information is required to develop effective and efficient anti-fraud strategies, MITRE has undertaken a study sponsored by the Department of Justice's (DOJ) Bureau of Justice Statistics (BJS) to determine:

- what information is currently available about the nature and scope of fraud in government programs;
- what data bases and information systems have been developed to define the nature and extent of fraud; and
- what issues must be resolved in order to improve current knowledge regarding fraud.

Specifically, this study will examine information describing the nature and scope of (1) detected fraud as well as (2) undetected fraud.

In order to analyze and interpret data regarding fraud in government operations and programs, it is necessary to understand the total systems context or environment of these operations and programs including such factors as the nature of the benefit programs themselves; the organization and operation of the agencies administering those programs; the organization and operation of those agencies reponsible for the prevention and control of fraud; the interaction between and among fraud control agencies and program agencies; and the applicable laws. Consequently, MITRE sought information on a wide variety of organizational and legal variables including those mentioned above.

Moreover, any effort to understand the systems context or environment must take into consideration the interaction of various levels of government. The development and implementation of government programs almost invariably involves complex interrelationships between the federal government and state governments not only in terms of administering large-scale programs (e.g., Aid to Families with Dependent Children, Food Stamps, and Medicaid), but also in controlling and preventing the occurrence of fraud. Consequently, the research strategy underlying this project involves two interrelated phases:

- the first phase provides a broad overview of the nature and scope of fraud from the perspective of a wide range of federal agencies involved in the prevention and control of fraud; and

- the second phase provides an "in-depth" study of Medicaid fraud focusing on the activities of state Medicaid fraud control units and state Medicaid agencies employing Medicaid Management Information Systems.

As a benefit program involving both federal and state agencies, the Medicaid program was selected as the subject of the second phase of the study for two reasons:

- first, the scope of the program itself--it is estimated that in Fiscal Year 1980 Medicaid served 22,881,000 persons and provided $14,770,896,000 in grants; and

- second, the Medicaid program has been the focus of two joint federal-state level efforts to control fraud--the state Medicaid fraud control unit (MFCU) and the Medicaid Management Information System (MMIS).

The research team met with staff of the Medicaid fraud control units and the Medicaid agencies in four states: California, Michigan, Vermont, and Washington. These states were selected on the basis of three criteria:

- each has implemented both a Medicaid fraud control unit (MFCU) and a Medicaid Management Information System (MMIS);

- both the MFCU and the MMIS have been operational for more than a year; and

- staff of both were willing to cooperate in this study.

In addition, MITRE staff also met with the Director of the State Fraud Control Division, Office of Inspector General, Department of Health and Human Services. The research effort also included an extensive review of the literature.

The case studies presented in this document describe the efforts of four states (i.e., California, Michigan, Vermont, and Washington) to control and prevent fraud in the Medicaid program. The focus of each is on the information needed (1) to detect accurately patterns of misutilization of Medicaid funds by health care providers; and (2) to prosecute those cases where investigation establishes that a pattern of potentially fraudulent activity exists.

In each state, visits were made to the single state agencies (SSAs) for Medicaid administration and the Medicaid Fraud Units to gather data regarding the information needs and strategies involved in fraud detection, investigation, and control. Interviews were conducted with key members of the Medicaid program administration (e.g., Medicaid Management Information System Specialists, Medicaid Fraud Unit Chiefs, etc.) and documents describing all relevant activities were collected.

While an attempt was made to adhere to the same generic topics in each of the case studies, the reader should note that the subject headings, and even the level of detail devoted to each, are a product of the information elicited from the various actors involved and the amount of supporting documentation made available to the authors. In addition, the reader is cautioned that the validity of some of the information acquired through the interview process is open to question because the interviews were conducted two and one-half years into the implementation of Medicaid fraud legislation and the recollections of the respondents may not always have been reliable.

C. FINDINGS

The findings of this phase of the study are based on interviews with the Director of the Division of State Fraud Control (Office of the Inspector General, Department of Health and Human Services), the chiefs of the four Medicaid fraud control units visited, and officials with the single state agency responsible for administering the Medicaid program in the states visited. The interviews were supplemented by the analysis of the reports produced by the single state agencies, the Medicaid fraud units, the Office of the Inspector General at Health and Human Services, Congressional hearings, and the General Accounting Office.

The findings may be summarized as follows:

- Estimates of fraud in the Medicaid program are not valid statistically.
- Statistics regarding detected fraud are available, but their utility is limited.
- Surveillance and Utilization Review System (SURS)/MMIS indicates cases for further review and investigation and may serve as an investigative tool.
- The prevention and control of Medicaid fraud is facilitated by a close working relationship between the Medicaid Fraud Unit and the Review Unit of the SSA.
- The investigation and prosecution of Medicaid fraud is a complex, lengthy process which may create backlogs.
- There is increasing emphasis on the need to prevent Medicaid fraud.

Estimates of fraud in the Medicaid program are not valid statistically.

In light of the findings of the first phase of this study, it was not surprising to learn that estimates of the nature and scope of fraud in the Medicaid program are unreliable. The Director of the Division of State Fraud Control (DSFC) has stated that, in his opinion, existing estimates of Medicaid fraud are not statistically valid. His view was confirmed by officials at the Medicaid agencies and Medicaid fraud units (MFU) in the four states visited during this phase of the

study. The concept of using MMIS to estimate fraud did not find much favor among the individuals interviewed during this phase of the project. State officials emphasized that SURS/MMIS can only identify those providers who appear to represent exceptions to set limits or parameters. A long review process is required to identify the cases excepted by SURS which do, in fact, involve abuse or misutilization. Additional analysis is then required to identify those instances where fraud may be involved.

Statistics regarding detected fraud are available, but their utility is limited.

Each of the Medicaid fraud units produces an annual report which provides some statistics regarding Medicaid fraud such as the number of investigations, indictments and convictions; the types of providers involved; and the amount of restitution, savings, and recoveries. However, both the Director/DSFC and the heads of the four MFUs pointed out there are some serious problems in interpreting the results of any statistical analysis. For example, a serious analytical problem is caused by the fact that the state MFUs tend to define such variables as fines, restitutions, overpayments, and savings in different ways and in accordance with the criminal and civil codes of their respective states. Thus, it is difficult to aggregate data across states. Moreover, it is difficult to obtain a reliable estimate of the amount of dollars lost to detected fraud because there are rarely statements as to the provable dollar amount lost to detected fraud included in the MFCU reports. Furthermore, as the Director/DSFC pointed out, any attempt to analyze existing data requires a thorough knowledge of the operational environments of the MFUs and the related single state agencies (SSAs).

SURS/MMIS indicates cases for further review and investigation and may serve as an investigative tool.

There is a general agreement among the officials interviewed that the SURS does not detect fraud nor was it ever intended to do so. What the SURS does do, however, is to indicate cases for further review and investigation. A lengthy, complex review process is required to identify which excepted cases should be the subject of corrective action by the SSA and which should be referred to the MFU. Once a case is referred to the MFU, SURS/MMIS may be used as an investigative tool by the MFU. SURS/MMIS is capable of providing the type of audit trials needed by MFU auditors and investigators to "build a case".

The prevention and control of Medicaid fraud is facilitated by a close working relationship between the Medicaid Fraud Unit and the Review Unit of the SSA.

All the state officials visited stressed the need to establish and maintain a close working relationship between that unit of the SSA which is assigned responsibility for case review and the Medicaid fraud unit. Failure to achieve cooperation impedes the successful detection, investigation, and prosecution of fraud. Close cooperation and coordination is also required to identify and correct the programmatic vulnerabilities which provided the opportunity for fraud.

The investigation and prosecution of Medicaid fraud is a complex, lengthy process which may create backlogs.

The investigation and prosecution of Medicaid fraud requires an intensive as well as extensive effort on the part of both the fraud unit and its counterpart at the SSA. This lengthy, complex process may create a backlog for the MFU in its case processing. The length of time required to investigate and prosecute a case of Medicaid fraud may well run beyond the statute of limitations.

There is increasing emphasis on the need to prevent Medicaid fraud.

Both the MFUs and the review units recognize that while the detection, investigation, and prosecution of Medicaid fraud are important, these activities alone are not sufficient to deal with the problem. Consequently, there is increasing emphasis on activities designed to prevent fraud. The units visited are stressing the identification of the vulnerabilities of the Medicaid program which create opportunities for fraud. Where necessary, they are seeking changes in legislation and regulations to "tighten the loopholes" in programs which provide the opportunity for fraud.

D. POLICY ISSUES

An analysis of the data gathered during interviews with officials of the Medicaid fraud control units and single state agencies responsible for the administration of Medicaid in California, Michigan, Vermont and Washington, indicates that there are many similarities in the problems faced by the Inspectors General at the federal level and those confronting state officials in their efforts to control and prevent fraud in

the Medicaid program. This section identifies four major issues evident at the state level which may also be of particular concern to the IGs at the federal level. These issues focus on:

- the need for statistics regarding Medicaid fraud,
- coordination between the Fraud Unit and the Medicaid Agency,
- the operation of SURS, and
- the review process.

The need for statistics regarding Medicaid fraud

The first phase of this study indicated serious knowledge gaps regarding the nature and extent of fraud in government programs and operations at the federal level. The same condition exists at the state level in the Medicaid program. The problem is even more complex because of variation across states in terms of the organization and operation of their Medicaid fraud units and single state agencies administering the Medicaid program. The utilization of fiscal intermediaries exacerbates the problems of collecting and analyzing comprehensive, reliable statistics regarding detected fraud — all the way from initial detection to final disposition.

The current methods of gathering statistics regarding fraud in the Medicaid program raise a number of policy questions for both state and federal officials. For example, what statistical data is needed by state vis-a-vis federal officials? What is the most effective and efficient means of accommodating different needs? To what extent is standardized reporting across states required? How can the desired degree of standardization be best achieved? How can privacy and security requirements be met? How can the dollar amount lost to Medicaid fraud be measured?

Coordination between the Fraud Unit and the Medicaid agency

Both the fraud units and the Medicaid agencies recognize the need to cooperate in order to control and prevent fraud effectively and efficiently. The problem is how to best overcome some of the difficulties inherent in establishing inter-organizational coordination. The problem becomes even more complex when fiscal intermediaries are involved in the Medicaid program. An assessment of the liaison role between the fraud units and the Medicaid agencies could provide important information on how to improve their relationship.

The Operation of SURS

SURS has been described as a mechanism for detecting fraud. However, state level officials are of the opinion that—at best--it only identifies cases which exceed set limits or parameters. Whether or not fraud is involved can only be determined by a lengthy review and investigation process. However, the SURS/MMIS can be used as an investigative tool to provide the information needed in investigation and prosecution. Given the increased emphasis on the implementation of information systems to manage state and federal government programs and operations, particularly to control and prevent fraud, attention should be given to assessing the current capability of such systems to prevent and detect fraud as well as provide the kinds of data needed for investigation and prosecution.

The review process

The current review process of cases which may involve fraud performed by the single state agency is both complex and lengthy. The review process and the review unit itself should be examined to determine how it might be accomplished more effectively and efficiently. It is obvious that the program expertise of such review units plays an important role in the prevention and control of fraud. This is true at both the state and federal levels of government. The question becomes how to best bring this knowledge to bear on the program.

E. CONCLUSION

The overall findings of this phase of this study should be of direct interest to the Medicaid fraud units and the Medicaid agencies at the state level and to the Division of State Fraud Control and the Health Care Financing Administration at the Federal level. The information about statistics regarding Medicaid fraud should be of interest to the Bureau of Justice Statistics in its efforts to develop statistics regarding fraud in government operations and programs. At the present time, we have little or no comprehensive, reliable statistics regarding fraud at the state or federal levels.

1. INTRODUCTION

Fraud against the government has been defined as "willful wrongdoing by individuals or public and private organizations that affects the Government's interests."[1] The United States General Accounting Office (GAO), which has played a pioneering and principal role in the federal government's efforts to control and prevent fraud, has repeatedly emphasized the serious threat posed to government integrity and efficiency by the pervasive nature of fraud committed against the government. Indeed, fraud occurs at all levels of government—federal, state and local—and a bewildering array of methods are used in its commission ranging from the very simple and naive to the most intricate and devious of sophisticated computer techniques. Fraud is committed by a variety of perpetrators including individual recipients, service providers, vendors, contractors, and government employees. The cost of fraud goes far beyond dollars and cents. As GAO has emphasized:[2]

> "Fraud erodes public confidence in the Government's ability to effectively and efficiently manage its programs. In addition, fraud undermines program effectiveness. In some instances, illegal activities have adversely affected public health and safety."

1.1 The Prevention and Control of Fraud

The prevention and control of fraud in government programs has become one of the major policy thrusts of the new Administration, and the development of successful anti-fraud strategies is receiving heightened interest at all levels of government. To date, most fraud detection strategies have been largely reactive-in-nature; however, attempts are now being made to move toward the development of more proactive fraud prevention strategies which are designed to identify and correct program weaknesses as well as detect the occurrence of fraud. Efforts to develop proactive strategies have focused on a number of methods including vulnerability assessments (i.e., the identification of the susceptability of agency programs to fraud), telephone "hotlines," and computer-aided detection techniques. However, a major obstacle to their successful utilization has been the lack of timely, accurate, and comprehensive data needed by government agencies to:

- specify the nature and extent of fraud in government programs and, thereby,

- facilitate the systematic development, implementation, operation, and evaluation of proactive strategies and techniques for the prevention and control of fraud.

1.2 The Lack of Information

In 1978, former Deputy Attorney General Charles Ruff emphasized that the development of effective strategies for controlling and preventing fraud must be based on an informed estimate of the problem, stating: "...first and foremost...is the need for information."[3] However, according to another high ranking Department of Justice (DOJ) official, "effective data collection is...our weakest point in our attempts to effectively combat the problems of program abuse."[4] But, some three years later and in spite of all the increased emphasis on the control and prevention of fraud, GAO has pointed out that little has changed. Thus, concrete, definitive knowledge regarding the nature and scope of fraud seems to be as scarce today as fraud is pervasive.

For example, recently GAO attempted to estimate the amount of dollars lost in cases of detected fraud. Based on a statistical projection, GAO estimated that between $150 and $220 million were lost in the 77,000 cases analyzed. These cases consisted of incidents of fraud and other related activities reported during a 2-1/2 year period from October 1, 1976 through March 1, 1979. In spite of the high quality of this study, the findings do have some limitations.[5] For example, the estimated loss does not include cases in which state and local agencies had primary responsibility for investigating the loss of federal funds. Among the federally funded programs administered by the states are such large programs as Medicaid (an estimated expenditure of $16,086,557,000 and 22,899,000 recipients in Fiscal Year 1981) and Aid to Families with Dependent Children (an estimated expenditure of $7,727,515,000 in Fiscal Year 1981 and 10,763,000 recipients). Moreover, if there is little comprehensive, organized knowledge of fraud in federal programs administered by the state agencies (and investigated by them), there seems to be even less knowledge of fraud perpetrated against programs directly sponsored by local and state agencies.

1.3 The Present Study

Under the terms of the Justice System Improvement Act of 1979, the Bureau of Justice Statistics, U.S. Department of Justice, has been given the responsibility for collecting and analyzing a wide array of information concerning the nature and extent of criminal activities including fraud in government programs. Recognizing the need for information regarding the nature and scope of fraud, the Bureau of Justice Statistics has sponsored a study conducted by the MITRE Corporation, McLean, Virginia, to address three broad questions regarding the development of comprehensive and reliable data needed to control and prevent fraud in government.

- What information is currently available about the nature and scope of fraud in government programs?

- What databases and information systems have been developed to define the nature and extent of fraud?

- What issues must be resolved in order to improve current knowledge regarding fraud?

Specifically, this study examines information describing the nature and scope of (1) <u>detected</u> fraud as well as (2) <u>undetected</u> fraud.

However, in order to understand data regarding fraud, one must first understand the total <u>systems context or environment</u> in which fraud occurs, including such factors as the nature of the benefit programs themselves; the organization and operation of the agencies administering those programs; the organization and operation of those agencies responsible for the prevention and control of fraud; the interaction between and among fraud control agencies and programmatic agencies; and the applicable laws. It cannot be over-emphasized that the interpretation of data regarding fraud cannot occur in a vacuum. Consequently, MITRE sought information on a wide variety of organizational and legal variables including those mentioned above.

Moreover, any effort to understand the systems context or environment must take into consideration the interaction of various levels of government. The development and implementation of government programs almost invariably involves complex interrelationships between the federal government and

state governments not only in terms of administering large-scale programs (e.g., Aid to Families with Dependent Children, Food Stamps, and Medicaid), but also in controlling and preventing the occurrence of fraud. Consequently, the research strategy underlying this project involves two interrelated phases.

- The first phase provides a broad overview of the nature and scope of fraud from the perspective of a wide range of federal agencies involved in the prevention and control of fraud.

- The second phase provides an "in-depth" study of Medicaid fraud focusing on the activities of state Medicaid fraud control units and state Medicaid agencies employing Medicaid Management Information Systems.

1.3.1 The First Phase

During the first phase of this study, MITRE reviewed the efforts of 10 of the 16 Offices of Inspectors General: the Departments of Agriculture, Education, Health and Human Services, Housing and Urban Development, Labor, Interior, the Veterans Administration, the Small Business Administration, the General Services Administration, and the Community Services Administration. In addition, MITRE reviewed the roles of other federal agencies involved in the control and prevention of fraud: the Office of Management and Budget (OMB), the Office of Economic Crime Enforcement, the General Accounting Office (GAO), and the Executive Group to Combat Fraud and Waste in Government (the predecessor to the President's Council on Integrity and Efficiency).

As a result of this phase of the study, a report was published which discusses a number of findings focusing on the needs of federal agencies for information to be used in the development of fraud control and prevention strategies.[6] Included among these findings were the following.

- Existing estimates of fraud are unreliable. Moreover, there is little standardized information available regarding incidents of detected fraud.

- More emphasis needs to be placed on the use of such proactive techniques as vulnerability assessments, the

analysis of regulations, computer-aided detection, and the tightening of internal controls. However, the development of such techniques requires accurate, timely, and complete information regarding incidents of fraud and program weaknesses.

- There is a need for the exchange of data among agencies regarding fraud in order to eliminate opportunities for such practices as duplicate billing and the under-reporting of income, as well as to facilitate the tracking of offenders. However, no such central repository now exists to serve these needs.

- Information systems can provide a useful tool in preventing and controlling fraud. Continued efforts are needed to develop management information systems to support the Inspectors General in their efforts to implement proactive strategies.

1.3.2 The Second Phase

During the second phase of the project, MITRE focused on state and federal efforts to ensure the integrity and efficiency of the Medicaid program. As a benefit program involving both federal and state agencies, the Medicaid program was selected for two reasons:

- First, the scope of the program itself-- it is estimated that in Fiscal Year 1980 Medicaid served 22,881,000 persons and provided $14,770,896,000 in grants; and

- Second, the Medicaid program has been the focus of two joint federal-state level efforts to control fraud — the state Medicaid fraud control unit (MFCU) and the Medicaid Management Information System (MMIS).

The research team met with staff of the Medicaid fraud control units and the Medicaid agencies in four states: California, Michigan, Vermont, and Washington. These states were selected on the basis of three criteria:

- each had implemented both a Medicaid fraud control unit (MFCU) and a Medicaid Management Information System (MMIS);

- both the MFCU and the MMIS had been operational for more than a year; and

- staff of both were willing to cooperate in this study.

In addition, MITRE staff also met with the Director of the State Fraud Control Division, Office of the Inspector General, Department of Health and Human Services. The research effort also included an extensive review of the literature.

1.4 Purpose and Organization of This Report

This report is intended to present the results of the second phase of the study. The remainder of this report is organized into seven chapters:

- Chapter Two—an overview of the Medicaid program, the state Medicaid fraud control unit (MFCU) and the Medicaid Management Information System (MMIS);

- Chapters Three through Six—case studies of MFCU and MMIS as implemented in California, Michigan, Vermont and Washington; and

- Chapter Seven—analysis and synthesis of the data collected.

The case studies presented in this document describe the efforts of four states (i.e., California, Michigan, Vermont and Washington) to control and prevent fraud in the Medicaid program. The focus of each is on the information needed (1) to detect accurately patterns of misutilization of Medicaid funds by health care providers; and (2) to prosecute those cases where investigation establishes that a pattern of potentially fraudulent activity exists.

In each state, visits were made to the single state agencies (SSAs) for Medicaid administration and the Medicaid Fraud Units to gather data regarding the information needs and strategies

involved in fraud detection, investigation, and control. Interviews were conducted with key members of the Medicaid program administration (e.g., Medicaid Management Information System Specialists, Medicaid Fraud Unit Chiefs, etc.) and documents describing all relevant activities were collected.

While an attempt was made to adhere to the same generic topics in each of the case studies, the reader should note that the subject headings, and even the level of detail devoted to each, are a product of the information elicited from the various actors involved and the amount of supporting documentation made available to the authors. In addition, the reader is cautioned that the validity of some of the information acquired through the interview process is open to question because the interviews were conducted two and one-half years into the implementation of Medicaid fraud legislation and the recollections of the respondents may not always have been reliable.

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[1]See U.S. General Accounting Office, Fraud in Government Programs:--How Extensive Is It?--How Can It Be Controlled?, Vol. I, AFMD-81-57, May 7, 1981, p. 2.

[2]Ibid, pp. i-ii.

[3]Testimony of former Assistant Deputy Attorney General Charles Ruff, as cited in U.S. Congress, Senate, Committee on Appropriations, Fraud in Government, Hearing, before a subcommittee of the Committee on Appropriations, 95th Congress, 2nd Session, 1978.

[4]Statement of the Chief, Criminal Division, Department of Justice, as cited in U.S. Congress, House, Committee on Government Operations, Hearings before a subcommittee of the Senate Committee on Government Operations, on H.R.2819, 95th Congress, 1st Session, 1977, p. 419.

[5]General Accounting Office, op. cit.

[6]Joseph C. Calpin and Frank C. Jordan, Jr., The Need for Information to Control and Prevent Fraud: The Federal Perspective, The MITRE Corporation, McLean, VA, WP-81W00102, 1980.

2. THE MEDICAID PROGRAM: FRAUD--ITS CONTROL AND PREVENTION

In 1965, Congress established the Medicaid Assistance Program (otherwise known as Medicaid [Title XIX]). Under the auspices of this program, the federal government shares with the states the cost of providing medical assistance to individuals--regardless of age--whose income and resources are inadequate to pay for health care.[1] Since then, numerous investigations, audits, and legislative hearings have revealed the apparent widescale existence of fraud in the Medicaid Program.[2] Efforts to control and prevent the problem of Medicaid fraud have been marked by the implementation of two organizational innovations at the state level sponsored by the federal government:

- the Medicaid Management Information System (MMIS)—intended, among other purposes, to identify cases of suspected fraud; and
- the state Medicaid fraud control unit (MFCU)—intended to investigate and prosecute Medicaid fraud.

In order to understand the current state of knowledge regarding the nature and extent of Medicaid fraud, the reader must have some appreciation of the:

- intracacies of the Medicaid Program and its operations, as well as
- federal/state efforts to control and prevent fraud.

Consequently, this chapter presents an overview of:

- the Medicaid Program itself; and
- both MMIS and MFCU.

2.1 The Medicaid Program

This section provides a synopsis of:

- the legislative history of Medicaid;

- the administration of Medicaid; and
- the existence of Medicaid fraud.

2.1.1 Medicaid Legislation

Medicaid/Medicare legislation was first enacted into law in 1965.[3] Congress overwhelmingly passed the new legislation by a vote of 313-115 in the House of Representatives and 68-21 in the Senate. The new programs were written as amendments to the Social Security Act of 1936. Medicaid shared federal funds with the states in an effort to cover the health costs of all persons considered medically indigent. Medicare, by far the broader of the two programs, provided all persons, 65 and older, with compulsory hospital insurance financed through Social Security (Part A); it also subsidized voluntary insurance for other medical bills (Part B). Part A benefits included 90 days of hospital care, 100 days of nursing home care and hospital outpatient services. Part B included 80 percent of what were termed "reasonable" physician's fees, additional nursing home coverage, in-hospital laboratory and diagnostic procedures and an assortment of other services.

The legislative history[4] of Medicaid can be traced back to the early 1960's when three types of legislative proposals for the provision of health insurance for the aged were being advocated. The first of these, of which the Forand Bill was an example, typified the universal social security approach. The second type, the Kerr-Mills Bill, typified the welfare approach. States which chose to participate in Kerr-Mills, for example, would be given federal grants to broaden the scope of their public assistance programs to include medical care for those among the aged whose eligiblity could be determined by a state standard or means test. The third method typified the income tax credit approach. It would have provided an income tax credit or a certificate for purchasing insurance for those without tax liability of up to $125 a year for private medical insurance for persons 65 and over with financing from general revenues.

Of the three proposals, only Kerr-Mills would be enacted into law as a means of encouraging the states to provide medical care for "medically needy" but "self-maintained aged" in the general populace. On June 13, 1960, the House Committee on Ways and Means voted out the Mills bill. In August 1960, the Senate

Finance Committee reported out the Kerr version of the Mills bill. In its initial test before the Senate, it passed by an overwhelming 391-2 margin. The Kerr-Mills bill was accepted by both houses and approved by President Eisenhower on September 13, 1960.

In 1963, a subcommittee of the Special Committee on Aging reviewed the impact of the Kerr-Mills legislation and concluded that the program had done very little in the way of providing medical care for the self-maintaining aged. As a consequence, a subcommittee of the Senate Special Committee on Aging issued a report to the effect that three-years of Kerr-Mills operation had "demonstrated that the congressional intent has not and will not be realized."[5]

In 1964, proposed legislation was introduced before both houses of Congress to correct the shortcomings of the Kerr-Mills legislation. The new bills (H.R. 1 and S. 1) contained the Administration's hospital insurance proposal as well as many of the provisions considered by the Congress as part of earlier bills. They also included a provision to authorize nonprofit associations of private insurers, through exemption from federal and state antitrust laws, to develop health benefit plans covering costs not met by the government program. Another new provision would set up a separate trust fund for hospital insurance, distinct from the old age and survivors insurance fund.

In the House of Representatives, Congressman Wilbur Mills, who had served as co-sponsor of the Kerr-Mills Act of 1960, became the Bill's concilliator and manager within the House where it was debated in April 1965. The House then passed the bill by a roll call vote of 313 to 118. The Senate held public hearings on the Bill from April 29 through May 19, and following executive sessions reported the Bill out with a number of amendments on June 30, 1965. The Senate passed its version of the Bill in July by a roll call vote of 68 to 21.

The Bill had had a relatively easy time passing in the Senate. Two major points of contention were a separate payment method for hospital specialists and the comprehensiveness of the package. The Senate version called for increased hospital benefits and provided for separate payment for hospital specialists. Senate and House conferees met regularly between

July 14 and 21. When they announced the resolution of differences between the two bills, the House position dominated and the final bill was almost identical to the original House version. The conference report was filed on July 26, 1965, with House approval (307 to 116) coming on July 27 and Senate approval (70 to 24) on July 28. Two days later, on July 30, 1965, President Johnson signed the Bill into law.

2.1.2 The Administration of the Medicaid Program

Under the Medicaid Program,[6] federal funds are made available to the states to match their expenditures for medical assistance to:

- cash assistance recipients, and
- other medically needy (in certain states) who would be eligible for cash assistance except for income and resources.

The federal share for Medicaid expenditures ranges from 50 percent to 78 percent. The exact portion of federal contributions is determined by a formula based on the relation of state per capita income to national per capita income.

The Social Security Act requires that state Medicaid programs provide a wide range of medical services for the categorically needy including both inpatient and outpatient hospital services; physicians' services; home health care services for persons over 21 years of age; laboratory and x-ray services; family planning services; early and periodic screening, diagnosis, and treatment of those over 21; and skilled nursing home services. Under the Medicaid program, states must provide to the medically needy any seven of these services for which federal participation is available. States may elect to include additional services in their Medicaid program.

In the Medicaid Program, the term "categorically needy" is defined as those persons who are over 65, blind, disabled, and members of families with dependent children. In some states, individuals who are under 21 years of age may apply to a state or local welfare agency for assistance under the Medicaid program. In those instances where a person is eligible for both Medicaid and Medicare benefits, the Medicare program is the first payer of benefits. The eligibility of a person to

participate in the Medicaid Program is determined by the state in accordance with federal regulations. It is estimated that during Fiscal Year (FY) 1980 the Medicaid program provided assistance to 22,881,000 recipients. During that same year, $14,770,896,000 were obligated in formula grants.[7]

At the federal level, the Department of Health and Human Services (HHS) has overall responsibility for administration of the Medicaid Program. Within HHS, the Health Care Financing Administration (HCFA) has immediate responsibility for overseeing the administration of state Medicaid programs. Although these programs must be operated under a HHS approved plan and fiscal and statistical reports submitted to HCFA, each state is responsible for the direct administration of its own Medicaid program. States may elect to contract with private organizations to help administer their Medicaid programs. The specific responsiblities assigned to such contractors (known as fiscal agents) vary according to the contractural arrangements entered into by a state. Some states administer the entire program through the state agencies assigned responsibility for Medicaid assistance programs.

2.1.3 Medicaid Fraud

Since the inception of the Medicaid program, the problems of fraudulent activities within the program have been a matter of widespread and increasing concern at all levels of government.[8] As former Senator Frank Church, Chairman of the Senate Special Committee on Aging, pointed out:[9]

> "Investigations and hearings before this committee show that medicaid fraud exists on a massive scale. These proceedings revealed such practices as providers charging medicaid for expensive personal luxury items, kickbacks to nursing home owners by suppliers, and forced contributions by relatives as a condition for accepting a patient."

In testimony before Congress, former Secretary Joseph A. Califano of the Department of Health, Education, and Welfare (HEW--now Health and Human Services) cited four cases uncovered by HEW's auditors as an example of the nature and scope of Medicaid fraud:[10]

> "According to medicaid records, on each of 42 different days in a single year one beneficiary had the same

prescription filled twice for the same drug at the same drug store.

During one year, there were payments for one medicaid beneficiary covering 298 prescriptions filled at five drug stores.

During a single year, a physician was paid for 5,500 comprehensive office examinations of 2,009 medicaid patients. According to the records, one patient received 43 comprehensive examinations from that physician in one year. Payments for comprehensive examinations amounted to $155,500 of that physician's total medicaid billings for $220,800.

Another, a physician in general practice, was paid $73,000 for 10,500 separate services to 225 medicaid patients over an 11-month period--including an average of 42 lab tests per patient compared with the statewide average of 3."

Although no reliable and comprehensive knowledge currently is available regarding the nature and extent of fraud in government programs and operations,[11] estimates of Medicaid fraud range in the billions of dollars.[12] In 1975, Congressman Fountain, who sponsored the Inspector General Act of 1978, cited estimates of Medicaid/Medicare fraud and abuse that totaled three billion dollars a year or 10 percent of the money spent on these programs.[13] Whatever the exact amount of dollars lost to fraud (both detected and undetected), the impact of fraud goes far beyond dollars and cents--as Senator Church has emphasized:[14]

"My point is this: Whatever the losses to the system are, and we still have only estimates of these losses, the bottom line is a loss to the taxpayers in the States and the Federal Government and, most important of all, reduced medical services to those who can least afford the loss."

Senator Dole, one of the sponsors of the Medicare and Medicaid Anti-Fraud and Abuse Amendments (P.L. 95-142) points out the real and direct threat posed by Medicaid fraud to the integrity and efficiency of that program:[15]

"Medicare and medicaid fraud and abuse are diseases, and are potentially fatal processes that may serve to destroy

these programs. Those who are adversely affected by these abuses are the recipients, those poor and elderly in our communities that depend on these programs for survival. These individuals suffer because fraud and abuse takes the money needed for service to these people, and puts it in the hands of the unscrupulous whose sole purpose is an increase in their own wealth.

Legitimate health care providers also suffer because the names of many good practitioners are needlessly blackened, and their professionalism is in question because of those who are unethical.

Finally, the taxpayers suffer because they expect that the money they have put into the system will be used for the purpose that is intended, but instead the money is abused, and the taxpayers cheated."

Efforts to control and prevent fraud in the Medicaid program have been marked by the implementation of two organizational innovations at the state level sponsored by the federal government:

- the Medicaid Management Information System--intended, among other purposes, to identify cases of suspected fraud; and
- the state Medicaid fraud control unit--intended to investigate and prosecute Medicaid fraud.

The following sections provide a brief overview of both these innovations. Case studies of the implementation and operation of each are presented in subsequent chapters.

2.2 The Medicaid Management Information System

The Medicaid Management Information System (MMIS) is basically a data storage/retrieval and claims processing system.[16] It was developed in response to a variety of management control problems experienced in the Medicaid program including:[17]

...fragmentation of operations, lack of information needed for planning and management controls, overlong claims payment operations, lack of safeguards against improper or duplicate payment, lack of assurance that proper payment is

made to qualified providers for authorized service to eligible recipients,...

MMIS is intended to assist the states to more efficiently manage the operation of the Medicaid program and to improve the quality of care provided to recipients.[18] Specifically, it has been suggested that the operation of MMIS can enable the state Medicaid agency to: (1) improve its Medicaid management controls; (2) improve the quality of care provided and the access of recipients to that care; (3) identify possible instances of abuse; (4) expedite legislative decisions; (5) facilitate reportings; and (6) increase the efficient utilization of medical personnel.[19]

In order to achieve the objectives of MMIS, the general conceptual design (see Figure 2-1, page 2-9) of the system calls for the development of six subsystems: recipient; provider; claims processing; reference file; surveillance and utilization review (SURS); and management and administrative reporting (MARS). Conceptually, the first four subsystems are intended to function as an integral unit in order "to process and pay each eligible provider for every valid claim for a service provided to an eligible recipient". MARS is designed to present reports describing the financial and operational status of the Medicaid program. SURS purpose is to provide information which can be used to (1) examine the level and quality of care provided, and (2) identify suspected cases of fraud and abuse for further investigation.[20]

According to the provisions of the 1972 Amendments to the Social Security Act,[21] the federal government will provide 90% of the funding needed to design, develop, and install MMIS in a state. Accordingly, states are responsible for adapting the general systems design discussed earlier to meet their own needs while continuing to fulfill the basic objectives of the system. Moreover, once a state has implemented MMIS, the federal government will provide 75% of the funds required to operate the system. At the time this report was prepared, 32 states[22] had been approved for 75% funding.[23]

2.2.1 The Direct Operations Subsystems

The Recipient, Provider, Claims Processing, and Reference File Subsystems are termed direct operations subsystems because they are concerned with maintaining program operations in accordance

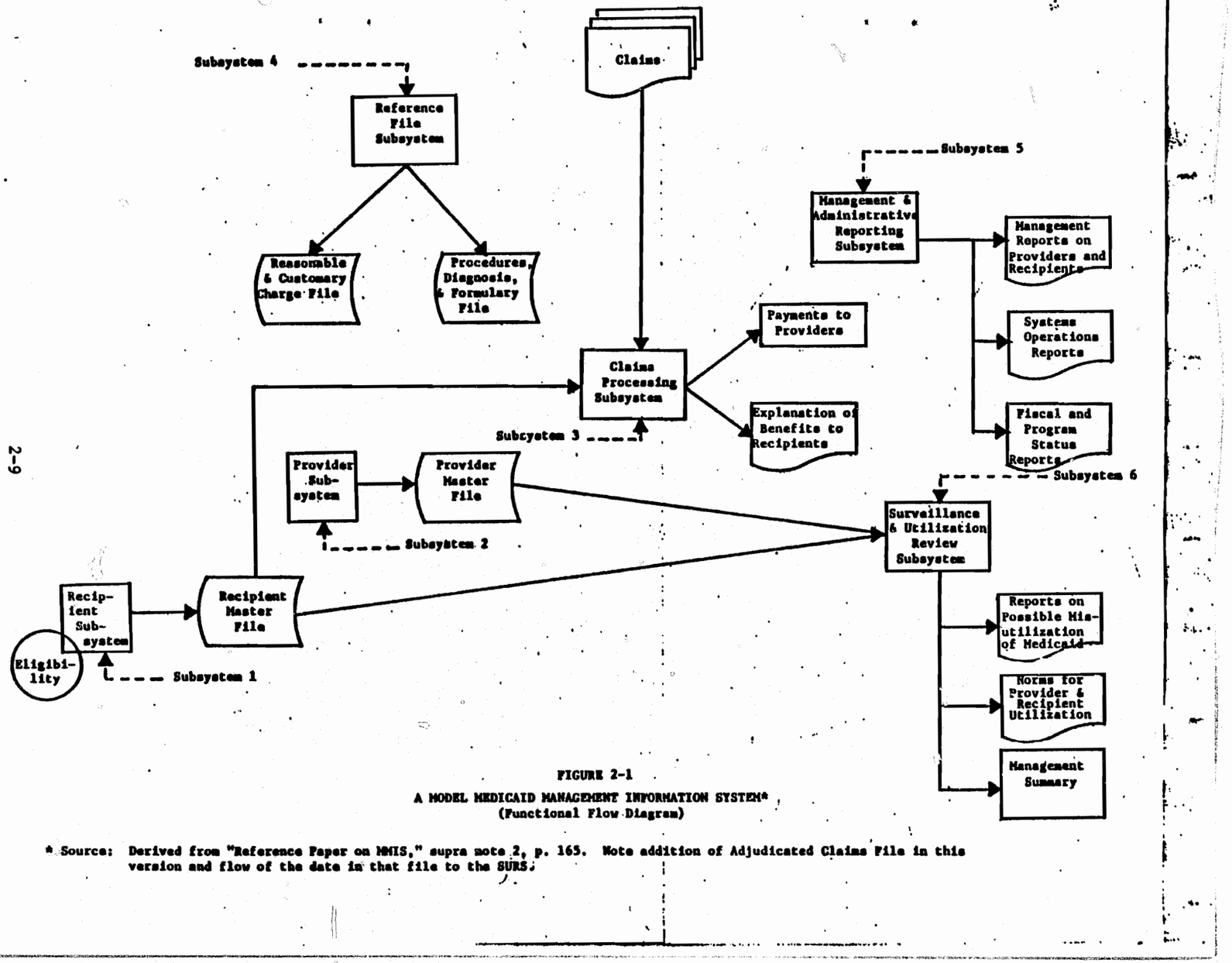

FIGURE 2-1

A MODEL MEDICAID MANAGEMENT INFORMATION SYSTEM*
(Functional Flow Diagram)

* Source: Derived from "Reference Paper on MMIS," supra note 2, p. 165. Note addition of Adjudicated Claims File in this version and flow of the data in that file to the SURS.

with Medicaid rules and regulations. The Mangement and Administrative Reporting Subsystem and the Surveillance and Utilization Review Subsystem basically provide the administrators of the state Medicaid agency with data describing the progress and problems experienced in the Medicaid program. These latter two subsystems will be discussed in separate sections of this chapter.

2.2.1.1 The Recipient Subsystem

This subsystem (see Subsystem 1, Figure 2-1, page 2-9) is the point at which data are entered into MMIS regarding applicants including their eligibility for the Medicaid program, certification, and any change in status. Transactions are subjected to computer edits in order to determine the validity and completeness of each piece of data. If an error is identified in any transaction, the computer places it into a suspense file until corrective action is taken. This process is intended to insure the integrity of the Recipient Master File. Thus, among other functions, the Recipient Subsystem provides a computerized file of all eligible recipients to support the operations of the Claims-Processing Subsystem, the Surveillance and Utilization Review Subsystem, and the Management and Administrative Review Subsystem.

2.2.1.2 The Provider Subsystem

This subsystem (see Subsystem 2, Figure 2-1, page 2-9) is intended to process the applications of providers for participation in the Medicaid program once they agree to adhere to the rules and regulations of Medicaid. Applications for participation are submitted to the state Medicaid agency for approval. The information contained in these applications is entered into the system and is used to create the Provider Master File. The Provider Master File may also contain data on the current rates charged by both individual and institutional providers of service. The Provider Subsystem is also intended to ensure that only qualified providers are paid for services for which they make claims. In addition, this subsystem supports the Claims Processing, the Surveillance and Utilization Review, and the Management and Administrative Reporting Subsystems by maintaining a file of all eligible providers participating in the Medicaid program.

2.2.1.3 The Claims Processing Subsystem

This subsystem (see Subsystem 3, Figure 2-1, page 2-9) has been described as having five major functions:[24]

- ensuring that claims and transactions related to those claims are entered in a timely and accurate fashion into the system;
- implementing controls so that
  - claims are processed completely and promptly, and
  - discrepancies are resolved quickly;
- verifying the eligibility of providers and recipients as well as the validity of the data submitted in support of the claims;
- making certain that payments are made correctly and in a timely fashion to institutional and individual providers; and
- supporting both the Surveillance and Utilization Review Subsystem and the Management and Administrative Reporting Subsystem by establishing a file of adjudicated claims.

In terms of transactions, once a service has been provided to a recipient, the individual or institutional provider submits a request for payment to the state Medicaid agency or to the contractor acting as fiscal agent for the state. Each claim is entered into the system and then is subjected to a set of checks intended to verify its authenticity. This validation process involves a number of steps including: confirming the provider's eligibility and authority to provide the service rendered; verifying the eligibility of the recipient; and determining if the claim duplicates or conflicts with a previously processed one. Any claim failing to pass all verification checks is suspended from processing and examined manually to determine the necessary corrective action.

2.2.1.4 The Reference File Subsystem

One of the primary functions of this subsystem (see Subsystem 4, Figure 2-1, page 2-9) is to update the reference files used in the processing of claims. This subsystem can be employed to produce listings of changes in the files of medical procedures, drug formulary, and medical diagnoses. The Reference File Subsystem also subjects any changes in these files to editing procedures designed to detect error. Another major function is the generation of information about the "usual and customary" charges of practioners. These data provide the basis for the periodic analysis of provider charges. The final function of this subsystem is to produce a variety of listings of suspended claims.

2.2.2 The Management and Administrative Reporting Subsystem

The Management and Administrative Reporting Subsystem (MARS) is intended to produce such reports as expenditure analyses designed to indicate both the operational and financial situation of the Medicaid program (see Subsystem 5, Figure 2-1, page 2-9).[25] Consequently, MARS has seven major functions:[26]

- "to furnish the state agency with information to support management review, evaluation, and decision-making;
- to provide management with the financial information necessary to conduct proper fiscal planning and exercise proper control;
- to provide management with information needed to help in developing improved policy and regulations;
- to monitor claims processing operations, including the status of provider payments;
- to analyze provider performance with regard to the extent and adequacy of participation in the program; and
- to analyze recipient participation by the nature and extent of services rendered."

In order to generate reports, MARS collates information from the data collected by the Recipient, Provider, and Claims Processing Subsystem. Selected data from these subsystems are collated with manual input data to produce summary history files. MARS reports are intended to meet information requirements in four areas: (1) administration, (2) operations, (3) provider relations, and (4) recipient relations.[27]

2.2.3 The Surveillance and Utilization Review Subsystem

In terms of the general conceptual design of MMIS (see Subsystem 6, Figure 2-1, page 2-9), the Surveillance and Utilization Review Subsystem (SURS) has been described as having three primary purposes:[28]

- "to develop a comprehensive statistical profile of health-care delivery patterns and utilization;
- to identify instances of suspected fraud or abuse of the program by individual recipients, providers, and service organizations;
- to provide information that could indicate potential defects in the level or care or the quality of service provided."

The information needed by the SURS to accomplish these purposes is provided by the Claims Processing Subsystem. Additional identification and demographic data on recipients and providers needed are furnished by the master files of the Recipient and Provider Subsystems.

In order to identify suspected incidents of fraud, SURS employs a method termed computerized exception reporting which is based on the analysis of medical activity patterns. The application of exception reporting to the Medicaid program is based on the assumption that "...if a provider or a recipient activity deviates from an acceptable value by more than some specified range, the individual is potentially a program abuser."[29]

Basically, an exception reporting system (ERS)[30] operates by first classifying all provider and recipients into homogenious categories on the basis of selected, key characteristics. A statistical profile is then developed for each group as well as for each individual participant in the program. The profiles of

individuals are then compared to the profile (or norm) of their respective peer group. An individual profile which differs "markedly" from the norm of its group is selected for investigation to determine the existence of fraud or abuse.[31]

The implementation of SURS as an exception reporting system to indicate possible incidents of fraud involves critical decisions in five key areas:[32, 33]

- first, the development of peer groups;
- second, the designation and specification of reporting items or exception indicators for each group;
- third, the assignment of individual providers to peer groups;
- fourth, the development of the group norms; and
- fifth, the specification of exception limits.

The establishment of peer groups is a critical step in the development of an exception reporting system (ERS). For an ERS to operate effectively and efficiently, the peer groups must be homogeneous, that is, the providers placed in the same category must be similar in terms of selected, key characteristics. Categories of providers can be developed on the basis of medical and demographic characteristics. Furthermore, peer groups may also specify such characteristics as the type of service (e.g., individual or group); the geographic area (e.g., urban or rural); the category of service (e.g., inpatient, hospital, independent clinic); and the area of medical expertise (e.g., radiology, allergy, podiatry). Failure to construct homogeneous peer groups will lead to the development of invalid profiles and make any comparison of individual providers to a group profile meaningless.

Once peer groups have been constructed, report items or exception indicators must be specified for each group. Different items of information will be used as exception indicators for each classification or peer group. This variation is necessary because of the differences in medical activities performed by the various peer groups. Among the general types of information which may be used as exception indicators are: the amount of dollars paid, the types of

services provided, the number of recipients served, and the number of office visits per recipients. The exact number of information items used as exception indicators for each peer goup will vary according to the complexity of the services provided as well as the amount and specificity of data required to satisfactorily examine the medical activities involved.[34] The basic problem in this process is the identification of those items of information which provide the best indicators of potential incidents of fraud.[35]

A third critical step in the development of an ERS is the assignment of individuals to peer groups. If an individual is misclassified, that is, if an individual is inappropriately assigned to a peer group, the homogeneity of the peer group is lessened. Thus, the profile or norms developed for that group will be skewed. The use of such a skewed peer profile in an ERS will probably increase the number of false positives, that is, those individual providers incorrectly identified as being involved in potential incidents of fraud. Moreover, the misclassification of an individual affects the reliability of an ERS since the individual will be profiled against an inappropriate group, the wrong activities screened, and the liklihood of a false positive increased.[36]

Another key decision involves the development of norms or profiles for each peer or classification group. In order to identify cases which involve a "significant departure from normal medical practice"[37] it is first necessary to determine what is "normal medical practices". Obviously, the determination of these norms will affect the setting of exception reporting limits which, in turn, are used to define significant departures from normal medical practice which may involve fraud. The norms developed for each peer group may be skewed by a number of factors including the development of the peer groups themselves and the assignment of individuals to peer groups.

The final key decision in developing an ERS is concerned with establishing the exception control limits. Generally speaking, cases which fall beyond certain set limits are identified as potentially involving fraud and selected for further investigation. Setting the proper exception control limit is an important task as it affects the number of participants identified as potential fraud suspects.[38] If the exception control limit is set too low, the number of possible incidents

of fraud may be so large that the manual review process may be overwhelmed. On the other hand, if the limit is set too high, the effectiveness of the ERS to identify suspected cases of fraud may be impaired.

2.2.4 The Review Process for Cases Suspected of Involving Fraud

In any discussion of the exception reporting function of SURS, it is important to remember that this subsystem does not detect fraud. SURS does, however, identify cases which appear to involve a "significant departure from normal medical practice".[39] Once these cases have been identified, a manual review process must then be initiated to determine if these cases do, in fact, involve significant departures which may indicate fraud or abuse. In order to accomplish this task, the state Medicaid agency must have sufficient staff with the necessary technical qualifications to review the cases identified by SURS; determine which ones do, in fact, involve departures indicating fraud or abuse; and recommend the necessary corrective action.[40] During this review process, MMIS can be used to provide the data needed by the review staff to conduct their follow-up investigations.[41]

2.3 The State Medicaid Fraud Control Unit

In response to Medicaid fraud, Congress enacted in 1977 Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendements,[42] to "...facilitate federal and state efforts to identify and prosecute cases of fraudulent and abuse activities..."[43] Toward this end, Public Law 95-142 sought to improve the ability of states to investigate and prosecute incidents of Medicaid fraud by supporting the implementation and operation of state Medicaid fraud control units. Prior to the enactment of this legislation, each state Medicaid agency was responsible for the detection, investigation and development of suspected incidents of fraud.[44] Under this legislation, the state Medicaid fraud control unit is to be established as a separate entity from the state Medicaid agency to investigate and prosecute fraud. Each unit should consist of a team of lawyers, investigators, and auditors as well as professionals with experience in the various services, components, and requirements of the Medicaid program.

In a parallel development, the Office of the Inspector General (IG) was established at the Department of Health, Education and Welfare (now known as Health and Human Services)[45] and began operation in 1977.[46] The IG has been given the primary responsibility within the Department of Health and Human Services (HHS) to:

- conduct audits and investigations of HHS programs and operations; and
- coordinate and recommend policies designed to
  - promote efficiency in HHS programs; and
  - prevent and detect fraud and abuse.

2.3.1 Funding

Public Law 95-142 seeks to encourage state governments to establish state Medicaid fraud control units by providing 90 percent matching funds for the implementation and operation of these units during the three year period from October 1, 1977 to October 2, 1980.[47] According to the Office of Management and Budget (OMB), $40,660,000 was obligated to support these units during Fiscal Year 1980.[48] At the time of the preparation of this report, 30 fraud control units had been certified for funding.[49]

It was expected that the state Medicaid fraud control units (H.R.3 units) would become self-supporting upon expiration of federal support. The assumption was that after these units had been operating for a few years, the amount of dollars recovered would begin to equal or exceed the cost of operating these units.[50] However, in a study of H.R.3 units, GAO found that most of these organizations may not become self-supporting. In spite of this finding, GAO concluded that the H.R.3 units can be an effective force in countering Medicaid fraud by increasing the capability of states to deter fraud as well as investigate and prosecute its occurrence. Consequently, GAO recommended that Congress fund the units beyond September 1980.[51]

This recommendation paralleled an earlier suggestion made by the Office of the Inspector General, Department of Health and Human Services. In 1979, the OIG recognized that if the state Medicaid fraud control units were to achieve their full

potential, legislation was needed to provide funding beyond the 1980 deadline set by Public Law 95-142. The OIG suggested two possible modifications in the existing legislation to ensure continued support of the fraud units.[52]

- "Permit 90 percent Federal support of any unit for a full three-year period from the date of initial certification of such Unit, provided that it earns annual recertification, and

- Permit continued special Federal funding support of any Unit, subject to annual recertification, after its initial three-year period of operation is completed. This could be at:

  - a Federal support rate of 90 percent or, alternatively,

  - a Federal support rate of 75 percent."

In 1980, Congress passed the Omnibus Reconciliation Act of 1980 (also known as Public Law 96-499). This legislation provides permanent funding for state Medicaid fraud control units at a 90 percent match for the first three years of operation. Furthermore, the law provides funding at a 75 percent match for continued support of the fraud control units upon completion of their initial three-year period of operation.[53]

2.3.2 Operational and Organizational Requirements

In order to obtain federal funding, state Medicaid fraud control units must meet several operational and organizational requirements established by the federal government governing such factors as:[54]

- the relationship between the unit and the state Medicaid agency;

- its organization and location;

- the unit's operations; and

- staffing patterns.

These criteria are important not only because the units must meet them in order to achieve certification, but also because, by their very nature, they shape the nature of the fraud control units in terms of such factors as placement, organization, and operations.

2.3.2.1 The Relationship with the State Medicaid Agency

According to Public Law 95-142, the state Medicaid fraud control unit must be "separate and distinct" from the state Medicaid agency. An analysis of this legislation indicates that the state Medicaid fraud control units were established as separate from the state Medicaid agencies for the same reason the Inspectors General at the Federal level were made independent: "...to ensure that the Inspectors General would be able to perform their duties without undue pressures from agency and department heads, with their own agendas and special interests, the Act gave them full independence of the federal agencies to which they would be attached."[55] Accordingly, "no official of the Medicaid agency shall have authority to review the activities of the unit or to review or overrule the referral of a suspected criminal violation to an appropriate prosecuting authority."[56]

Although not a part of the state Medicaid agency (or Single State Agency), the unit is required to cooperate with the Medicaid agency in the investigation and prosecution of fraud. Consequently, the fraud unit and the Medicaid agency are required to enter into a memorandum of understanding ensuring that the H.R.3 unit receives the information and support required to pursue incidents of fraud.[57] Under the terms of this agreement, the state Medicaid agency must refer all cases of suspected fraud to the H.R.3 unit. In this regard, the Medicaid Management Information System, particularly its Surveillance and Utilization Review subsystem,[58] can play a key role by screening profiles of medical activity and other data to identify cases of suspected fraud. Moreover, when requested by the H.R.3 unit, the Medicaid agency must provide (1) access to, and free copies of, any records or information kept by the agency or its contractors, (2) computerized data stored by the agency or its contractors, and (3) access to any information kept by the providers to which the agency is authorized access by Section 1902(a)(27) of the Social Security Act (Title XIX).[59] Thus, cooperation between the state Medicaid fraud control unit and the state Medicaid agency seems

to be a prerequisite for development of an effective and efficient program for the control and prevention of fraud.

2.3.2.2 Organization and Location

The legislation which created the fraud units set forth three alternative locations for these units within a state government. The unit could be located (1) within the office of the state attorney general; (2) within an organization that possesses authority for prosecution on a statewide basis; or (3) within an agency that has established a formal working relationship with the state attorney general.[60] This requirement can create a barrier to certification because in most states the attorney general has relatively little authority for criminal prosecution. Most of the authority for criminal cases resides with the local district or prosecuting attorney.

2.3.2.3 Operations

According to the Office of Inspector General, Department of Health and Human Services, the operations of state Medicaid fraud control units involve four areas:[61, 62]

- "the identification and prosecution of Medicaid fraud;
- the review, investigation, and prosecution of cases of patient abuse or neglect in nursing homes or other health care facilities;
- the identification of practices or procedures in state Medicaid operations that lend themselves to fraud and abuse; and
- making recommendations to the state Medicaid agencies for improvements in their programs."

Although the detection, investigation, and prosecution of fraud are important fuctions, they are basically reactive in nature; that is, the fraud unit and the Medicaid agency are, for the most part, merely reacting to complaints. In order to effectively and efficiently combat Medicaid fraud, it is necessary to develop proactive strategies of prevention and control; that is, strategies which are designed to identify and correct program vulnerabilities as well as target detection and investigative resources. The state Medicaid fraud control units

employ a very critical proactive technique: the analysis of legislation and regulations governing the Medicaid program. These analyses enable the fraud control units and the Medicaid agencies to identify vulnerabilities to fraud created by the very legislation that established the Medicaid program and the regulations by which it is administered.[63]

2.3.2.4 Staffing

Public Law 95-142 recognized that the control and prevention of Medicaid fraud is a complex task requiring a wide variety of skills. Consequently, the law requires that the state Medicaid fraud control units employ a multidisciplinary team including attorneys, criminal investigators, and auditors, as well as other professionals knowledgeable about the Medicaid program.

2.3.3 Oversight

When Public Law 95-142 became effective in October 1977, the Health Care Financing Administration was given responsibility for certifying and funding the state Medicaid fraud control units. In 1979, the Office of the Inspector General assumed federal responsibility for the H.R.3 units. This change was made because the investigation and prosecution activities of these units paralleled those of the Inspector General.[64] Within the Office of the Inspector General, the Division of State Fraud Control was established to coordinate anti-fraud activities with the states in joint state and federal programs (e.g., Medicaid, Aid to Families with Dependent Children) and was assigned responsibility for certifying, funding, and monitoring the H.R.3 units.

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[20]Weinberg, supra note 18, p. 164.

[21]1972 Amendements to the Social Security Act, Section 235, Public Law 92-603; see also Title 42, CFR 443, Subpart C, September 29, 1979.

[22]Those states are Alabama, Arkansas, California, Colorado, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kansas, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York (New York City), North Carolina, North Dakota, Ohio, Oklahoma, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin.

[23]Institute for Medicaid Management, Status of Medicaid Management Information System (MMIS), Department of Health and Human Services. See also U.S. General Accounting Office, Attainable Benefits of the Medicaid Management Information System Are Not Being Realized (hereinafter referred to as Benefits of MMIS), HRD-78-151, September 26, 1978. This report discusses MMIS in Ohio, Michigan, and Washington including the adequacy of Health, Education and Welfare's (now Health and Human Services) review of state systems for approval; the adequacy of HEW's information on the operational costs of systems; the extent to which those benefits expected from approved systems are being realized; and the compatibility of Medicaid and Medicare information systems. For additional GAO reports, see U.S. General Accounting Office, Pennsylvania Needs an Automated System to Detect Medicaid Fraud and Abuse, HRD-113, September 24, 1979; and U.S. General Accounting Office, Ohio's Medicaid Program: Problems Identified Can Have National Importance, HRD-78-98A, October 23, 1978.

[24]"Reference Paper on MMIS," supra note 17, p. 166.

[25]Benefits of MMIS, supra note 23, p. 31.

[26]"Reference Paper on MMIS," supra note 17, p. 168.

[27]Ibid.

[28]"Reference Paper on MMIS," supra note 17, pp. 167-168; see also Benefits of MMIS, supra note 23, pp. 31-32.

[29]Benefits of MMIS, supra note 23, p. 36.

[30]For a detailed discussion of similar computer-aided techniques (i.e., selective case screening and selection case action) in another critical program (i.e., the Aid to Families with Dependent Children Program) see Michael Fischel and Lawrence Siegel, Computer-Aided Techniques Against Public Assistance Fraud: A Case Study of the Aid to Families with Dependent Children (AFDC) Program, The MITRE Corporation, McLean, Va, Janaury 1980, pp. 7-61 to 7-76.

[31]"Reference Paper on MMIS," supra note 17, p. 168.

[32]Benefits of MMIS, supra note 23, pp. 33-36.

[33]Given the nature and scope of this study, it is not possible to assess either the effectiveness of SURS in terms of identifying possible cases of fraud or the impact of the key decisions described in this section.

[34]Benefits of MMIS, supra note 23, pp. 33, 36.

[35]Ibid., p. 34.

[36]Ibid., pp. 34, 36.

[37]Ibid., p. 36.

[38]Ibid.

[39]"Reference Paper on MMIS", supra note 17, pp. 167-168, 172-173; Benefits of MMIS, supra note 23, p. 37.

[40]U.S. General Accounting Office, Federal Funding for State Medicaid Fraud Control Units Still Needed (hereinafter referred to as Medicaid Fraud Control Units), HRD-81-2, October 6, 1980, p. 23; Benefits of MMIS, supra note 23, p. 37.

[41] Title 42 C.F.R.--Public Health, Part 455--Program Integrity, Subpart A--Medicaid Agency Fraud Detection and Investigation Program, Federal Register, Vol. 43, No. 190, Friday, September 29, 1978, pp. 45262-45263.

[42] Public Law 95-142, "The Medicare-Medicaid Anti-Fraud and Abuse Amendements," October 25, 1977. See generally H.R.3, supra note 10.

[43] U.S. Congress, Senate, Special Committee on Aging, Medicaid Anti-Fraud Programs: The Role of State Fraud Control Units (hereinafter referred to as Medicaid Anti-Fraud Programs), Hearing, before the Special Committee on Aging, 95th Congress, 2nd Session, July 25, 1978.

[44] Ann Slayton, "Fraud Control Units Gear Up to Detect Illegal Billings and Prosecute Offenders," Forum, Vol. 2, No. 4, April 1978, p. 3.

[45] Public Law 94-505, Title II, Office of the Inspector General, October 15, 1976.

[46] Thomas D. Morris, "The HEW Inspector General's First Year--And a Look Ahead," The Prosecutor, Vol. 13, No. 6, July-August 1978, pp. 413-415.

[47] OMB, supra note 1, pp. 379-380, May 1980, No. 13,775, pp. 379-380.

[48] Ibid., p. 380.

[49] At the time of this report, the District of Columbia and 29 states had certified fraud units: Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Montana, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Washington, West Virginia, and Wisconsin.

[50] U.S. General Accounting Office, Federal Funding for State Medicaid Fraud Control Units Still Needed, (hereinafter referred to as State Medicaid Fraud Control Units), HRD-81-2, October 6, 1980, pp. 7-8; Slayton, supra note 44, p. 4.

[51] State Medicaid Fraud Control Units, supra note 50, pp. 18-20.

[52] Office of Inspector General, Department of Health, Education and Welfare, Annual Report: January 1, 1979 to December 31, 1979, Washington, D.C., March 31, 1980, p. III-8.

[53] Office of the Inspector General, Department of Health and Human Services, Annual Report: Janaury 1, 1980 to December 31, 1980, Washington, D.C., March 31, 1981, p. 24.

[54] Public Law 95-142, Section 17, Subsection (c).

[55] Calpin and Jordan, supra note 11, p. 2-3.

[56] 42 CFR, Part 455 - Program Integrity, Subpart 4 - Medicaid Agency Fraud Detection and Investigation Program, Section 455.21 - Cooperation with State Medicaid Fraud Control Units, Federal Register, Vol. 43, No. 190, Friday, September 29, 1978, p. 45264.

[57] 42 CRF, Part 455 - Program Integrity, Subpart D - State Medicaid Fraud Control Units, Section 455.300(e)(4), Federal Register, Vol. 43., No. 190, Friday, September 29, 1978, p. 45264.

[58] See generally, Benefits of MMIS, supra note 23.

[59] 42 CRF, Part 435 - Program Integrity, Subpart 4 - Medicaid Agency Fraud Detection and Investigation Program, Section 455.21 - Cooperation with State Medicaid Fraud Control Units, Federal Register, Vol. 43, No. 190, Friday, September 29, 1978, p. 45262.

[60] Public Law 95-142, Section 17, Subsection (c); 42 CRF, Part 455 - Program Integrity, Subpart D - State Medicaid Fraud Control Units (d), Federal Register, Vol. 43, No. 190, Friday, September 29, 1978, p. 45264.

[61] Office of the Inspector General, Department of Health, Education and Welfare, Quarterly Report of the Inspector General, July-September 1979, Washington, D.C., November 30, 1979, p. 6.

[62] Public Law 95-142.

[63] Quarterly Report of the Inspector General, supra note 61, p. 6.

[64] Quarterly Progress Report of the Inspector General, supra note 46, p. 8.

3. CALIFORNIA

California, whose Medicaid program was the first in the nation to be implemented, now services the health care needs of 2,000,000 Medicaid eligibles annually through Medi-Cal, the term coined by the state to describe its Medicaid program. During Fiscal Year (FY) 1979-80, Medi-Cal's total budget exceeded four billion dollars. Of this amount, $3,779,689,700 (94.7%) was spent on the actual delivery of health care services while the remaining $297,482,165 (7.3%) was allocated to Medicaid administrative costs.

The California Department of Health Services (CDHS) is the single state agency (SSA) with overall responsibility for the management of the Medi-Cal program (see Figure 3-1, p. 3-2). The claims processing aspects of Medi-Cal administration are managed by fiscal intermediaries. During FY 1979-80, fiscal intermediary operations comprised $73.9 million (25%) of the total administrative costs of Medi-Cal. These monies were apportioned among the three fiscal intermediaries that handled Medi-Cal during the year: (1) Medi-Cal Intermediary Operations (i.e., Blue Cross North, Blue Cross South and Blue Shield), the former fiscal agents that were in the process of being phased out, received approximately $42.4 million; (2) Computer Sciences Corporation (CSC), the current fiscal agent, received $25.1 million; and (3) the California Dental Services, the fiscal agent for all dental claims, received $3 million. The three fiscal intermediaries received $70.5 million, amounting to 95% of all funds allocated to fiscal intermediary administrative costs.

3.1 The Identification of Suspected Cases: SURS/MMIS

California's Medicaid Management Information System (MMIS) is composed of the six subsystems (i.e., Recipient, Provider, Claims Processing, Reference File, Surveillance and Utilization Review [SUR] and Management and Administrative Reporting [MAR]) called for in the prototype federal model. The MMIS data base is compatible with the mechanized payment system used by Medicare in California. Medi-Cal and Medicare utilize a tape-to-tape crossover system which works in the following way: when a provider is billing for a Medicare beneficiary, for example, but also knows that the beneficiary is a Medi-Cal eligible, he or she is required to place a Medi-Cal eligibility sticker, along with all other relevant data, on the claim and

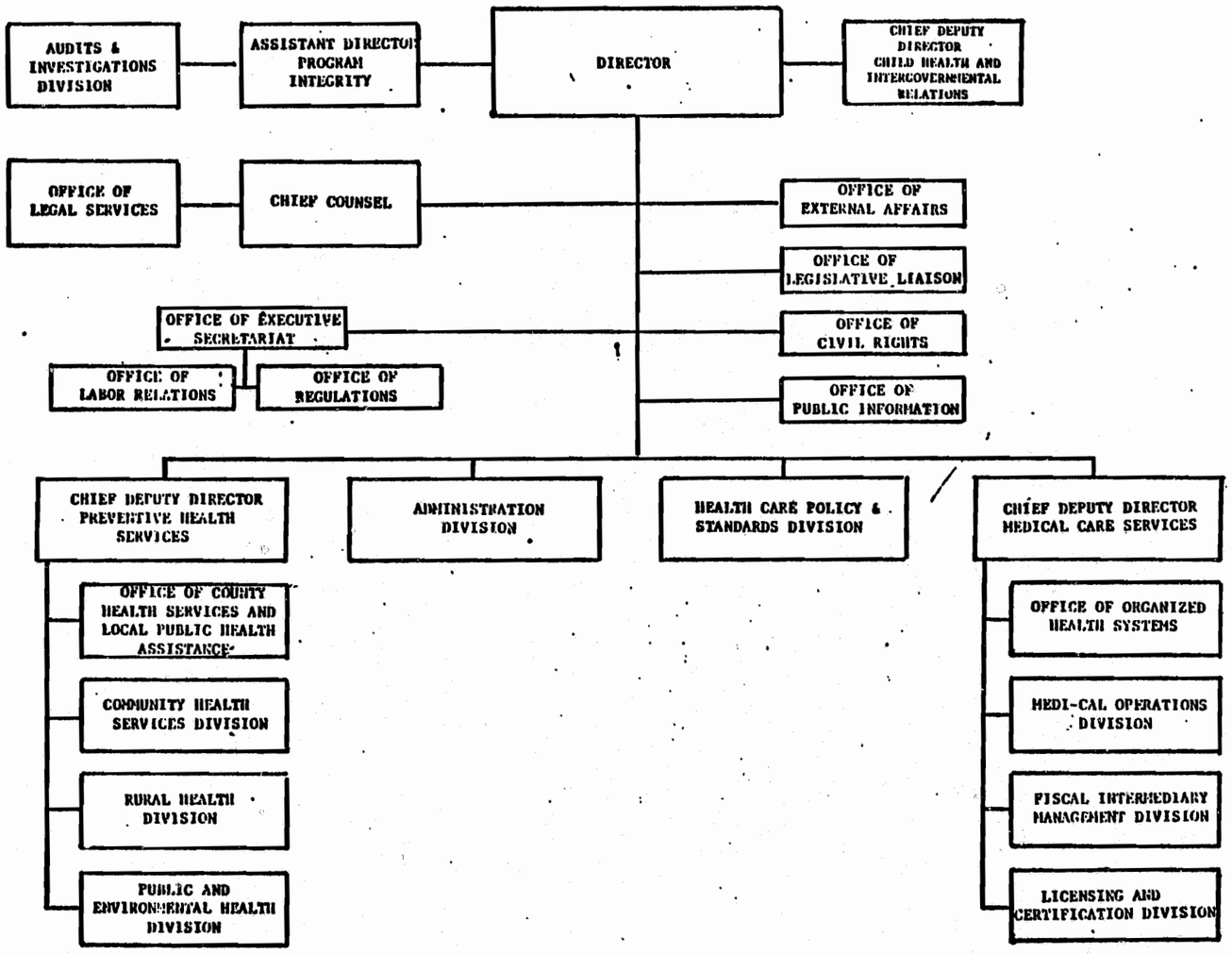

FIGURE 3-1

CALIFORNIA DEPARTMENT OF HEALTH SERVICES

forward it to Medicare. Medicare processes the claim for all valid Medicare coverage services, sends the provider the payment for the Medicare portion of the claim and creates a tape to be sent to the Medi-Cal fiscal intermediary containing all data about the transaction. CSC, upon receipt of the data tape, processes it and pays the provider for the valid Medi-Cal portion of the crossover claim.

3.1.1 The Management and Administrative Reporting Subsystem

California's MARS subsystem produces all the MMIS and federal reports that are required for financial and management reporting. These reports are used primarily by the audit, budgeting and accounting staffs of the single state agency and are described as "static in nature"; that is, they have parameters that are set and inflexible and which yield the same type of information on a monthly basis.

The Audits Branch makes use of the Management and Administrative Reporting Subsystem (MARS) to determine how much the fiscal intermediary has paid each institutional provider in California in a given year. Computer Sciences Corporation provides Audit Branch with a computer printout which includes, in addition to total dollars paid, summary information by month and by patient for all routine and auxillary services for which Medi-Cal pays. The MARS reports thus contain all the patient third party liability data which institutional providers report and which, during the audit process, can be verified against the record.

3.1.2 The Advanced Surveillance and Utilization Review Subsystem (ADSURS)

The reports produced by California's version of SURS are described as being extremely flexible in providing information useful for assessing the adequacy and quality of health care among Medi-Cal eligibles and for uncovering and facilitating the timely investigation of fraudulent, abusive, and poor management practices on the part of Medi-Cal providers and recipients. Called Advanced Surveillance and Utilization Review Subsystem (ADSURS), the California system produces all the federally-required reports. In addition, the single state agency contract with Computer Sciences Corporation contains more stringent reporting requirements (e.g., the fiscal intermediary performs provider profiling on a monthly basis in Medi-Cal whereas the federal standards are quarterly) than those

specified in the federal mandate. CSC also produces a second series of reports called SRNs or Special Reporting Needs reports. Although these are said to be less flexible than the regular ADSURS reports, they have also been described as useful for developing cases of fraud, waste, and abuse. ADSURS employs all of the essential steps of the computerized exception reporting technique (i.e., the development of peer groups; the assignment of particular providers to peer groups; the specifications and definitions of report items per peer group; the construction of profiles; and the development of group norms and exception reporting limits) defined by the MMIS model. In general, the ADSURS subsystem is described as functioning in the following manner to detect cases of fraud:[1]

> Our ADSURS staff follow each of the steps outlined in the MMIS model, concluding with the setting up of exception reporting limits. Because the system is user-oriented, it is up to the user to determine if he or she wants to set absolute limits or statistical limits. Printing out, for example, everybody who is above 2000 or 5000 patient visits or by the number of standard deviations from the norm, 2.76 or 3.5 standard deviations, let us say, it's up to the user. He or she can have the limits set in either of these two ways and have the reports cover specific time periods as well.

Thus, California's ADSURS system, in order to detect cases of suspected fraud, begins with the user identifying those categories or types of individuals to be assessed; that is, providers in the program who can be broken out by provider type, peer or class group, program areas, practice patterns or whatever measurable items the user wishes to examine.

The principle underlying ADSURS is the same as that for the earlier prototype SURS: to use automated review of paid claims to identify aberrant patterns of supplying services by providers or obtaining services by beneficiaries. An exception reporting system, ADSURS works with the data files that result after the claims have been paid. A 15-month claims history file is used to detect aberrant service patterns for individual providers and recipients. For example, a general practitioner with an exceptionally high ratio of visits per patient, when compared with other general practitioners in his geographical area, might very well represent an excessive amount of return visits for the purpose of maximizing revenues. Thus, when exceptions such as

this one are detected, the system prints out detailed profiles for each excepted provider and recipient. These are then analyzed to determine whether the case warrants further corrective action. In the most extreme cases, an investigation for possible fraud, waste or abuse may be initiated.

3.2 The Processing and Review of Suspected Cases: The Audits and Investigations Division

Three branches (i.e., Surveillance and Utilization Review, Investigations, and Audits) of the Audits and Investigations Division of the California Department of Health Services are the primary users of ADSURS data (see Figure 3-2, p. 3-6). Just how each branch uses ADSURS data to detect patterns of misutilization and/or potentially fraudulent practices is described below.

3.2.1 Surveillance and Utilization Review Branch

Within the Surveillance and Utilization Branch, the chief users of ADSURS data are the staff of the Case Development and Detection Unit (CDDU). According to the CDDU's Case Detection Coordinator, the information generating process works as follows:[2]

> Within CDDU, we construct a peer group norm, an evaluator's table which says "take these participants or providers and look at this type of activity within these providers." The system churns for awhile and then tells you, on each of your measurement criteria, what the current state of affairs is. For example, it will give you the average per participant or provider, the standard deviation value, the logical exception limit and what your class group performance rate is. We examine the array of data generated, decide what is reasonable and what is not, and where we want to call exceptional performance on a given measurement item. Through our own on-line capacity, we then transmit that information to the system. ADSURS then takes each individual in the class group and compares his performance against the exception levels and the rest of the group's performance and generates lists and comparison data on how each individual in the group fared given our measurement criteria and our exception levels.

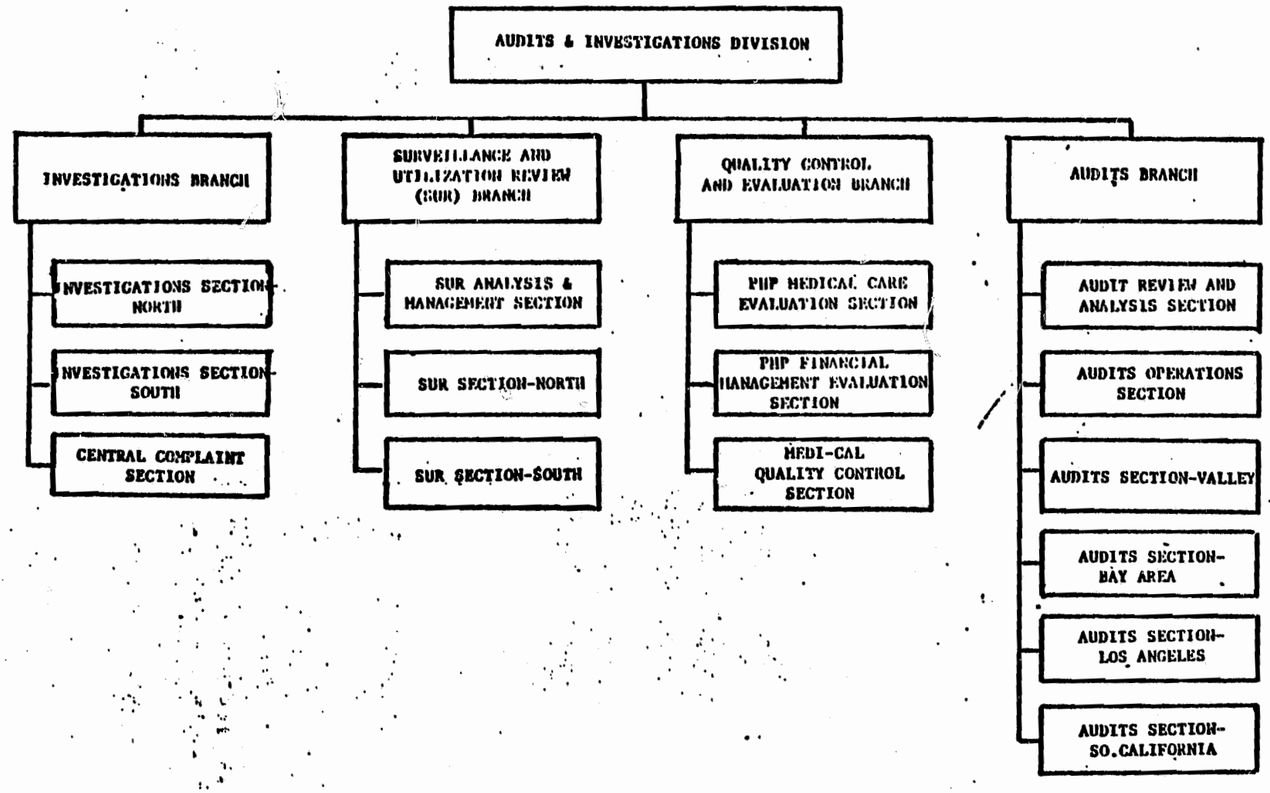

FIGURE 3-2

AUDITS AND INVESTIGATIONS DIVISION OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES

At that point, CDDU selects those individuals that are seemingly deserving of further investigation and instructs ADSURS to provide further detail on these suspected providers. It then prints out individual profiles of their performance on the selected measurement criteria. Using that output, CDDU does some comparison investigation of the measurement criteria for interrelationships and exception indicators of potential abuse. Once CDDU selects an area or areas wherein a provider appears abnormal, the claims detail module is accessed to generate some detailed history on the provider, based on a new set of parameters put into the system. The system output is a targeted history of the individual provider. At this point, CDDU's health care professional staff examine the data, which are replete with detailed listings of provider identifications, diagnoses and treatment patterns, to assist in making a logical decision about the necessity of certain services or patterns of possible system abuse.

CDDU employs eight registered nurses who perform a full desk review, from the stand point of medical logic, on each case developed by the analytical staff. The major purpose of this review is to determine if what was seemingly detected by the analytical group as representing an aberrant pattern is consistent with or suggestive of a finding of abuse or is merely an anomaly of an otherwise acceptable medical practice. If the desk review staff finds that a provider's performance appears to have failed to meet acceptable standards of medical practice, the case is forwarded to Branch Management staff for further review and a recommendation that it receive on-site review at the provider's regular place of business to determine whether or not the abuse is occurring. When concrete suggestions of fraud are uncovered, CDDU refers the case to the Investigations Branch for further handling.

Using ADSURS, the CDDU can develop as many peer groups as they need because the system has the capacity to build 999 peer groups in any single cycle. This points up another difference in SURS and ADSURS. With the former, CDDU would have had to specify 18 months in advance which peer groups it wanted and would be locked into those exclusively. With ADSURS, peer groups can be changed by sitting down at an on-line terminal and keying in some message changes. Basically, peer groups are constructed using 5 or 6 variables (e.g., geographic locale, common practice characteristics, provider types, etc.). CDDU combines these elements to build as large or as small a peer group as necessary to examine patterns of provider practice.

Within the context of ADSURS, a measurement item is defined as a mathematical or arithmetic measure of a procedure in comparison with some other number (e.g., frequency of contact) in terms of a particular class group. The measurement item is used to rank order an individual provider among others in the same peer group for purposes of determining if that provider constitutes an exeption. According to CDDU staff interviewed, any discussion of the reliability of developed measurement items as indicators of potential cases of fraud is premature. However, it is possible to use ADSURS to develop a range of measurement items, many of which say nothing about system abuse but may be very useful when evaluating overall utilization patterns. Another mechanism used by CDDU to detect aberrant provider practices is the enhanced capability of the ADSUR system to perform provider profiling. In ADSURS, provider profiling is a three-stage user intervention cycle set up to operate off the primary module that operates the system. The routine SURS provider profiling module requires that the user sit down with the programmer, define what the data needs are, and then wait as the programmer goes off to plug the data in and design a system around it. Eventually, this process generates quarterly reports containing the same data items for the user to work with. In ADSURS, the user, on a regular cycle, can sit down at a computer terminal and reformat or redefine the data needs as his information requirements change. ADSURS can produce reports containing indications of aberrant medical practice patterns as often as they are needed; however, its profiling module routinely produces six investigative reports per monthly cycle, for use by the staff of CDDU.

3.2.2. Investigations Branch

The Investigations Branch within the Audit and Investigations Division is the second major user of ADSURS data. It examines all cases referred to it by the various offices and divisions of the CDHS where fraud, mismanagement, or abuse are suspected; makes a determination as to which cases may involve fraudulent practices; and acts as liaison between (1) the CDHS and the Medi-Cal Fraud Unit of the Office of the Attorney General, in the case of suspected provider fraud; and (2) the CDHS and local district attorneys, in the case of suspected recipient or beneficiary fraud. Basically, the Investigations Branch looks at cases of administrative and/or civil fraud. It employs 60 investigators who are located throughout the State of California. The current ratio of investigator to investigation

caseload is 1 to 25. As of January 1981, some 5000 pending cases were transferred to a new unit established within the Investigations Branch called Central Complaint Section (CCS). Complaints of suspected fraud now filter into CCS at the rate of 50 per work day or 1000 per month. Of the 1000 complaints received monthly, 400 relate to suspected provider fraud and 50 of the 400 (12.5%), on the average, may get referred to the Fraud Control Unit following a preliminary investigation. The Investigations Branch Chief has explained the steps his unit takes as follows:[3]

> We have several major sources of potential fraud complaints--eligibility and welfare workers; county investigators; the Board of Medical Quality Assurance, which licenses providers; local police departments and sheriff's offices; and beneficiaries, either through Central Complaint Section's toll free hot line or through the Beneficiary Explanation of Medical Benefits or BEOMB's program, where, on a monthly basis, we sample one percent of our 2,000,000 beneficiaries through a mass mailing to determine the validity of services providers claim to have rendered them.
>
> If we receive a complaint or complaints on a particular provider which appears to have merit, we generally go directly to the fiscal intermediary through our on-line computer terminal which we maintain in this office. We simply enter the provider's name and other pertinent data items and we get ample information on the provider's background to enable us to make a determination as to the validity of the complaint. If we suspect criminal fraud, we do a preliminary investigation in this Branch and if we are reasonably certain a provider may be doing something criminally fraudulent, we package all our evidence and make a referral to the Medi-Cal Fraud Unit. They have 60 days to review the case and make a determination as to whether they want to pursue the case criminally. If they decide against criminal prosecution, for whatever reason, they refer the case back to us for whatever action this agency deems necessary.
>
> By and large, the majority of suspected fraud cases--over 90 percent--are handled administratively within this agency. In addition, the Medi-Cal Fraud Unit returns more than 95 percent of the cases we refer to it without having

taken any action. Sometimes we are precluded from pursuing the case further because of staff resources, the 3-year statute of limitations, etc. What initially appears to be fraud is usually categorized as waste, mismanagement, or abuse.

In 1978, with the advent of Proposition 13 in California, the Investigations Branch was stripped of its audit staff and because of the creation of state-level Fraud Units, lost many of its investigative staff to the newly formed group. As a consequence, its focus is on the most flagrant abuses in the program. These are processed administratively and the steps involved are summarized in the comment below:

> Administratively, the worst thing that can happen to a provider is suspension from the Medi-Cal program. In order to obtain a suspension, we would have to demonstrate that something short of criminal--as defined by statute--was occurring in a provider's practice. We would perform the investigation, collect the evidence and have our lawyers on the civil side of the Attorney General's Office prepare an accusation saying: These are the facts of our investigation and we are moving to suspend you from the Medi-Cal program. If you don't agree with this finding, you have a right to a hearing before an Administrative Law Judge.

Under the California Administrative Code, an accused provider can file a written petition for an administrative hearing before an administrative law judge. The hearing may occur at two levels: (1) an informal hearing which is the technical, fact-finding session to ascertain that all the audit figures are accurate and supportable; and (2) a formal hearing to dispose of matters of law. To date, 75 percent of all administrative appeals have been disposed of at the informal hearing level with the remaining 25 percent disposed of at the second level.

Investigations Branch does not routinely request nor does it receive any regular reports generated by the Advanced Surveillance and Utilization Review (ADSUR) component of the Medicaid Management Information System maintained by Computer Sciences Corporation. It does, however, run providers and/or beneficiaries suspected of fraudulent activities through the computerized ADSURS system maintained by the fiscal intermediary. This activity may yield a provider whose practice

on the face of it, may appear to be fraudulent, but such an assessment is never made without field investigation to determine the exact nature of the suspected program abuse or possibly fraudulent activity.

3.2.3 Audits Branch

The Audit Branch makes use of both ADSURS and MARS data to initially identify potential targets for the comprehensive audits it performs throughout the State of California. These audits, utilizing teams comprised of auditors, physicians, nurses, pharmacists and other health care professionals as needed, examine claims paid by Medi-Cal to ensure that medical services paid for are necessary, authorized and documented in accordance with Medi-Cal program and reimbursement principles. In the case of multidisciplinary audits, the provider groups are selected using a judgement sample based on an evaluation of apparent need for medical review. Initially, the Audit Staff selects a group of provider institutions and subdivides them into geographical areas within the state. Within geographical areas, facilities are ranked based on the Health Facilities Commission's reported average cost per day. A second set of rankings are then developed based on the relative percentage of Medi-Cal participation in each facility. Finally, a third ranking is developed which combines several criteria (e.g., ratio of special care days to total days, etc.). A weighted average of the selected facilities is determined and those providers comprising the top quartile are then audited. In the case of the medical and cost watch audits, a random sample of claims are selected for each provider from the lists of Medi-Cal paid claims reports maintained by the CDHS Center for Health Statistics, utilizing a computerized random selection procedure. The medical charts represented by these randomly selected claims are reviewed by each member of the audit team and questionable medical areas are noted for detailed review.

3.2.4 The Impact of Legislative and Regulatory Guidelines on Fraudulent Activities

Hospital claims are paid by the fiscal intermediary on a full cost-reimbursement basis (i.e., the more costs hospitals can find to charge against Medi-Cal, the more they are paid), whereas nursing homes in California are paid on a "cost-related, rate-setting" basis. The two payment methods employed demonstrate how legislative and regulatory guidelines can do

much to either enhance or deter risks to fraudulent activities. According to the Chief of the Audits Branch,

> Because the law allows hospitals to be paid for whatever they can find to charge off against the system, they are the one area where the risk to fraud is most prevalent. Our initial Cost Watch Audits, for example, demonstrated that the reasonable cost concept of reimbursement as defined by the Federal Medicare guidelines and subsequently adopted by Medi-Cal is simply too broad and unspecific. We found hospitals and health care programs charging such things as private club fees, season tickets to sports events, luxury automobiles and oversea's travel to Medi-Cal even though no relationship to patient care could be determined.
>
> Nursing homes, on the other hand, are paid in accordance with an uniform accounting system and we are required by state law to audit each of the state's nursing homes in order to determine if the costs are reasonable. The Rate Development Branch, based upon reported costs and a set of price indexing factors, are able to compute what may be termed the reported costs for each nursing home. We then go out to each nursing home and perform an audit, disallowing any costs which we determine to be invalid, coming up with an adjusted cost per day. The rates setting people then factor the reported cost by our audit adjustment factor. In the last two years, for example, we've consistently found a 5 percent audit adjustment factor which means we reduced the nursing home rates, overall, by 5 percent. In California, that 5 percent translates into approximately $20 million in cost avoidance due to our uncovering a number of fraudulent billing practices.

Interestingly, the regulations and legislation governing Medi-Cal are so loosely written that they do not preclude providers from including questionable costs in subsequent audits after those costs have been disallowed. For two years, the CDHS has had before the California legislature a bill which would (1) charge interest at the going rates for all established overpayments; (2) require full restitution plus a 10 percent penalty for charges reincluded by providers after being disallowed in a previous audit; and (3) require full restitution, interest at the going rate and a 25 percent penalty

for any charges later found to be fraudulent. The proposed legislation has met with formidable opposition from a number of powerful special interest groups (e.g., the California Hospital Association, the United Hospital Association, the AMA, etc.) which has thus far stymied all chances for enactment.

3.3 The Roles of the Fiscal Intermediary Management and Medi-Cal Operations Divisions

The Fiscal Intermediary Management Division (FIMD) consists of four branches (see Figure 3-3, p. 3-14) set up to supervise the activities of Medi-Cal's fiscal agent, Computer Sciences Corporation (CSC). As previously stated, CSC is new to the role of fiscal intermediary, and according to FIMD staff interviewed, is only now beginning to get a handle on a number of problems (e.g., inadequate data on provider records and actual medical services billed, etc.) which seemed insurmountable under the former fiscal intermediaries. Medical Intermediary Operations, a consortium headed by Blue Cross and Blue Shield, fell under severe critism from the California legislature for its failure to monitor more carefully the activities of providers of health care services to California's beneficiary population. Currently, CDHS is more actively involved in fiscal intermediary management through the 90 professionals (i.e., accountants, data processing specialists, analysts, medical and health care professionals, generalists) which comprise FIMD. Approximately 20 FIMD staff are on site at CSC to monitor the performance of the fiscal intermediary. Part of the staff of FIMD's Operations Analysis Section has responsibility for the testing and implementation of the management reports produced by the Advanced Surveillance and Utilization Review Subsystem (ADSURS).

The Medi-Cal Operations Division (see Figure 3-4, p. 3-15) is comprised of the Recovery and Field Services Branches and the Utilization Control Section. The Recovery Branch includes a General Collection Section which acts as the collection agent for the state and performs three types of recoveries: (1) compliance; (2) casualty insurance; and (3) health insurance. The compliance area relates to those amounts of Medi-Cal funds recovered from providers found to have been engaging in fraud-related activities. The Recovery Branch also works with beneficiaries and insurance companies in order to effect the recovery of other monies identified as being improperly paid by

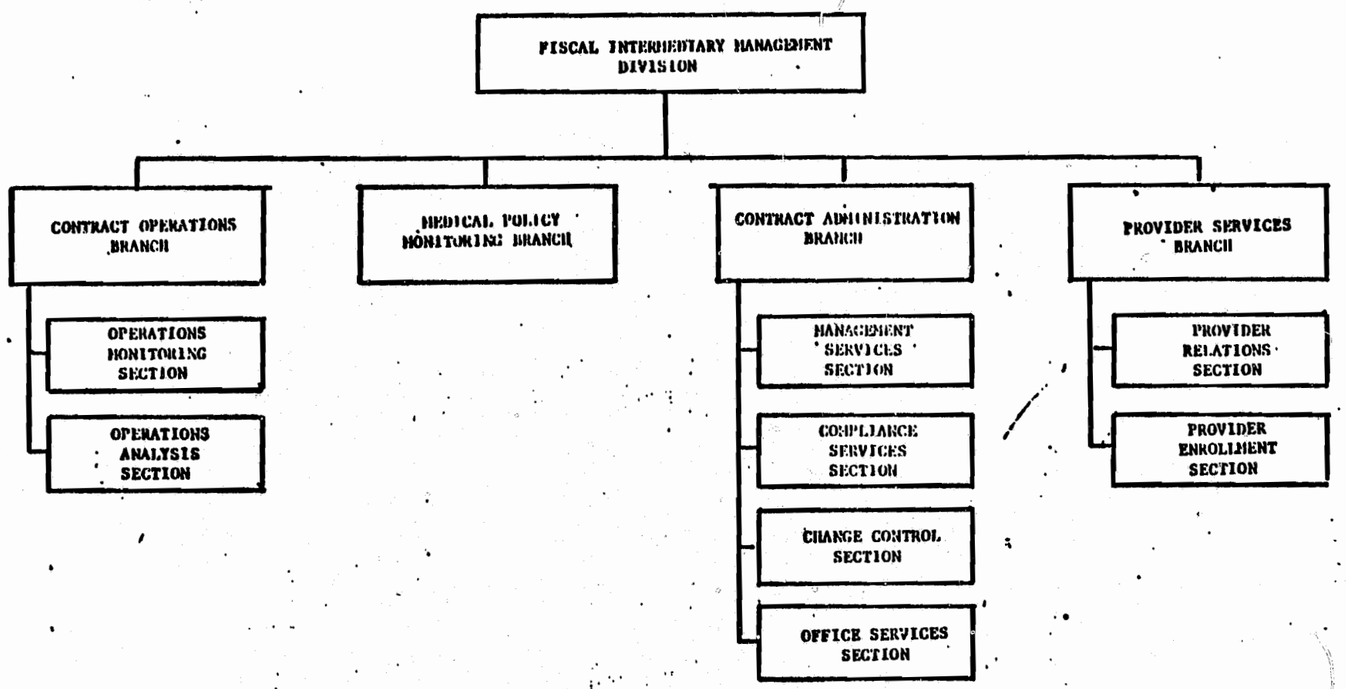

FIGURE 3-3

FISCAL INTERMEDIARY MANAGEMENT DIVISION OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES

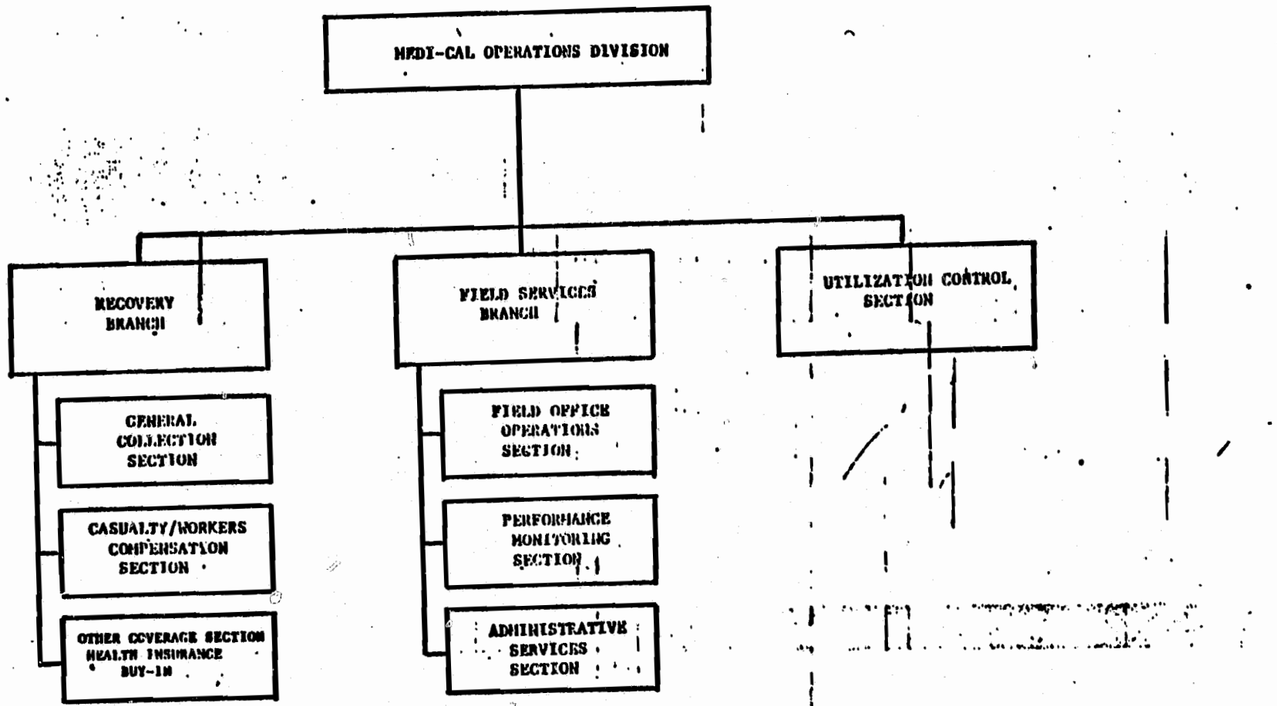

FIGURE 3-4

THE MEDI-CAL OPERATIONS DIVISION OF THE CALIFORNIA DEPARTMENT OF HEALTH SERVICES

Medi-Cal. Whenever an administrative action or civil judgement on the part of the California Department of Health Services, or a criminal conviction obtained by the Medi-Cal Fraud Unit results in recoveries of funds through restitutions, penalties and fines or combinations thereof, these funds are collected by the Recovery Branch of the Medi-Cal Operations Division.

3.4 The Investigation and Prosecution of Suspected Cases: The Medi-Cal Fraud Unit

The California Medi-Cal Fraud Unit was established in accordance with federal requirements to act as the state criminal enforcement agent for the Medicaid program in July 1978. California's Medi-Cal Fraud Unit is charged with the responsibility for investigating, auditing, and prosecuting all types of Medicaid fraud involving providers of medical and pharmaceutical services throughout California. The overall objective of the Medi-Cal Fraud Unit is to protect from fraud and abuse the state and federal funds that are designated to provide adequate health care to the poor. More directly, the Medi-Cal Fraud Unit is tasked with the following specific objectives:[6]

- the identification and criminal prosecution of Medi-Cal providers who defraud the program;
- the deterrence and prevention of fraud and abuse through strong visible enforcement methods;
- the recovery of funds through fines and restitutions, as a result of the prosecution of all fraudulent activities;
- the identification, through criminal investigation, of overpayments to providers that can be referred to the California Department of Health Services for possible recovery through administrative or civil action;
- the provision of assistance to the legislature and the California Department of Health Services by recommending legislative, regulatory, or programmatic changes that will control or prevent fraud and abuse of the Medi-Cal program; and

- the coordination of all efforts to prevent and control fraud and abuse with other state agencies (i.e., the California Department of Health Services and the California State Controller's Office) with a similar mandate.

3.4.1 Organization and Staffing

As part of California's Office of the Attorney General, the Medi-Cal Fraud Unit is located organizationally within the Division of Criminal Law. Figure 3-5 is an organizational chart which depicts the Medi-Cal Fraud Unit's basic structure and lines of authority. Table 3-1 is a listing of the actual and projected expenditures for the Medi-Cal Fraud Unit for fiscal year 1980-1981.

At the time that the Medi-Cal Fraud Unit was organized and began operation on July 1, 1978, and through December 1980, the Unit was authorized a total of 56 positions, comprised of investigators, auditors, attorneys, and clerks. In December 1980, the Unit formally received authorization of an additional 34 positions--for a total of 90. The headquarters' office is located in Sacramento, and includes the chief of the Unit, a senior assistant attorney general; the chief investigator; and a program analyst. The Unit's four regional offices are located in Sacramento, Los Angeles, San Francisco, and San Diego, and are presently staffed by 10 attorneys, 8 supervising investigators, 37 line investigators, and 4 auditors.

3.4.2 Prosecution Statutes

As was previously stated, the federal statute that authorizes statewide prosecution by Medicaid Fraud Control Units is contained in Public Law 95-142. Although California makes use of a number of statutes in its prosecution of Medi-Cal Fraud cases,[7] the three principal criminal statutes used are enumerated below:

- Section 14107 of the California Welfare and Institutions Code (W&I Code): Section 14107 of the Welfare and Institutions Code is a specific statute which prohibits a person from knowingly and intentionally filing a false Medicaid claim. Violation

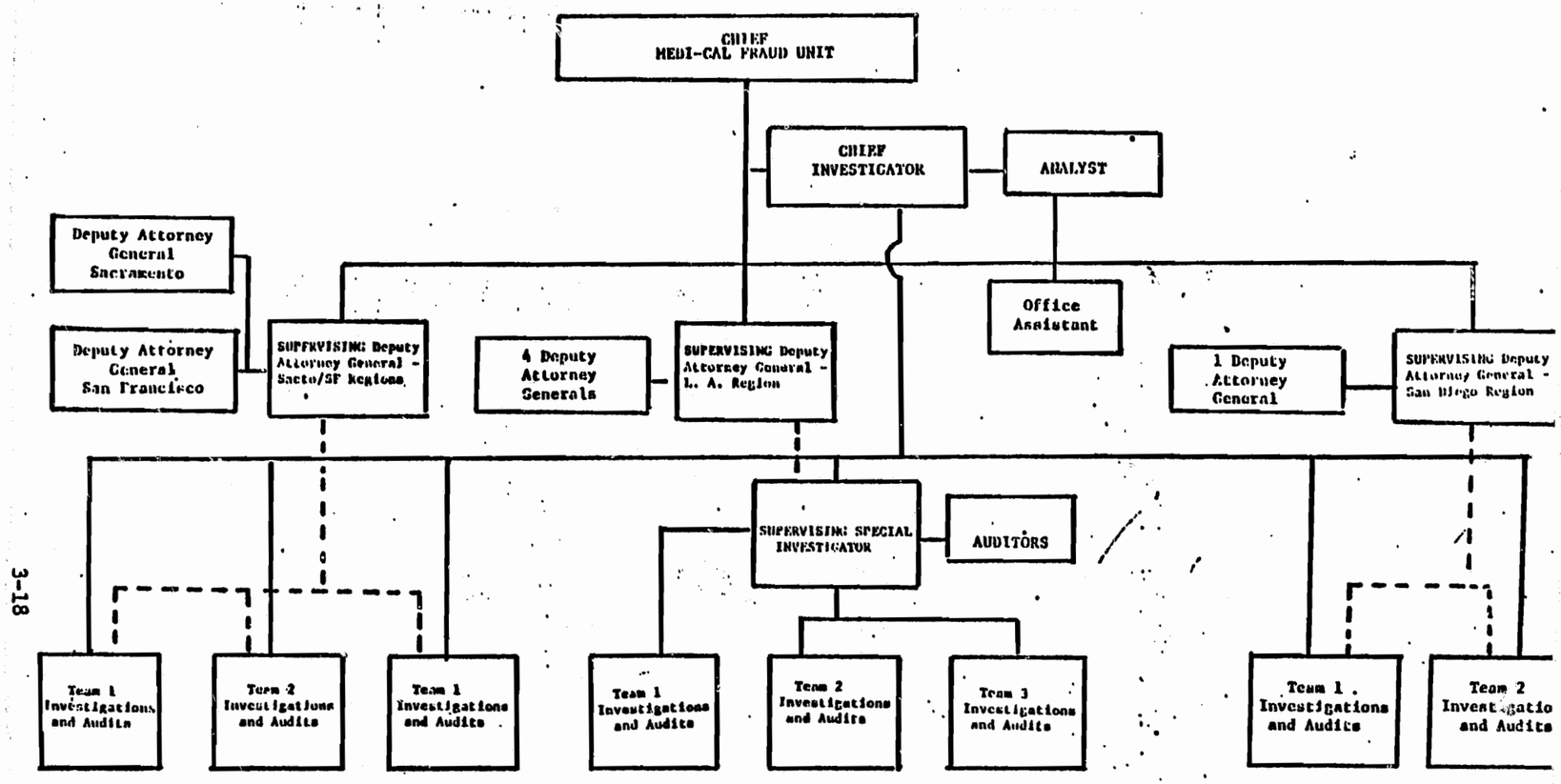

FIGURE 3-5

ORGANIZATION CHART: MEDI-CAL FRAUD CONTROL UNIT

TABLE 3-1

COSTS INCURRED BY THE MEDI-CAL FRAUD UNIT
1980-1981

Major Budget Categories	Actual Expenditures 1980-1981*
a. Personnel	$ 917,876
b. Staff Benefits	277,748
c. Travel	56,180
d. Equipment	279,580
e. Supplies	8,741
f. Contractual	10,165
g. Construction	-0-
h. Other	206,059
i. Total Direct Charges	1,756,349
j. Indirect Charges	210,145
k. Total	1,966,494

* Expenditures for the period July 1, 1980 through March 31, 1981.

is punishable up to one year in the county jail or up to five years in state prison or by a fine of up to $5,000 or by both fine and imprisonment.

- Section 72 of the California Penal Code: Section 72 of the California Penal Code is a more general statute which prohibits the intentional filing of false claims against state boards and agencies. Violation of this statute is punishable by up to one year in the county jail and/or a fine of up to $1,000 or by imprisonment in the state prison of up to five years and/or a fine not exceeding $10,000.

- Section 487 of the California Penal Code: Section 487 of the California Penal Code is a specific statute that prohibits the theft of money, labor, or real or personal property of a value exceeding $200 when the property is taken from the person of another. Theft is defined as the stealing or misappropriation of property or the obtaining of money, labor, property or credit by fraud or false reports. Violation of this section is a felony and is punishable by imprisonment in the county jail or state prison for not more than one year.

Importantly, California has a three-year statute of limitations which governs what cases the Medi-Cal Fraud Unit accepts for full-scale criminal investigations. Thus, no matter how flagrant a given provider's activities may alleged to have been, the long, complicated, obstacle-ridden and costly road to criminal prosecution is often thwarted by the statute of limitations requirement that the accused be prosecuted within 3 years of the occurrence of the alleged violation of the California Criminal Code.

3.4.3 The Case Classification Process

Because of what has been described in its annual report for 1979-80 as an exceedingly high rate of "closures without investigation" for a number of "good, solid cases of Medi-Cal fraud",[8] the Medi-Cal Fraud Unit has established a set of administrative and/or managerial procedures to ensure that those cases with the best potential for criminal prosecution will receive the largest investment of staff time. Accordingly, a case prioritization classification scheme has been devised in which all cases are classified into one of four rank-ordered categories as follows:[9]

Category I and II - Cases which have a high potential for successful criminal prosecution. Category I cases are active cases (limited to three per investigator). Category II cases are pending.

Category III - Cases which probably involve criminal activity but are not thoroughly investigated due to lack of staffing.

Category IV - Cases in which the criminal activity is not readily apparent. After this determination is made, they are typically returned to the Department of Health Services for possible civil or administrative action.

Case classification is usually done by the supervising investigator of the Medi-Cal Fraud Unit team. He or she reviews the contents of each referral and prioritizes it using a set of guidelines which take into consideration such variables as provider earnings, source of complaint (e.g., referrals made by district attorneys, law enforcement agencies, local medical societies or other peer review groups would be given a great deal of weight), knowledge of prior criminal activity, knowledge of prior complaints about the same provider, knowledge that a provider's activities involve potential bodily injury to beneficiaries, a case is of an unusual nature or the allegations are unusually specific.

The supervisor then categorizes the investigation as either a I, II, III, or IV. The number of Category I cases is limited to three per investigator. This number was decided upon because prior investigatory experience indicated that no investigator would be optimally effective if assigned more than three Category I cases. Previously each investigator had been assigned a caseload of 20 to 30 cases for investigation. However, because they tried to devote time to all of the cases, they were spread too thin and were unable to complete even a single investigation. When a Category I case is completed, the investigator is assigned a Category II case, assuming the pool of Category I cases has been exhausted. The Category II case is then upgraded to a Category I case.

3.4.4 Statistics Regarding Fraud

The Medi-Cal Fraud Unit receives referrals of cases involving possible fraudulent activities on the part of providers from the following sources: law enforcement officers, social workers, welfare eligibility workers, the Board of Medical Quality Assurance, beneficiaries, and the California Department of Health Services. During its first full year of operation (FY 78-79), the Unit opened a total of 709 cases; however, approximately 50 percent of these cases were closed without any action being taken.

During fiscal year 1978-79, the Medi-Cal Fraud Unit filed a total of 6 cases for which the Unit was directly responsible for both the investigation and prosecution of the case. During the first 9 months of 1979-80 the Unit increased its productivity and filed a total of 10 Medi-Cal fraud cases.

Table 3-2 contains some transactional statistics on all investigations that were either pending disposition, opened or closed, by provider type between April 1, 1980 and March 31, 1981. Of 160 cases pending disposition on April 1, 116 were closed after investigation indicated that the evidence was insufficient to warrant prosecution. Over the same time period, 81 new cases were opened so that on March 31, 125 cases were in the pending disposition category. Thus, 241 cases were in active status at some point during the year and 116 (48%) were closed during the investigatory process. This could suggest that fraud cases are not being selected as carefully as they should be. A more likley scenario, however, is that the complicated nature of fraud cases and the enormous amount of field work involved in establishing evidence that will be convincingly effective before a jury are such that some investigation will have to be done before the Unit can say with certainty whether it should or should not proceed with a given case.

The Medi-Cal Fraud Unit does not maintain statistics on undetected fraud because it defines fraud only in terms of the California Criminal Code, i.e., those offenses which result in convictions in the California criminal courts. Moreover, no case the unit undertakes is considered, at the outset prosecutable. The Fraud Unit Chief has explained the process as follows:[10]

TABLE 3-2

MEDI-CAL FRAUD UNIT
INVESTIGATIONS OPENED AND CLOSED BY PROVIDER TYPE

PROVIDER TYPE	ACTUAL 1980-1981*			
	Pending 4/1/80	Opened	Closed**	Pending 3/31/81
Medical Doctor	42	39	32	49
Psychiatrist	29	8	19	18
Psychologist	3	4	2	5
Pharmacy	22	3	20	5
Dentist	1	3	2	2
Optometrist	8	1	5	4
Chiropracter	1	1	0	1
Medical Transportation	10	1	2	9
Hearing Aid Supplier	3	0	2	1
Assistive Device & Supply	3	0	2	1
Hospital	9	7	8	8
Out Clinic	5	6	5	6
Podiatrist	6	1	2	5
Laboratory	14	2	9	7
Intermediate Care Facility	0	0	0	0
Skilled Nursing Facility	2	1	2	1
X-Ray Services (Portable)	1	0	0	1
Other Providers Not Named Above	2	4	4	2
TOTAL	160	81	116	125

* Actual - used statistics for 12-month period (April 1, 1980 - March 31, 1981)
** Cases investigated but not prosecuted due to insufficient evidence

> To render a case prosecutable requires a major investment of investigative time on our part, and it is not always possible to make the right guess about whether or not a case will result in a conviction. We've gotten well into cases--invested a couple of hundred hours in staff time--only to discover that the key witness has fallen apart or that the documentation, once examined, fails to support what we've been told by, let us say, the bookkeeper in a provider's office. Now, there's no way you can predict turns-in-events of this kind at the outset.

On a monthly basis, the Medi-Cal Fraud Unit provides the single state agency with a report on those cases that are in active, on-going status in the Unit. When it obtains a conviction and final disposition on a case, the Unit provides CDHS with complete information on all aspects, including restitution, penalties and fines ordered. This procedure has a two-fold purpose: (1) to inform the single state agency of the status of all cases the Unit disposes of; and (2) to enable the single state agency to proceed either administratively or civilly against providers who have defrauded the program. The Medi-Cal Fraud Unit is familiar with Health Care Finance Administration (HCFA) Forms 50 and 54 and reports all such data as are considered essential for statistical and transactional analysis purposes.

3.4.5 Fraud Prevention and Control: Programmatic and Regulatory Sources of Risk

The Chief of the Medi-Cal Fraud Unit stresses the need to prevent opportunities to commit fraud.[11]

> I'm convinced that the solution to the fraud problem is not in these Units although I think these Units are absolutely essential for as long as we continue to operate as we do. But the ultimate solution to the fraud problem is to design a system which does not allow fraud because you pay only the bottom dollar. If a lab test can be performed with computerized equipment, then you pay only for that. If you can do an abortion by saline injection in five minutes, then you pay only for that. Prepaid Health Plans, ultimately, are the way to go because these systems are designed to prevent fraud from occurring.[16]

There are programmatic flaws in the California system of delivery and billing which lend themselves to the commission of fraud. For example, a psychiatrist is paid a certain amount for one hour of one-on-one psychotherapy. He or she is paid a significantly smaller amount for group therapy or for a 15-minute therapy session. To receive payment, the therapist must obtain a sticker from the Medi-Cal beneficiary to submit with the claim for payment. Once the sticker has been removed from the back of the beneficiary's eligibility card, there is nothing to prevent the psychiatrist from billing Medi-Cal for the maximum allowable amount, regardless of the time actually spent with the beneficiary.

Another area where the California system encourages fraud is in the payment guidelines covering abortions. Medi-Cal pays for abortions at the $200 rate; however, California's abortion regulations are unclear as to whether the $200 fee covers just the abortion or is designed to cover all the ancillary services associated with the surgical procedure. A provider may routinely bill Medi-Cal $200 for the abortion and an additional series of fees for whatever ancillary services (e.g., fees for a physical exam, pregnancy test, counseling, etc.) Medi-Cal regulations will allow.

California experiences a large amount of fraud associated with lab services. This is because the system allows two different types of billing: a large fee, when lab tests are performed in the traditional, more archaic way at the physician's office; or a small fee, when the tests are performed using a modern, computerized testing system which runs through an entire panel of test results at one time. This dual payment mechanism invites at least a couple of system breakdowns. On the one hand, the physician can bill Medi-Cal at the higher rate reserved for the more archaic, manual system while having the tests performed using the computerized system, pocketing the difference in the two costs. On the other hand, the lab can perform its own billing of Medi-Cal, collecting payment for each section of the panel of tests, as if each was done separately when in reality they were all completed in one computer run.

3.5 Liaison Between the California Department of Health Services and the Medi-Cal Fraud Unit

The Medi-Cal Fraud Unit's current relationship with the California Department of Health Services has been described as

both "productive and developing".[12] Its Chief has described her Unit's data needs on two levels:

> We are in need of, I think, an adequate screening process for referrals. We need CDHS, through their operations, to identify or give us the information from which we can identify the worst cases. In other words, when we perform our selection process out of all these hundreds of cases, we should have the information to do so. In the past, a lot of the problem has been procedural. We have, for example, received drug cases which had not previously been referred to CDHS' own drug utilization review group for a drug audit and dental cases not previously referred to the DentaCal system to determine whether or not the practices under question were significantly above the norm. Health (CDHS) is in the process of ironing out these difficulties now...They're getting there.
>
> We would also like to see them interview complainants when the contact is initiated through CDHS and at the very least, ask the beneficiary the essential questions regarding a complaint. Quite often, they send them over to us rather naked. Especially with providers a SURs or DURs onsite audit, which they can perform, would be useful. We can't do that kind of thing because we're law enforcement and can't go in without a search warrant. As users of their system, we have to tell them what we want. So, we're having to sit down with them as we look at the referrals and decide what data items we need or don't need. I have no doubt but that the situation with the printouts will improve.

Currently, the Medi-Cal Fraud Unit has no official direct contact with the fiscal intermediary. Instead, all requests for data from Computer Sciences Corporation are made through CDHS' Audits and Investigations Division. (Ironically, the offices of the Medi-Cal Fraud Unit and Computer Sciences Corporation are located directly across the street from each other while the offices of the single state agency are located in another part of the city of Sacramento.) In explaining the Unit's need for fiscal intermediary data, its chief has stated the following:[13]

> A basic tool for a fraud investigation of the kind we do is the profile of the provider's billing practices which is

> maintained in the computer files at the Fiscal Intermediary. When an investigator in the field needs computer data, he needs it rapidly so that the investigation can proceed. This is because the provider under scrutiny may get wind of the whole affair and destroy his records before we can ever get a search warrant executed so that we can access those records.
>
> Here is the cumbersome and time consuming process that is involved. A Fraud Unit investigator must sit down and write a detailed memorandum to my chief investigator. He, in turn, must forward the memo to Investigations Branch at CDHS. Investigations Branch then must write a memo to the Fiscal Intermediary Management Division detailing our request. Meanwhile, the investigator in the field is waiting all this time for a search warrant to access the data.

In all fairness to both sides of this matter, it must be said (and this has been confirmed by both agencies) that California is undergoing a major transition from a fiscal intermediary that had no contract with the state and was not carefully monitored to a new one that is experiencing many of the problems associated with the implementation of a new system. What is more, there has been no overlapping of the two systems.

On occasion, the California Medi-Cal Fraud Unit has developed its own leads in fraud cases but prefers not to do so because of incurring the further animosity of the provider community. As the Unit Chief has explained it, "they are paranoid about us, imagining that we are roving about the medical community without reason, looking for criminal cases. To the extent that we undertake the generation of our own cases, we are confirming their paranoia."[14]

During the last quarter of 1980, the Medi-Cal Fraud Unit reports having received only one case from the California Department of Health Services.[15] However, since that time, referrals from CDHS have increased remarkably. In the view of the Medi-Cal Fraud Unit's Chief, this improvement is a direct result of the new Investigations Branch Chief's implementation of a more effective screening and prioritization system. In fact, as of May 22, 1981, the Medi-Cal Fraud Unit had received fifty-eight 1981 referrals from CDHS. Of these 58 cases, MCFU accepted 10 (17%) for criminal investigation, retained 10 (17%) other cases

CONTINUED

1 OF 3

pending receipt of additional data and returned 38 (66%) to CDHS without having taken any action.

3.6 Conclusion

California, possessor of this nation's largest Medicaid program, has managed to make gradual improvement in its overall program of fraud detection, prevention and control. Both the California Department of Health Services and the Medi-Cal Fraud Unit are staffed with highly competent and skilled professionals who understand the extremely politicized environment in which they are required to work and the current relationship between the two agencies can only be described as continually improving.

Two actions within CDHS--the reorganization of the Investigations Branch and the implementation of the ADSURS of MMIS--have greatly enhanced the single state agency's fraud detection and investigation capabilities and it is now becoming more responsive to the data needs of the Medi-Cal Fraud Unit. For its part, the Medi-Cal Fraud Unit has always been proactive in its approach to fraud investigation and prosecution and with an increased staff allocation, expects to improve its prosecution statistics appreciably.

Through ADSURS, the CDHS is able to identify patterns of misutilization. Following some investigative work by the staffs of the Investigations and SURS branches, CDHS refers a number of cases which reflect patterns of potentially fraudulent practices to the Medi-Cal Fraud Unit. At this time, the majority of these cases are not being accepted by the Medi-Cal Fraud Unit for investigation because of a number of problems with the screening process.

Neither Unit has any data estimating the amount of detected and undetected fraud in the Medi-Cal program. Over the life of the Medi-Cal Unit, it has prosecuted some 33 cases and maintains complete and accurate information on all cases it opens to the point of closure.

The information presented in this case study amply demonstrates that most of the dollar losses incurred by Medi-Cal to the provider community are a result of problems in the legislative structure, regulatory guidelines and administrative policies governing the California health care and delivery system. As the Chief Medical Consultant, SURS Branch, has put it, "Frankly,

a provider doesn't have to engage in fraud to get phenomenally rich out of this program. All he has to do is stretch or overuse or provide inappropriate services and submit bills for whatever the system will pay off on."[16] In truth, the systemic loopholes, brought on by legislative and regulatory guidelines and procedures which have produced an extremely flawed, abuse-inviting payment system, are just that plentiful.

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[2]Interview with David Helmson, Coordinator, Case Detection and Development Unit, Surveillance and Utilization Review Branch, Audits and Investigations Division, California Department of Health Services, conducted by Frank C. Jordan, Jr., May 22, 1981.

[3]Interview with Charles H. Shuttlesworth, Chief, Investigations Branch, Audits and Investigations Division, California Department of Health Services, conducted by Frank C. Jordan, Jr., May 20, 1981.

[4]Ibid.

[5]Interview with Frank Martucci, Chief, Audits Branch, Audits and Investigations Division, California Department of Health Services, conducted by Frank C. Jordan, Jr., May 20, 1981.

[6]Annual Report for 1979-1980, California Medi-Cal Fraud Unit, May 1, 1980.

[7]Ibid.

[8]Ibid.

[9]Ibid.

[10]Interview with Marjorie Winston Parker, Assistant Attorney General and Chief, Medi-Cal Fraud Unit, conducted by Frank C. Jordan, Jr., May 22, 1981.

[11]Ibid.

[12]Ibid.

[13]Ibid.

[14]Ibid.

[15]Ibid.

[16]Interview with Dr. Edward Rosen, Chief Medical Consultant, SURS Branch, Audits and Investigations Division, California Department of Health Services, conducted by Frank C. Jordan, Jr., May 21, 1981.

4. MICHIGAN

The Medicaid program in Michigan receives and processes daily some 65,000 invoices which represent health care services provided to Medicaid recipients. The number of individuals eligible for Medicaid assistance ranges each month from 800,000 to 1.2 million persons. Furthermore, approximately 30,000 providers of health care services have enrolled in the Medicaid program[1]. It was recently estimated that the Medicaid program cost approximately one billion dollars per year in Michigan with some 70 percent of those funds going to nursing homes and hospitals.

In Michigan, the Department of Social Services (DSS) has been designated as the single state agency responsible for the administration of the Medicaid program.[2] The State of Michigan does not utilize a fiscal agent in its Medicaid program. Within the Department of Social Services, the Medical Services Administration (MSA) has direct responsibility for Medicaid program administration (see Figure 4-1, p. 4-2). The Bureau of Health Services Review (BHSR), as part of MSA, has been tasked with the responsibility for monitoring the use of the Medicaid program by both recipients and health care providers. Within the Bureau of Health Services Review, the Medicaid Monitoring and Compliance Division (MMCD) has the responsibility for the planning and control of the Fraud and Abuse Program initiated by the Medical Services Administration.[3] In order to monitor the Medicaid program, the MMCD uses the Surveillance and Utilization Review System (SURS) of Michigan's Medicaid Management Information System (MMIS).

4.1 The Identification of Suspected Cases: SURS/MMIS

Michigan's MMIS has been described as basically "...an integrated group of procedures and computer processing operations developed to effectively process and control claims and provide MSA with the necessary information for planning and control."[4] Designed and developed by Touche, Ross and Company, Michigan's MMIS became operational in 1977. However, the Bureau of Information Services (BIS), Department of Social Services, is directly responsible for the systems, programs, and processing of MMIS. In accordance with the general conceptual design of MMIS, Michigan has implemented the four direct operations subsystems as well as the Management and

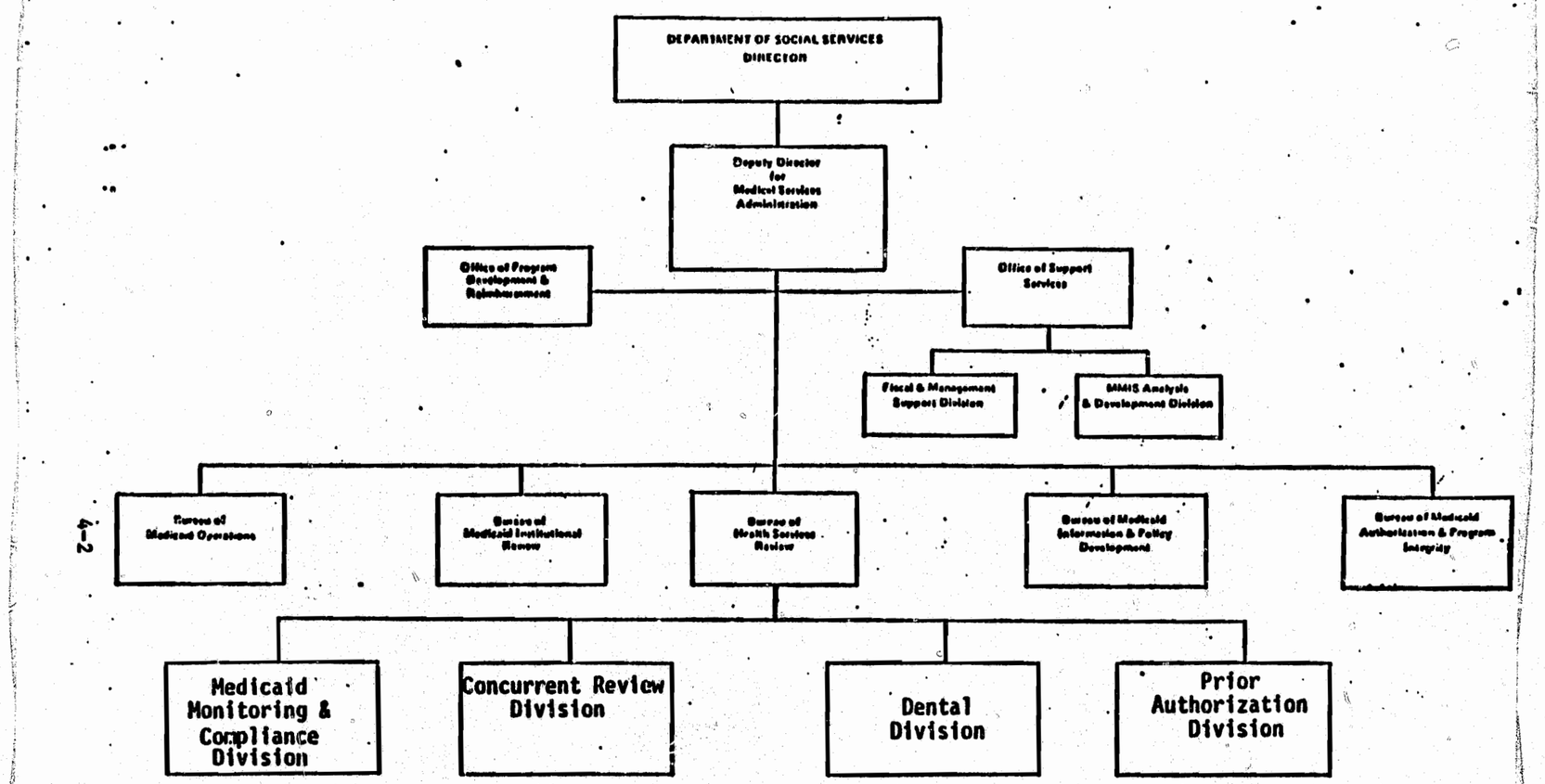

FIGURE 4-1

ORGANIZATIONAL CHART OF THE DEPARTMENT OF SOCIAL SERVICES
STATE OF MICHIGAN

Administrative Reporting and the Surveillance and Utilization Review Systems.

4.1.1 The Direct Operations Systems

In Michigan, the Direct Operations Systems are labelled Client Information, Provider Enrollment, Invoice (i.e., claims) Processing, and Systems Table File (i.e., reference).

4.1.1.1 The Client Information System

The Client Information System (CIS) of Michigan's MMIS performs four major functions.[5] First, CIS maintains identification for all those recipients who are eligible for assistance under the Medicaid program. Second, this subsystem provides the means for updating the eligibility records of Medicaid recipients. Third, CIS exerts control of information relevant to the eligibility of recipients. Finally, CIS provides a file of all eligible recipients to support three other systems: Invoice Processing, Management and Administrative Reporting, and Surveillance and Utilization Review.

4.1.1.2 The Provider Enrollment File

The Provider Enrollment File (PEF) has three basic functions.[6] First, PEF serves to process and enroll providers in the Medicaid program. This is, of course, contingent on their agreement to comply with the requirements of Title XIX. PEF also provides a check to ensure that services are provided to recipients only by qualified providers. Finally, like CIS, PEF provides a file of all eligible providers to support Invoice Processing, MARS, and SURS.

4.1.1.3 The Invoice Processing System

The Invoice Processing System (IPS) has been described as performing five primary functions.[7] Four of these functions[8] are concerned with the processing of claims:

- "ensure that all claims and related transactions are accurately input into the system at the earliest possible time;
- establish strict system controls to ensure that all transactions are processed completely and promptly and that all claim discrepancies are resolved expeditiously;

- verify the eligibility of both the recipient and the provider and the validity of the claim information submitted; and
- ensure that correct payment is made to providers on a timely basis."

In addition, IPS also provides a file of adjudicated claims for use in MARS and SURS.

4.1.1.4 The Systems Table File

The Systems Table File (STF) is the fourth direct operations system of Michigan's MMIS.[9] It is the equivalent of the reference file subsystem called for by the general conceptual design of MMIS. As such, it has three primary functions. First, it provides the capability to update the reference files used in the processing of Medicaid claims. Second, STF provides data regarding the usual and customary charges of providers participating in the Medicaid program and incorporates these data into the system. Finally, the STF generates various lists of Medicaid claims which have been suspended because of errors.

4.1.2 The Management and Administrative Reporting System

The Management and Administrative Reporting System (MARS) is intended to provide the Medical Services Administration with the data needed for management review, evaluation, and decision-making.[10] Specifically, the functions of MARS include:[11]

- "provide management with financial data for proper fiscal planning and control;
- provide management with information to assist in the development of improved medical assistance policy and regulations;
- monitor the progress of claims processing operations, including the status of provider payments;
- analyze provider performance in terms of the extent and adequacy of participation; and
- analyze recipient participation in terms of the nature and extent of services received."

MARS also provides the information needed by MSA to meet the reporting requirements of federal regulations.

4.1.3 The Surveillance and Utilization Review System

Generally speaking, the Surveillance and Utilization Review System (SURS) in Michigan may be described as having two purposes:

- provide information needed to assess the level and quality of health care services provided to recipients; and
- provide information which reveals and facilitates the investigation of suspected cases of fraud and abuse.

In order to accomplish these purposes, SURS consists of a set of computer programs designed to organize and screen the large volume of claims received by the MSA in order to identify on the basis of exception logic (see Chapter 2) those providers and recipients who are "above or below prescribed or statistically calculated norms."[12] Thus, SURS represents a mechanism for identifying cases which may involve abuse of the Medicaid program. Whether or not such cases, once verified, involve fraud is seen as a question for the State Medicaid Fraud Control Unit to decide.

4.1.3.1 The Operation of SURS

In order to identify suspected cases of abuse, the SURS (see Figure 4-2, p. 4-6)[13] maintains detailed information on claims paid to providers and for recipients for 12 months. Based on demographic data, medical factors, and utilization characteristics, the system categorizes both recipients and providers into "Class Groups" or peer groups. Thus, for example, SURS places general practitioners in Wayne County (Detroit and its suburbs) into one Class Group and radiologists in the Upper Pennisula region of Michigan in another. In its approach to exception reporting, the Michigan SURS uses 45 Class Groups in what is termed the practitioner module.

A statistical profile is prepared for each Class Group against which the profiles of individuals are compared. Each class profile can contain up to 200 report items. Some 20 of these items are considered critical indicators and provide the basis

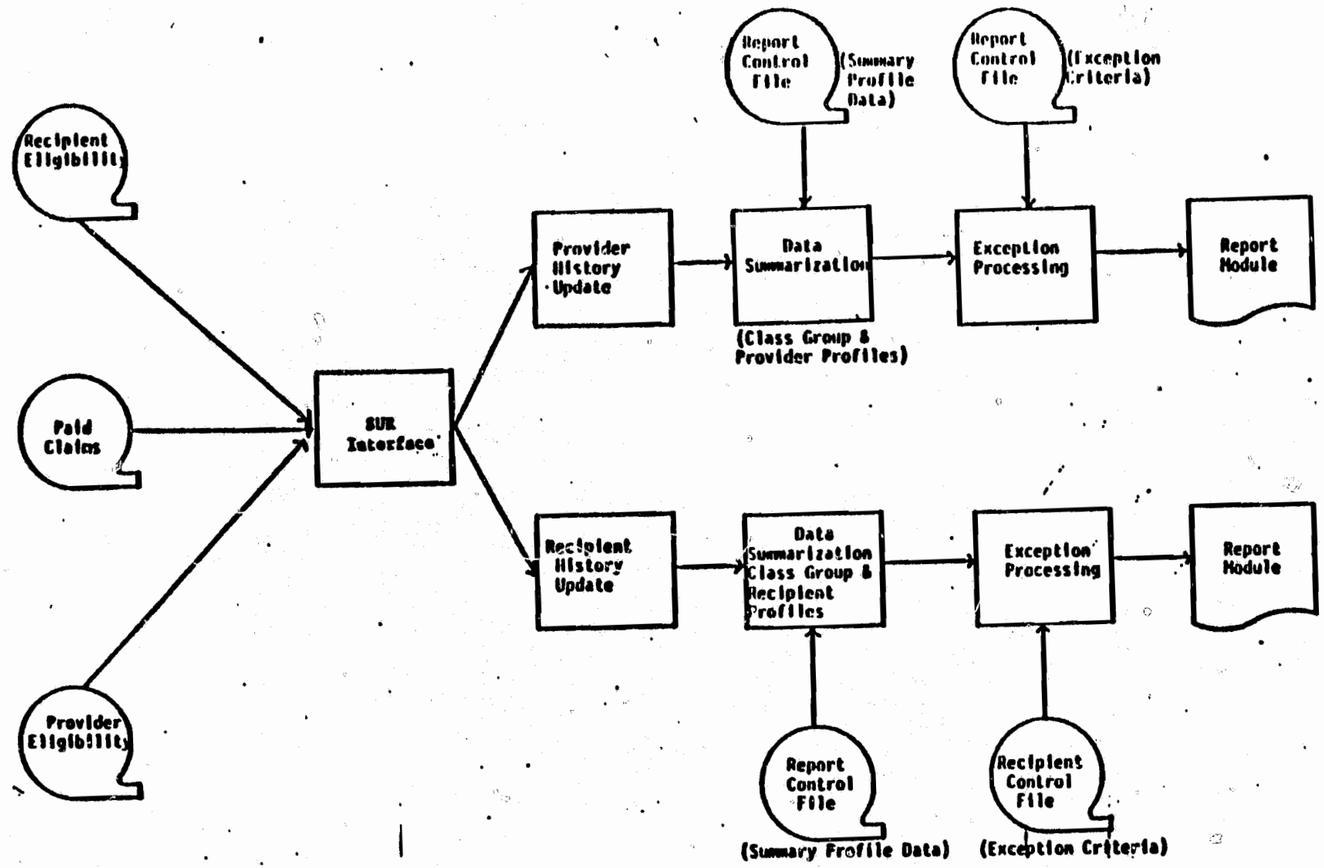

FIGURE 4-2

THE SURVEILLANCE AND UTILIZATION REVIEW SYSTEM OPERATED BY THE MMIS ANALYSIS AND DEVELOPMENT DIVISION

for the exception reporting process. For example, exception indicators for practitioner Class Groups include such items as total payments, total recipients, and total office visits. The exact number of key indicators vary from Class Group to Class Group. The items of information which do not serve as exception indicators are used to provide a description of the utilization patterns of recipients as well as the Medicaid practices of providers. The SURS then identifies those providers (and recipients) who exceed the established exception limits and prints reports of their profiles. The exception limits are set statistically at plus or minus two standard deviations or in absolute values entered by the analysis staff.[14]

4.1.3.2 SURS Reporting

Seven different types of reports are produced by SURS: five of these are management reports; two are analysis reports.[15]

- The Management Summary Class Profiles Report contains a two-part profile for each Peer Group within a specific category of health care service. This report is used to analyze medical activity patterns and set realistic exception reporting limits.

- The Exception Control Limits Report specifies the current exception limits for each report item contained in the Peer Groups.

- The Exception Review Log Report identifies those providers or recipients who were excepted (that is, identified as exceeding exception control limits) during the current reporting period. It provides a basis for prioritizing the analysis of those recipients or providers who have been excepted.

- The Exception Summary Report presents a summary of the exceptions identified during exception processing. It may be used to (1) determine the number of exceptions in each Peer Group and (2) assess the validity of the exception control limits.

- The Frequency Distribution Report presents the number of recipients or providers falling within each frequency range or class internal established for selected report items. This report can be used to establish exception

control limits where those provided by the SURS are considered unacceptable.

- The Profile Report presents the profile of the utilization pattern of an individual provider or recipient and may vary in content according to specifications set by the user. This report provides the starting point for the analysis of cases of excepted providers or recipients to identify indications of possible fraud.

- The Claim Detail Report provides a listing of claims for which a provider has been paid. This listing can be employed to quantify and verify billing problems and instances of potential abuse.

Every three months, Michigan's SURS generates Profile Reports for some 1,300 physicians, 50 podiatrists, 50 chiropractors, 100 laboratories, 250 hospitals, and 180 dentists.[16]

4.2 The Processing and Review of Suspected Cases: The Medicaid Monitoring and Compliance Division

The MMCD was created in 1979 when the Medicaid Recovery Unit was transferred from the Office of the Inspector General in Social Servies to the BHSR and coupled with the Bureau's Medicaid Monitoring Unit to form the MMCD. Thus, the MMCD consists of two separate, but operationally related sections: the Medicaid Compliance Section and the Medicaid Monitoring Section (see Figure 4-3, p. 4-9). This centralization of anti-fraud and abuse efforts in the MMCD is intended to (1) maximize the detection and correction of irregular claims submitted by providers and (2) coordinate and direct the anti-fraud and abuse activities conducted by other organizations within MSA.[17]

Specifically, the MMCD has been assigned responsibility for monitoring the Medicaid assistance program in order to identify: "(1) possible program abuse; (2) possible provider or recipient fraud; (3) program overpayments; and (4) defective or inadequate policy or procedures."[18] When such instances have been uncovered on the basis of post payment analyses, the MMCD has recourse to a variety of corrective methods including:[19]

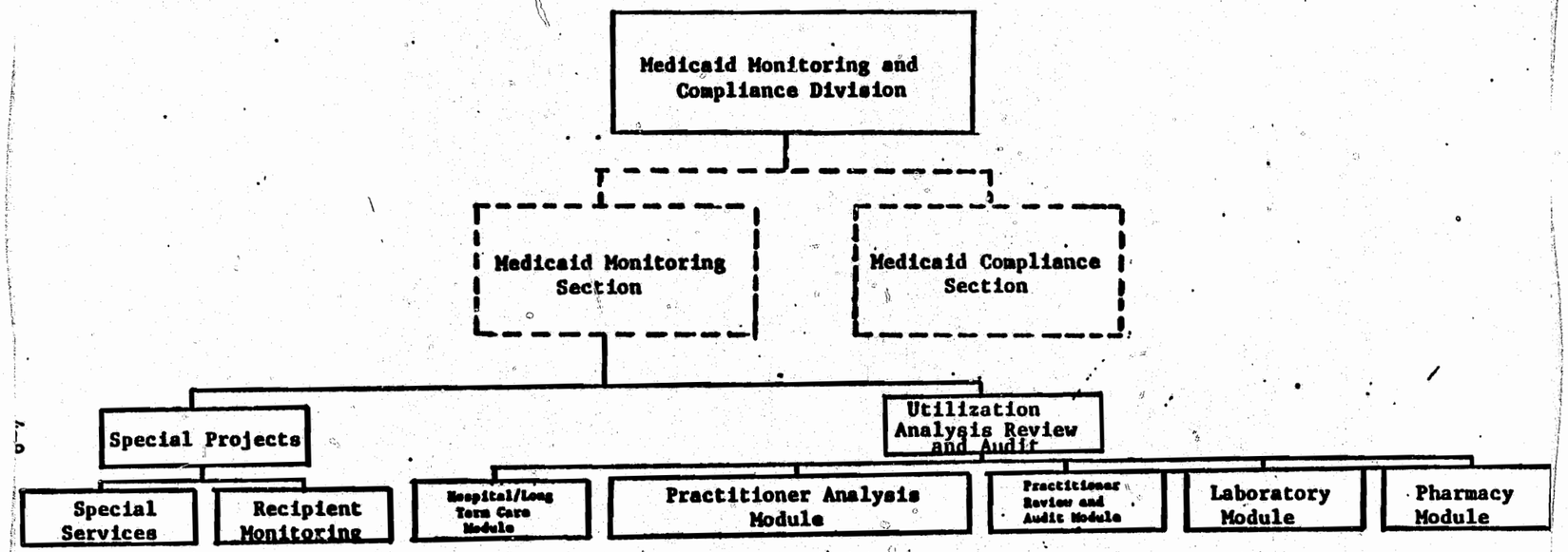

FIGURE 4-3

ORGANIZATIONAL CHART OF THE MEDICAID MONITORING AND COMPLIANCE DIVISION, BUREAU OF HEALTH SERVICES REVIEW, MEDICAL SERVICES ADMINISTRATION

- "case referral to the appropriate investigative agency including the State Attorney General, Medicaid Fraud Unit;
- review of a provider's medical records and subsequent administrative or legal action;
- recoupment of funds; and/or
- recommendations for new policy or policy changes."[20]

4.2.1 Case Processing Operations

Once a case has been excepted by SURS, a labor intensive process begins involving the 65 persons currently assigned to MMCD[21]. The MMCD health care analysts begin the review process by analyzing the information items contained in the summary profiles in an effort to determine why the exceptions occurred.[22] If the exception can be satisfactorily explained, the case is closed. If not, a claims detail report is prepared based on the relevant SURS history file. Analysis of the claims detail report will result in one of the following decisions:

- case closure;
- quantification of overpayments;
- recommendation for a field audit;
- both quantification of over-payments and recommendation for a field audit; or
- referral to the appropriate legal agency.

Figure 4-4 (see p. 4-11) presents a General Analysis Flow Chart outlining this process. Health care analysts follow the same process no matter which Analysis Module they are examining; that is, the practitioner, laboratory, pharmacy, or dental modules (see the Utilization Analysis Review and Audit Subsection of the Medicaid Monitoring Section, Figure 4-3, p. 4-9). Moreover, virtually the same process is followed if a case is referred to MMCD by some source other than SURS.[23]

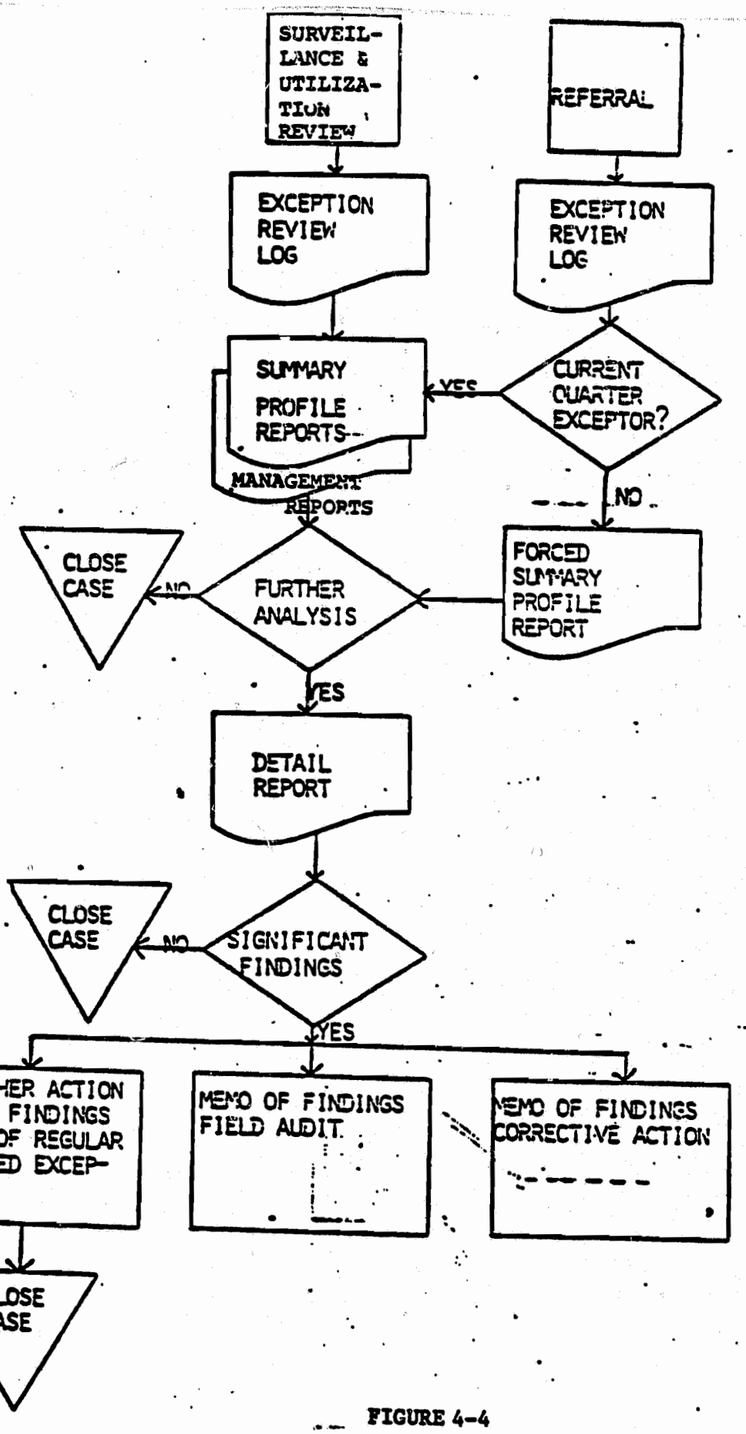

FIGURE 4-4

THE GENERAL ANALYSIS FLOW CHART

4.2.2 The Review Process

If the health care analyst determines that there is a satisfactory explanation for an exception, the case is closed with no further action. However, if a satisfactory explanation cannot be found, a Memorandum of Findings (MOF) is prepared which summarizes the pattern of medical activity of the provider or recipient. The MOF also highlights the problems identified by the health care analyst and recommends a course of action and method of follow-up. A copy of the MOF is forwarded to the State Medicaid Fraud Unit which determines whether or not fraud is involved and what action should be taken by the Department of the Attorney General. Concurrently, MSA will proceed with whatever course of action is deemed appropriate through the Medicaid program. If the analysis of a claims detail report uncovers an indication of overpayment, the health care analyst first quantifies the amount of overpayment and the corresponding refund. The provider is then notified of the details of each overpayment and given 20 days to appeal the findings. If the provider chooses not to file an appeal, the overpayment is recouped through a debit against future billings.

A review of claims detail reports may also indicate the potential problems of abuse or questions of medical practice or medical necessity. In such instances, the health care analyst would recommend a field audit. Basically, a field audit consists of a review conducted by physicians and nurses of a random sample of a provider's medical records. A field audit may also involve a review by the appropriate peer review committee and their recommendations for administrative action. As a result of a field audit, overpayments of funds can be recouped or a provider terminated from the program.

In discussing the role of SURS in the review process, the MMCD Director expressed the opinion that Michigan's SURS is efficient in accomplishing its intended purpose, that is, the identification of cases of potential abuse for follow-up by the MMCD and the MFU. He pointed out that efforts are continually being made to improve the performance of SURS. However, he emphasized that no matter how efficient SURS becomes, there is no substitute for the painstaking review process which the MMCD follows in order to positively identify cases of abuse for follow-up action by the MFU.

4.2.3 The Need for Coordination

As may be seen, the process followed by the MMCD in developing and adjudicating a case is a complex, tiresome, and time consuming one. As the MMCD's Director has pointed out,[24] it frequently involves coordination of actions with other organizations and individuals operating independently of MMCD including peer review groups, consulting physicians, the Medicaid Fraud Unit, and the Inspector General of the Department of Social Services. Although there is some coordination with other MSA units during the preliminary stages of analysis of excepted cases, the need for external liaison becomes imperative once the health care analyst decides that there is not a satisfactory explanation for the exception and consequently prepares a MOF. It is at this point that the MMCD becomes involved with such organizations as Peer Review Groups. Once the review cycle has been completed, the provider is notified of the findings. Concurrently, the Medicaid Fraud Unit (MFU) is notified. The MMCD considers those cases it refers to the MFU incidents of abuse. It is then the MFU's responsibility to determine whether or not fraud is involved.

4.2.4 The Availability of Fraud-Related Data

According to MMCD's reports,[25,26] during fiscal year 1979-1980, MMCD reviewed the utilization of services rendered by 8,370 providers. See Table 4-1, p. 4-14 for a breakdown of this figure according to the type of service provided; for example, laboratory analysis, dentistry, and podiatry. The figure of 8,370 providers contains some duplication as providers and recipients will continue to be reported by SURS from quarter to quarter as long as they continue to exceed the selected limits. In any event, practitioners represent the largest number of providers selected (65.4% of the total) followed by pharmacists (13.0% of the total). With the exception of a category of providers labeled "all others," chiropractors were the smallest group excepted (2.4% of the total). From these cases, health care analysts selected 2,587 providers for case analysis. Again, practitioners represented the largest group (93%) excepted by SURS (see Table 4-2, p. 4-15).

As a result of the analysis of these cases, 215 cases were developed and steps were taken to recoup funds and/or terminate the providers involved (see Table 4-3, p. 4-16). Another 48

TABLE 4-1

NUMBER OF PROVIDERS REVIEWED IN FISCAL YEAR 1979-1980
BY CATEGORY OF PROVIDER[a]

CATEGORY OF PROVIDER	NUMBER[b]	PERCENT[c]
Practitioners	5,480	65.4
Laboratories	453	5.4
Pharmacists	1,084	13.0
Dentists	569	7.1
Vision Providers	218	2.6
Chiropractors	203	2.4
Podiatrists	222	3.0
All Others	141	1.7
TOTAL	8,370	100.6

[a] This table was derived from material presented in a report entitled Provider Process Data prepared by the Medicaid Monitoring and Compliance Division.

[b] There are a number of possible alternative explanations for differences in the number of cases in each category of provider. It is beyond the scope of this report to determine why these relative differences occurred.

[c] Total percentage does not equal 100.0 percent because of rounding.

TABLE 4-2

NUMBER OF PROVIDERS SELECTED FOR CASE ANALYSIS
IN FISCAL YEAR 1979-1980 BY CATEGORY OF PROVIDERS[a]

CATEGORY OF PROVIDER	NUMBER[b]	PERCENT[c]
Practitioners	2,401	93.0
Laboratories	84	3.2
Pharmacists	----	----
Dentists	15	0.6
Vision Providers	5	0.2
Chiropractors	----	----
Podiatrists	76	3.0
All Others	6	0.2
TOTAL	2,587	100.2

[a] This table was derived from material presented in a report entitled Provider Process Data prepared by the Medicaid Monitoring and Compliance Division.

[b] There are a number of possible alternative explanations for differences in the number of cases in each provider category. It is beyond the scope of this report to determine why these relative differences occurred.

[c] Total percentage does not equal 100.0 percent because of rounding.

TABLE 4-3

ACTION TAKEN AGAINST PROVIDERS IN FISCAL YEAR 1979-1980 BY CATEGORY OF PROVIDER[a]

CATEGORY OF PROVIDER[b]	FULL SCALE AUDIT	CORRECTIVE ACTION GROSS AUDITS	TOTAL[e]
Practitioners	(31.3%)[c] 58 (82.9%)[d]	(69.0%)[c] 127 (87.5%)[d]	(100.3%)[c] 185 (86.0%)[d]
Laboratories	(10.0%)[c] 2 (3.0%)[d]	(90.0%)[c] 18 (12.4%)[d]	(100.0%)[c] 20 (9.3%)[d]
Pharmacists	(100.0%)[c] 7 (10.0%)[d]	—	(100.0%)[c] 7 (3.2%)[d]
Dentists	(100.0%)[c] 3 (4.2%)[d]	—	(100.0%)[c] 3 (1.4%)[d]
TOTAL[e]	(32.6%)[c] 70 (100.2%)[d]	(67.4%)[c] 145 (100.0%)[d]	(100.0%)[c] 215 (99.9%)[d]

[a] This table was derived from material presented in a report entitled Provider Process Data prepared by the Medicaid Monitoring and Compliance Division.

[b] There are a number of possible alternative explanations why these providers were selected for action; moreover, there are several possible explanations for the differences in action taken between categories.

[c] Row totals.

[d] Column totals.

[e] Total percentage may not equal 100.0 percent because of rounding.

cases were presented to Peer Review Groups. Four of these cases have been closed by felony convictions; six, with a refund.

During this period, a total of 447 cases were referred to the Medicaid Fraud Division (see Table 4-4, p. 4-18). Overall, 244 cases (54.4%) were retained by the Medicaid Fraud Control Unit. Of these 244 cases, 70.5 percent of those referred on the basis of the return of the Explanation of Benefits (EOB) notifications were retained. EOBs are notices sent to Medicaid recipients of the services which have been provided to them. Should there be any discrepencies between what the Medicaid program has been billed for and the amount and type of services received by the clients, the recipients are requested to notify the Medicaid program. In contrast to cases referred on the basis of EOBs, only 24.2% of those based on complaints and 5.3% of those based on developed cases were retained by the Medicaid Fraud Control Unit.

During the period from 1972 to 1981, 32 providers were convicted of felonies involving fraud against the Medicaid program in the State of Michigan. Twenty-two of those convictions (68.7%) were obtained by the State; 10 (31.2%), by the Federal government. The convicted providers included 20 practitioners, four laboratories, one pharmacist, three dentists, three chiropractors, and one podiatrist. The participation of 28 of these providers in the Medicaid program has been terminated.

4.3 The Investigation and Prosecution of Suspected Cases: The Medicaid Fraud Unit

In the State of Michigan, the Medicaid Fraud Unit (MFU) is part of the Economic Crime Division, Department of the Attorney General.[27] The MFU began operation in 1977 with state funding. In October 1978, the MFU was certified by the then Department of Health, Education, and Welfare as eligible to receive federal support under the auspices of Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendements. In 1980, the MFU was recertified for participation in the program.

TABLE 4-4

INITIAL DISPOSITION OF CASES REFERRED TO THE MEDICAID FRAUD UNIT (MFU) IN TERMS OF THE TYPE OF REFERRAL BY THE MEDICAID MONITORING AND COMPLIANCE DIVISION (MMCD)[a]

TYPE OF REFERRAL TO MEDICAID FRAUD UNIT	INITIAL DISPOSITION BY MEDICAID FRAUD UNIT[b]		
	Number of Cases Returned to MMCD	Number of Cases Retained by MFU	TOTAL[e]
Developed Cases (Medicaid Monitoring & Compliance Division)	(91.5%)[c] 141 (69.4%)[d]	(8.4%)[c] 13 (5.3%)[d]	(99.9%)[c] 154 (34.5%)[d]
Explanation of Benefits (EOBs)	(19.1%)[c] 40 (20.0%)[d]	(81.1%)[c] 172 (70.5%)[d]	(100.2%)[c] 212 (47.4%)[d]
Complaints	(27.1%)[c] 22 (11.0%)[d]	(73.0%)[c] 59 (24.2%)[d]	(100.1%)[c] 81 (18.1%)[d]
TOTAL[e]	(45.4%)[c] 203 (100.4%)[d]	(54.5%)[c] 244 (100.0%)[d]	(99.9%)[c] 447 (100.0%)[d]

[a] This table was derived from material presented in a report entitled Provider Process Data prepared by the Medicaid Monitoring and Compliance Division.

[b] There are a number of possible alternative explanations for the differences in rates of retention cases. However, it is beyond the scope of this report to determine the reasons for these differences.

[c] Row totals.

[d] Column totals.

[e] Total percentage may not equal 100.0 percent because of rounding.

4.3.1 Objectives of the MFU

The unit's Chief Investigator described the MFU as having three primary objectives:

- the prosecution and conviction of cases involving Medicaid fraud;
- the recovery of monies lost to program fraud; and
- coordination with the staff of the single state agency responsible for the Medicaid program to tighten "loopholes" in the program.

Although the Chief Investigator considers all three objectives to be important, he is of the opinion that the last objective is the most critical because it focuses on the key to the prevention and control of fraud: that is, the elimination of opportunities for fraud.

4.3.2 Legislative Authority

The MFU has been granted statewide prosecutional power to deal with incidents of Medicaid fraud occurring within any jurisdiction in the State of Michigan. By statute, the unit is empowered to prosecute all cases of Medicaid fraud (no matter where they occur) in Lansing, Michigan (the state capital). The justification for this arrangement is based on the fact that the Medical Services Administration issues checks to both Medicaid recipients and providers from its headquarters in Lansing.

In Michigan, the MFU prosecutes Medicaid fraud under the auspicies of the Medicaid False Claims Act. Previously, Medicaid fraud had been prosecuted under the Obtaining Money Under False Claims Act. The Medicaid False Claims Act was passed by the legislature at the request of the MFU which sought stiffer penalties for Medicaid fraud. Violation of this act is a felony punishable by imprisonment for not more than four years and/or a fine of not more than $50,000. Moreover, the act provides for the imposition of civil penalties. The State may seek a civil penalty equal to the full amount fraudulently obtained plus triple the amount of damages suffered.

4.3.3 Staffing and Funding

Michigan's MFU employes a multi-disciplinary staff of 45 persons in its efforts to control fraud in the Medicaid program. The

professional staff includes five attorneys, 15 investigators, and 11 auditors. In addition, there are 10 support personnel including an evidence clerk and an investigative aide. It is hoped that with continued federal funding the MFU will be able to reach a total strength of 61 personnel. However, the uncertainty of federal funding has made it difficult to recruit the personnel needed. For Fiscal Year 1980-1981, a budget of $2,138,866 was proposed. Of this amount, the largest obligation ($1,464,160) was for personnel.

4.3.4 The Detection of Medicaid Fraud

Allegations regarding fraud are received from a wide variety of sources including the Screening Committee of the Division of Social Services (DSS) which reviews complaints about fraud received from sources within the DSS as well as sources external to the DSS. For example, the complaints received by the DSS may be the result of field audits of institutional providers. Other sources include DSS field personnel and practitioners themselves. The MMIS operated by the Medical Services Administration (MSA) provides two sources of potential leads to the MFU: returns of Explanation of Benefit (EOB) forms and cases identified by the SURS as exceptions to norms for medical activities.

An EOB is basically a notification sent to Medicaid recipients detailing the services they have received according to MSA's records. Currently, two percent of the EOBs sent out are sampled on an annual basis. The cases sampled are examined to determine if there are discrepencies between the services MSA was billed for and those received by the clients of the Medicaid program. Where discrepencies do exist, the cases are analyzed to determine if there are indications of fraud. Thus, the analysis of EOBs can be used to identify providers who may be committing fraud and target them for further investigation and prosecution as warranted.

The SURS also produces potential leads for further investigation by the MFU. As discussed previously, the cases excepted by SURS are referred to the MFU only after extensive analysis by the Medicaid Monitoring and Compliance Division (MMCD) of MSA (see Figure 4-4, p. 4-11). In this regard, the Chief Investigator of the MFU is in agreement with the Director of the MMCD that SURS is not intended to identify instances of fraud or instances of

potential fraud. In their opinion, SURS is intended to identify cases which may involve abuse. The identification of fraud requires the collection and analysis of complex data by auditors and investigators; the development of the various elements of evidence needed for prosecution and conviction; and the establishment of willful intent to defraud the Medicaid program. Consequently, the Chief Investigator of the MFU does not think that SURS has or will have the capacity to identify provable cases of fraud. However, as has been seen, cases excepted by SURS, after intensive analysis by the MMCD, are referred to the MFU for further analysis to determine if they involve fraud. The examination of these SURS produced cases does provide the MFU with leads for further investigations.

Although the majority of leads investigated by the MFU are received from the sources described above, the unit does seek to develop its own leads whenever possible. Usually, these leads are generated from ongoing investigations of leads produced by other sources. The MFU implemented a "hotline" as a means of identifying alleged cases of Medicaid fraud; however, the program was not considered successful enough to be continued. The Chief Investigator of the MFU is of the opinion that the successful operation of a "hotline" requires a high level of continuous publicity as well as the active cooperation of all the law enforcement and program agencies concerned with Medicaid fraud.

As of October, 1980, the MFU had initiated criminal investigations in 279 cases of suspected fraud.[28] More than half (53.8%) of these cases were referred to the MFU by the Division of Social Services (see Table 4-5, p. 4-22). Of the remaining cases, 15.17 percent were referred by state agencies other than the Division of Social Services; 31.1 percent by others such as the Department of Health and Human Services and anonymous informants. An analysis of an earlier (March 6, 1980), albiet more detailed, description of the sources of referrals[29] to the MFU indicated that 43 percent of the referrals (N = 151) from the Division of Social Services (DDS) were produced by Institutional Reviews (see Table 4-6, p. 4-23). SURS accounted for 22.5 percent of the referrals. Thus, on the basis of these figures alone, one might conclude that Institutional Reviews may be more "effective" than SURS in identifying potential cases of Medicaid fraud. However, as in every other subject involving the prevention and control of fraud (especially statistics regarding fraud) the answer is neither that simple nor that obvious.

TABLE 4-5

CATEGORIES OF PROVIDERS UNDER INVESTIGATION BY THE MEDICAID FRAUD UNIT IN TERMS OF SOURCE OF REFERRAL[a]
(As of October 1, 1980)

CATEGORY OF PROVIDER	SOURCE OF REFERRAL: Division of Social Services	SOURCE OF REFERRAL: Other State Departments	SOURCE OF REFERRAL: Other	TOTAL
Medical Doctor	(62.0%)[c] 26 (17.3%)[d]	(9.5%)[c] 4 (9.5%)[d]	(28.5%)[c] 12 (14.0%)[d]	(100.0%)[c] 42 (15.0%)[d]
Doctor of Osteopathy	(52.1%)[c] 24 (16.0%)[d]	(4.3%)[c] 2 (5.0%)[d]	(43.4%)[c] 20 (23.0%)[d]	(99.8%)[c] 46 (16.5%)[d]
Podiatrist	(67.0%)[c] 2 (1.3%)[d]		(33.3%)[c] 1 (1.1%)[d]	(103.3%)[c] 3 (1.1%)[d]
Dentist	(44.4%)[c] 4 (3.0%)[d]		(55.5%)[c] 5 (6.0%)[d]	(99.9%)[c] 9 (3.2%)[d]
Chiropractor			(100.0%)[c] 1 (1.1%)[d]	(100.0%)[c] 1 (0.3%)[d]
Optometrist	(100.0%)[c] 3 (2.0%)			(100.0%)[c] 3 (1.1%)[d]
Therapist		(33.3%)[c] 1 (2.3%)[d]	(67.0%)[c] 2 (2.3%)[d]	(103.3%)[c] 3 (1.1%)[d]
Hearing Aid Dealer	(100.0%)[c] 1 (0.7%)[d]			(100.0%)[c] 1 (0.3%)[d]
Hospital	(43.0%)[c] 3 (2.0%)[d]	(43.0%)[c] 3 (7.1%)[d]	(14.2%)[c] 1 (.1.%)[d]	(100.2%)[c] 7 (2.5%)[d]
Nursing Home	(72.0%)[c] 69 (46.0%)[d]	(23.0%)[c] 22 (52.3%)[c]	(5.2%)[c] 5 (6.0%)[d]	(100.2%)[c] 96 (34.4%)[d]
Clinic	(27.2%)[c] 3 (2.0%)[d]		(73.0%)[c] 8 (9.2%)[d]	(100.2%)[c] 11 (4.0%)[d]
Laboratory	(64.2%)[c] 9 (5.0%)[d]	(14.2%)[c] 2 (5.0%)[d]	(21.4%)[c] 3 (3.4%)[d]	(99.8%)[c] 14 (5.0%)[d]
Ambulance	(33.3%)[c] 1 (0.7%)[d]		(66.6%)[c] 2 (2.3%)[d]	(99.9%)[c] 3 (1.1%)[d]
Pharmacy	(10.7%)[c] 3 (2.0%)[d]	(18.0%)[c] 5 (12.0%)[d]	(71.4%)[c] 20 (23.0%)[d]	(100.1%)[c] 28 (10.0%)[d]

TABLE 4-5

(Concluded)

CATEGORY OF PROVIDER	SOURCE OF REFERRAL: Division of Social Services	SOURCE OF REFERRAL: Other State Departments	SOURCE OF REFERRAL: Other	TOTAL
Intensive Care Facility			(100.0%)[c] 1 (1.1%)[d]	(100.0%)[c] 1 (0.3%)[d]
Transportation Company		(100.0%)[c] 1 (2.3%)[d]		(100.0%)[c] 1 (0.3%)[d]
Medical Supplier			(100.0%)[c] 1 (1.1%)[d]	(100.0%)[c] 1 (0.3%)[d]
Optical			(100.0%)[c] 3 (3.4%)[d]	(100.0%)[c] 3 (1.1%)[d]
X-Ray		(50.0%)[c] 1 (2.3%)[d]	(50.0%)[c] 1 (1.1%)[d]	(100.0%)[c] 2 (0.7%)[d]
Other	(50.0%)[c] 2 (1.3%)[d]	(25.0%)[c] 1 (2.3%)[d]	(25.0%)[c] 1 (1.1%)[d]	(100.0%)[c] 4 (1.4%)[d]
TOTAL[e]	(54.0%)[c] 150 (100.3%)[d]	(15.0%)[c] 42 (100.1%)[d]	(31.1%)[c] 87 (100.3%)[d]	(100.1%)[c] 279 (99.7%)[d]

[a]This table was derived from a chart dated October 1, 1980 presenting the categories of provider under criminal investigation by the Medicaid Fraud Unit. See Medicaid Fraud Unit, Economic Crime Division, Department of the Attorney General, Report to the Attorney General, October 1, 1980, Lansing, Michigan, p. 10.

[b]There are a number of possible alternative explanations for the differences in the number of referrals by different sources as reflected in this table. However, it is beyond the scope of this project to determine the reason(s) for these differences. Therefore, the reader should be extremely careful in attempting to analyze these data and interpret the results.

[c]Row figures.

[d]Column figures.

[e]Total percentages may not equal 100.0 percent because of rounding.

TABLE 4-6

CATEGORIES OF PROVIDERS UNDER INVESTIGATION BY THE MEDICAID FRAUD UNIT IN TERMS OF SOURCE OF REFERRAL WITHIN THE DIVISION OF SOCIAL SERVICES
(As of March 6, 1980)

CATEGORY OF PROVIDER	SOURCE OF REFERRAL WITHIN DIVISION OF SOCIAL SERVICES[b]						
	Surveillance & Utilization Review System	Screening Committee (DSS)	Institutional Review	Inspector General (DSS)	County DSS Official	Other	TOTAL[a]
Medical Doctor	(50.0%)[c] 11 (32.3%)[d]	(13.6%)[c] 3 (16.6%)[d]		(4.5%)[c] 1 (50.0%)[d]	(4.5%)[c] 1 (16.6%)[d]	(27.2%)[c] 6 (23.1%)[c]	(99.8%)[c] 22 (14.6%)[d]
Doctor of Osteopathy	(53.5%)[c] 15 (44.1%)[d]	(25.0%)[c] 7 (38.8%)[d]		(3.5%)[c] 1 (50.0%)[d]	(3.5%)[c] 1 (16.6%)[d]	(14.3%)[c] 4 (15.4%)[d]	(99.8%)[c] 28 (18.5%)[d]
Podiatrist	(100.0%)[c] 1 (2.9%)[d]						(100.0%)[c] 1 (0.7%)[d]
Dentist	(25.0%)[c] 1 (2.9%)[d]	(50.0%)[c] 2 (11.1%)[d]				(25.0%)[c] 1 (3.8%)[d]	(100.0%)[c] 4 (2.6%)[d]
Optometrist						(100.0%)[c] 1 (3.8%)	(100.0%)[c] 1 (0.7%)[d]
Hearing Aid Dealer						(100.0%)[c] 1 (3.8%)[d]	(100.0%)[c] 1 (0.7%)[d]
Clinic	(50.0%)[c] 1 (2.9%)[d]					(50.0%)[c] 1 (3.8%)[d]	(100.0%)[c] 2 (1.3%)[d]
Laboratory	(55.5%)[c] 5 (14.7%)[d]					(44.4%)[c] 4 (15.4%)[d]	(99.9%)[c] 9 (6.0%)
Ambulance		(100.0%)[c] 1 (5.5%)[d]					(100.0%)[c] 1 (0.7%)[d]
Pharmacy		(60.0%)[c] 3 (16.6%)[d]				(40.0%)[c] 2 (7.7%)[d]	(100.0%)[c] 5 (3.3%)[d]
Skilled Nursing Facility		(1.4%)[c] 1 (5.5%)[d]	(90.2%)[c] 65 (100%)		(5.5%)[c] 4 (66.6%)[d]	(2.8%)[c] 2 (7.7%)[d]	(99.9%)[c] 72 (47.7%)[d]
Hospital						(100.0%)[c] 2 (7.7%)[d]	(100.0%)[c] 2 (1.3%)[d]
Medical Suppliers		(100.0%)[c] 1 (5.5%)[d]					(100.0%)[c] 1 (0.7%)[d]
Other						(100.0%)[c] 2 (7.7%)[d]	(100.0%)[c] 2 (1.3%)[d]
TOTAL[e]	(22.5%)[c] 34 (99.8%)[d]	(11.9%)[c] 18 (99.8%)[d]	(43.0%)[c] 65 (100.0%)[d]	(1.3%)[c] 2 (100.0%)[d]	(3.9%)[c] 6 (99.8%)[d]	(17.2%)[c] 26 (99.9%)[d]	(99.8%)[c] 151 (101.1%)[d]

[a]This table was derived from a chart dated March 6, 1980 presenting the categories of providers under criminal investigation by the Medicaid Fraud Unit. See Medicaid Fraud Unit, Economic Crime Division, Office of the Attorney General, Report to the Attorney General, October 1, 1980, Lansing, Michigan, p. 10.

[b]There are a number of possible alternative explanations for the differences in the number of referrals by different sources as reflected in this table. However, it is beyond the scope of this project to determine the reason(s) for these differences. Therefore, the reader should be extremely careful in attempting to analyze these data and interpret the results.

[c]Row figures.

[d]Column figures.

[e]Total percentage may not equal 100.0 percent because of rounding.

Further analysis indicates that institutional reviews identified cases of potential abuse which may involve fraud in only one class of providers--skilled nursing facilities. On the other hand, SURS identified potential cases of abuse which may involve fraud in six different classes of providers: medical doctor, doctor of osteopathy, podiatrist, dentist, clinic, and laboratory. Interestingly enough, the third source of referrals within the DSS was the subcategory labelled "other sources" which accounted for 17.2 percent of the referrals. Moreover, these "other sources" identified potential instances of abuse in the Medicaid program which may involve fraud in nine categories of providers: medical doctor, doctor of osteopathy, dentist, hospital, skilled nursing facility, clinic, laboratory, optometrist, and hearing aid dealer.

4.3.5 Investigation and Prosecution

Rather than concentrate on one type of provider, the MFU has sought successfully to target several different types of providers for investigation and prosecution. For example, during Fiscal Year 1979-1980, the MFU obtained six convictions involving both institutional and individual providers. The experience of the MFU indicates that although provider fraud may involve a wide range of illegal activities, the most common forms of fraud involve "billing for services not received" and "generic substitution."

Regardless of how a potential case of fraud is detected, the investigative process is usually long and involved. During an investigation, MFU auditors and investigators collect and analyze a wide range of information including details of the alleged offense, criminal history record information, state tax returns, and data regarding civil law suits. Much of the information needed to investigate cases of suspected fraud is obtained from MSA. When the MMCD initially refers a case to the MFU to determine if fraud exists, it also provides the MFU with a wealth of information regarding the case including such items as the results of the medical review conducted by MMCD health care analysts, the outcome of any peer reviews conducted, and any consultant reports. The good relationship existing between the MFU and the MMCD facilitates obtaining additional information which may be needed during the course of the investigation.

As discussed earlier, the MFU prosecutes Medicaid fraud under the Medicaid False Claims Act. The MFU seeks both civil and criminal sanctions against those violating this law. As Table 4-7 (see p. 4-27) indicates, the number of arrests and subsequent convictions obtained by the unit have been increasing over time. Most of these convictions have been obtained on the basis of plea negotiations and involve restitution. Whenever possible, MFU seeks the assistance of the MMCD to perform an audit of the entire practice of a provider currently being investigated. Such audits seek to establish additional losses to fraud, beyond those provable in the instant case. When this dollar amount is available prior to the court's judgment, it is included in the amount of restitution requested by the state. The MFU also seeks reimbursement for the costs of the investigations it conducts.

4.3.6 Caseload

The investigations of the MFU have proven to be time consuming, whether or not they result in a conviction. For example, based on the past experience of the MFU, the following conservative estimates of the average time required to investigate a case have been developed:[30]

- for non-institutional providers (e.g., doctors)—12 weeks per case; and
- for institutional providers (e.g., skilled nursing facilities)—16 weeks per case.

Given the length of time needed to investigate a case coupled with a shortage in personnel, the MFU is faced with a backlog of cases.[31] The unit's Chief Investigator hopes to decrease or eliminate this backlog by adding additional personnel to the unit.

4.3.7 Statistics Regarding Fraud

Currently, the MFU has no empirical estimates of the amount of undetected fraud in Michigan's Medicaid program. The unit's Chief Investigator pointed out that while there may be several possible ways of estimating the amount of undetected fraud, any approach would have problems in terms of validity and reliability. Moreover, he questioned the real value of such estimates. However, the MFU does have information available regarding detected fraud. As Table 4-7 (see p. 4-27) indicates,

TABLE 4-7

DISPOSITION OF CASES BY FISCAL YEAR[a]
(October 1, 1977 to September 30, 1980)

DISPOSITION OF CASES	TIME PERIOD		
	October 1, 1977 to Sept. 30, 1978	October 1, 1978 to Sept. 30, 1979	October 1, 1979 to Sept. 30, 1981
Arrests	10	4	23
Counts	82	14	178
Dismissals	2	1	2
Convictions	3	4	6
Acquittals	—	—	—
Sentences, Jail & Probation	—	2	—
Sentences, Probation Only	3	2	3
Suspensions	1	2	—

[a]This table was derived from a chart presented in a publication prepared by the Medicaid Fraud Unit, Economic Crime Division, Department of Attorney General, Report to the Attorney General, October 1, 1980, Lansing, Michigan, Attachment 1.

there are some basic transaction statistics available regarding incidents of detected fraud.

Although the data presented in Table 4-7 provide information regarding the amount of fraud in terms of case dispositions, the data do not provide the reader information about the amount of dollars lost to fraud. However, Table 4-8 (see p. 4-29) does present some indications of the financial loss. According to the MFU's Chief Investigator, the most reliable indicator of the amount of dollars lost to fraud is contained in the column labeled "Restitutions." However, he noted that this figure does not include monies sought via civil suits.

Moreover, the amount of restitution actually ordered by a judge may in some instances be less than that requested by the State. The MFU's Chief Investigator cautioned against using any figure derived from "Overpayments Established" (see Table 4-8) for several reasons. First, the figure may be inflated as a result of double counting by fraud control units and the single state agencies. Second, the establishment of an overpayment does not mean that the state actually recovered the money. He felt that the use of a category entitled "Dollars Saved" would create additional problems--particularly in summarizing across states--because of variations in how the term is defined and calculated.

The MFU does complete on a quarterly basis HCFA-54, the "Fraud Investigation Activities Summary Report" and HCFA-50, the "Medicaid/Medicare Fraud Report" on individual cases of fraud. Both these reports are ultimately sent to the Division of State Fraud Control, Office of the Inspector General, Department of Health and Human Services. The information needed to complete both these forms is drawn from the unit's case files. There were no problems encountered in completing these forms, but there was some questions as to their utility. The Chief Investigator was of the opinion that the forms could be improved to meet the information needs of the MFU as well as the Federal government by focusing on major transactions in case processing. The cooperation of the Medical Services Administration should be enlisted in the development of such a form in order to reflect the information needs of both agencies in the prevention and control of fraud in the Medicaid program.

TABLE 4-8

SUMMARY OF TRANSACTION STATISTICS REPORTED BY THE MEDICAID FRAUD UNIT[a]

REPORTING PERIOD	CRIMINAL JUSTICE STATISTICS					FINANCIAL STATISTICS[b]					
Date Quarter Ended	Workload	Number of Cases Opened	Number of Cases Closed	Number of Indictments	Number of Convictions	Overpayments Established[c]	Fines & Court Costs[d]	Investigation Costs[e]	Restitution[f]	Money Held in Escrow[g]	Total Amount Without Escrow
09/30/78	--	--	--	--	--	--	--	--	--	--	--
12/31/78	0	22	9	1	1	--	$ 150.00	--	$ 11,290.07	--	$ 11,440.07
03/31/79	13	5	3	2	4	$ 383.95	4,750.00	--	15,606.14	--	20,740.09
06/30/79	15	1	2	0	0	--	--	--	68,859.90	--	68,859.90
09/30/79	14	6	1	1	1	11,387.32	--	--	50,000.00	--	61,387.32
12/31/79	19	6	3	7	1	44,719.89	1,200.00	$ 5,017.50	24.32	--	50,961.71
03/31/80	22	19	4	1	2	16,493.60	2,400.00	2,860.00	7,035.40	--	28,789.00
06/30/80	37	8	4	1	1	--	100.00	700.00	590.00	--	1,390.00
09/30/80	41	2	4	14	0	1,647.23	--	--	--	$165,756.72	1,647.23
12/31/80	39	3	3	6	5	--	--	1,000.00	345,012.00	40,132.26	346,012.00
03/31/81	43	10	6	5	6	--	10,685.00	16,811.00	3,768.08	8,397.05	31,264.08
TOTALS				38	21	$74,631.99	$19,185.00	$26,388.50	$502,185.91	--	$622,491.40

[a]This summary was derived from a chart reflecting monies recovered by the Medicaid Fraud Unit. This chart was an attachment to the Michigan Medicaid Fraud Control Unit Quarterly Report for the period January 1, 1981 through March 31, 1981.

[b]Some criminal justice statistics (e.g., restitution) are included in this category because they do provide a surrogate indicator of the probable dollar amount lost to fraud and represent recoveries.

[c]Amounts established as overpayments but not prosecuted; returned to Single State Agency for administrative action.

[d]Fines and court costs assessed by Court as part of sentence on criminal prosecution.

[e]Amounts assessed by Court to be paid to Medicaid Fraud Unit to off-set expenses incurred.

[f]Amounts to be restored to Medicaid Program as part of criminal prosecution sentence.

[g]Amounts being held by Single State Agency pending outcome of audit and/or criminal charges.

4.4 Liaison Between the Medicaid Monitoring and Compliance Division and the Medicaid Fraud Unit

Both the Chief Investigator of the MFU and Director of the MMCD stressed the need for close liaison between the MFU and the MMCD in order to carry out their separate, but interrelated functions and accomplish their common goal of prevention and control of fraud in the Medicaid program. Both individuals agreed that their units had achieved a high degree of coordination and cooperation. The staff of both the MFU and the MMCD meet on a weekly basis to exchange information, discuss cases, and resolve mutual problems. One important topic is the identification of program vulnerabilities such as weaknesses in internal controls which create the opportunity for fraud in the Medicaid program. Such vulnerabilities or "loopholes" are frequently created by the very laws, regulations, and procedures which govern the Medicaid program. Both the Chief Investigator of the MFU and the Director of MMCD emphasize the importance of "closing the loopholes" as a proactive means of preventing fraud.

One important area of cooperation between the MFU and the MMCD involves the conduct of audits of providers suspected of fraudulent activities. Whenever possible, the MFU seeks to have the MMCD conduct an audit of the medical activities of providers targetted for prosecution. Thus, the State is able to ask the court to order restitution not only for the provable amount of dollars obtained by fraud in the instance(s) in question, but also for other activities uncovered by an audit. If this audit is not carried out prior to the court's judgment, it is then necessary to initiate a separate civil action to recover the losses revealed by later audits. The Director of the MMCD pointed out that this situation occurs usually when the MMCD is unaware that the MFU intended to develop a case for prosecution.

Another area requiring coordination of the activities of the MFU and the MMCD is the initiation of administrative action against providers by the MMCD. The MMCD has an agreement with the MFU that it is free to pursue administrative remedies while a case is under criminal investigation. However, both units have agreed to coordinate administrative action on criminal investigations so that the pursuit of administrative remedies will not interfere with the criminal investigations. In those instances where the initiation of administrative remedies would interfere, the agreement is to delay the administrative action.

There is one critical area of liaison between the MFU and the MMCD which distinguishes their approach to preventing and controlling Mediaid fraud from efforts by similar units in other states. In Michigan, the MMCD does not review cases to determine which ones involve fraud in order to refer them to the MFU. The MMCD refers cases of potential abuse to the MFU which, in turn, examines these cases to determine if fraud is involved. This approach seems to be contrary to federal rules and regulations which stipulate that "the agency (i.e., the single state agency responsible for administering the Medicaid program) must refer all cases of suspected provider fraud to the unit (i.e., the state Medicaid fraud control unit)"[32] In Michigan, this statement was interpreted to mean that it was the responsibility of the MMCD to identify suspected cases of fraud and then refer them to the MFU. However, both the Director of the MCMD and the Chief Investigator of the MFU agree that the MFU should review cases potentially involving abuse of the Medicaid program to determine which of these may involve fraud. Both officials are of the opinion that this is an effective and efficient division of functions because the MFU has the experience in law and investigations needed to identify cases which may involve fraud, while the MMCD does not. However, once suspected cases of fraud have been identified, the MMCD is able to contribute its knowledge of the administration and operation of the Medicaid program as well as its expertise in monitoring medical activities.

4.5 Conclusion

At the present time, efforts to control and prevent Medicaid fraud in the State of Michigan are characterized by close coordination and cooperation between the Medicaid Monitoring and Compliance Division (MMCD) and the Medicaid Fraud Unit (MFU). It appears that both units seek to enhance each other's efforts and both emphasize the need for proactive approaches to control and prevent fraud. Particular attention has been paid to the enactment of legislation and the development of regulations to "tighten loopholes" which provide opportunities for fraud.

The MMCD and the MFU agree that SURS can be used to detect cases which may potentially involve Medicaid abuse. However, the objective of the MMCD in examining cases excepted by SURS is to determine which of these cases actually involves abuse. The MMCD does not make a determination of which cases involve fraud; that decision is seen by both the MMCD and the MFU as the responsibility of the MFU.

Neither the MMCD nor the MFU have any empirical estimates of the nature and extent of Medicaid fraud which remains undetected. Although the heads of both organizations felt that some reasonable "guesstimates" could be made, they stressed that such estimates would be just that--informed guesses.

In contrast, there were some data available regarding the nature and extent of detected fraud. However, some difficulty was encountered in analyzing published reports to determine the dollar amount lost to fraud. The heads of the MMCD and the MFU indicated that establishing the exact amount of dollars lost to provable fraud would require additional data collection and analysis.

REFERENCES

[1] SURS Overview, prepared by the Medicaid Monitoring and Compliance Division, Bureau of Health Services Review, Medical Services Administration, Lansing, Michigan, October 16, 1979, p.1.

[2] Ibid., p.1.

[3] Bernard Higgins, Administrative Remedies Manual, Medical Services Administration, Lansing, Michigan, May 1979, Section I - Management Overview.

[4] Higgins, supra note 3, Appendix C, p. 3.

[5] Ibid., Appendix C, p. 1.

[6] Ibid., Appendix C, p. 3.

[7] Ibid., Appendix C, p. 2.

[8] Ibid.

[9] Ibid., Appendix C, p. 4.

[10] Ibid., Appendix C, p. 2.

[11] Ibid.

[12] SURS Overview, supra note 1, p. 1.

[13] Ibid.

[14] Ibid.

[15] Ibid.

[16] SURS Overview, supra note 1, p. 4.

[17] Higgins, supra note 3, Section II - Systems and Procedures.

[18] SURS Overview, supra note 1, p. 1.

[19] Ibid., supra note 1, p. 2.

[20]This final method, that is, the development of recommendations for new policy or policy changes represents a proactive approach to the control and prevention of fraud and abuse.

[21]Much of the information presented in this chapter regarding the operation of the Medicaid Monitoring and Compliance Division was gathered during a personal meeting with Bernard Higgins, the Director of the Medicaid Monitoring and Compliance Division in Lansing, Michigan in April 1981.

[22]SURS Overview, supra note 1, p. 5.

[23]Ibid.

[24]Bernard Higgins, "Year-end Report, FY 79-80," Memorandum, Department of Social Services, State of Michigan, Lansing, MI, February 12, 1981; Provider Process Data, Medicaid Compliance and Monitoring Division, FY 79-80 and FY 80-81.

[25]The reader should be careful not to draw any definitive conclusions from the data presented in this section as they have some rather severe limitations. For example, the data contained in these reports do not indicate the total number of providers in each category who are enrolled in the Medicaid program. The same providers may be excepted more than once as SURS will continue to except from quarter to quarter as long as they exceed the set limits. Moreover, sheer differences in the number of providers in the different categories excepted and then selected for case analysis may be due to any one of the following factors or combination thereof such as policy decision(s) regarding review; differences in SURS exception reporting; and the total number of providers in each category.

[26]Higgins, supra note 24.

[27]Much of the information presented in this chapter regarding the operation of the Medicaid Fraud Unit was gathered during a personal meeting with C. William Howe, Chief Investigator of the Medicaid Fraud Unit in Lansing, Michigan, in April 1981.

[28]Medicaid Fraud Unit (hereinafter referred to as MFU), Economic Crime Division, Department of the Attorney General, Report to the Attorney General, Lansing, Michigan, October 1, 1980, pp. 9-10. The reader is cautioned not to confuse statistics produced by the MFU and presented in this section with those produced by the MMCD appearing in Section 4.2.4. Both sets of statistics are produced independently by different organizations for different purposes. Thus, there is no one-to-one correspondence between the figures produced by the MMCD and those presented by the MFU.

[29]Attachment to letter (dated March 30, 1981) sent to one of the co-authors of this report by Mr. Edwin M. Bladen, Assistant Attorney General in charge of the Economic Crime Division.

[30]Report to the Attorney General, supra note 28, p. 11.

[31]Ibid., pp. 11-12.

[32]Title 42 C.F.R.--Public Health, Part 455--Program Integrity, Subpart A--Medicaid Agency Fraud Detection and Investigation Program, Section 455.21(a)(1)--Cooperation with State Medicaid fraud control units, Federal Register, Vol. 43, No. 190, Friday, September 29, 1978, p. 45263.

5. VERMONT

Vermont, with a total population of 520,000, currently has 47,000 active Medicaid eligibles in its health care delivery system, with total annual outlays of $58,000,000. The single state agency (SSA) for overall Medicaid management is the Vermont Department of Social Welfare, Medicaid Division. Aspects of Medicaid management have been delegated to New Hampshire/Vermont Health Plan, Incorporated (i.e., Blue Cross/Blue Shield) which has served as the state's fiscal (i.e., administrative) agent since 1978. Commencing October 1, 1981, Electronic Data Systems (EDS) Federal will become Vermont's fiscal agent.

The SSA has as its major objective the monitoring and controlling of the expenditures of Medicaid funds. To this end, it conducts regular reviews of the activities of Vermont's 1690-member (i.e., 1000 physicians, 250 dentists, 245 nursing homes, 130 pharmacies, 45 psychologists, 16 hospitals and 4 physical therapists) Medicaid provider community.

The Medicaid Division of the Vermont Department of Social Welfare (DSW) has specific responsibility for ensuring the proper use of all medical services provided by the state. To this end, it conducts three types of reviews:

- prospective; i.e., the process whereby certain aspects of medical care (e.g., preadmission certification, prior authorization of specific medical services) are assessed and certified to be medically necessary prior to the service having been rendered;
- concurrent; i.e., those conducted while the Medicaid beneficiary is still confined to an institution; and
- retrospective, i.e., the process whereby an assessment is made of both the necessity and reasonableness of the service after it has been rendered.

Of the three types of medical reviews it can perform, Vermont is on record as favoring the retrospective review process as the most effective means of accomplishing its goal of providing high quality, timely and cost effective care to its Medicaid eligibles.

5.1 The Identification of Suspected Cases: SURS/MMIS

Vermont's current Medicaid Management Information System (MMIS) has been described as a conceptual equivalent of the federal prototype. As such, it is composed of six subsystems, five of which (i.e., claims processing, provider relations, reference, management and administrative reporting, and surveillance and utilization review) are maintained by the fiscal intermediary. The sixth subsystem (i.e., the recipient file) is maintained by the single state agency for its use in determining Medicaid eligibility. Under EDS Federal, Vermont expects to upgrade its system design with an improved SURS capability and more flexible and responsive computer software.

5.1.1 The Medicaid Claims Processing System

The Medicaid Claims Processing System is made up of four subsystems which interact frequently during the claims processing function to adjudicate requests for payment:

- the Recipient Subsystem,
- the Provider Subsystem,
- the Claims Processing Subsystem, and
- the Reference File Subsystem.

5.1.1.1 The Claims Processing Subsystems

The Recipient Subsystem contains information on all eligible and previously eligible recipients of Medicaid. Eligibility transactions, maintenance and updates are initiated by the Vermont Department of Social Welfare. The Recipient master file is used in the claims processing subsystem and in other reporting subsystems.

The Provider Subsystem contains information on all providers that are certified by the State. The files are used in the claims processing subsystem. They contain information that is pertinent to claims adjudication in so far as eligibility of providers is concerned.

The Claims Processing Subsystem contains the claims adjudication module which accesses the Recipient, Provider and Reference Subsystems for eligibility validation, all editing functions including such edits as diagnosis-procedure relationship edits, prepayment utilization review, and duplicate claims checking. The Subsystem also performs suspense of payment and payment processing including the production of remittance advices, check registers, master invoices, checks, history audits, time-lapse and summary reports.

The Reference File Subsystem contains the Drug Pricing Physician/Supplier Fee and Suspense files. These files are all used as reference by the claims processing subsystem to complete processing procedures.

5.1.1.2 The Editing of Provider Claims

A series of edits are employed when claims from providers (i.e., physicians, mental health clinics, independent laboratory and other services) are passed through the payment system. The edits serve to reduce some of the postpayment requirements for utilization review and fraud detection and control. During the processing of claims, three major types of edits are performed:

- Physician Edits,
- Drug Claim Edits, and
- Provider Utilization Review Edits.

5.1.1.2.1 Physician Edits

This first edit is accomplished by comparing the last name, first initial, identification number and date of birth of the recipient against the Recipient Subsystem. If a match is made, the claim will continue through payment; if a match is not made, the claim may be suspended, developed or denied. Provider eligibility is verified by matching the provider number and the provider name against the provider subsystem. All non-matches are suspended pending manual review. Provider utilization screening is performed to ensure that only services authorized by the Department of Social Welfare are passed through the system for payment.

5.1.1.2.2 Drug Claim Edits

The Medicaid Drug Edit Module of the Medicaid Claims Processing System is used strictly for processing drug claims submitted by pharmacy providers. As they relate to the SURS operation, five procedures (i.e., validation of beneficiary eligibility, validation of provider eligibility, pricing of drug services using a drug pricing file, performance of duplicate claims testing, and generation of a drug history file and adjudicated claims file records for all processed claims) are performed by this module. These procedures are designed to allow only valid requests for drug payments to pass through the system and enter the history files. The Drug Abuse Control System accesses these files for the drug claim information that is stored in the Drug Master and Drug Work files. Three specific edits are performed by this module:

- Drug claim validation--This procedure is performed by checking the type of claim and the date of service. If the claim is greater than one year old, it is automatically denied.

- Recipient eligibility--This is accomplished by verifying the recipient data entered on the claim against the Recipient Subsystem. A determination is made to ensure that the recipient was eligible for Medicaid benefits on the date of service. During this phase, verification of prior authorization, for those drugs requiring prior authorization, is checked for the recipient being processed. If prior authorization is not indicated, the claim is denied.

- Provider eligibility--This module is used to verify provider eligibility by ensuring that the provider number is valid, that the name is valid and matches the number, that the provider is qualified to render service and that the provider was eligible for Medicaid reimbursement on the date(s) of service specified. The prescribing physician number is checked at this time for the same conditions. When the pharmacy provider is an out-of-state provider, the Provider Eligibility File is not accessed but the provider name, number and address is checked for completeness and accuracy.

5.1.1.2.3 Provider Utilization Review Edits

These edits are accomplished by passing claims through the Provider Utilization Review File, prior to payment, to suspend claims for any given provider. Post payment analysis of physicians, institutions or pharmacies provides the input parameters necessary to identify the providers whose claims will be suspended. The purpose of these edits is to facilitate manual review of providers who have been identified as deviating from the norms established and ensuring that their patterns of health care delivery are in the range of their peers. Input parameters supplied by the Department of Social Welfare cause claims to be edited for all provider, hospital, physician, and drug claims.

5.1.2 The Management and Administrative Reporting Subsystem

Vermont's MARS subsystem produces all MMIS and federal reports used in management reporting. Like SURS, the MARS subsystem works off the same databases (i.e., paid claims and reference files) but the focus is on management rather than utilization data. According to Vermont's Medicaid Deputy Director, some of the reports produced by MARS can be useful in fraud detection when put against the output of SURS. However, the two subsystems have been designed for functionally different purposes and it is Vermont's view that they are better used in the performance of their prescribed functions. Thus, it is difficult to cross reference MARS and SURS reports in the Vermont system because a MARS report, for a given quarter, will be based on services paid during that quarter while a SURS report during the same quarter will be based on services rendered.

5.1.3 The Surveillance and Utilization Review Subsystem

The Surveillance and Utilization Review Subsystem was developed to provide Vermont's Department of Social Welfare with an automated exception reporting system to aid in the following tasks:

- making assessments as to the adequacy of medical care;

- performing long-range Medicaid program planning; and

- detecting possible patterns of overutilization by recipients and providers.

The primary objectives of the separate modules of the system are:

- to develop a comprehensive statistical profile of health care delivery and utilization patterns established by participants (i.e., providers and beneficiaries) in the Medicaid program;

- to provide data to (1) assist in the identification of potentially fraudulent activities and (2) develop procedures that promote corrective action;

- to provide profile data to aid in uncovering potential deficiencies in the levels and quality of care provided to Medicaid beneficiaries; and

- to produce special reports, as requested by the Utilization Review Control Staff, to aid in achieving the utilization review and fraud control objectives of the Vermont Medicaid program.

The SUR Subsystem was designed to accomodate the utilization review requirements of the Vermont DSW in four distinct reporting systems:

- Medicaid Hospital Postpayment Utilization Summary Report;

- Joint Profile System (JPS);

- Drug Abuse Control System (DACS); and

- Postpayment Utilization Review System.

5.1.3.1 The Medicaid Hospital Postpayment Utilization Summary Report

The Medicaid Hospital Postpayment Utilization Summary Report is a computerized listing of Medicaid inpatient and outpatient hospital statistics extracted from paid claims history and based on the primary diagnosis reported on the adjudicated claim. The reported statistics are hard coded in the program but the

requestor has control over the spread of data by date selection on the input parameter card. Routinely, this report is provided on a semi-annual basis; however, the user has the option of requesting any desired time period, up to 12 months, for the study being conducted. Two types of listings are produced. The first is a listing by diagnosis within provider and the second is by diagnosis within state (Vermont and New Hampshire separately).

5.1.3.2 Joint Profile System

The Joint Profile System (JPS) is a computerized reporting system with the capacity for analyzing potentially deviant patterns of institutional health care utilization. The basic data recording unit of the system is the patient episode of illness profile which allows the user extensive flexibility in generating norms. The JPS approach to a "total episode of care" links institutional services with physician services to display, as an integrated whole, the care provided by an institution and all services provided by physicians, to a single patient within a user defined period of time.

JPS allows total user control over population groupings according to user specified decision rules, giving the Vermont Department of Social Welfare the flexibility necessary to conduct reviews according to their needs. With this flexibility, the analyst is not limited to a hard-coded reporting system which may or may not provide the statistical profiling desired.

The sources for data contained in the JPS files are the Adjudication Claims File and the Provider File. The majority of the information in JPS history is extracted from adjudicated claims, providing the system user with a history file of claims which have been paid by the Vermont Department of Social Welfare. The Provider File is accessed to obtain the information necessary in formulating peer groups.

The JPS database is updated quarterly from paid claim tapes from the previous three month pay periods. However, the data extracted from the pay tapes are sorted by date of service and placed in the quarter in which the service occurred. Thus, the user is able to develop a profile of cases based on the date when service was delivered, rather than the date of payment.

5.1.3.3 The Drug Abuse Control System

The Drug Abuse Control System is a specialized version of the Joint Profile System modified to analyze patterns of drug dispensing, prescribing and usage in Vermont Medicaid. The data recording unit in DACS is the drug usage profile.

5.1.3.4 The Post Payment Utilization Review System

The Post Payment Utilization Review System (hereinafter referred to as POST) is a computerized reporting system used in the identification of providers whose delivery of health care services exceeds their peers' services by a variety of standards. POST assembles all information related to a provider's practice for the purpose of monitoring providers on a postpayment basis. The system provides the user with 22 basic reports and two optional reports. In addition, the system provides an option whereby the user can create selective "history" files based on the review being conducted. Each of the reports focuses on a particular aspect of the provider's practice ranging from total dollars allowed to a general peer group comparison. The system also has the capacity for reporting claims detail information on recipients in the non-institutional setting. The information retrieval module gives the system flexibility in allowing the user to identify the statistically significant provider.

The overall goal of this computerized utilization review system is to monitor, retrospectively, the health care delivery of providers to ensure quality service and to detect aberrant practices. The objectives of the POST system are:

- to provide concise statistical reference data on all participants in the non-institutional setting who have received payment for medical services rendered to recipients of Vermont Medicaid; and
- to provide a means of profiling non-institutinal providers for the purpose of detecting possible overutilization of the Medicaid Program.

To achieve these objectives, POST provides the user with a variety of report formats and a range of selection criteria.

Two types of files (i.e., POST Extract and Compressed Master) are available for use. POST Extract represents the basic, yet more comprehensive database. It includes information on both recipients and providers. The Extract normally contains one calendar quarter of paid claims history from which reports are produced, but can produce reports based on a 12-month version of this file. (This is also the database used to create the Physician Master/Work File in the Joint Profile System.) The Compressed Master file is a summary of the Extract containing non-institutional provider data only. Recipient data is excluded to provide a file that can be easily read by the system to rapidly produce statistics on exceptional providers in comparison to their peers. The Compressed Master consists of, and routinely reports, 15 months of paid claims data.

5.2 The Role of the Fiscal Agent

As previously mentioned, New Hampshire/Vermont Health Plan, Incorporated is the fiscal intermediary for Vermont's Medicaid Program. Operating under powers delegated by the state, it is responsible for providing the computer systems and programs, the processing and payment of claims and certain surveillance and utilization review functions. Specific responsibilities are outlined as follows:

- conduct maintenance on the Medicaid Mangement Information System, to reflect any changes in the federal or state regulations affecting the operations of the Vermont Medicaid Program;
- receive, organize and pay or deny invoices and statements from providers and make determinations regarding compliance with applicable regulations of the Vermont Department of Social Welfare;
- assist the SSA in maintaining an effective utilization control plan to ensure quality and cost-effective health care delivery to the beneficiary population; and
- supply all surveillance and utilization review reports to the Medicaid Division for its use in postpayment review and fraud prevention and control.

5.3 Processing and Review of Suspected Cases: The Utilization Review Program

Vermont's efforts to detect fraud, waste and abuse in the Medicaid program are centered around its Utilization Review Program which joins the efforts of the single state agency with those of its fiscal agent. As Vermont has defined it, utilization review encompasses a number of interrelated approaches to fraud prevention and control. For example, it makes use of both prepayment screens and postpayment reviews to examine provider payment patterns, thereby picking up aberrant behavioral practices or exceptions which may lead, ultimately, to an uncovering of fraud, waste and abuse.

Utilization review by Vermont's fiscal agent is a process whereby claims which do not meet established criteria built into the manual and automatic claims processing mechanisms are initially reviewed by clerical personnel. If a claim can not be reconciled at this level, it is then referred to medical personnel for a decision. The Department of Social Welfare has staff specifically assigned to utilization control functions. These individuals are responsible for performing postpayment reviews and for exercising oversight of activities conducted by the fiscal agent.

The staffs at DSW and the fiscal agent, who are assigned to review and process individual claims and to analyze patterns of provider services, are reported by the SSA to work cooperatively together. The relationship between DSW and the fiscal agent relative to utilization review is depicted in Figure 5-1 (see p. 5-11).

5.3.1 The Utilization Control Section

The Utilization Control Section of the Medicaid Division handles all postpayment utilization review and control. The process of utilization review and control involves three major phases:

- analysis,
- development, and
- resolution.

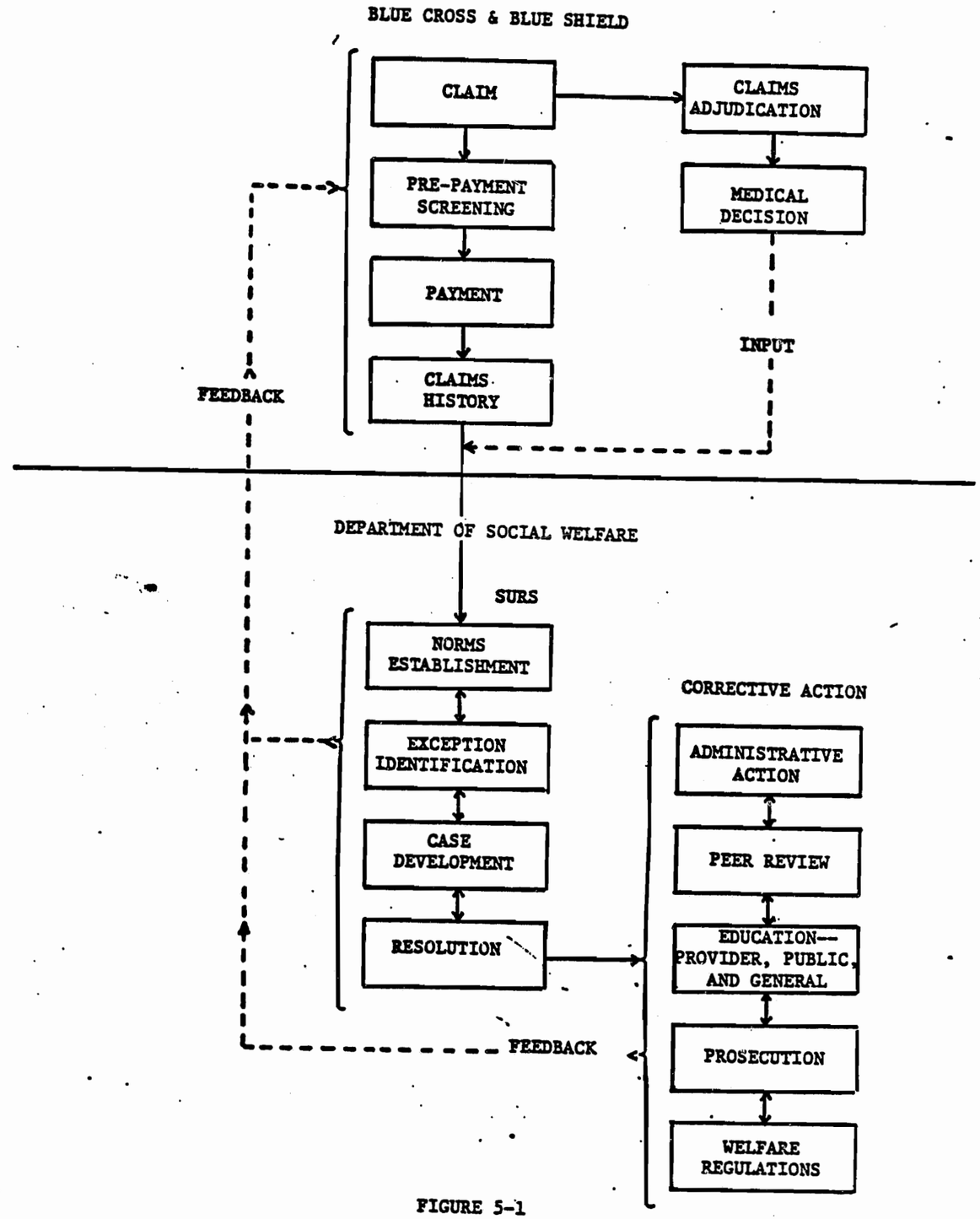

FIGURE 5-1

VERMONT MEDICAID ORGANIZATIONAL RELATIONSHIP CHART

5.3.1.1 Analysis

This activity involves making use of computer output supplied by the fiscal agent along with norms established by the SSA to determine which program beneficiaries and providers warrant further study. SURS produces a number of reports which DSW finds useful in identifying what it terms patterns of overutilization. According to the Medicaid Division's Deputy Director:[2]

> SURS does not detect fraud; the most our system does is show us patterns of service provision or patterns of payment which stick out as exceptional. Some person has got to look into that case and determine why something is happening. SURS tells us that something looks funny; our utilization review staff must then investigate whether or not it looks like possible fraud. It's the court's job to say, finally, whether or not it really is fraud.

5.3.1.2 Development

This phase involves collecting whatever data may be required following analysis and correlating that data with existing reports. It will often require on-site provider reviews, since the goal of this phase is to ascertain whether or not the provider or beneficiary identified as exceptional in the analysis stage is really exceptional or whether an acceptable reason exists for the abnormal utilization pattern.

5.3.1.3 Resolution

Following the development phase, a decision is made regarding the appropriate actions to undertake. If, for example, the case is one of suspected fraud of the Medicaid Program by a provider, the case will be referred to the Medicaid Fraud Control Unit. If the case is one of abnormal health care delivery or use, there exists a number of alternative dispositions (e.g., referral to a peer review group or to a PSRO, in the case of hospitals; administrative action; etc.). During the resolution phase, the overall objectives of the single state agency are:

- to stop or severly inhibit whatever fraud, abuse and/or abnormal practices that may be occurring in the program; and

- to recover any overpayment of funds which may have already occurred.

For providers engaging in these offenses, a range of corrective actions of varying degrees of severity (e.g., the recovery of past payments, either voluntarily or in the form of credit against outstanding or future obligations; the recovery of past payments by legal actions; the temporary or permanent suspension of a specific provider from participation in the program; the referral of a provider to the grievance committee of the relevant professional association; the referral of a provider to the proper legal authority for possible prosecution on a charge of criminal fraud) can be taken by the single state agency.

5.3.2 Fraud-Related Data

Vermont's SURS subsystem produces approximately 50 cases of suspected overutilization per quarter. Twelve of the reports described above are routinely produced each reporting period and it is possible to produce as many as 60 peer groups per reporting period. Once cases of suspected overutilization have been identified, they are reviewed by a specialist to determine their accuracy and importance. This initial screening effort is performed manually and may require an effort ranging from five minutes to two days. Following the initial investigation phase, 8 to 15 cases remain as possible cases of fraud. The actions taken on these cases depend on the nature and severity of the alleged offense. Administrative action occurs one to two times per quarter and one case, on the average, is handled in the civil courts per year.

On an annual basis, DSW refers five to six cases to the Medicaid Fraud Control Unit. Of these cases, three or four are returned to the single state agency as non-prosecutable. These cases are then reviewed administratively and corrective sanctions applied.

Vermont's DSW has no estimates of the nature and extent of fraud in the Medicaid program. Its system of detecting patterns of overutilization is viewed as a successful one; however, it does not identify fraud. Working with a new fiscal agent, DSW expects to improve the screening capability of the SURS subsystem by developing enhancements to SURS.

5.4 The Investigation and Prosecution of Suspected Cases: The Medicaid Provider Fraud Unit

The Medicaid Provider Fraud Unit (MPFU) of the Office of the Attorney General, State of Vermont, was originally certified on October 25, 1978 retroactive to October 1, 1978. The MPFU became fully staffed (i.e., two attorneys, two auditors, two investigators, one secretary) on February 5, 1979. Vermont's fraud unit is currently one of the smallest such units in operation.

5.4.1 Case Development

Since MPFU became fully operational, some 31 investigations have been undertaken and three convictions obtained. As MPFU has defined it, case development involves (1) investigations; (2) prosecutions; and (3) actions other than prosecution.

5.4.1.1 Investigation

During the period October 1, 1979 to the present, one half of the Unit's investigative and audit resources (i.e., one investigator and one auditor) have been committed to the investigation of allegations of fraud and abuse among pharmacy providers. An intensive examination (which has included the review of several thousand documents) of allegations relating to two of Vermont Medicaid's largest pharmaceutical providers reflected substantial evidence of a scheme to defraud the Vermont Medicaid Program. Other pharmaceutical provider investigations by the Unit have revealed, at a minimum, violations of dispensing and prescribing procedures and a disregard of applicable Medicaid regulations. Patterns of fraud and abuse by pharmaceutical providers which have been documented by the Unit's investigations include dispensing of generic drugs but claiming the higher priced brand name drug on Medicaid claims; charging higher than normal or customary prices to Medicaid eligibles; mislabeling of drugs dispensed to Medicaid eligibles; dispensing drugs without a physician's authorization; dispensing in quantities less than those claimed to Medicaid; and failure to comply with state and federal regulations governing the dispensing of controlled substances.

Vermont's MPFU director has stated that "the quality of information from the fiscal intermediary and the use of that information by the SSA have not been consistent with the development of good potential fraud cases."[3] This has lead to an increased processing time between case opening and closing, especially in regard to the auditor work.

Although MPFU investigations during the past year have involved all provider types, it should be noted that in addition to pharmaceutical providers, a significant portion of the Unit's investigative and audit resources have concentrated on alleged abuse and waste in the funding of Community Mental Health clinics. Preliminary findings of MPFU's investigation indicate substantial overbilling, overutilization, and inadequate monitoring of Medicaid services. The Unit's investigation, though not yet completed, has already led to administrative and regulatory reforms within the administering Agency. It is anticipated that additional reforms consistent with the recommendations of the Unit will result in an abatement of abuse and waste.

5.4.1.2 Prosecution

Vermont prosecutes fraud cases under Title 33, Section 2581 of the Criminal Discovery Procedures governing the Vermont DSW. The statute is an extremely liberal one which gives co-defendants in white collar prosecutions the absolute right to sever their trials. These factors tend to add to the length of time needed to pursue criminal prosecutions for fraud.

Because of the complexity of Medicaid fraud cases, it is the operating policy of the Office of Attorney General to assign two prosecutors to each case. Thus, except in unusual circumstances, the MPFU is limited by its prosecutorial resources (i.e., two attorneys) from conducting more than one trial at a time.

During the time period from August 1979 to the present, MPFU obtained the first State conviction of a Medicaid provider in the history of the Vermont Medicaid program. Also during this time period, ten felony charges pending against five nursing homes were nolle prosequi. The nursing homes and their owner agreed to pay the State of Vermont $30,000 in fines and costs. That agreement is now the subject of litigation. The Unit is in the process of filing felony counts of Medicaid fraud against

two of the Vermont Medicaid Program's largest pharmaceutical providers.

5.4.1.3 Actions Other Than Prosecutions

In addition to its law enforcement function, the MPFU has consistently drawn upon its investigative experiences to recommend and otherwise instigate needed reforms in the Vermont Medicaid Program.

The Unit's efforts in this area during the past year are characterized by actions in two different but related areas of state provider regulation. First, the MPFU has prompted hearings by state licensing boards which have disciplinary authority over the professional licenses of providers. Where investigations by the MPFU have revealed violations of the rules and regulations governing the provider's particular profession, the Unit has brought the evidence to the attention of the respective licensing board. The Unit's actions have had the effect of bringing questionable activities of providers under greater peer and public scrutiny. Secondly, the Unit has encouraged increased monitoring and accountability in the administration of the state Medicaid program. The Unit has referred cases of provider abuse to the single state agency with documented findings and recommendations of administrative sanctions. Additionally, the Unit has made programmatic recommendations to the single state agency where, in the judgment of the MPFU, state administrative deficiencies contributed to abuse and waste.

5.4.2 Caseload

Regarding caseload size, MPFU is on record as considering it "unrealistic as well as counterproductive to increase the Unit's caseload beyond the approximate range of twenty to twenty-five cases"[4] at any given time. On the average, any investigation with the likelihood of leading to criminal charges in Vermont is reported to require a minimum commitment of six months of staff time. However, MPFU reports that a realistic estimate of the time period between the filing of charges and final disposition averages one year, making total time of unit involvement with a prosecutable case a minimum of 18 months.

5.4.3 Statistics Regarding Fraud

MPFU estimates that its activities have resulted in recoveries in dollars from providers in excess of $50,000. In states like Vermont, with a false claim statute, dollar amounts are not alleged in the criminal information. Thus, MPFU does not attempt to recover dollars in criminal cases except as they might be incidental to a court ordered fine or restitution.

The items of information routinely collected on cases of detected fraud include the amount of Medicaid money paid to the provider as well as estimated financial impact on some, but not all cases. Although all collections for recoveries are handled through the administrative and civil processes open to the SSA, the MPFU is able to use the information it collects during the process of criminal investigation to estimate the amounts of monies involved. The MPFU has traditionally used a figure of five percent of total dollars paid as an estimate of fraud and abuse in the program based upon the national experience with Medicaid fraud, and on all data collected by MPFU itself.

MPFU completes statistical reporting forms HCFA 50 and 54. It believes that the information requested on the former is "totally useless" and that requested on the latter is "not particularly useful." Regarding HCFA Form 54, the MPFU has stated that "the form should be revised, particularly in reference to the questions about investigations."[5] It also believes that the distinction between Integrity Review and Fraud-Full Scale Investigation is not a useful one and that the data requested are not particularly accessible in the format desired by HCFA 54.

Since its inception, the unit has obtained the first criminal convictions of a Vermont Medicaid provider in the history of the State's Medicaid Program. The Unit has also conducted 28 investigations of allegations of provider fraud and abuse. Of the 19 investigations which have been completed, 12 have resulted in the filing of criminal charges or in the referral for the filing of criminal charges or have been referred to appropriate state agencies for recommenced disciplinary action including Medicaid program suspension, professional licensing suspensions and/or civil recovery.

5.5 Liaison Between the Utilization Control Section and the Medicaid Provider Fraud Unit

Vermont's MPFU and the Utiization Review staff of the DSW maintain almost daily contact with each other and work on cases of fraud together. MPFU's director has stated that he believes DSW can work more closely with this unit to formulate computer programs and edits that will assist in the identification of patterns of fraud.

MPFU provides the SSA and its fiscal intermediary with examples of patterns of provider conduct that can be utilized in identifying potentially fraudulent situations. Some examples of findings and recommenations made by MPFU to the SSA regarding implementation procedures to tighten its fraud prevention and control activities are cited below:[6]

- Provider Group: Dentists

  Finding: The State of Vermont does not have in place an effective mechanism for monitoring duplicate claims for denticaid services.

  Recommendation: The computer program monitoring denticaid claims should be modified to include edits which would identify duplicate claims for services.

- Provider Group: Pharmacists

  Finding: A disproportionately high percentage of Medicaid claims by pharmacies stated that the prescribing physician had required the dispensing of the brand name drug.

  Recommendation: Pharmaceutical providers should be notified that a claim to Medicaid stating that the prescribing physician had required the dispensing of a brand name drug must be supported by a prescription on file at the pharmacy bearing the physician's hand written notation that a brand name dispensing was required.

- Provider Group: Community Mental Health Clinics

  Finding: Services billed to Medicaid were inadequately documented and/or improperly billed.

  Recommendation: Auditing methods and utilization monitoring of Medicaid services provided by Community Mental Health Clinics should be improved.

Each of the above recommendations has been or is in the process of being implemented.

5.6 Conclusion

Vermont, which has one of this nation's smallest Medicaid programs, has been very active in its efforts to detect, investigate and control fraud and abuse. Both the Utilization Review Program of the Department of Social Welfare and the Medicaid Provider Fraud Unit of the Office of the Attorney General participate in the case development process which identifies patterns of misutilization among Medicaid providers. However, the major emphasis in DSW's program is on the monitoring and controlling of the expenditures of Medicaid funds as part of the claims processing system.

Of the types of reviews the Utilization Control Section performs, it is on record as favoring retrospective over prospective reviews even though the latter type is more likely to enhance its opportunities for detecting and preventing patterns of misutilization from developing. Nonetheless, the single state agency is perceived by the MPFU to be cooperative and the two agencies are currently enjoying an excellent working relationship.

The DSW maintains no data on criminal fraud of any kind except that forwarded to it by the MPFU upon the conviction of a Medicaid provider. In addition, it has no estimates on the nature and extent of detected or undetected fraud in the program it administers.

On the average, Vermont prosecutes one fraud case a year. This is because the case development process in Vermont is a long and complicated one characterized by costly and extensive field work in support of the relatively few cases where provider intent can be proven.

REFERENCES

[1]Vermont Department of Social Welfare, Utilization Control Manual, undated, p. I-2.

[2]Interview with James Berry, Deputy Director, Medicaid Division, Vermont Department of Social Welfare, conducted by Frank C. Jordan, Jr., June 16, 1981.

[3]Interview with Jeffrey Amestoy, Director, Medicaid Provider Fraud Unit, Office of the Attorney General, State of Vermont, conducted by Frank C. Jordan, Jr., June 15, 1981.

[4]Ibid.

[5]Ibid.

[6]State of Vermont Medicaid Provider Fraud Unit Recertification Report, 1980.

6. WASHINGTON

The State of Washington counts 300,000 Medicaid eligibles among its 4,600,000 citizens. The total dollars expended annually on Medicaid health care delivery amounts to $420,000,000. Washington's Department of Social and Health Services (DSHS) is the umbrella agency in charge of overall Medicaid management with its Medicaid Division assigned the role of single state agency (SSA). Electronic Data Systems-Federal (hereinafter referred to as EDS-Federal) enjoys an arrangement with the SSA wherein it provides the computer, software expertise and data entry, while the State of Washington provides all other aspects of claims adjudication (e.g., microfilming, corrections of edits and audits, provider relations, third-party resource identification, etc.). DSHS calls its agreement with EDS-Federal a facilities manager arrangement but does not consider this to imply the role routinely performed by fiscal intermediaries, although the state's original MMIS was both designed and installed by EDS-Federal.

Within DSHS, the Division of Medical Assistance coordinates all MMIS functions. Its Office of Provider Services is responsible for the management of the MMIS contract; however, its Office of Analysis and Medical Review has the responsibility for coordination among and between the single state agency and all MMIS users. Thus, Division of Medical Assistance is the overall major user of Washington's MMIS in terms of administering the medical assistance program, paying all claims and directing all other health care delivery services. Additional users of Washington's MMIS include the following:

- the Office of Operations Review;
- the Vendor Audit Review Section;
- the Hospital Settlement Unit;
- the Bureau of Nursing Home Affairs;
- the Division of Mental Health;
- the Bureau on Alcoholism and Substance Abuse;

- the Intermediate Care Facility for Mental Retardation Program;
- the Division of Developmental Disabilities; and
- the Office of Special Investigations - Medicaid Fraud Control Unit.

Through the oversight activities of the Medical Services Review Section of the Office of Analysis and Medical Review, DSHS coordinates all Medicaid claims processing functions. It also investigates and uncovers potential misutilization and promotes the correction of actual misutilization by the 20,000 individual providers and 300,000 beneficiaries comprising the Washington Medicaid delivery system.

6.1 The Identification of Suspected Cases: SURS/MMIS

The Office of Analysis and Medical Review maintains overall responsiblity for the programmatic aspects of Washington's MMIS with its Medical Services Review Section carrying out all SURS activity. The Medical Services Review Section is composed of four units (i.e., prepayment review, postpayment review, field analysis, and education) which review selected medical claims, perform field analyses where appropriate and provide instruction to the Medicaid participant community when necessary.

6.1.1 The Medicaid Management Information System

Washington's MMIS is composed of each of the six subsystems called for in the federal prototype. The MMIS database is only partially compatible with the claims processing database used by the state's Medicare carrier. Washington's Chief of the Office of Provider Services has explained the problem as follows:

> The two databases are compatible only to the extent that we can take Medicare data and run it through our system to make payments; however, the two systems use different coding procedures. For example, we use Current Procedure of Terminology Codes for Vendors and International Classification of Diseases Diagnostic Codes and Medicare uses neither. When your codes are different you have a translation problem. What we need--and the federal government can do this--are standardized data on all claims forms.

6.1.2 The Management and Administrative Reporting Subsystem

The Washington MARS subsystem produces those reports needed to support sound decision making in four functional areas: (1) administration and finance; (2) provider participation; (3) recipient participation; and (4) federal reporting. MARS also produces a subset of reports in the claims processing system that talk about the performance of the state in terms of its payment of claims. The state has gone beyond the functions traditionally performed by MARS and produces financial data which are reformatted into more useful budget or fiscal data. In conjunction with EDS-Federal, Washington has developed a set of financial reports that were spun off the MARS database and a manual model for delineating increases in costs in the Medicaid program and then linking the growth to such factors as increases in users and utilization, etc.

6.1.3 The Surveillance and Utilization Review Subsystem

In general, Washington's SURS system is designed to perform the following functions:

- develop statistical profiles of provider and recipient utilization;
- facilitate the identification of potential misutilization of Medicaid services;
- facilitate the assessment of the level and quality of care provided; and
- accomplish the above-stated objectives with minimal clerical effort.

6.1.3.1 General Operation of SURS

Both MARS and SURS are generated from the same adjudicated claims database. Thus, the MARS and SURS subsystems consolidate, organize and present data that facilitate effective management and control of the Medicaid program. MARS supplies essential data for sound program policy decisions while SURS supports the identification of potential misutilization.

The SURS subsystem generates profiles, sorts claims and classifies beneficiaries and providers into various categories.

It employs a computerized exception reporting technique to: (1) develop peer groups; (2) assign participants to each; (3) specify and define report items for each peer group; (4) construct profiles; and (5) develop group norms and exception reporting limits.

6.1.3.2 The Development of Peer Groups, Profiles, and Exception Indicators

To date, Washington has developed approximately 10 peer groups. These have been generally established by provider type, speciality and recipient eligibility group. Each was developed by SURS staff with input from the SSA's medical advisor and is modified as experience and data needs dictate. The system allows 40 line items for each category of service. They are user defined and are reviewed quarterly for possible change or modification.

From the MMIS General System Document, the following statement is made about exception indicators:[2]

> In order to complete the scope of the SURS System, the following additional functions are performed on the basis of information developed by the process of exception reporting:
>
> - Investigate suspected misutilizers by examination of their adjudicated claims, by peer review, and by the conduct of field audits.
>
> - Determine actual misutilizers.
>
> - Initiate appropriate corrective action against actual misutilizers according to the nature of their deviant activities and practices.

6.2 The Processing and Review of Suspected Cases: The Medical Services Review Section

In Washington, the Medical Review Section is responsible for reviewing cases excepted on the basis of SURS. There are two basic targets of exception analysis performed within the Washington Medicaid Program - fraud and misutilization or abuse. Provider fraud occurs when the provider willfully obtains payment for services that were not performed. Recipient

fraud can involve obtaining an eligibility card through misrepresentation of information or loaning the eligibility card to friends or relatives who are not in the Program (card passing). The possibility of fraud can be detected through use of the SURS reports, but actual fraud cannot be documented or proven without extensive and complicated field reviews.

6.2.1 Indicators of Fraud

Illegitimate receipt of an eligibility card by a recipient cannot be identified through SURS, although inappropriate use of the card by an unauthorized person can. A recipient whose Summary Profile indicates numerous providers, diagnosis, dollars, and services is the first indication of recipient fraud by card passing. These factors are not conclusive, especially when the patient is on disability or old age assistance as numerous specialists may be involved in the treatment of seriously ill patients. An analysis of the patient's History Detail Report is essential to find inconsistencies in the treatment patterns such as dates of service, inappropriate drug services for the patient's age or condition, or conflicting diagnoses. Eligibility cards for nursing home residents are especially susceptible to fraudulent use by relatives and nursing home staff.

A field review for suspected provider fraud can involve interviewing recipients concerning services they allegedly received or visiting the provider's facility to determine if he or she has the equipment and staff necessary to perform the services for which payment has been requested. Suspected fraud by providers could be indicated by any number of patterns. A few examples of the types of patterns Washington's Medical Review Section analysts look for among identified providers are:[3]

- Use of elaborate lab, radiology, and other "special" medical procedures.

- Duplicating billing for once-in-a-lifetime surgical procedures for the same patient with different dates of service (such as an appendectomy in February and another in July). Field review is performed to determine whether the billing was intentional and not simply the result of poor bookkeeping practices.

- Services billed for by a provider which are not in accordance with the services billed by other providers for the patient's treatment during the same time frame. This particularly applies to institutionalized (hospital) patients, but can also apply to ordered lab and radiology services.

Specific factors identified as being associated with provider abuse of the Washington Medicaid Program include:[4]

- excessive referral to practitioners or facilities with which the referring physician has a financial arrangement or interest;
- need to maintain an adequate patient population in institutions (hospital and nursing home);
- provision of excess services for medical staff training purposes;
- desire to safeguard against malpractice claims by "over-treating" patients and overutilizing consultants to avoid charges of negligence;
- desire to rapidly amortize expensive equipment and facilities;
- use of institutional facilities for care suitable to office treatment or other forms of ambulatory care;
- unorganized systems for recording the medical care services which result in duplicate or repetitive services which could have been avoided by the proper transfer of medical records;
- eccentric patterns of patient care; and
- promotional and sales efforts to provide services for which recipients felt no need and which they would be unlikely to use properly, as may be the case with dentures, hearing aids, prosthetic appliances, and equipment for care of invalids.

6.2.2 Provider Case Development

In Washington, the first step involves identifying suspicious practices and constructing a working list of providers for whom further investigation appears warranted. This step is accomplished through a review of the Provider Ranking Report by Exception Weight for the appropriate Category of Service. The list is compiled by starting with the most deviant cases and continuing down to the less deviant cases until a manageable workload is achieved. It should be noted that many providers with high weighted practices will be eliminated from the list due to various justifications, in particular, low volume practices for which the research will not be cost effective. For providers practicing in Categories of Service included in the Treatment Analysis Subsystem, a review of the Treatment Exception Rank Report should also be performed in establishing the list of priority cases. Once the providers for review have been selected, the case development for each individual can begin. At each level of review described below, the case analyst is expected to decide if the case should or should not be pursued further based on the indications of the information to that point. If the decision is made not to investigate further, a record is made of the decision with an appropriate explanation placed in the provider's file. Six levels are involved in the case development process. Each level involves different types of analytic and investigative activities; for example:[5]

- Level I - Note the medical activity of the provider on the Ranking Report and on the Summary Profile. Identify the specific areas where exceptions occurred. Give special attention to those items which excepted in more than one reporting period. Compare the provider to the peer group activity if appropriate.
- Level II - For providers in the Categories of Services processed through Treatment Analysis, review the medical activity on the Treatment Exception Ranking Report and the Diagnosis Treatment Exception Report. Note the procedures and diagnosis where the exceptions occurred. Determine which exceptions created the highest utilization and criteria weights. Compare the activity of this provider to that of the peer group on the Phase II reports for supportive documentation when it is felt that this provider performed a majority of the services for this procedure.

- Level III - Review the provider's History Detail Report to identify and document the specific cases involved in the exception areas previously noted. Obtain claim copies where applicable. A Recipient Claims History Report is obtained from the Claims Processing System for a cross-section of the provider's patients to identify other provider services linked to his practice such as drugs and consultations. Patients who have been institutionalized by this provider is given special attention in this report.

- Level IV - Summarize the findings of the Level I, II and III reviews. Outline recommended corrective action. Present the case package to the appropriate authority.

- Level V - A decision is made on the disposition of the case by the appropriate state agency. These officials may recommend provider education, field reviews, more extensive documentation, recovery of funds, or various punitive actions.

- Level VI - The action indicated by Level V is carried out. This could involve the actual recoupment proceedings, installation of prepayment audits for claims monitoring, referral to law enforcement authorities, ongoing post-payment review to ensure the problem has been resolved after the provider is notified, etc.

A filing system has been established for providers selected for review. All information and correspondence accumulated for each provider is placed in this file for reference in the event the provider comes up for review again. Level I and Level II reviews are performed periodically for all providers on whom corrective action has been taken.

Washington's SURS reports are designed to identify potential abuse or misutilization cases on a quarterly basis. Once a sample of cases has been identified, further case selection and validation of exception ranking occurs. This screening is performed by a SURS supervisor who, by scrutinizing the data output, will eliminate 10 percent of those cases identified as possibly involving abuse or misutilization. The remaining cases are then developed by a SURS analyst to determine if further

action is warranted. After this second level investigation, no action is taken in 90 percent of all referred cases. Of the remaining cases, the majority will be disposed of administratively; however, on the average, one case per month is referred to the Medicaid Fraud Control Unit. These cases are always accompanied by a case summary with claims documentation. To date, all cases submitted to the Medicaid Fraud Control Unit by the single state agency have been returned as non-prosecutable. According to the Medical Review Section, MFCU always provides disposition of data for all cases in its files for recommended disposition. The SSA states that it makes use of the information forwarded to it by MFCU to refine the referral process and to collect overpayments due to provider abuse or misutilization.

6.2.3 Corrective Action

The ultimate purpose of Washington's SUR System is to correct inappropriate use of Medicaid services. Once the nature of a beneficiary or provider problem has been defined and documented, corrective or punitive action can be initiated. These often include one or more of the following actions: education, administrative action, peer review, recovery of funds, suspension or termination, referral to licensing boards, or referral to law enforcement.[6]

6.2.3.1 Education

Recipients can be made aware of their misutilization, whether it was intentional or unintentional, through contact with the local case worker or written correspondence from state agencies. Inappropriate provider billing practices can normally be corrected through visits or communication with the EDS-Federal Provider Representative. To correct the performance of inadequate or excessive medical services, contact with the provider by the Medical Director or other medical consultants is usually initiated.

6.2.3.2 Administrative Action

Recipients who have continuously abused the program through the use of numerous providers can be "locked-in" to one physician and one pharmacist. Prepayment audits can be established for abusive providers to generate claim worksheets for review. Using this method, a provider can be put on full review or only

partial review. Administrative action can also include warning notices and continued postpayment monitoring.

6.2.3.3 Peer Review

The single state agency often consults with the Professional Standards Review Organization (PSRO) or other professional review boards for their medical opinion on problem cases.

6.2.3.4 Recovery of Funds

Recoupment of paid program funds can be made for several reasons. Often claims are paid erroneously for duplicate services due to keypunching errors, resolution clerks overriding audits, and alteration of information on claims for the same services. Recoupment amounts for these types of payments are computed by determining what the provider should have been paid for the service and subtracting this amount from what the provider was actually paid. A letter is then sent to the provider explaining why he or she was paid in error and notifying the amount to be recovered.

In some cases of procedure overutilization, it may be desirable to recover the amount paid for services in excess of those allowed by the peer group treatment models. The Diagnosis Treatment Exception Report for the provider can be used to compute the excessive number of services and the recoupment amount based on amount paid per service. As a severe penalty for flagrant abuse, all dollars paid for the overutilization procedures could be recovered, not just for those services in excess of the peer group norm.

6.2.3.5 Suspension or Termination from Participation in the Program

This is the most effective method of halting provider or recipient abuse. In the case of providers, it is used with caution. A provider may be the only one of his type (hospital, physician, pharmacist, etc.) in a rural area who accepts Medicaid patients. To remove such a provider from the program would eliminate availability of total medical care for the Medicaid patients in the area.

6.2.3.6 Referral to Licensing Boards

In cases of extreme abuse, where the provider's practice may be detrimental to the patients' mental or physical health, it may be desirable and appropriate to bring the case to the attention of the state licensing board for consideration. They, in turn, have the right to revoke the provider's license to practice in the state. Cases for which this action should be taken would involve such acts as extensive unwarranted surgeries, inappropriate prescribing (or dispensing) of hard narcotic and psychotherapeutic drugs, or poor quality of care resulting in deterioration of the patients' conditions.

6.2.3.7 Referral to Law Enforcement Authorities

Cases identified as potentially fraudulent through SUR activities are referred to the proper law enforcement authorities. All documentation, including the results of field reviews, are relinquished to the appropriate authorities to support the prosecution efforts. In the case of providers, suspected criminal fraud cases are referred to the Medicaid Fraud Control Unit; in the case of beneficiaries, such cases are referred to the offices of local district attorneys for possible prosecution.

6.2.4 Fraud-Related Data

The SSA has no reliable estimates of the nature and extent of fraud in Washington's Medicaid Program. Commenting on the nature of fraud, the Chief of the Office of Provider Services has stated the following:

> There are some very strict legal definitions about what fraud is and is not. And there are many steps in the process before ever a decision is rendered regarding fraud. We never deal with fraud. Our database is generated from claims that are billed--procedure codes, diagnostic codes and other kinds of auxilliary information--those items are just general claims processing information. Our system does not accumulate nor can it feedback the kind of data that is so critical to a determination of fraud. Fraud is a matter of intent and you have to go into the field and thoroughly investigate a provider's circumstances before you can establish intent.

Thus, the single state agency keeps no data on known fraud, either in terms of total cases or dollar dispositions, except that provided by the Medicaid Fraud Control Unit. In all cases, this information was obtained through thorough field investigations and the criminal court process. Overall, the data generated in SURS reports provide a total picture of Medicaid activity throughout the State of Washington. This includes summary and detailed information on all Medicaid eligibles and providers which can be placed in profiles and peer groups to enhance all case development activities. From the standpoint of the single state agency, such information is useful for detecting patterns of misutilization and with further refinements, will improve the capability of the SURS subsystem to provide more accurately patterns of potential misutilization and abuse.

6.3 The Investigation and Prosecution of Suspected Cases: The Medicaid Fraud Control Unit

The Medicaid Fraud Control Unit (MFCU) in the State of Washington is located in the Office of Special Investigations of the Department of Social and Health Services (see Figure 6-1). As such, MFCU is under the same umbrella as the Division of Medical Services which, in the strictly technical sense, serves as the single state agency for Medicaid management. Between 1974 and 1978, Washington had in place a five person Medicaid Task Force to look at fraud and abuse in its Medicaid program. With the acceptance of the federal grant under Public Law 95-142, Washington increased the size of its Medicaid fraud staff to a 23 person interdisciplinary team of auditors, investigators and attorneys. This occurred in July 1978 and the MFCU became operational on August 1, 1978. Currently, the Medicaid Fraud Control Unit has 16 professional staff (i.e., 3 auditors, 9 investigators, 3 attorneys, and the Unit's director). The Unit also uses, on an as needed basis, other professionals knowledgeable in medicine and pharmacy who are on retainer by the single state agency for Medicaid management to assist in the case development and investigation process. MFCU has a seven person support staff. The current annual operating costs of the unit is $480,000.

6.3.1 Prosecutorial Powers

The Office of the Attorney General in the State of Washington did not have statewide prosecutorial powers until a session of

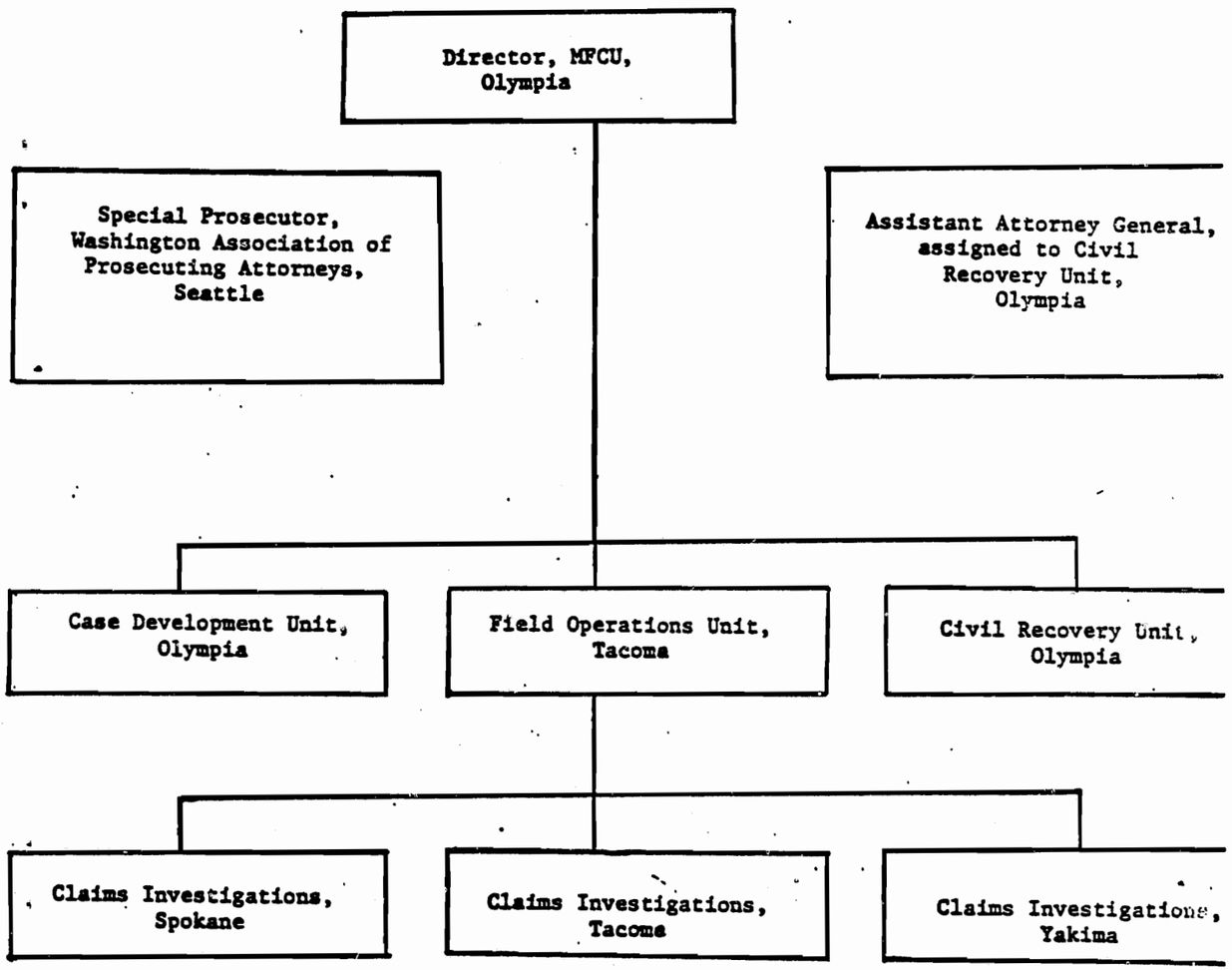

FIGURE 6-1

OFFICE OF SPECIAL INVESTIGATIONS, MEDICAID FRAUD CONTROL UNIT (MFCU), STATE OF WASHINGTON

the legislature passed a bill in May 1981 authorizing the Attorney General, under limited conditions, to proceed in criminal investigations and prosecutions. Prior to the new legislation, all such powers were invested in the 39 county prosecutors by constitutional mandate. Although the Attorney General has expressed an interest in becoming involved in the prosecution of fraud cases, the MFCU's current source of authority to prosecute is a contractual agreement with the 39 county prosecutors and the Washington Association of Prosecuting Attorneys.

MFCU prosecutes under criminal statutes 74.09.210 through 74.09.240 which set forth the criminal definitions of fraudulent practices relating to Medicaid and describe all other pertinent data such as access to records, subpoena powers, damages, fines, and restitution. Civil penalties can be assessed up to as much as triple damages in monies received to which a provider or vendor was not entitled and one percent interest additionally. Criminal sanctions range from a minimum of five years to a maximum of 20 years incarceration upon conviction.

Prior to 1979, the only available statute providing a basis for prosecuting Medicaid fraud was an embezzlement and grand larceny statute which did not allow the creativity and flexibility MFCU needed in presenting its cases. Through the joint efforts of the Washington Association of Prosecuting Attorneys and the MFCU, criminal and civil bills covering fraudulant practices were drafted and introduced before the state legislature. The 74.09 series mentioned earlier came about as a result of this effort and represents a strong prosecuting statute from the standpoint of penalties, sanctions and fines.

6.3.2 Case Development

Over the three year life of the Medicaid Fraud Control Unit, it has prosecuted successfully 22 fraud cases. See Figure 6-2 for a schematic of the case development process. For calendar year 1980 and January - February 1981, 63 cases were closed after investigations. Over the same time period, $105,620 was recovered through overpayments and $146,395 through identified civil recoveries.

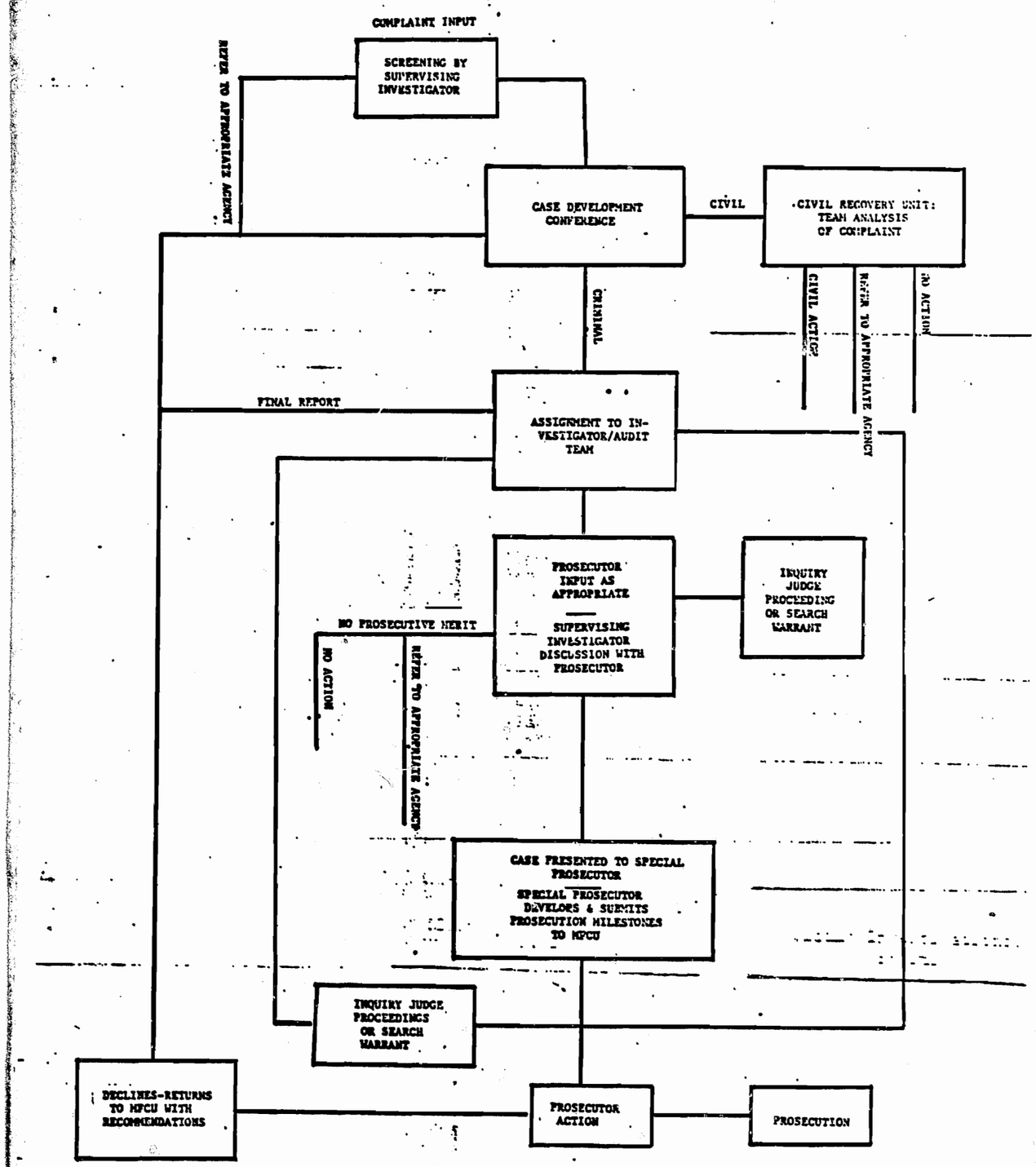

FIGURE 6-2

MEDICAID FRAUD CONTROL UNIT: CASE PROCESSING

6.3.2.1 Investigations and Prosecutions

Currently, the MFCU has six field offices (Olympia, Seattle [2], Spokane, Takoma, and Yakima) located strategically throughout the State of Washington to perform interdisciplinary investigations and prosecutions of provider fraud. Teams comprised of auditors, investigators and other necessary medical personnel, perform the field investigations, and determine what corrective action needs to be taken. Exceptional activity and consistent patterns of misutilization are brought to the attention of each provider or recipient reviewed. Punitive action is not routinely taken, although recommendations are made to correct inappropriate utilization.

When developing a complete fraud and abuse detection strategy, sufficiently more staff resources need to be allocated to each case of provider fraud than to recipient fraud. Extensive research and documentation is required to develop concrete cases for referral to law enforcement agencies, to support judicial proceedings, or to determine improperly paid funds that are to be recovered.

Only four of 22 cases prosecuted have been a result of referrals from the single state agency. From the perspective of the Medicaid Fraud Control Unit, the most beneficial tool in the hands of the SSA is the Explanation of Medical Benefits (EOMB) program. This is because it asks the beneficiaries of services whether or not a series of services have been rendered. Because the sample of recipients are carefully selected based on provider lists where aberrant behavioral patterns have been demonstrated, the results from EOMBs in Washington are reported to be excellent.

MFCU receives leads on cases involving potential fraud from the single state agency administering medicaid (10%); the general public (40%), and law enforcement and regulatory agencies (50%). Washington's MFCU director has stated the following regarding referral sources:[8]

> At the outset, the federal government said MMIS would be the largest sources of our cases. That has never happened. As of October 1-80, the federal government revised its policy to encourage Units to go into a more proactive mode and we are just now gearing up to develop our own cases.

The Washington MFCU considers its basic objectives to be: (1) to identify and eliminate fraud and abuse in the Medicaid program; and (2) to identify and recommend procedures for closing all loopholes in the program which allow fraud and abuse to take place. This second objective is given more prominence in the State of Washington than it is in some other fraud units visited because of the MFCU's placement organizationally in the same umbrella organization as the single state agency for Medicaid management.

6.3.2.2 Dispositions Other Than Criminal Prosecution

Since the Department of Social and Health Services has a civil recovery function, MFCU considers itself to be involved in the pursuit of other dispositions than prosecution on charges of criminal fraud. In that role, MFCU addresses the appropriate programmatic areas that affect civil actions and reviews all program recommendations and contractural agreements with the medical community. Most cases referred to MFCU by the single state agency involve the escalation of procedure charges. Thus, although a service is always provided, it is the level or intensity of that service that is generally called into question. In its case development mode, the MFCU tries to sort out what constitues the appropriate action to be taken. Such a decision is generally made in concert with the Attorney General for the civil side of DSHS and the particular county prosecutor in whose jurisdiction the alleged offense has occurred.

Recommendations are also made by the MFCU concerning the administrative handling of cases. Where a pattern of misutilization and/or abuse has been demonstrated, a recommendation of full recovery of established dollars lost is always made. In all instances, cases are referred back to the single state agency for some level of administrative action ranging from suspension and revocation of providers to recovery of overpayments and other corrective actions.

6.3.3 Statistics Regarding Fraud

The Medicaid Fraud Control Unit has no estimates of any kind on the nature and extent of undetected fraud in the Medicaid program. The amount of information collected routinely on fraud varies from case to case but is linked to the level of case development needed to render a case prosecutable. Because the MFCU works for the same umbrella organization (DSHS) as the SSA,

it often uses the information it collects to identify loopholes in the program and to devise methods for closing those loopholes.

All final dispositions and other pertinent information on the cases under active investigation are forwarded to the single state agency for their use in collecting all overpayments (i.e., actual dollars identified as monies received to which a provider was not entitled), restitutions, fines and other civil and administrative actions that are appropriate.

The MFCU's director stated that he regularly completes reporting forms HCFA 50 and 54. He also indicated that the data requested must be reformatted to meet the federal requirements but that in neither case does the information requested meet the data needs of the State of Washington.

6.4 Liaison Between the Medicaid Fraud Control Unit and the Division of Medical Assistance

The Medicaid Fraud Control Unit and the single state agency have entered into a Memorandum of Understanding pursuant to 42 CFR 455.300 to eliminate fraud in the Washington Medicaid Program.[9] The terms of the State of Washington's Memorandum of Agreement were worked out at a very high level within the Department of Social and Health Services and since November 1-80, both the MFCU and the SSA have been working extremely hard to perform their respective duties. One pivotal entity in the arrangement is the role of the Medicaid Abuse Control Board.

This Board is a working entity, comprised of representatives of the Offices of Analysis and Medical Review and Operations Review, the Nursing Home Board, and Medicaid Fraud Control Unit. It meets on a bimonthly basis to coordinate all referrals and complaints to the Medicaid Fraud Control Unit. In the view of the MFCU director, the Board has been an excellent mechanism for hearing especially questionnable cases and for refining the referral process.

The MFCU stated that it has only been over the last nine months that the single state agency has been able to provide it with sufficient information and support to adequately investigate Medicaid fraud in the state. Because the SSA has not always had the staff to provide support to the MFCU, the latter has had to access the files of the SSA for claims and microfiche copies of

information on cases under active investigation. MFCU is aided by having its own on-line computer terminal which allows it to access a 15-month computerized payment history which it can use for basic analysis; however, any information beyond the 15-month period must be accessed manually from archival data.

The MFCU and the SURS unit of the single state agency are in frequent contact (i.e., 3 to 4 times daily) as part of the MFCU case development function. MFCU requests profile data from the SSA on an as needed basis. Since May 1981, both units have jointly developed a formatting and maintenance program for the MFCU. The MFCU can not request computerized data tapes from EDS-Federal without costs to the Unit.

The Medicaid Fraud Control Unit director believes that the solution to the problem of better data for fraud control lies somewhere else in the system.[10] He has explained the situation in the following manner:

> Over the past several months, we--and here I mean 23 or so Fraud Unit directors--have said to the single state agency and personnel at the federal level that if this system is going to work on either side, we need to come to grips with defining the real purpose and use of that MMIS equipment. If the federal sector really sees MMIS as a mechanism that would be advantageous for identifying fraud, waste and abuse through a system of audits and edits, then they should design a standard packet and mandate its use at every user level while allowing the states to address any audits and edits it felt were also essential to the claims processing function.
>
> The source of the conflict centers around the claims processing function and the fact that there are federal and state mandates that claims be processed in a timely manner. What audits and edits that there are in the system that are advantageous to identifying patterns of fraud and misutilization occasionally have to be turned off to meet the demands of the payment function. I think the claims processing function will always be given priority over the reviewer function and it is the latter that needs to be given attention if we are going to have better data for fraud identification. It's a problem that can only be solved at the national level.

6.5 Conclusion

Currently, the State of Washington's efforts at detecting, investigating and prosecuting Medicaid fraud have moved beyond the early developmental phase and now reflect a high level of coordination between the single state agency for Medicaid administration and the Medicaid Fraud Control Unit. Uniquely, both agencies are located organizationally under the aegis of the Department of Social and Health Services; however, it has only been since November 1980 that a workable agreement has been reached between the two units and a positive effort has been expended by the SSA to provide the MFCU with the kinds of data needed to process its cases. Because the MFCU finds itself aligned organizationally with DSHS, it concentrates a great deal of its efforts on the enactment of appropriate legislation and the closing of regulatory loopholes which often enhance opportunities for misutilization and abuse to occur.

In the view of the MFCU's director, the SURS data focuses almost totally on the claims processing function to the detriment of the utilization review aspects of the program; however, both groups are in agreement that SURS data can be used to detect possible misutilization patterns. Most importantly, MFCU and SSA staff recognize that the complicated nature of fraud detection and prosecution requires a major and long term commitment in resources to establish patterns of willful intent.

These agencies possess no empirically derived estimates of the nature and scope of undetected fraud in the Medicaid program, although they do maintain statistics on known fraud (i.e., fraud based on convictions in the criminal courts). Unfortunately, these data represent so small a piece of the "fraud, waste and abuse" mosaic as to not be particularly meaningful.

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6 Ibid.

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7. FINDINGS AND ISSUES

This chapter presents an analysis and synthesis of the data gathered during the course of this study. The findings and issues of this phase of the study, presented below, are based on interviews with the (1) Director of the Division of State Fraud Control (Office of the Inspector General, Department of Health and Human Services), (2) chiefs of the four Medicaid fraud control units visited, and (3) officials with the single state agencies responsible for administering the Medicaid program in the respective states visited. The interviews were supplemented by the analysis of the reports produced by the single state agencies, the Medicaid fraud units, the Office of the Inspector General at Health and Human Services, Congressional hearings, and the General Accounting Office.

7.1 Findings

7.1.1 Estimates of Fraud in the Medicaid Program Are Not Valid Statistically

In light of the findings of the first phase of this study, it was not surprising to learn that estimates of the nature and scope of fraud in the Medicaid program are unreliable. The Director of the Division of State Fraud Control (DSFC) has stated that in his opinion existing estimates of Medicaid fraud are not statistically valid. His view was confirmed by officials at the Medicaid agencies and Medicaid fraud units (MFU) in the four states visited during this phase of the study. There was some question raised by many of the agency officials interviewed as to the utility of such estimates even if they could be developed.

The concept of using MMIS to estimate fraud did not find much favor among the individuals interviewed during this phase of the project. State officials emphasized that SURS/MMIS can only identify those providers who appear to represent exceptions to set limits or parameters. A long review process is required to identify the cases excepted by SURS which do, in fact, involve abuse or misutilization. Additional analysis is then required to identify those instances where fraud may be involved. As state officials pointed out, one can only be certain that fraud—in a legal sense—has been involved when it is proven in court.

7.1.2 Statistics Regarding Detected Fraud Are Available, But Their Utility is Limited

Each of the Medicaid fraud units produces an annual report which provides some statistics regarding Medicaid fraud such as number of investigations, indictments, convictions; types of providers involved; and the amount of restitution, savings, or recoveries. These data are also reported to the Division of State Fraud Control via Health Care Financing Administration (HCFA) form HCFA-50, which focuses on the individual case, and form HCFA-54, which is a summary of statistical data. The Director of the DSFC stated there is a need for a thorough analysis of the data produced by the state MFUs; however, his current resources limit the extent to which statistical analyses can be conducted.

Moreover, both the Director/DSFC and the heads of the four MFU pointed out there are some serious problems in interpreting the results of any statistical analysis. The most serious problem is created by the variation among state MFUs in targetting their investigations. Some may target only certain types of providers; others, all types. Still others may select to investigate recipients rather than providers, or some combination thereof. Another serious analytical problem is caused by the fact that the state MFUs tend to define such variables as fines, restitutions, overpayments, and savings in different ways and in accordance with the criminal and civil statutes within their respective states. Thus, unless there is a definite statement as to the provable dollar amount lost to fraud, it is difficult to obtain a reliable estimate of the amount of dollars lost to detected fraud. Furthermore, as the Director/DSFC pointed out, any attempt to analyze existing data requires a thorough knowledge of the operational environments of the MFUs and the related single state agencies (SSAs). In order to correctly interpret data regarding fraud, one must know what each state is doing (e.g., what are its investigative priorities) and why (e.g., what are the criteria for referrals)?

Both the Director/DSFC and the heads of the MFUs visited indicated some dissatisfaction with current HCFA reporting forms. The Director/DSFC is seeking to revise these forms so that they can be used at the state level for management purposes and at the federal level for purposes of data analysis.

7.1.3 SURS/MMIS Indicates Cases for Further Review and Investigation and May Serve as an Investigative Tool

There is general agreement among the officials interviewed that SURS does not detect fraud nor was it ever intended to do so. What SURS does do, however, is to indicate cases for further review and investigation. As noted earlier, SURS operates on the basis of exception limits. A lengthy, complex review process is required to identify which excepted cases should be the subject of corrective action by the SSA and which should be referred to the MFU.

Once a case is referred to the MFU, SURS/MMIS may be used as an investigative tools by the MFU. SURS/MMIS is capable of providing the type of audit trails needed by MFU auditors and investigators to "build a case". The system may also provide the kind of data useful in seeking restitution as well as the dollar amount sought in civil suits.

7.1.4 The Prevention and Control of Medicaid Fraud Is Facilitated by a Close Working Relationship Between the Medicaid Fraud Unit and the Review Unit of the SSA

All the state officials visited stressed the need to establish and maintain a close working relationship between that unit of the SSA which is assigned responsibility for case review and the Medicaid fraud unit. Close cooperation and coordination is also required to identify and correct the programmatic vulnerabilities which provided the opportunity for fraud. Failure to achieve cooperation impedes the successful detection, investigation, and prosecution of fraud.

7.1.5 The Investigation and Prosecution of Medicaid Fraud Is a Complex, Lengthy Process Which May Create Backlogs

As has been seen, the investigation and prosecution of Medicaid fraud requires an intensive as well as extensive effort on the part of both the fraud unit and its counterpart at the SSA. This lengthy, complex process may create a backlog for the MFU in its case processing. As was seen in one state (i.e., California), the length of time required to investigate and prosecute a case of Medicaid fraud may well run beyond the statute of limitations. Moreover, the length of time needed to proceed criminally and/or civilly is another reason for stressing administrative actions.

7.1.6 There Is Increasing Emphasis on the Need to Prevent Fraud

Both the MFUs and the review units recognize that while the detection, investigation, and prosecution of Medicaid Fraud are important, these activities alone are not sufficient to deal with the problem. Consequently, there is increasing emphasis on activities designed to prevent fraud. The units visited are stressing the identification of vulnerabilities at the Medicaid program level which create opportunities for fraud. Where necessary, they are seeking changes in legislation and regulations to "tighten the loopholes" in programs which provide the opportunity for fraud.

7.2 Issues

An analysis of the data gathered during interviews with officials of the Medicaid fraud control units and single state agencies responsible for the administration of medicaid in California, Michigan, Vermont and Washington, indicates that there are many similarities in the problems faced by the Inspectors General at the federal level and those confronting state officials in their efforts to control and prevent fraud in the Medicaid program. Four major issues evident at the state level, which may also be of concern to the IGs at the federal level, are: (1) the need for statistics regarding Medicaid fraud; (2) coordination between the fraud unit and the Medicaid agency; (3) the operation of SURS; and (4) the fraud review process.

7.2.1 The Need for Statistics Regarding Medicaid Fraud

The first phase of this study indicated the incomplete state of knowledge regarding the nature and extent of fraud in government programs and operations at the federal level. The same condition exists at the state level in the Medicaid program. The problem is even more complex because of variation across states in terms of the organization and operation of their Medicaid fraud units and single state agencies administering the Medicaid program. The utilization of fiscal intermediaries exacerbates the problems of collecting and analyzing comprehensive, reliable statistics regarding detected fraud—all the way from initial detection to final disposition.

The current methods of collecting statistics regarding fraud detailed in the Medicaid program raise a number of critical

policy questions for both state and federal officials. What statistical data are needed by state vis-a-vis federal officials? Does the data itself, level of aggregation or method of analysis change according either to the level of government involved or to the purposes for which it is used (i.e., reporting, research, or management)? If such variation exists, what is the most effective and efficient means of accommodating different needs? To what extent is standardized reporting across states required? How can the desired degree of standardization be best achieved? How can privacy and security requirements be met? How can the dollar amount lost to Medicaid fraud be measured?

7.2.2 Coordination between the Fraud Unit and the Medicaid Agency

Both the fraud units and the Medicaid agencies recognize the need to cooperate in order to control fraud effectively and efficiently. The problem is how to best overcome some of the difficulties inherent in establishing inter-organizational coordination. The problem becomes even more complex when fiscal intermediaries are involved in the Medicaid program. An assessment of the liaison role between the fraud units and the Medicaid agencies could provide important information on how to improve their relationship. Such an assessment could also impact on the operations of the Inspectors General (IG) at the federal level. It has recently been recognized that the IGs must depend on the program agencies as the "first-line of defense" against fraud. Increased cooperation and coordination between the IGs and the program agencies can only increase overall efforts to enhance integrity and efficiency in government programs and operations.

7.2.3 The Operation of SURS

SURS has been described as a mechanism for detecting fraud. However, state-level officials are of the opinion that—at best— it only identifies cases which exceed set limits or parameters. Whether or not fraud is involved can only be determined by a lengthy review and investigation process. However, the SURS/MMIS can be used as an investigative tool to provide the information needed in investigation and prosecution. Given the increased emphasis on the implementation of information systems to manage state and federal government programs and operations, particularly to control and prevent fraud, attention should be given to assessing the current

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capability of such systems to prevent and detect fraud as well as to provide the kinds of data needed for investigation and prosecution. Based on such evaluations, methods should be identified for improving the performance of these information systems.

7.2.4 The Review Process

The current review process performed by the single state agency is both complex and lengthy. The review process and the review unit itself should be examined to determine how they might more effectively and efficiently accomplish their intended objectives. It is obvious that the programmatic expertise of such review units plays an important role in the prevention and control of fraud. This is true at both the state and federal levels of government. The question becomes how to best bring this knowledge to bear on the problem.

7.3 Conclusion

The overall findings of this phase of the study should be of direct interest to the Medicaid fraud units and the Medicaid agencies at the state level and the Division at State Fraud Control and the Health Care Financing Adminsitration at the federal level. The information about statistics regarding Medicaid fraud should be of interest to the Bureau of Justice Statistics in its efforts to develop statistics regarding fraud in government operations and programs. At the present time, we have little or no comprehensive, reliable statistics regarding fraud at the state or federal levels.

APPENDIX A

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