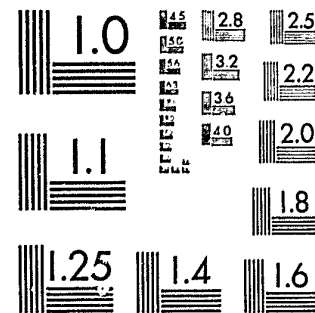


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RESPONSES TO FRAUD AND ABUSE IN AFDC AND MEDICAID PROGRAMS

Executive Summary

January 1983

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RESPONSES TO FRAUD AND ABUSE IN AFDC AND
MEDICAID PROGRAMS

ABSTRACT

In a two-year study of fraud and fraud control in AFDC and Medicaid, carried out by SRI International and the University of Illinois at Chicago, government reports and research literature on fraud and fraud control were reviewed and analyzed, a statistical analysis was made of AFDC grant overpayments in Denver and Seattle, and program and control personnel were interviewed in Colorado, Illinois, and Washington.

No statistics are available to measure fraud in welfare programs. Interviews with AFDC recipients suggest that annual overpayments may range from a minimum of \$376 million to a maximum of \$3.2 billion. An estimate of fraud and abuse in Medicaid suggested a 1977 level of \$668 million. This lack of statistics is symptomatic of the unwillingness of many groups (including legislators and administrators) to confront the reality of fraud and abuse in government benefit programs.

While the federal agencies that fund AFDC and Medicaid require state agencies to adopt measures to reduce erroneous expenditures, decisions about the nature and extent of programs to prevent fraud or take action against violators are left to state and local welfare agencies, and to criminal justice agencies. Such decisions are rarely made on the basis of programmatic efficacy in preventing fraud; they are made instead on the basis of the self-interest of the deciding group--as when prosecution is declined because the sum involved is "too small".

Even though there is some empirical evidence that fraud control can be cost effective, it is unlikely that criminal justice agencies can handle the task alone, or that taxpayers will provide additional funds for fraud control. Welfare agencies can, however, focus prevention efforts on major types of fraud and can designate specific individuals and units to deal with

fraud problems. To compensate for shortcomings in the criminal justice system, fraud cases can be handled with administrative sanctions and civil fraud prosecutions. Unless program and control agencies are given additional incentives to stress fraud control, however, it is unlikely that substantially greater attention will be paid to problems of fraud and abuse.

PREFACE

In 1980, the National Institute of Justice awarded a grant to SRI International to study fraud and abuse in government benefit programs. Focusing on the AFDC and Medicaid programs implemented in the states of Colorado, Illinois, and Washington, the project was designed to:

- . Estimate the nature and extent of fraud and abuse in these programs.
- . Identify measures currently being taken by federal and state agencies to prevent fraud and abuse, and to impose sanctions on violators.
- . Determine factors which influence the nature and extent of current fraud control programs.
- . Identify prevention and enforcement strategies which might improve current control efforts.
- . Identify strategies which might increase public and official support for fraud control programs.

These topics were pursued through a combination of interviews and an analysis of relevant literature. Research literature, government reports, and Congressional studies were evaluated and categorized in terms of project issues, leading to the preparation of a research framework which was discussed with the project Advisory Committee. In 1981, field research began with interviews with federal officials in Washington and Baltimore, and with professional associations concerned with welfare and fraud control issues. The research framework and our federal interviews led to the development of interview guides to structure our work in Colorado, Illinois, and Washington State. Over a period of 3 months in 1981, lengthy, face-to-face interviews were held with state legislators, federal regional office officials of HCFA and SSA, state AFDC and Medicaid program officials, fraud investigators, prosecutors, and legal assistance and welfare rights organizations (see Appendix). Case studies were prepared on each state and

program, leading to the analysis of fraud control issues summarized in this report.

While fraud and abuse issues have been frequent subjects of Congressional and General Accounting Office attention since the early 1970s, the literature about them is of uneven quality. The administration of AFDC programs has been analyzed much more frequently than Medicaid administration. In both programs, Quality Control systems have been created to measure the frequency of erroneous payments, but no statistical measures of fraud exist. Individual cases of AFDC and Medicaid fraud have been documented in legislative hearings, prosecutions, and the mass media, but no major research studies of these crimes have been published. Legislators and agency officials have debated various techniques to improve program administration and enforcement activities, but almost none of them have been subjected to rigorous evaluation.

Because the data and literature on fraud and fraud control are limited, any conclusions and recommendations must necessarily be tentative in nature, awaiting detailed evaluation of the many innovations which are under way in benefit programs. Furthermore, drawing general conclusions is rendered more difficult because of the diversity of state benefit programs. Each state operates within different legal, administrative, and political constraints, leading to different fraud problems and control responses. We hope, however, that our research has clarified major issues about fraud control policy and identified promising strategies for improvement.

The complete findings and recommendations from the project are contained in two Research Reports:

- (1) John A. Gardiner and Theodore R. Lyman, with Andrew R. Willard, Responses to Fraud and Abuse in AFDC and Medicaid Programs.
- (2) Harlan Halsey, Frederick Nold, and Michael Block, AFDC: An Analysis of Grant Overpayments.

Copies of these reports are available from the National Criminal Justice Reference Service Inter-Library Loan Program, Box 6000, Rockville, Maryland 20850.

The first Research Report includes detailed case studies of the implementation of AFDC and Medicaid fraud control programs in Colorado, Illinois, and Washington. The second provides an intensive statistical analysis of overpayments to groups of AFDC recipients in Denver, Colorado, and Seattle, Washington.

This Executive Summary presents the major findings and policy recommendations of the project. Part I describes the structure of AFDC and Medicaid, and presents estimates of the extent of fraud and abuse in the programs. Part II analyzes agency efforts to prevent overpayments, and the processing of cases in which fraudulent or unintentional overpayment has occurred. Part III identifies strategies that might improve fraud control efforts, and policy changes that might provide greater incentives to emphasize fraud control. Part IV summarizes the conclusions and recommendations and suggests the role of Congress, the states, and local agencies in implementing improvements.

ACKNOWLEDGMENTS

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We also acknowledge the important roles played by several colleagues. Andrew Willard of SRI assisted in designing the project and working with Washington officials in research on that state's programs. Judith A. Hill of the University of Illinois assisted in the Illinois-based research. Harlan Halsey, Frederick Nold, and Michael Block were helpful in the overall development of the project, and prepared an analysis of AFDC grant overpayments.

The project was guided by an Advisory Committee whose members helped resolve conceptual issues and commented constructively on draft materials. Members included Gilbert Geis, University of California, Irvine; Steven Hitchner and Julie Samuels, U.S. Department of Justice; Norman Jacknis, former New York State Welfare Inspector General; Ronald Schwartz, Department of Health and Human Services; Alfred Ulvog, Department of Agriculture; and Philip J. Cook, Duke University. Carol Dorsey, National Institute of Justice, and James A. Carroll, Syracuse University, also provided valuable comments on draft materials.

National and regional officials of the Department of Health and Human Services, and legislators, program managers, and law enforcement officials in each of our case study states, provided invaluable information about their programs and their perspectives on fraud control issues. Our promise

to keep their specific insights confidential prevents us from acknowledging them by name.

Finally, we acknowledge our gratitude to our colleagues who managed to put our work into readable form--Patricia Quintana, Shirley Hentzell and Judith Davis of SRI International, and Alicia Reed, Agnes Foster, and Debra Sibert of the University of Illinois at Chicago.

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I THE NATURE AND EXTENT OF FRAUD AND ABUSE IN AFDC AND MEDICAID PROGRAMS

In the Great Depression of the 1930s, and again during the Great Society optimism of the 1960s, Congress and the state legislatures worked to expand social programs--to raise benefit levels, to change delivery systems to improve "outreach" to intended clients, and to humanize bureaucratic treatment of recipients. Although there was concern with program expenses and fraud control in the 1960's, it was in the 1970s that the emphasis in public debate intensified and turned to focus on ways to reduce program expenditures. General Accounting Office reports and Congressional hearings began to publicize mismanagement of social programs. Inspectors-General were appointed to oversee federal agencies, and the agencies themselves began to emphasize savings as major indicators of their accomplishments.

As anti-government movements and taxpayer revolts brought social programs under attack, the issue of "fraud, waste, and abuse" came to play a central role in the controversy. Debates over ways to improve social programs were overshadowed by exposés of welfare queens, Medicaid mills, poverty pimps, and nonexistent school lunches. By 1978, a defensive President Carter was appearing before a conference of 1,200 officials to proclaim, "This Administration has declared war on waste and fraud in government programs ... We are concerned with more than saving dollars, crucial as that is today. We must restore and rebuild the trust that must exist in a democracy between a free people and their government" (Carter, 1978: 21).

Two major targets of critics of social programs have been the Aid to Families with Dependent Children (AFDC) and Medicaid programs. In Fiscal Year 1981, 3.8 million families received payments totaling \$12.5 billion under the AFDC program, and 22.5 million people received services under the Medicaid program totaling \$22.8 billion (Office of Management and Budget,

1982.) Before detailing their fraud and abuse problems, we must describe how the programs work--how individuals apply for and receive benefits, how providers are reimbursed, and how the programs are funded and administered.

The Administration of State AFDC Programs

When Congress established the AFDC program in 1935, the federal government began funding state programs which complied with broad federal guidelines. States were given substantial latitude to define who would be eligible for AFDC benefits, what level of benefits would be offered, and how the programs would be administered. As a result, instead of one AFDC program, there are 54 (one in each state, plus in the District of Columbia, Guam, Puerto Rico, and the Virgin Islands.)

The amount paid to an AFDC family is determined by the composition of the "assistance unit" and its resources. The AFDC agency determines the unit's "need" by comparing available resources (in general, property resources and income from wages, child support payments, and other benefit programs) with a "standard of need" which reflects costs of essential basic living needs. A family with no resources will receive the full amount provided for a family of its size; payments will be reduced if resources are available, or an application will be denied if resources exceed the standard of need.

Procedures used to handle AFDC applications vary from state to state. All applicants are asked to complete an application form, and may be asked to document age, family composition and relationships, citizenship, residence, social security numbers for each family member, school attendance, resources, and expenses. Unless exempt, the applicant will also be required to register for the Work Incentive Program, to cooperate if necessary in efforts to establish paternity and collect child support payments, and to assign support payments to the state. Once the agency has verified application information, the family starts to receive periodic cash payments. Under federal regulations, the states are required to review each

case at least once every 6 months to determine if the recipient is still eligible and should receive the same level of benefits.

The federal government (the Office of Family Assistance in the Social Security Administration) pays 50% of each state's AFDC administrative costs and between 50% and 65% of the costs of benefit payments, depending on the per capita income of the state. In 11 states, counties pay a share of the nonfederal costs; the rest is paid by the states. Apart from certain monitoring efforts, the federal government plays no role in AFDC program administration. The day-to-day handling of applications and payments follows one of two basic patterns: 36 states have "state-administered" systems, in which local offices of the state welfare department process applications and issue checks; 18 states have "state-supervised" systems, in which the state only supervises the operations of local (usually county) welfare agencies. In both systems, local welfare offices process Food Stamp and Medicaid as well as AFDC applications. All AFDC recipients also receive Food Stamps and Medicaid benefits; some persons qualify for the latter programs without being eligible for AFDC.

State Administration of Medicaid Programs

The Medicaid program, created in 1965, provides federal funding for health care services delivered to persons who are receiving cash assistance from AFDC or the Supplemental Security Income program (covering aged, blind, or disabled persons), or who are "medically needy" (persons who fit within AFDC or SSI categories and have enough resources to pay their basic living expenses, but not enough to pay for their medical care.) All states cover AFDC and SSI recipients; 33 states also provide for the medically needy. Medicaid recipients are enrolled by the local welfare offices which process AFDC applications; these offices may or may not be part of the Medicaid agency.

The state Medicaid agencies contract with hospitals, nursing homes, physicians, pharmacies, and other providers to accept Medicaid patients,

requiring that they accept Medicaid fees as full reimbursement for services. While it arranges for provider participation and sets reimbursement rates, the Medicaid agency may contract with an insurance company or fiscal agent to process provider claims. The agency must monitor and audit providers' costs, and establish a system to refer appropriate claims to other sources ("third party liability"), e.g., insurance companies, the Veterans Administration, or Medicare, since Medicaid is designed to be only a "payor of last resort."

Each state's Medicaid plan specifies how providers will be reimbursed. Federal regulations require that hospitals and nursing homes be reimbursed on some reasonable cost basis, but the states can establish their own systems to reimburse other providers. The federal government (the Health Care Financing Administration) pays 50% of each state's administrative costs, and between 50% and 78% of benefit costs, again depending on the state's per capita income. HCFA will also pay 90% of the costs of developing automated claims processing and management information systems, and 75% of their operating costs.

Estimates of the Nature and Extent of Fraud and Abuse

Widely varying estimates of improper government expenditures often are due to the fact that people are talking about different things. Five distinct problems are often lumped together:

- Fraud usually refers to a violation of a civil or criminal statute, and involves intentional misrepresentation of facts for the purpose of obtaining unauthorized benefits from a program; the misrepresentation may involve either the provision of incorrect facts or the failure to provide correct facts.
- Errors involve program decisions which violate relevant rules, and may be intentional or unintentional, substantial or technical, and may be caused by the official (e.g., not knowing the rules, or incorrectly applying the rules to the facts) or the client. A decision involving an error could either incorrectly award benefits or incorrectly deny them.

- Abuse most frequently is used in a circular fashion to refer to "improper utilization of a program." While intentional fraud and unintentional error would also constitute "improper utilization," the term abuse usually refers to situations in which "benefits are obtained or used in ways which are not intended by those who design or administer programs, but which are not specifically prohibited by law or regulation" (Lange and Bowers, 1979: 15). Since there are no definitions of behaviors which were not "intended," apart from those which have been specifically prohibited, perceptions of abuse are quite elastic.
- Waste is a concept even more vague than abuse. In general, it refers either to ineffective expenditures (expenditures which do not accomplish programmatic goals) or inefficiencies, things which cost more than is necessary.
- Corruption, unlike the previous terms, specifically refers to actions by officials. Some definitions are formal in nature ("behavior which deviates from the formal duties of a public office for private wealth"); others are broader (e.g., "behavior of public officials which deviates from accepted norms in order to serve private ends.") (Definitions of corruption are discussed in Gardiner and Lyman, 1978: Chapter One). In some agencies, corrupt activities are termed "employee fraud."

Attempts to estimate the nature and extent of these problems in AFDC and Medicaid programs have been limited by serious data collection and labeling problems. Data collection is expensive, and is usually intended to serve a specific management purpose, e.g., to identify performance problems in a program or agency, not to address abstract research issues. Labeling an identified overpayment as fraud, abuse, or error is clouded both by the issue of intent (Did Mrs. Jones forget to report her babysitting job, or was she intentionally concealing this income?) and by ambiguities in applicable rules (Had a teen-aged son "left the family" if he spent only 10 days at home last month? Was it improper for the pediatrician to give every member of the family a complete physical examination when one child had a sore throat?) Compounding these methodological problems are problems of bias: data collectors and analysts may try to overstate or understate errors, in order to attack a benefit program or justify enforcement budgets, or to protect a program by blaming errors on a few welfare queens or Medicaid mills. Since the agencies which collect information about overpayments vary in their biases and their investments in measurement, it is almost impossible to compare their estimates.

Federal Quality Control Systems

The most systematic attempts to identify benefit payments in violation of federal and state regulations have been the Quality Control (QC) systems established for Food Stamps (1971), AFDC (1973), Supplemental Security Income (1974), and Medicaid (1975). The AFDC QC system, using both federal and state analyses, illustrates problems of measuring accuracy in recipient eligibility and payment levels. Every 6 months each state welfare agency draws a sample of cases to be reviewed (about 150 in the smaller states, and about 1,200 in states with more than 60,000 AFDC families). State QC reviewers look at these case files to determine the accuracy of the grant amount and the recipient's eligibility; factors such as family income, resources, and other grant requirements are verified through contacts with persons such as recipients, landlords, and employers. The reviewers calculate "case error rates" (proportions of ineligible cases, overpaid but eligible cases, and underpaid cases) and "payment error rates" (the proportion of erroneous payments in each case error category). (A smaller set of cases in which the agency has denied applications--"negative case actions"--is also reviewed.) QC staff from the regional offices of DHHS then select a subsample of the cases reviewed by the states, and re-review them to assess the accuracy of state conclusions. After federal-state differences on individual cases have been resolved (DHHS has the final word), official state error rates are computed.

Nationally, the AFDC quality control reports for the period April to September of 1980 indicate that 5.0% of the cases reviewed were ineligible, 10.2% were eligible but overpaid, and 4.3% were eligible but underpaid. Payments to totally ineligible cases amounted to \$215 million; overpayments to eligible cases amounted to \$176 million. Client errors (not reporting information or reporting incomplete or incorrect information) occurred in 8.2% of all cases, and 47% of the error cases. Client errors accounted for 80% of all resource errors and 53% of errors concerning earned income and other benefit program receipts (Social Security Administration, 1982). (Error rates and their corrective action implications are examined in depth in Bendick, 1978.)

Recipient Fraud: Implications of Recipient Surveys

Quality control systems have been criticized for a variety of reasons. In Part III, we will discuss the criticisms which focus on their fiscal sanction implications, including proposals that states with high error rates will receive reduced federal cost-sharing, and their potentially dysfunctional effects (that pressures on the welfare agencies to reduce errors will cause them to give short shrift to other goals such as service to recipients, speedy processing of applications, efficiency, etc.). At this point, we will note that for both substantive and methodological reasons, quality control surveys are only imperfect measures of the extent of recipient fraud in a benefit program. Substantively, their focus on "errors" (awards in violation of regulations) avoids the issue of intent: client errors may correctly indicate causality but mingle intentional concealment with such things as forgetfulness, ignorance, and laziness. Methodologically, the QC process may encourage intentional data suppression by state reviewers who want to make their agency look good, an overrepresentation of errors which are easy to find (regular jobs reported to the Department of Labor, school attendance, etc.) and, most importantly, underrepresentation of more easily concealable assets, income, and family structure factors. Since the reviewers do not conduct full-scale criminal-type investigations of the recipients whose files they are examining, they are heavily dependent upon official records, statements by banks or employers they know about (e.g., present or past employers identified by the recipient), and the statements made by the recipients themselves (Richardson, 1977; General Accounting Office, 1980 and 1981).

A unique opportunity to go beyond the findings of the QC reviews was provided by the Seattle and Denver Income Maintenance Experiments (SIME and DIME). SIME, running from 1970 through 1976, and DIME, running from 1972 through 1977, were the largest of four income maintenance experiments conducted by the federal government to simulate conditions in which there was a universal negative income tax. In the experiment, a treatment group received grants similar to but more generous than AFDC; a control group received no grant but was allowed to participate in other welfare programs,

including AFDC. During the experiments, both treatment and control households were interviewed approximately three times a year by interviewers from Stanford Research Institute (SRI); respondents' statements were not reported individually to the local welfare agencies or to the federal sponsors.

Extensive efforts were made in the interviews to record the structure of the family and each member's earnings and employment. Data were also collected directly from the welfare agencies on control families who reported participation in AFDC. Thus it is possible to compare the data reported to AFDC with the data reported to the SRI interviewers. (Since SIME/DIME and AFDC defined family units differently, it was necessary to reconstruct the SIME/DIME data to match the AFDC families.) Analysis of 848 households in Seattle and 1,294 households in Denver produced the following findings (Halsey, Nold, and Block, 1982):

- (1) About one-half of the households in each city had reportable income. Of these, one-quarter of the Seattle households and one-third of the Denver households reported no income to AFDC. The average amount of monthly earnings not reported to AFDC by households which reported income to SRI was \$322.36 in Seattle and \$354.45 in Denver. The earnings of male heads of households were far less likely to be reported than female heads; income by nonhead members of the family was rarely reported. About one-quarter of nonwage income (primarily alimony and other government benefits) was reported in Seattle, and about one-half in Denver.
- (2) With regard to family structure, 47% of the Seattle households and 42% of the Denver households failed to report the existence of male heads, and 8% (Seattle) and 9% (Denver) overreported children (i.e., reported children who either did not exist or did not live in the household).
- (3) Aggregating the effects of income and family structure misreporting, Halsey, Block, and Nold concluded that the total amount of annual overpayments in Seattle was between \$1.4 and \$7.1 million; in Denver, the range was between \$2.0 and \$9.9 million.
- (4) In terms of types of misrepresentations, they concluded that AFDC recipients tend to overstate the number of nonincome earning dependents but understate the number of family members capable of earning income (male heads, teenagers), and to report only a fraction of wage and nonwage income. When the family acknowledges

a particular source of income (e.g., a specific job), it tends to report a high percentage of the income from it; other sources are not reported at all.

As we have indicated, the SIME/DIME data are a unique source of recipient-reported data on income and family structure. It is likely that the SIME and DIME households concealed some information from the SRI interviewers, so Halsey, Nold, and Block's conclusions probably miss some fraud. We have no way of knowing whether Seattle and Denver families are more or less likely than other American AFDC families to misrepresent facts in reporting to AFDC agencies. However, if we make the assumption that there is a nationally constant proportion of overpayments in AFDC caseloads, then national estimates such as those presented in Table 1 are possible. Dividing the Halsey et al. estimates of overpayments by the number of AFDC families in the two cities, we can produce low (line D) and high (line E) estimates of overpayments per AFDC family. Multiplying these estimates by the total number of AFDC families in 1980, we can derive low (line G) and high (line H) estimates of the national overpayment problem: AFDC overpayments may range from \$376 million to \$3.2 billion annually.^{1*}

Provider Fraud and Abuse

Unlike the problem of recipient fraud and error, no statistically valid surveys of provider fraud and abuse exist. The Medicaid quality control system checks a sample of Medicaid claims, but error findings indicate only that a payment violated a program rule (e.g., by paying for a service not covered, by paying an incorrect amount); QC reviewers do not check to see if the service was provided as claimed. While Medicaid agencies annually report "overpayments identified" and the penalties levied on participating providers, they do not systematically seek to measure which types of provider services are most frequently abused and to what extent. The agencies that audit and investigate Medicaid providers concentrate their

* Notes are listed at the end of the report.

Table 1
ESTIMATES OF AFDC OVERPAYMENTS NATIONWIDE, BASED ON SIME/DIME DATA

	Seattle	Denver	Nation
A. City AFDC Families, approximate average, 1974-1975 ¹	14,500	11,400	
B. Low estimates of annual overpayments	\$1,420,236	\$1,975,032	
C. High estimates of annual overpayments	\$7,101,178	\$9,875,175	
D. Low estimates of overpayment/family (B/A)	\$97.95	\$173.25	
E. High estimates of overpayment/family (C/A)	\$489.74	\$866.24	
F. Number of AFDC families in the nation, 1980 ²			3,842,534
G. Lowest estimate of total annual overpayment (FxD)			\$376,376,205
H. Highest estimate of total annual overpayment (FxE)			\$3,328,556,652

¹ Source: Halsey, Nold, and Block (1982).

² Source: Social Security Administration (1980: 8).

attention on those providers who receive the most payments (hospitals, nursing homes, and poverty area group practices, or Medicaid mills) and on those whose billing practices are significantly different from their peers; such emphases increase the opportunities for agencies to recover overpayments and to apprehend particularly greedy providers, but they do not lead to representative data on fraud and abuse problems. In 1979, the Inspector-General of HEW estimated that "Medicaid fraud and abuse, including unnecessary nursing home costs" in 1977 amounted to \$668 million, with the notation "Number is incomplete and probably low" (HEW, 1979: 192). No indication was given as to how the estimate was derived, or the distribution of fraud and abuse among different types of providers. In 1982, the House of Representatives Select Committee on Aging concluded, "The best estimates place the extent of fraud and abuse from 10 to 25 percent of the entire Medicaid program" (House Select Committee on Aging, 1982: 10). Perhaps acting on these estimates of the magnitude of provider fraud, the HHS Inspector General, in 1982, refocused its enforcement efforts from a balanced attack on recipients and providers to a concentrated attack on individuals and institutions suspected of defrauding or abusing the Medicaid program.

Conclusion

A variety of definitions have been given to fraud, abuse, and related concepts. No data systems exist which specifically measure fraud. The "client errors" identified by quality control systems indicate that misrepresentations by recipients amount to many millions of overpaid dollars each year; the unique SIME and DIME data suggest that many cases are not discovered by the QC review process. While no comparable data exist on Medicaid provider fraud and abuse, many insiders in welfare agencies believe that its scale far exceeds losses due to recipient fraud.

II STATE RESPONSES TO FRAUD CONTROL PROBLEMS

While federal funding agencies require that state AFDC and Medicaid agencies develop plans to reduce erroneous payments (and control fiscal rewards and penalties for errors), basic decisions about the nature and extent of fraud control efforts are made by state and local, not national, agencies. They decide whether to accept recipient application and provider claim data at face value or to engage in extensive verification efforts, and whether to ignore discovered fraud or impose penalties. The extent, comprehensiveness, and effectiveness of fraud prevention and enforcement programs therefore depend on state decisions about which control strategies to adopt, and how actively to pursue them.

Interviews with federal officials and our research in Colorado, Illinois, and Washington led to the following general conclusions about state fraud control efforts:

- (1) Legislative and administrative decisions about fraud control issues are closely linked with decisions regarding health and welfare policies, budgetary issues, intergovernmental relations, agency management, and crime control.
- (2) Welfare administrators, while under pressure to reduce costs and errors, have little incentive to punish recipients beyond asking them to repay excess assistance. While provider fraud and abuse cases are generally larger than recipient fraud cases, the welfare agencies emphasize recovery of overpayments rather than prosecution in most cases.
- (3) Criminal justice agencies often have little interest in fraud cases. Most recipient fraud cases involve small dollar amounts;

except for the larger, aggravated cases, they seem less important than other forms of crime. Provider cases, while involving larger dollar amounts, are usually difficult to investigate and are unlikely to lead to significant sentences. Few recipient or provider fraud cases lead to criminal prosecution.

Policy Issues Affecting Fraud Control

The relatively limited emphasis which is placed on fraud control, and the techniques used for prevention and enforcement, are not only products of decisions about fraud and abuse problems, but are also the by-products of decisions about other issues. For most of the groups participating in these decisions, issues of fraud and abuse are less important than other matters--how society should handle health and welfare problems, how governmental functions should be allocated among federal, state, and local governments, how government budgets should be distributed, and how the criminal justice system should function. As fraud and abuse became major public issues in the mid-1970s, they were thrust into a policy formulation and implementation system which was structured along other lines. At federal, state, and local levels, other issues and priorities had already determined legislative committee systems, the organization chart of the executive branch, criminal justice procedures, and the priorities of major professional associations and interest groups. Except for the relatively narrow issues which concerned only persons who were already active in fraud control, fraud and abuse had to stand in line to compete for attention.

Welfare policy issues concern the level of welfare benefits and the procedures used to distribute them; recipients and their advocates compete with fiscal conservatives for legislative and gubernatorial support. Health policy issues involve both the range of services to be offered to recipients and the reimbursement to be given providers; providers try to convince the legislature that reimbursement should approximate private patient care rates. Criminal justice issues include both substantive questions--the definition of fraud and the penalties to be assessed--and the structure of

the enforcement system; some states established separate units to process fraud cases, while others rely on existing investigation and enforcement systems, requiring the setting of priorities both among fraud cases and between fraud and other types of crimes.

Three other sets of issues affect funding and administration. Fiscal issues concern both the allocation of government funds among programs and the sources of those funds. What should be the scale of government expenditures and how should they be allocated? Which levels of government should fund welfare programs and control their administration? Within welfare systems, how should control be divided--between the federal Department of Health and Human Services and state welfare agencies, and between the state agencies and their local or county offices?

Unless scandals or taxpayer revolts precipitate crises, voters, taxpayers, and the mass media are uninvolved in the resolution of these issues. Public attitudes are ambivalent, sympathizing with the plight of the poor yet feeling that government costs should be contained and that defrauders should be punished. The governors and legislators who set agency policies and budgets, however, must become involved in these issues. Depending on the relative numbers of recipients and providers among their constituencies, they may seek to increase grant levels or reimbursement rates, or to strengthen control efforts. Since they usually wish to avoid tax increases, and since other programs and lobbies are competing for funds, governors and legislators often wish to avoid close involvement with welfare and fraud issues, letting the welfare system and criminal justice agencies take the heat for low benefit levels, high costs, and any fraud or abuse which becomes known.

Recipients' and Providers' Perspectives

In the AFDC program, the size of grants depends on the number of dependents included in the assistance unit and the resources available to support it; overstating dependents or understating resources therefore work

to the recipient's advantage. Providers can likewise increase their Medicaid receipts by claiming additional services, labeling a service at a higher level, or inflating hospital and nursing home costs. A less obvious incentive to cheat comes from the fact that providing information to the welfare agency is time-consuming and possibly risky. A provider may feel that it is not worth his time and effort to verify a patient's Medicaid eligibility, third party liability, or even that the person in his office is Jane Smith; to call Medicaid to determine whether the service rendered should be marked Code X or Code Y is more work than to claim whichever service pays more. More importantly, asking too many questions may invite the caseworker or claims processor to scrutinize your file more carefully.

If recipients and providers have no financial incentives to support fraud control, do they have normative or ethical incentives? Frequently, ambiguities in program regulations and recipients' ignorance of bureaucratese mean that misstatements arise from ignorance or error rather than fraudulent intent. But many recipients and providers may regard the welfare agencies with hostility and contempt. Caseworkers may be seen as hostile policemen, prying into recipients' personal affairs in order to fill out meaningless papers; providers may regard claims processors as mere clerks who know nothing about health care or economics. Cooperating with fraud control efforts means turning in people like yourself--fellow providers or basically poor people. The health care professions have historically rejected the notion that anyone other than "peers" can evaluate medical decisions, so they have fought proposals to open providers' records to scrutiny by Medicaid investigators.

Compounding these financial incentives to cheat and the lack of normative support for fraud control is the absence of any significant threat of penalties: few penalties are imposed and most penalties are trivial. A high proportion of fraud is never detected, most of the known cases lead to no action, and most of the cases where action is taken require only reimbursement rather than additional penalties. Even when reimbursement is requested, the welfare agency will usually settle for a promise of partial payment and then take few steps to collect it. Most welfare recipients have

few assets which can be seized, and few providers will be put out of business or terminated from the Medicaid program. While all studies have concluded that the majority of recipients and providers do not cheat, their honesty cannot be explained by either financial incentives or the deterrent effects of fraud control programs.

Program Administrators' Perspectives on Recipient Fraud Control

Except in those cases in which a tipster has turned in a welfare cheat, the identification of ineligible or overpaid recipients depends on the efforts of the welfare agency to verify information supplied by the applicant. Verification may involve conducting home visits with potential recipients or contacting secondary information sources. These contacts may include letters, calls, or computer-based inquiries to employers, banks, schools, and other government agencies to obtain independent confirmation of information provided by an applicant. Although most states now employ extensive verification methods, the philosophy attached to verifying eligibility information at application has undergone a significant shift in recent years. During the 1960s, federal initiatives and regulations encouraged welfare agencies to base AFDC eligibility, as far as possible, on the information volunteered by applicants. Extensive verification was discouraged in favor of increasing agency responsiveness to recipients and decreasing the extent of intrusion into their personal lives as a requirement of program participation. By the early 1970s, however, concerns that de-emphasizing verification encouraged fraud in the AFDC program led to the policy reversal that now characterizes the program--one which encourages independent verification of at least some of the information provided by applicants (Congressional Research Service, 1977: 30).

Eligibility for AFDC assistance and the amount of assistance available to a family can change substantially over time. Changes in circumstances, such as an increase or decrease in income, changes in family composition, or changes in living expenses may not only affect the amount of the AFDC grant, but may also render a family ineligible for the program. Federal

regulations require states to establish procedures to ensure that alterations in circumstances are systematically brought to the attention of welfare agencies so that grant adjustments can be made.

Two processes are used by welfare agencies to ensure that adjustments are made--client reporting and redetermination of eligibility. In all states, AFDC recipients are informed at application of their responsibilities to report changes in their status which might affect their eligibility for assistance. A welfare agency might require a recipient to report, as a condition of continuing eligibility, such matters as changes in income, family composition, residence, school attendance, and participation in work or training programs. Recipients are first informed of their reporting responsibility when they complete the AFDC application. At this time, they typically are asked to sign an application which includes a certification that they will report status changes that might affect their eligibility. Signing the AFDC application is an acknowledgment that the recipient understands that failure to report changes in status may result in criminal penalties.

State practices with regard to reporting vary widely. Some states systematically mail AFDC recipients a change of status/reporting form periodically (monthly or quarterly). In those states that utilize periodic reporting forms, some require that it be returned to the welfare agency only if a change in status has occurred, while others require that the form be returned regardless of any change. Failure to submit the form in the latter case is often reason for the agency to terminate or delay payment of AFDC benefits. In practice, reporting procedures in most states usually focus on recipients' income because of the high potential for change and the prevalence of abuse by recipients when reporting this information (Congressional Research Service, 1977: 88).

Eligibility for benefits under the AFDC program is not a permanent condition. Regulations require that AFDC eligibility be formally redetermined at least every 6 months. The intent of these regulations is to insure that AFDC cases are comprehensively reviewed so that those in error

not continue for long periods of time. The redetermination process, like the application process, also differs significantly among the states. For example, redetermination procedures often vary in the degree to which specific information is reviewed, the kind of documentation required, and the extent to which (and methods by which) information is verified. The redetermination procedures in a state may involve practices as complete as the process of initial application or they may involve a simpler procedure in which only certain facts are checked and reverified (Congressional Research Service, 1977: 40-44; Bendick, Lavine, and Campbell, 1978: 41-51).

The frequency with which AFDC cases are redetermined also differs among states. Some states follow the minimum federal requirements and conduct redeterminations every 6 months. Other states perform redeterminations more often, especially for certain types of cases. For example, states may require more frequent redeterminations for cases in which the father is present in the home or in cases where recipients have earned income, because these cases are considered to be potentially more likely to involve errors or fraud.

In deciding how actively to pursue the verification efforts which will uncover recipient fraud, AFDC agencies must deal with both goal conflicts and resource problems:

- (1) Maximizing accuracy (minimizing overpayments or the enrollment of ineligible recipients) can decrease service delivery. A 1978 analysis of AFDC errors by the Urban Institute pointed out that "corrective actions to reduce errors can result in decreased accessibility to benefits by legitimate claimants:

"Pressure on eligibility workers to rule conservatively on discretionary matters and thereby reduce ineligibility and overpayment errors may generate an increase in underpayment errors and incorrect denials of eligibility.

"Increases in frequency of reporting or the extent of documentary verification required of clients increases the burdens on clients and the rate of denial of applications for failure to comply with procedures.

"Requiring more extensive case investigation by eligibility workers, if not accompanied by increase in staff, may result in delays in processing applications." (Bendick, 1978: 36-37)

- (2) Maximizing accuracy costs money. The Urban Institute study concluded that "reduction of error rates is associated with rises in administrative costs. In such circumstances, the concern that the incremental rise in administrative cost under a program of further corrective action might be larger than the incremental savings in payment errors avoided is a legitimate concern" (Bendick, 1978: 34). A 1977 study by the House Agriculture Committee estimated that "complete verification of every aspect of a Food Stamp application would take twelve hours and would cost eight times as much in additional salaries as it would save in reductions in fraud and error" (Stover, 1981: 21).
- (3) Maximizing one or more of these goals may conflict with other, nonprogrammatic goals, such as maintaining good relations with recipients, legislators, or work associates. Recipients and sympathetic legislators may rebel against increased "harrassment," caseworkers and their unions may object to increased paperwork, etc.

Even when, in spite of these problems, they decide to emphasize fraud control, administrators face other difficulties. They often have little control over the day-to-day work of local office caseworkers, and cannot force criminal justice agencies to prosecute. They also may know little about the consequences of corrective action programs. The quality control system provides information about the types of fraud which exist in the program (unreported income, absent children, etc.) and thus identifies targets for a corrective action program, but it does not tell the administrator who is causing the problem (which offices or workers are more accurate than others) or what response, if any, will solve it. In part, this is a result of the small sample size of the QC process; while sufficient to measure statewide error rates, the samples are not statistically valid for local offices. Even where the states draw larger

samples to measure office-level error rates, so few fraud cases are found that the administrator can't reach statistically meaningful conclusions about the causes of fraud or the effectiveness of different response options. As a 1980 study of AFDC administration in Wisconsin concluded, "For most local agencies in this state neither the critical information on quality nor appropriate local procedures to monitor quality are presently available" (Witte, 1981: 28).

Finally, many administrators conclude that they have few incentives to control fraud:

- (1) Incentives to control fraud are usually less significant to administrators than incentives to maintain the flow of benefits to recipients. Therefore, fraud control strategies which interfere with routine case intake and case management processes will be adopted less frequently than strategies which do not interfere.
- (2) Incentives to control fraud are less significant to administrators than incentives to control costs and errors. Fraud control strategies which will reduce costs and errors will be adopted more frequently than strategies which increase, or leave unaffected, costs and error rates.
- (3) Incentives to control fraud will be increased by threats to the autonomy of the agency. Such threats can be caused by scandals, legislative investigations, or fiscal crises.
- (4) Disincentives to control fraud will be reduced if the costs of control efforts are absorbed by someone else (e.g., if another level of government will fund control efforts, if another agency will provide the staff to handle investigations and prosecutions, etc.).
- (5) The distribution of incentives to control fraud is inversely proportional to opportunities to control fraud. Federal and state

administrators face the strongest incentives but the weakest opportunities, while local caseworkers have the most opportunities but the fewest incentives to do anything about fraud.

As a result of these problems, administrators are likely to respond to suggestions that they reduce recipient fraud with feelings of helplessness, confusion, and anger. They feel helpless because of the fragmentation of power among levels of government and among the thousands of workers who alone can catch most mistakes. Also, resources allocated to fraud control must be taken away from some other function. They feel confused because they get conflicting signals from the public, the legislature, and others as to what they should do, and because there are no "magic bullets" which can be shot at fraud targets. Finally, they feel angry, but at two very different groups. Certainly they are angry at the aggressive defrauders who rip off the system, but they are also angry at outsiders who use the occasional welfare queen to denounce the welfare system. Program administrators might say: "These people are poor. Does it really matter that much if some of them are making a few extra dollars on the side? Is recipient fraud really important enough to justify warfare between federal agencies and the state, and to turn the caseworker into a spy?"

Thus, any measure that is presented to program administrators as worthy of adoption to prevent fraud must:

- Be fraud-specific (thus profiles of persons likely to engage in fraud may result in disallowing or hindering persons who seem to fit the profile, not persons committing frauds).
- Cause a minimum of intrusion and difficulty.

Program Administrators' Perspectives on Controlling Medicaid Provider Fraud and Abuse

When the Medicaid program was created in 1965, recipients, providers, and state agencies shared a common interest in an expansive approach to implementation; getting recipients into the system and payments out to providers overrode concern for the development of systems to control

expenditures. Just as the AFDC agencies could decide how extensively to verify recipient application information, the Medicaid agencies had to decide whether to encourage provider participation with high reimbursement rates and simple and rapid claim processing, or to build controls into their administrative systems. Table 2 illustrates aspects of "provider" and "control" orientations.

Most state agencies initially adopted a provider orientation, because it reflected the intent of the Congressional legislation, because it was believed necessary in order to induce providers to participate, because provider groups were politically powerful in many states, and because most agencies lacked the technical capacity to develop monitoring systems. Until the late 1970s, most agencies also felt little financial incentive to control provider costs; when fiscal stress arose, however, the states often found themselves without a mechanism to identify fraudulent or abusive claims. To address this problem, DHEW began in 1970 the development of a model Medicaid Management Information System (MMIS), whose Surveillance and Utilization Review System (SURS) was intended to:

- Develop, over time, a comprehensive statistical profile of health care delivery and utilization patterns established by provider and recipient participants in various categories of service authorization under the Medicaid program.
- Reveal, for further investigation, potential misutilization and promote correction of actual misutilization of the Medicaid program by its individual participants.
- Provide information which will reveal and facilitate the investigation of potential defects in the level of care or quality of service provided under the Medicaid program.
- Accomplish the substantive objectives stated above with a minimum level of manual clerical effort and with a maximum level of flexibility with respect to management objectives. (General Accounting Office, 1978: 32)

After 12 years, the SURS systems have yet to fully meet these objectives. Many states had problems in developing operational MMIS systems (see Thompson, 1981: 135-37). Even when states solved their basic programming problems, analytical and staffing difficulties remained.

Table 2
AGENCY POLICIES TOWARD PROVIDERS

Provider Orientation	Control Orientation
Rates approaching costs or private patient rates	Lowest possible rates to procure services
Simple enrollment process	Comprehensive enrollment process
Simple claim forms	Comprehensive claim forms requir- ing detailed documentation of services
Simple prepayment screening of claims	Prepayment analysis of all elements of claim
Rapid reimbursement	Thorough claims review prior to reimbursement
Minimal post-payment audit and investigation	Systematic analysis of utilization patterns and investigation of aberrant practices

Developing statistical profiles requires both categorization of recipients and providers and accumulation of historic data; determining what constitutes "significant departure from normal medical practice" requires some definition of "normality"; and analysts must be available in sufficient numbers and with sufficient training to review the profiles generated by the computer. A 1978 study by the General Accounting Office concluded that states were having difficulty satisfying these requirements (General Accounting Office, 1978: Chapter Four). There is disagreement or uncertainty as to the appropriate composition of comparison groups, as to whether "normal medical practice" should be defined statistically (e.g., by the average treatment reflected in claims data) or by panels of experts, and as to methods of selecting which of the thousands of "exceptions" flagged by the computer are most likely to merit detailed investigation (Thompson, 1981: 142-148). The GAO report concluded, "States are uncertain as to what indicates abuse and/or how many indicators are needed. This uncertainty is perpetuated because the [SURS] system has no capability to determine which indicators do the best job of identifying potential abusers who are found to be abusers when investigated. This missing link--identifying which indicators best identify abusers--has not been developed" (General Accounting Office, 1978: 34).

While their incentives systems have changed so as to move administrators toward a control orientation, and technological developments have improved their ability to know where to look for problems, administrators still must make decisions concerning resource allocations and responses to individual fraud and abuse cases. The resource allocation problem for Medicaid program administrators, as opposed to the leaders of control programs, is one of deciding what proportion of staff and other resources to devote to control (SURS, audit, and investigation) rather than other functions (e.g., provider relations and claims processing). State administrators have to deal with finite administrative budgets and personnel ceilings, even though HCFA pays 75% of MMIS (and SURS) costs. No matter how obvious the cost-effectiveness of additional expenditures (e.g., that each extra auditor will recover ten times his salary), the administrator may not

be allowed to make them, and may well conclude that he also cannot afford to take funds and staff away from other functions.

A more troublesome problem is what to do once fraud or abuse has been proven by agency auditors or investigators. Bruce Stuart notes:

Counting subtle distinctions, intervention strategies are unlimited, but they can be classified into some ten basic options according to degree of governmental coercion. The least coercive strategies include two forms of moral suasion designed to induce voluntary change in provider or recipient behavior: (1) public pressure through disclosure and "jawboning" and (2) institutionalized peer pressure. Potentially more coercive are four methods of tying reimbursement to "approved behavior:" (3) prior review, (4) prior authorization, (5) concurrent review, and (6) postdelivery denial of payment. The most coercive options are administrative and judicial: (7) restrictions placed directly on recipient utilization and/or provider delivery, (8) cancellation of program affiliation, (9) payment retrieval proceedings and civil penalties, and (10) criminal prosecution (Feder, 1980: 458-9).

We will consider later a number of the evidentiary and procedural problems presented by each of these alternatives. With regard to the perspectives of administrators, however, we might note that pursuing these alternatives involves different costs. As Judith Feder and John Holohan point out, "Identifying and proving fraud, that is, willful intent, are difficult and expensive. Despite glaring examples in newspaper accounts, the line between abuse and 'defensive medicine' is difficult to establish. It is not surprising that states are somewhat unwilling to devote extraordinary resources to the differentiation. Advocates of increased monitoring efforts often overlook the fact that the costs of limiting overprovision can be quite high once the most glaring problems are eliminated" (Feder, 1980: 52).

While it is difficult and expensive to document and defend charges of fraud or abuse, it is comparatively simple to disallow claims (putting the burden of proof on the provider to establish that services were provided). It is also less difficult to terminate a provider from the program than to win a civil or criminal prosecution. The response selected in all likelihood is based on two factors--the nature and magnitude of the offense

and whether the agency wishes to continue to utilize the provider. If the offense involves only a small amount, Stuart's first six options are likely to seem sufficient. If the offense involves large-scale and repeated transgressions, and/or there are indications that the provider is also practicing bad medicine, however, the agency is more likely to want to be rid of him or her. Termination, accompanied by disallowance of claims, will thus provide some measure of cost savings and prevent a large measure of future harm, and can be accomplished through the agency's internal sanction processes.

Control Agency Perspectives on Recipient Fraud

From the point at which a welfare recipient is initially suspected of fraud to the point at which the case is closed, a series of filtering decisions are made--decisions which move the case closer to civil or criminal adjudication, divert the case via administrative action, or end the process with nothing being done. Investigators scan leads from a variety of sources, referring some to prosecutors; prosecutors scan these referrals and file formal civil or criminal charges on some; judges (and occasionally juries) determine guilt and pass sentence. At each stage in the process, decisionmakers can conclude that suspicions were unfounded, that further action is inadvisable or not cost-effective, or that other actions (grant reduction or termination, recoupment of overpayments through grant reductions, or voluntary repayment agreements) are appropriate dispositions.

The general effects of this filtering process can be seen in Table 3 which presents AFDC data for Fiscal Years 1971 through 1980 from the annual report, "Disposition of Public Assistance Cases Involving Questions of Fraud," compiled by the Department of Health and Human Services from data submitted by each state welfare agency. The columns headed "Administrative Disposition" list all cases in which a question of fraud has been raised ("Total Cases"), cases in which the agency has concluded that there is "sufficient evidence to support a question of fraud" ("Facts Indicating

Fraud"), and cases which have been referred to a prosecutor. The "Legal Disposition" columns, while supplied to DHHS by the welfare agencies, are based on prosecutors' records; there is an unexplained loss of some cases between the cases referred for prosecution (B) and the total cases processed by the prosecutors (C), even allowing for a time lag. The "Dispositions/Families" columns divide referrals and prosecutions by the number of AFDC families supported each year.

In interpreting Table 3, we must recognize that state agencies are very likely to vary in their definition of a "case" (some may list any case where a question has been raised, while others may include only those which have been checked out), on when they feel that there is supporting evidence, and on when the case has been "referred" (some agencies may list all cases where they have requested prosecution, and others may list only those which the prosecutor has agreed to take). If we assume that these problems remain constant over time, Table 3 shows that from 1971 to 1980, there was a seven-fold increase in the number of cases with "Facts Indicating Fraud," a five-fold increase in referrals for prosecution, and a four-fold increase in actual prosecutions. Controlling for the expansion of the AFDC population, referrals (B/E) and prosecutions (D/E) roughly tripled. Looking at rates of response to those cases in which there were facts indicating fraud, however, we can see that the rate of referral (B/A) fell from over 50% to less than 40%, and the rate of prosecutions (D/A) fell from 26.4% to 15.6%. If we assume that these data reflect actual policy changes rather than improved reporting systems or changing definitions, then the welfare agencies were becoming more active in identifying fraud problems and, in absolute but not proportional terms, sending defrauders to court. Prosecutors were similarly increasing the number of fraud prosecutions, but continued to file charges on only 40-50% of the cases they considered. Overall, the proportion of the AFDC caseload referred for prosecution rose from .5% to a high of 1.5%, and actual prosecutions rose to a high of .7%.

We noted earlier that welfare agency administrators are primarily interested in the cost containment aspects of recipient fraud; once grant awards have been corrected and recovery procedures initiated, they have

TABLE 3

DISPOSITION OF SUSPECTED AFDC FRAUD CASES BY WELFARE AGENCIES AND PROSECUTORS

Fiscal Year	Administrative Disposition				Legal Disposition				Dispositions/Families		
	Total Cases	Facts Indicating Fraud	Referred for Prosecution	Referral Rate	Total Cases	Prosecution Initiated	Prosecution Rates		Total AFDC Families	Referrals/Families	Prosecution/Families
							(D/C)	(D/B)			
	(A)	(B)	(B/A)		(C)	(D)			(E)	(B/E)	(D/E)
1971	41,767	18,907	10,331	54.6%	10,083	4,988	49.5%	26.4%	2,587,000	.40%	.19%
1972	58,851	30,036	17,125	57.0	16,202	8,732	53.9	29.1	2,934,924	.58	.30
1973	98,201	49,907	25,932	52.0	22,000	9,174	41.7	18.4	3,141,407	.83	.29
1974	110,597	63,699	29,542	46.4	25,001	13,126	52.5	20.6	3,178,210	.93	.41
1975	144,306	80,974	39,651	49.0	38,390	17,982	46.8	22.2	3,365,812	1.18	.53
1976	166,342	86,842	40,721	46.9	37,395	18,475	49.4	21.3	3,573,038	1.14	.52
1977	183,190	106,687	43,611	40.9	40,901	21,857	53.4	20.5	3,426,147	1.27	.64
1978	220,870	143,449	51,926	36.2	43,291	23,936	55.3	16.7	3,412,654	1.52	.70
1979	225,858	133,847	52,037	38.9	42,300	17,263	40.8	12.9	3,377,498	1.54	.51
1980	248,262	145,783	37,720	25.9	39,938	22,780	57.0	15.6	3,464,761	1.09	.66

Sources: Data on administrative and legal dispositions are taken from the annual E-7 report, Disposition of Public Assistance Cases Involving Questions of Fraud. Until FY 1976, the E-7 report was issued by the National Center for Social Statistics of DHEW's Social and Rehabilitation Service; since FY 1977, the report has been issued by the Office of Research and Statistics of the Social Security Administration. Data on families receiving AFDC payments is taken from the A-2 report, Public Assistance Statistics, issued monthly by the same office. January statistics are presented for each year.

Definitions: The E-7 reports are compiled from data submitted by state welfare agencies. For the columns listed in the table as "administrative disposition," the agencies were instructed to include all cases in process where a suspicion of fraud had been raised (the "Total Cases" column); the "Facts Indicating Fraud" column includes cases in which the agency has concluded that there is "sufficient evidence to support a question of fraud;" "Referred for Prosecution" lists cases which the welfare agency has "referred to the agency empowered to prosecute." The columns listed as "legal disposition" provide data on case actions by "agencies empowered to prosecute cases;" "Total Cases" includes both prosecutions initiated and cases which were disposed of without prosecution.

little incentive to seek additional penalties. This perspective may help to explain the fact, shown in the B/A column in Table 3, that welfare agencies send less than one-half of their substantiated fraud cases to prosecutors for further action. People with control responsibilities (investigators, prosecutors, and judges), however, have somewhat different perspectives on recipient fraud. Most of the cases which are referred to control agencies contain clear indications that the recipient received excess assistance, providing a sufficient basis for recoupment or repayment actions. It is more difficult, however, to prove intent--that the recipient "willfully and knowingly" defrauded the welfare agency. In some "aggravated cases," controllers will find that the recipient systematically deceived the agency by establishing fictitious social security numbers, concealing a full-time job, claiming nonexistent children, etc.; in other cases, the recipient has only failed to report changed circumstances, the agency has failed to conduct redeterminations, or the issue of mens rea or moral culpability may be in doubt.

Out of their assessment of the facts of each case, modified upward or downward by aggravating or mitigating circumstances, controllers form an impression of what should be done. Whether they act accordingly, however, is influenced by their perceptions of how other controllers will look at the case: Investigators in the welfare agency will try to anticipate the reactions of prosecutors, and prosecutors will try to anticipate the reactions of judges. Since each succeeding filter in the control process becomes more selective, investigators must consider whether prosecutors will agree to file charges and prosecutors must consider whether judges will convict and impose sentences worth the effort. Cases which clearly fit these expectations will be moved along, as will some cases whose fit is more ambiguous. Aggravated cases that anger controllers will be processed even if they are likely to be dismissed, in order to punish the offender with the embarrassment and inconvenience of prosecution.

Finally, individual cases are assessed in terms of the amount of work involved in each possible disposition. Glancing at a case file and saying "no," of course, is easy; the file is sent back to the welfare office for

administrative action. How much work is involved in seeking prosecution, and who will have to do the work, depend on the nature of the case and work assignments in the control system. A fraud case based on documents (unreported wage receipts, other government benefits, etc.) is simpler than a case which requires extensive interviews (e.g., to confirm cash income, a returned spouse). Some control agencies can call on welfare personnel to do this legwork and only have to fill out the necessary papers to issue an indictment; others have to do the work themselves, or will want to corroborate conclusions reached by prior investigations.

At each stage of the control process, investigators, prosecutors, and judges can alter the selectiveness of their filters, moving more or fewer of the cases before them closer to adjudication and sentencing. Presumably, all major and aggravated cases proceed to prosecution and all unfounded or trivial cases drop out of the control process. Decisions about what to do with the intermediate cases--how many cases to handle and what penalties should be sought--depend on a number of factors. Statutory definitions of fraud and court interpretations of them will affect evidentiary standards. Budgets and staffing will affect how many cases can be handled, how much can be spent for travel to interview witnesses, and so forth. Some agencies also have problems finding investigators and prosecutors with the training or competence to handle fraud cases.

The most important factor affecting control agencies' responses to fraud cases concerns specialization. Some welfare agencies have no specialized investigators, and caseworkers are expected to handle fraud investigations along with their other case management duties. In most counties and states, civil and criminal recipient fraud prosecutions are part of the general caseload of a district attorney or Attorney General, and most judges see only a few fraud cases a year. In these settings, fraud cases must compete for time with property and violent crime cases.

In contrast with this generalist organization of fraud control, in Union County, New Jersey, a demonstration grant from the Social Security Administration has funded a special unit combining prosecutors and welfare

agency investigators. A 1981 review by SSA found that the unit reduced delays in case processing and that "Since the Assistant Prosecutor deals exclusively with welfare fraud, these cases receive a high priority. His attention and efforts are concentrated in this area rather than dispersed among several types of cases. This gives the Prosecutor a great deal of expertise with cases of welfare fraud which allows time to more readily determine if the evidence in the case is strong enough for conviction and if the case would best be handled as a criminal violation or as a civil action. He is involved with the case from the time of investigation to the time of judicial decision, and is more aggressive in his arguments for realistic amounts of restitution in the court order" (Social Security Administration, 1981: 13).

As Table 3 indicated, welfare agencies do not refer the majority of fraud cases for prosecution, and prosecutors do not file criminal charges in most of the cases which are referred to them. In large cities, the average welfare fraud case will not receive media coverage. Unless there is a public outcry against welfare cheats, there is little political mileage to be gained from bringing welfare mothers into court; jail sentences are rare, and most fines are never paid. Control agencies will probably take some fraud cases as a courtesy to the welfare agencies, but there is little incentive for the nonspecialized agencies to devote more than a bare minimum of their resources to the problem.

Control Agency Perspectives on Medicaid Provider Fraud and Abuse

Unlike recipient fraud, cases of Medicaid provider fraud and abuse involve large dollar amounts and difficult evidentiary problems. Control agencies have problems deciding which of the millions of provider claims submitted each year to investigate, in determining whether services were provided as claimed, and in establishing whether overpayments were due to fraudulent intent or innocent billing error. Claims can be disallowed if the provider cannot prove that the service was delivered, but felony prosecution requires the government to prove knowledge and intent.

Compounding the difficulties posed by these evidentiary problems is a fundamental staffing problem: Medicaid provider fraud and abuse cases involve technical problems which are unfamiliar to many of the professionals in control agencies. Auditors who are trained to conduct financial or compliance audits often lack experience in detecting or documenting fraud; investigators, prosecutors, and judges who normally handle street crime cases lack experience in dealing with more complex white collar crime cases. In addition, while program people don't understand the legal requirements for a civil or criminal fraud prosecution, many criminal justice personnel are unfamiliar with both Medicaid program regulations and medical issues (was X treatment justifiable given Y problem?). In 1977, a New Jersey Medicaid prosecutor testified before a Congressional committee on the importance of specialized expertise. "In the day-to-day priorities of many prosecutors' offices, other things may tend to come first. ...We found that by having a special unit which has nothing to do but specialize in this, they developed an expertise. They know how to build these cases. They know how to go through the paper. They know how to use computer applications to sift through thousands of claims" (Medicare-Medicaid Antifraud and Abuse Amendments, 1977: 205).

The agencies which participate in these control functions vary in a number of important respects. As can be seen in Table 4, some agencies deal only with Medicaid issues while others handle a variety of programs or criminal justice problems. In addition, some (such as auditors, investigators, and prosecutors) deal only with control functions, while others also have program management or professional functions. Organizationally, some control agencies are parts of larger government agencies, while others are independent; as a result, control personnel may or may not need the concurrence of their agencies to pursue fraud or abuse cases. In part because of these organizational factors, agencies also vary as to whether they play proactive or reactive roles in the control process; some initiate their own control efforts while others simply react to cases submitted to them by other agencies. Finally, these agencies vary in the potential sanctions which they can impose. Medicaid agencies can exercise the first nine intervention strategies described by Bruce Stuart earlier

(although they may need the assistance of prosecutors to seek civil penalties), and prosecutors and judges dominate the criminal justice process.

Provider cases involve a somewhat different mix of incentives and disincentives for control agencies than do recipient cases. Control agencies working for Medicaid agencies will be most interested in the cases which promise high recoveries and/or which involve providers of poor quality health care. Surmounting the technical complexities of provider fraud investigations produces more professional satisfaction than proving that a welfare mother concealed earnings. But pursuing a provider case beyond the point of documenting a demand for reimbursement may well involve more staff time and more expertise than most control agencies can afford. Since most providers have high social status, it is unlikely that jail sentences will be imposed. Except for the providers of bad medicine, society or the Medicaid agency may want the provider to remain in business; hence, seeking criminal penalties may be dysfunctional.

Finally, for many control agencies, Medicaid provider fraud may seem to be someone else's problem, a problem that can be handled elsewhere as well or better, or a problem that someone else may even have caused. Many of the federal officials we interviewed felt that Medicaid fraud was basically a state problem, many officials in the Medicaid agencies felt that prosecution (as opposed to recoveries or other administrative sanctions) was something for the prosecutors to worry about, and many prosecutors felt that the Medicaid agencies are so fuzzy in writing regulations and lax in implementing them that they don't deserve help. These attitudes lead either to deference (offering assistance if sought, but not volunteering), or open hostility and turf fights. A HCFA investigator asked, "Why should we work up a case for criminal prosecution? If we give it to the Inspector-General or a U.S. Attorney, they'll take the credit; if we go the civil route, HCFA will get the credit and our people will have the satisfaction of seeing the case through to completion." In 1981, the president of the National Association of Medicaid Fraud Control Units noted the problems caused by Medicaid agency hostility toward the Units: "Before the Units could begin to understand the mechanics, the rules and regulations..., the Units had to

Table 4
SPECIALIZATION IN MEDICAID FRAUD CONTROL AGENCIES

Functional Specialization	Program Specialization	
	Medicaid Only	Other Programs*
Control Only	Medicaid auditors Medicaid investigators Medicaid Fraud Control Units	State auditor State law enforcement State Attorney-General District attorneys HCFA Office of Program Validation and Regional Offices of Program Integrity DHHS Inspector General Office of Investigations Audit Agency FBI Postal Inspectors U.S. Attorneys U.S. Department of Justice Civil Division Criminal Division State Courts Federal Courts
Other Functions	Medicaid claims processors (state agency or fiscal agent) Medicaid provider enrollment units SURS unit	State provider licensing and monitoring agencies Provider professional associa- tions Professional standards review organizations

* Some of these agencies may have specialized sub-units or short-term task forces to focus on fraud or even Medicaid fraud issues.

overcome the resistance to fancied invasions of bureaucratic turf, assaults upon ego, and various other personality problems that were inevitable with the establishment of a new 'kid on the bureaucratic block'" (Zerendow, 1981: 2). Surveying the fraud units' performance in 1980, the General Accounting Office concluded that "mutual distrust, concern over loss of control of fraud investigations, and personality conflicts" contributed to problems between the agencies and the MFCUs. (General Accounting Office, 1980: 32). Except for the MFCUs, which have to cooperate with both the Medicaid agencies and the courts to get anything done, control agencies may well decide to do as little as possible, or to follow strategies which do not require cooperation with other agencies.

The problems created by these conflicting incentives and disincentives are compounded by the fact the agencies involved in the control process have a variety of goals which they seek to accomplish. Some of these goals concern desired outcomes, e.g., to maximize the recovery of overpayments to providers, to maximize the quality of care provided to recipients, and to deter future violations. Other goals concern the control process, e.g., to minimize control costs, to maximize the agency's reputation, and to minimize conflicts with other agencies. As is indicated in Table 5, each of these goals has distinct, and at times conflicting, tactical implications. Maximizing recoveries, for example, implies directing control efforts at the highest volume providers with recoverable assets, while deterrence requires creating the impression that all providers are subject to scrutiny. The goal of deterrence implies seeking the maximum penalty in each case, while the health care goal may imply a more moderate penalty which will keep a valuable provider in the program. Easy and visible cases which are important to other agencies may not be those which are the most costly to the public or dangerous to recipients. Finally, maximizing the breadth and depth of control activities necessarily conflicts with the goal of minimizing control costs.

As a result, control agencies tend to focus on bigger cases, those cases which involve larger dollar amounts, bad medicine, and/or unambiguous guilt. Because of the uncertainties inherent in prosecution, agencies will

Table 5
CONTROL GOALS AND TACTICAL IMPLICATIONS

Control Goals	Tactical Implications
Outcome Goals:	
Maximize recoveries	Focus on high volume providers Focus on providers with recoverable assets
Maximize quality of health care	Educate and persuade providers Impose sanctions on those who provide bad health care
Deter future violations	Appear to monitor all provider types Impose substantial sanctions with speed and certainty
Process Goals:	
Minimize control costs	Select easy cases with a high ratio of benefits to control costs Defer action on cases which other agencies are willing to process
Maximize agency reputation	Select cases with public visibility Select cases for which agency will get credit
Minimize conflicts with other agencies	Pursue cases important to other agencies Avoid cases embarrassing to other agencies
Maintain control over cases	Minimize "interference" by other agencies Define referred cases to correspond with agency control objectives

tend to prefer negotiated settlements (reimbursement and/or withdrawal from the Medicaid program) or plea bargains rather than trials. Provider fraud thus involves a filtering process even more selective than was shown in Table 3 for recipient cases. In Fiscal Year 1977, Medicaid agencies disposed of 4,567 suspected fraud and abuse cases; 4,176 were closed by the agency and only 391 were referred to law enforcement officials. In the same year, 144 "law enforcement actions" led to 91 convictions, and 149 providers were terminated or suspended by administrative action (Health Care Financing Administration, 1979: 106).

III POLICY IMPLICATIONS AND RECOMMENDATIONS

Our case studies, and other recent analyses of AFDC and Medicaid programs, indicate that there is widespread concern about the costs of fraud and abuse, but that efforts to control them have been limited. State program agencies are experimenting with techniques to improve local office management, to provide caseworkers with information to assist in making eligibility and redetermination decisions, and to identify suspicious provider claims. Despite these efforts, it is clear that many recipient and provider violations go undetected, and that most detected violations do not lead to the imposition of penalties. Recipients and providers are given many incentives to overstate their eligibility or the services they have provided; if caught, they will only have to repay excess benefits. Many investigations lead only to the termination of an AFDC grant or the denial of a Medicaid claim; few fraud cases are brought into the criminal courts.

The perspectives of the participants in these programs help to explain these limited fraud control efforts. While agencies are under some pressure to cut costs and reduce errors, their ability and motivation to control fraud are constrained by several factors. As detailed in Section II, program agencies' control goals often conflict with their service goals, both operationally and politically. Operationally, Medicaid administrators fear that fraud control techniques will substantially reduce provider participation in their programs. AFDC and Food Stamp administrators may find unacceptable the tendency of more complex application procedures or monthly reporting requirements to exclude applicants who are in fact eligible for benefits (Mendeloff, 1977; Piliavin, 1978). Some measures to verify recipient and provider statements may be viewed as intolerable invasions of their privacy or civil liberties. Politically, control orientations may antagonize legislators who are sympathetic to recipients or to providers, possibly leading to budget cuts for the agencies.

Even where a decision-maker has decided that he wants to effect a change, he may find that it is illegal or that he lacks the resources to do so. Federal and state statutes and constitutions spell out the roles of administrative and judicial agencies, procedures for civil and criminal adjudication, how supervisors may control their subordinates, and standards and procedures for the termination of recipient benefits or provider participation. The legislation which created AFDC and Medicaid emphasized provision of services rather than tight control. AFDC grants and medical assistance were defined as entitlements rather than privileges; at least until the mid-1970s, legislative messages to the program agencies stressed the ease and speed of service delivery, not the development of prevention and enforcement efforts.

When welfare rights organizations and provider associations challenged agency operating procedures, some state and federal courts specifically prohibited activities which might uncover recipient and provider fraud. By requiring the agencies to act on recipient applications within 45 days, as a federal court did in Illinois, by limiting the number of "collateral contacts" to verify application information, or by requiring search warrants to examine provider records, the courts have made it more difficult for the agencies to question the information given to them.

Federal agencies, including the Social Security Administration and the Health Care Financing Administration, have encouraged state efforts to improve program operations, but they have had little direct control. The Quality Control programs permit the states to concentrate corrective action efforts on technical or trivial errors such as WIN registration or social security numbers, rather than the fraud problems which are more difficult to solve. While federal agencies have some leverage over the program agencies, the incentives and sanctions over which they have control are irrelevant to the control agencies which would have to process fraud prosecutions.

Except for such specialized federal subsidy programs as MMIS, Child Support Enforcement, and Medicaid Fraud Control Units, state agencies are unable to secure additional funding for control efforts. Particularly in

states facing severe resource constraints, legislatures have been unwilling to increase administrative budgets, and many states have reduced personnel ceilings and budgets. As AFDC applications and provider claims have grown, therefore, the program agencies have not received commensurate staff increases, and have been forced to allocate existing resources between program and control functions. As one Illinois administrator said, "I know that our investigations unit could use more men, but I can't take anyone away from our local offices; they're short of staff as it is."

Even where the federal government offers to match state expenditures for fraud control, a state may not be able to fund its share of costs. A 1978 report to the Department of Health and Human Services noted, "The state fiscal crisis reduces the attractiveness of federal matches. . . . and has produced severe cutbacks in many states and local programs--particularly in the Northeastern and North Central States. In such an atmosphere, federal programs requiring any state or local matching funds decrease in attractiveness. Indeed, even 100% federally funded programs may be unattractive because of associated overhead costs which must be paid by the states or localities" (Taddiken, 1978: 200).

Administrators who want to reduce fraud and errors have little control over the day-to-day work of caseworkers and claims processors, particularly the claims processors who work for fiscal agents. These front-line workers are already overburdened with more policy directives than they can implement, and can barely handle basic case actions within required deadlines; proactive efforts to detect fraud often can't be added to their other duties.

Program agencies find that independent control agencies have little interest in fraud cases. If the control agencies will decline most referrals, why waste time preparing them? Furthermore, if program agencies do not wish to relinquish control over the disposition of particular cases, referral for prosecution will not serve programmatic goals.

Finally, even where these obstacles have been overcome, agency leaders may not know what to do to control fraud. Before any technique will be adopted to solve a problem, the adopter must know that the problem exists, that the technique exists, and that the technique will solve the problem. Each of these conditions may be absent with regard to benefit program fraud. Quality Control reviews and provider audits document the existence of overpayments but, as we indicated in Part I, substantially underestimate the magnitude of the problem and its dollar costs to taxpayers. Perhaps more important, even when an administrator has accurate information about fraud and abuse, he may not know the cause, that is, the specific aspect of program design or implementation which permitted the error to occur. Given the decentralized nature of American welfare programs, it is not surprising that administrators and criminal justice personnel know little about the fraud control activities of their counterparts in other states or whether those activities would be transferable and effective. A 1981 study of error control efforts in eight AFDC programs offered the following conclusion about the information problems of program administrators:

The federally required quality control sample is of little use to state and local managers because it does not provide statistically valid data on local offices and what data is supplied is too late to be of any use in making improvements. The case study states vary in the quality and quantity of analysis with which they supplement the federal sample. Current federal quality control regulations do not allow states to use experimental designs while implementing corrective action plans. The resulting lack of data on the impact of any of these efforts makes assessment impossible, except very subjectively.

Of these eight states, California regularly collects and analyzes by far the most information on local office performance. Yet California officials know very little about what effects specific error reduction techniques have on the costs of the program, its efficiency, accuracy, or the quality of services provided to clients.

However, except for major changes, such as a computer system, it is not feasible to assess specific error reduction techniques. The system is so much like a Chinese wooden puzzle that it is difficult to know the effects of one action on the system. The demographics of the AFDC client (e.g., urban vs. rural) and the other forces external to state administrative control (such as the status of the state-local economy), appear to have as much or more impact on error as a new worker's handbook, or an improved

training program. Since these factors are different from office to office, and are constantly changing, scientific experiments may mislead rather than assist the welfare administrator, (Zeller, 1981: 84-85).

As one former welfare administrator summarized the problem, "Even if I knew that fraud and abuse cost a lot more than is currently believed, I still would not know what to do or where to make cuts in order to fund the remedy."

Given conflicts with service goals, legal and resource limitations, the difficulty of proving that intentional fraud has occurred, and control agencies' lack of interest in fraud cases, it is not surprising that AFDC and Medicaid agencies have concentrated on management improvements and cost control, devoting little effort to techniques specifically focused on fraud problems. When overpayments to recipients are discovered, grant reductions, recoupment, or repayment are typical responses to proven abuses.

Control agencies have somewhat different reasons to be unenthusiastic about fraud cases. Confined by low salary scales, they have found it difficult to recruit, train, and retain competent computer programmers, auditors, investigators, and prosecutors to handle fraud cases. Most recipient fraud cases are easy to document, but unraveling a nursing home or hospital's records to prove provider fraud requires a great deal of sophisticated work. Particularly when judges are likely to dismiss cases or impose light sentences, controllers will proceed cautiously or even unenthusiastically.

Recipient cases, unless they involve welfare queens, do not bring either media publicity or professional satisfaction. Prosecutors and judges in urban areas won't regard the average recipient fraud case as particularly important, so control agencies cannot expect that significant penalties will result from convictions. Provider cases, on the other hand, require a great deal of time to prepare, and will be contested by highly qualified defense attorneys. If the defendant is a well-respected member of his community, convictions may lead only to minor fines.

Finally, controllers must ask whether fraud cases are as important as their other duties. While specialized agencies such as the Medicaid Fraud Control Units only have to decide which fraud cases to pursue, other investigators and prosecutors must ask how much time they can take away from street crime cases. Confronted with these problems, the nonspecialized control agencies have generally decided not to invest many resources in handling fraud cases. Larger cases and a smattering of the smaller cases will be prosecuted, but negotiated settlements will be sought in as many cases as possible.

Improving Fraud Control: Prevention and Enforcement Strategies

Efforts to improve fraud control must recognize three fundamental constraints: So long as welfare benefits are tied to "need," and medical assistance is provided on a fee-for-service basis, recipients and providers will continue to have strong incentives to cheat. (The emerging oversupply of physicians and institutional capacity--hospitals and nursing homes--will only increase competition for income, legal or illegal, although it will reduce agency fears that control efforts will inhibit provider participation.) So long as taxpayers resent the costs of government in general and of welfare programs in particular, it is unlikely that significant amounts of new money will be made available for fraud control. So long as the criminal courts are overwhelmed by the street crime cases which have priority in the minds of the public, we cannot expect the criminal justice system to handle most fraud cases.

Within these constraints, however, prevention and enforcement can be improved if agencies are given incentives to emphasize fraud control. The experiences of the 1970s (see Zeller, 1981) suggest that many welfare agencies can make substantial progress simply by paying more attention to program operations. The basic maxims of administration ("Hire good people." "Train them well." "Tell them to be alert for possible problems." "Check their work." "Praise the workers who are doing a good job and push the ones who aren't.") are fundamental to this effort, and need not be

discussed further here. More specific opportunities to improve fraud control, however, require systematic problem analysis and concentration on fraud prevention, specialization in fraud control functions, and the development of more diversified sanctions against defrauding recipients and providers.

Fraud Prevention

As AFDC and Medicaid programs have grown, administrators have responded to criticisms by multiplying the instructions issued to their staffs, creating policy directives, forms, and paperwork to serve every conceivable purpose. Having been told to do so much, agency personnel have in effect been told nothing; not knowing which tasks take precedence, they do not know how to allocate their time. The General Accounting Office has also pointed out that many AFDC and Medicaid agencies lack such basic tools as cost and performance data, work measurement, and operations analyses.

In one report (General Accounting Office, 1982), GAO cited California's responses to these problems. A statewide cost control plan establishes standards of administrative efficiency and penalizes county welfare departments which fail to meet their goals. An extensive quality assurance program assesses selected operations down to the individual level. Costs are controlled by establishing worker productivity targets which are then measured against actual performance levels. Such measurement methods, when linked to operational analyses, give managers information for decision making. For example, this data provides information to (1) evaluate the performance of individuals and groups, (2) identify problems in production, supervision, absenteeism, and declining quality (or increasing signs of fraud and abuse), (3) determine county budgetary and personnel requirements, (4) prepare models for new systems, (5) run simulations of proposed changes in operations and programs, and (6) develop alternative systems and procedures. Advances in quality assurance are also evident in California. In addition to developing error data for a statewide sample, many counties in California develop their own quality measures. Analyses based on these

types of information, often called vulnerability assessments, risk analyses, or loss prevention studies, can be used both to identify opportunities for fraud and abuse and to structure prevention programs. Agencies might decide, for example, not to monitor single-headed households with small children, or providers who receive less than \$20,000 per year from Medicaid, in order to concentrate on the larger providers and on households which are more likely to have unreported income. The Seattle and Denver research reported in Part I, for example, suggests that recipient control efforts should concentrate on households with teenaged children or adults who may be holding regular jobs. Priority categories could be supplemented by specific leads provided by Hot Line tips, computer crossmatches, and indications that a provider is practicing poor medicine.

Fraud prevention priorities established by the agency must be reinforced through training programs, incentive systems, and resource allocation decisions. Caseworkers and claims processors must be trained to recognize the types of application and claim information which are most likely to indicate the possibility of fraud, and investigators must be trained to pursue these leads. Recipient applications and provider claim forms must articulate eligibility and billing requirements. Individual and office incentive systems must reward those who excel in fraud prevention efforts. Superior performance should lead to desirable assignments or financial awards. Illinois, for example, has begun to issue awards to local offices which reduce their error rates; in 1982, California began a program to return to the counties 10% of excess assistance recoveries.

Finally, agencies should be prepared to reallocate personnel and funds if new resources are not available for fraud control. In our case study states, for example, computerized and manual screening systems identified many recipients and providers who might be committing fraud, but very few leads were actually investigated, and crossmatch and SURS printouts lay unread in agency storerooms. Simple systems analyses of agency fraud control operations would suggest that resources should be transferred from the generation of new leads to the analysis of existing information on priority categories of recipients and providers. (Other strategies to

improve agency fraud prevention capabilities are discussed in Gardiner, Hentzell, and Lyman, 1982.)

Focusing Responsibility for Fraud Control

In Illinois, an AFDC administrator said, "We want everyone in the agency to be concerned about fraud and error." While this is inherently a good idea, it may mean that no one will have the time or ability to take action. Generalists have no specific training on fraud issues, and have other duties which may detract from their ability or motivation to pursue a potential fraud case. Specialization, however, can both develop staff expertise and avoid role conflicts. The state of Washington, for example, has created the position of VOCS (Verification, Overpayments, and Control System) worker in each local office; comparable specialization could be achieved in the offices which process Medicaid claims.

Going beyond specialization among individual front-line workers, separate units should be created to investigate and take action against potential fraud cases. Several organizational models might be considered. Prosecutors could be added to the staffs of welfare agencies, auditors and investigators can be employed by prosecutors, or the three skills can be combined in free-standing units. In one county in Colorado, the welfare agency created a fraud unit in cooperation with the county prosecutor. On several occasions, federal, state, and local agencies in Chicago have formed short-term task forces to deal with recipient fraud. The model recommended for federally funded Medicaid Fraud Control Units brings audit and investigation capabilities into the office of the state attorney-general.

Regardless of which organizational arrangement is employed to centralize fraud control expertise and reduce role conflicts, three potential dangers must be anticipated. First, designating certain units as fraud specialists may lead everyone else to ignore the problem; while enforcement can best be handled on a specialized basis, everyone in the agency must be repeatedly reminded of his or her role in fraud prevention.

Second, specialization may lead to rivalries and turf wars; as some Medicaid fraud control units have discovered, generalists may withhold information from specialists to keep them from stealing the glory or harming favored recipients or providers. Unless the leaders of the generalist and specialist units agree to share information, the specialists will require the capability to collect information on their own. Finally, the units which share enforcement responsibilities must communicate about their respective priorities and needs. If investigators and prosecutors conclude that they can only process cases over a certain dollar amount, or which meet certain evidentiary requirements, they should spell out these issues in negotiations with the AFDC and Medicaid agencies which generate case referrals.

Developing Alternative Sanctions

Ordering recipients and providers to repay excess receipts has little deterrent value; criminal prosecution is a realistic possibility only in the most aggravated cases. Between these two extremes lie many sanction possibilities which can be invoked rapidly, less expensively, and without the need to prove criminal intent. A number of states have adopted the simple expedient of adding interest charges and penalties to the overpayments which recipients and providers must repay. Civil fraud statutes permit prosecution without using the clogged criminal justice system; administrative sanctions bypass the judicial system entirely. In Washington, the welfare agency can administratively impose a 25% penalty on top of the excess assistance which a recipient must repay, and treble damages may be imposed for provider fraud. In the Omnibus Budget Reconciliation Act of 1981, Congress gave the Secretary of DHHS authority to impose administrative penalties on Medicaid and Medicare providers; penalties of up to \$2,000 and twice the amount of the submitted claim can be imposed for each service not provided, or provided in violation of regulations. Under both the Washington and the federal statutes, the provider must have had knowledge of the claim, but it need not be proved that he had fraudulent intent.

We propose several prevention and enforcement strategies, summarized below, based on two related conclusions from our research. First, many instances of fraud and abuse in government benefit programs defy detection and/or are not worth pursuing. For understandable political reasons--to give the appearance of control--agencies have created administrative systems which have inundated them with information they cannot utilize; they would be better off admitting (to themselves, if not publicly) that many abuses are uncontrollable. Second, however, we believe that welfare agencies can focus their efforts on cases which are worth pursuing, and can do a far more credible job in imposing sanctions in the cases they know about. Neither recipients nor providers can regard criminal prosecution as a real threat at present; a 25% repayment penalty on recipients or treble damages against providers, imposed swiftly through civil/administrative proceedings, would both increase the funds recovered by the agency and provide a more credible deterrent. The proposed strategies are as follows:

Prevention Strategies

- Risk analysis vulnerability assessment
- Concentrated monitoring on priority targets
- Staff training
- Incentive awards
- Information sharing
- Computer matching

Enforcement Strategies

- Specialized fraud control units
- Clarified case referral policies
- Interest charges and penalties
- Civil fraud penalties
- Administrative procedures and sanctions

Encouraging Utilization of Fraud Control Techniques

Techniques such as these significantly increase the ability of welfare agencies to control fraud, but they say nothing about the problem of motivation. If the current limited responses to fraud and abuse reflect the incentives and disincentives which program and control agencies now face,

why would they want to act any differently? Efforts to encourage more effective fraud control must not only convince decision-makers that a specific technique is an improvement over current practices, but also must demonstrate that in terms of all of the issues about which the decision-maker is concerned, enhanced fraud control will be more advantageous than staying with the status quo. Finally, strategies to encourage the utilization of fraud control techniques ("utilization strategies") must combat the inertia which is produced by decision costs ("I haven't got time to worry about that now") and/or the costs of other opportunities which must be forgone ("If I put in a fraud control unit this year, I won't have money to increase welfare grants/provider reimbursement rates/staff salaries").

In recent years, many of the changes which have occurred in welfare programs have been the result of sudden scandals or fiscal crises, often producing short-term antifraud crusades which temporarily disrupt program operations and then fade away. Longer term improvements require the development of fraud control orientations within both program agencies and the political systems and legislatures which influence their operations. Our research does not permit us to identify the specific individuals who can stimulate changes in each welfare and criminal justice system, or the specific fraud control techniques most appropriate for each system's specific problems. We also cannot--and do not wish to--suggest that systems adopt fraud control techniques that will tend to exclude eligible recipients or competent providers, or violate individuals' privacy or civil liberties. We can, however, suggest general strategies which might bring about more widespread efforts to control fraud and abuse.

Information Strategies

While some changes occur accidentally or involuntarily, intentional change requires a recognition that a problem exists (that current behavior is somehow unsatisfactory), that alternatives are available and possible (i.e., that legal or resource problems do not preclude change), and that an

alternative is preferable to the current activity. If a decisionmaker (legislator, program administrator, prosecutor, etc.) does not believe that a problem exists, he will neither search for information about alternatives nor seriously consider information which is given to him ("Why should I read that? It doesn't apply to me."). Even if he recognizes a problem, he may not search for information because of feelings that alternatives are impossible, that none exist, or that he can't afford the decision costs ("I won't be able to check this problem out until my desk is clear/the budget is submitted/next year," etc.). If he does search for and find information, he may reject it if either the source is not credible ("Why should I believe what he says? He doesn't know anything about our situation."), or the information is incredible ("There's no way that doing that will cut our error rates by 50%!") Finally, even credible information may not lead to change if the decision-maker concludes that the specific alternative is not possible or is inferior to current practices.

One basic strategy to increase the utilization of fraud control techniques is to improve the information-processing systems of relevant decisionmakers, especially legislators, program administrators, and control personnel. Current data systems impede problem recognition; many decisionmakers are unable to collect and analyze relevant information; and much of the information which they have received lacks credibility. Problem recognition, for example, requires an awareness of both the costs of fraud and abuse and the deficiencies of current control programs. At present, public perceptions of fraud and abuse are shaped by the exposes of welfare queens and Medicaid mills which capture the headlines, and officials' estimates of the extent of fraud and abuse are based upon quality control reports and provider audits; as was shown in Part I, these sources both include irrelevant data (technical errors, unintentional client errors, etc.) and exclude fraud and abuse which auditors and investigators never discover. Neither the newspaper headlines nor current data sources, therefore, accurately indicate for decisionmakers the scale of fraud and abuse or whether administration and enforcement efforts should be improved.

A second obstacle to information processing arises from an inability to collect and analyze information. While some decisionmakers actively seek information, reading relevant journals, attending conferences, contacting peers in other states, etc., others lack the time and/or technical expertise to search out information and relate it to local needs. Decisionmakers with political or operational backgrounds (e.g., who have risen through the ranks of the welfare agency or the criminal justice system), usually are familiar with managerial problems but unfamiliar with the techniques of analysis which would help them interpret data, explore alternatives, or conduct experiments. More simply, the imperatives of day-to-day administration do not permit them the luxury of keeping up with the literature, analyzing reports, and evaluating the local applicability of another state's approaches.

A third obstacle concerns the credibility of information sources and messages. While the state officials we studied often communicated with federal agencies about federal program requirements ("Is X consistent with federal regulations?"), most state officials felt that their counterparts in other states were better sources of information about substantive problems ("Do you have any suggestions about what we can do about Y?"). While federal agencies have long attempted to serve as sources of technical expertise for state and local program agencies, a 1977 assessment of several DHHS programs concluded,

Federal technical assistance faces several major problems in achieving greater effectiveness as an incentive strategy:

1. Limited federal staff resources--both at the central office and regional offices.
2. Lack of clear focus on assistance programs addressing priority areas of need (as defined by state and local officials and administrative reviews).
3. Lack of timeliness.
4. Inadequate depth and follow-through.
5. Absence of programs directed at state and local policy-makers (e.g., state agency leadership, legislators).

6. Insufficient state-of-the-art knowledge.
7. Limited incentives for technology transfer.
8. Inadequate dissemination and application of both practical research findings and existing technology (or expertise). (Taddiken, 1978: 219)

Furthermore, many messages which state and local agencies have received about fraud control in recent years have proven to be misleading--in the course of advocating MMIS systems and quality control reviews, for example, federal agencies grossly overstated their utility and underestimated implementation costs and difficulties. Even if these systems ultimately prove their worth, many state officials feel that they were sold a bill of goods by federal agencies. If the bugs had been worked out in pilot projects before nationwide utilization was mandated, if the full costs of implementation (e.g., spillover effects on caseworkers and criminal justice agencies) had been admitted in advance (Zeller, 1981: 90), and if attainable benefits had been predicted instead of the hyperbole which accompanied each recommendation, expectations would have been more realistic, and state agencies would have been more prepared to accept subsequent federal fraud control recommendations.

Recognizing these failings in past efforts, several approaches might be taken to provide information about fraud control. To assist in public and official problem recognition, statistical systems (or reports based on them) might be revised to stress decision-relevant data (e.g., separating technical and trivial errors from those which are significant and worth reducing). Federal funding for research and analysis units within state and local welfare units would provide focal points for data collection, problem analysis, experimentation and evaluation, and the dissemination of information about alternatives, the units should have both the time and the resources to bring issues to the attention of the legislators and administrators who can deal with them, creating audiences for information and institutionalized mechanisms for information utilization. To facilitate contact with sources of information, federal agencies might develop rosters.

of experts on various topics, and either fund their utilization by state agencies or support state travel to observe exemplary projects in action.

Even if such steps expand the demand for information, it will be necessary to improve the credibility of information suppliers. Since federal agencies are often viewed as uninformed or as "policemen" who are more interested in furthering their own ends than in assisting the states, better results will be achieved by using existing channels of communication among target audiences. If the Medicaid director from State X is recognized by peers as the best in that part of the country, for example, he or she should be used to disseminate information about specific tactics to prevent provider fraud; a respected fraud prosecutor should address prosecutors and investigators, etc. In many situations, a two-stage communications process may be necessary. Federal agencies, for example, might hold a training session for ten nationally recognized leaders in AFDC administration, who would then be able to "pass the word" to others in their regions. Alternatively, the National Governors Association or the National Conference of State Legislators might be used to stimulate general interest in fraud control, relying on members to push local officials to get the details from federal sources. To the extent that existing opinion leaders can be built into information strategies, the credibility problem arising from the attitude that "the feds don't know what they're talking about" will be reduced.

The potential impact of information strategies should not be overstated. Even a perfect understanding of the nature of fraud and abuse problems in a welfare system, and perfect communication among states regarding the different approaches being tried, will not reduce the complexity of control problems: even sophisticated research and analysis units will not be able to identify precise answers to all problems. Just by identifying types of problems (earned income cases, nursing home kickbacks to pharmacies, etc.) and types of responses, however, information strategies can initiate and focus problem-solving processes. As a senior DHHS official in the Carter administration put it: "We frequently were able to get the

states going just by publicizing problems and letting them know that there are ways of dealing with them."

Incentive Systems Strategies

Improving information systems can provide decision-makers with better data about the nature and extent of fraud and abuse, and with information about alternative approaches to fraud control. They can only be expected to adopt alternatives, however, if they see net advantages in doing so. Adopting an alternative approach would offer a net advantage if its benefits (less costs) exceed the benefits (less costs) of retaining current approaches. Strategies to enhance utilization of fraud control techniques could therefore seek to increase the costs of current approaches or the benefits of alternatives, or to decrease the benefits of current approaches or the costs of alternatives. Table 6 provides illustrations of current federal strategies intended to have these effects.²

Some of these strategies have been part of federal-state programs for decades. Federally specified program guidelines, planning requirements, reporting forms, and statistical systems provide opportunities for federal agencies to critique state intentions. Audit "exceptions" (conclusions that a specific action is not in compliance with regulations) may lead to disallowance of the federal share ("federal financial participation," or FFP) of improper expenditures. Planning and auditing processes thus provide settings in which federal agencies can point out potential (plan) or actual (audit exception) deficiencies in current state practices.

The central, and most controversial, part of the federal government's effort to stimulate changes in welfare management practices has been the quality control system, initially developed as a diagnostic tool and subsequently selected as a yardstick for the imposition of fiscal sanctions. HEW first required states to conduct quality control reviews of public assistance programs in 1964. This initial system, based only upon reviews of the information contained in case files, was revised in 1970 to

Table 6
PENALTY AND INCENTIVE STRATEGIES

<u>Strategies Aimed at Discouraging Current Approaches</u>	<u>Strategies Aimed at Encouraging Alternative Approaches</u>
Rejection or modification of annual plans or corrective action plans	Routine FFP in administrative costs
Audit exceptions and cost disallowances	State savings from reduced erroneous payments
Quality control systems	Additional FFP for costs of MMIS, Medicaid fraud control, child support enforcement, Food Stamp enforcement
Fiscal sanctions for high error rates	Fiscal sanctions for failure to implement MMIS or child support enforcement programs
	Fiscal incentives for low error rates

require both field investigations and the use of statistically valid samples, and states were required to develop corrective action plans in response to identified problems. A 1973 review of the system concluded that state efforts were not generating valid measures of the quality of administration and that federal agencies were not taking action against unresponsive states. As a result, HEW issued new QC regulations and for the first time threatened fiscal sanctions against states which did not reduce AFDC error rates to 3% for ineligible cases, 5% for overpaid (but eligible) cases, and 5% for underpaid cases. In 1976, however, before fiscal sanctions were imposed, the United States District Court for the District of Columbia ruled that the 3% and 5% tolerance levels were "framed in an arbitrary and capricious manner" and that the regulation was "an abuse of discretion" (Richardson, 1977). When HEW developed new regulations requiring error rate improvements on a sliding scale, Congress in 1979 (the "Michel Amendment") required all states to meet a 4% payment error rate goal by September 1982, making one-third progress toward that goal by 1980 and two-thirds by 1981. While FFP is to be reduced for erroneous payments in excess of these standards, the Michel Amendment authorizes the Secretary of DHHS to waive penalties if he determines "in certain limited cases, that states are unable to reach the required reduction in a given year despite a good faith effort." DHHS regulations give as examples of mitigating circumstances, natural disasters, personnel strikes, sudden workload changes, erroneous policy interpretations by federal officials, reasonable corrective action plans, management commitment to error reduction, information systems, and effective management of the corrective action process (Federal Register, 1980: 6320). The Medicaid error rate system similarly provides for fiscal sanctions which can be waived by DHHS; the eighteen states whose 1979 error rates exposed them to fiscal sanctions submitted corrective action plans which were acceptable to DHHS (General Accounting Office, 1981: 5).

While the planning, auditing, quality control, and fiscal sanctions processes have been designed to discourage state adherence to current practices, other strategies have been designed to increase the attractiveness of specific alternatives. As in the case of other

administrative costs, the federal government will pay at least 50% of the costs of fraud control innovations, and the states will save their share of reduced erroneous payments. To secure adoption of specific innovations, Congress has provided additional funding for the administrative costs of Child Support Enforcement programs (1975, 75% of administrative costs), Food Stamp enforcement programs (1977, 75%), Medicaid Fraud Control Units (1978, 75%), and Medicaid Management Information Systems (1972, 90% of design costs and 75% of operating costs). Fiscal sanctions were also threatened if states failed to set up Medicaid Management Information Systems and Child Support Enforcement Units. An additional incentive for error reduction efforts is tied to the QC error rates. Congress amended the Social Security Act in 1977 to provide that states which "reduce their payment error rates below 4% can participate increasingly in the Federal share of the money saved. For each one-half percent below 4%, a state receives an additional 10% of the Federal funds saved until its error rate is reduced below 2%, when the state's maximum share of the Federal funds saved is 50%" (General Accounting Office, 1980: 4-5). The Food Stamp program was also amended in 1977 to provide that states which reduce error rates below 5% will have an additional 10% of their administrative costs paid by the federal government.

Assessments of Incentive Strategies

The impact of these federal efforts over the past 10 years to improve welfare management and focus attention on fraud and abuse problems is unclear. Case studies of eight AFDC programs in 1980 found that managers are taking steps to reduce their error rates (Zeller, 1981), most error rates have decreased since the mid-1970s, and states are taking more actions against fraud cases. States have established Quality Control and Child Support Enforcement systems, most states have developed or are in the process of developing MMIS systems, twenty-eight states are using Medicaid Fraud Control Units, and so forth. In short, many things have been tried over the past 10 years to deal with fraud and abuse problems. It is impossible to say, however, how much of this effort is due to federal

incentives and threats, how much is due to local concerns about welfare costs, etc. Many events have occurred over a short period of time, and their effects are too interconnected to assess their separate roles.

While detailed evaluations are not possible, several lessons learned in the implementation of federal incentives and sanctions policies may help to improve future strategies to stimulate the utilization of fraud control techniques. The first is that money and threats may not always be needed: the mere fact that Congress, GAO, and federal agencies were devoting so much attention to fraud and abuse issues probably served to set an agenda for state and local policy-making. Just as the Great Society concerns of the 1960s led to consideration of the problems of the poor and minorities, so federal publicity about fraud issues in the 1970s led some legislators, administrators, and control personnel to think more about current practices and at least ponder the desirability of change. This self-assessment process produced improvements in a number of states before the federal government began to offer incentives or threaten penalties and before sophisticated technologies such as MMIS were developed.

Second, federal strategies based on incentives were, not surprisingly, accepted more readily than strategies based on threatened penalties. When special federal funding (75% of administrative costs) became available for fraud control (Medicaid Fraud Control and Food Stamp fraud enforcement), it became easier for proponents to compete for state and local funds. Perhaps more important, funding for specialized units such as Medicaid Fraud Control Units and the New Jersey AFDC fraud control demonstration project discussed in Part II ameliorated problems caused by conflicting responsibilities and inter-agency rivalries. Yet the availability of federal funding has not led to uniformly widespread adoption of fraud control techniques. A 1978 study, by the Center for Governmental Research, of state reactions to a number of DHHS initiatives suggested that the following factors may discourage state adoption of voluntary programs or may cause reluctance to comply with federal requirements:

- (1) Nonapplicability of program--subjective or objective.

- (2) Insignificance of problems intended for treatment relative to administrative machinery needed.
- (3) Lack of sympathy for aims of programs (e.g., value differences).
- (4) Fear that federal standards will push up state cost.
- (5) Lack of sufficient local knowledge and acceptance of a new program. (Taddiken, 1978: 184)

Several of these factors seem particularly applicable to the adoption of fraud control techniques. Many states and communities, as was noted earlier, simply no longer have the fiscal capacity to match federal funding. As uncontrollable costs (e.g., state payments for welfare) rose in the falling economy of the late 1970s and early 1980s, states could not even consider partial investment in additional activities of any form, no matter how cost effective they might seem. In states in which the beneficiaries of welfare programs (recipients and providers) had powerful political supporters, it was especially difficult for fraud control advocates to mobilize support to apply for federal funding. Some of the specific techniques endorsed by the federal agencies seemed irrelevant or wasteful; many states concluded that MMIS wouldn't work, that forcing recipients to register for the WIN program was a waste of time when there were no jobs available (Taddiken, 1978: 86-7), or that the negotiations necessary to bring about inter-agency cooperation (e.g., for WIN registration, Child Support Enforcement, or Medicaid Fraud Control Units) weren't worth the effort. Fiscal incentives for states whose error rates fall below 4% (AFDC) or 5% (Food Stamps) probably seem irrelevant to states which can't break a 10% barrier, and incentives programs open to welfare agencies mean nothing to the prosecutors and judges who receive fraud referrals from those agencies (Taddiken, 1978: 145).

In many states, criminal justice agencies are funded by counties, but it is the state welfare agencies whose administrative costs are subsidized by SSA and HCFA. Furthermore, recovered overpayments to recipients and providers are returned to the general treasury (Federal, state, and in some states, county), not to the agencies whose efforts brought about the recovery. If Congress wants control agencies to deal with fraud cases, it

should reimburse them for their costs, or allow them to share in recoveries. These policies are currently followed in the Child Support Enforcement program, and could be an effective modification to the AFDC and Medicaid programs.

Finally, the effectiveness of incentive strategies is limited by states' assessment of the recommended activity vs. other expenditure priorities. As the Center for Governmental Research report concluded:

There is growing tendency to policy resistance on the part of state and local government. This policy resistance, however, relates not so much to the desirability of a service but to its priority and the demand that it can legitimately make upon the state treasury. As state and local governments are faced with continuing shortfalls in their own resources, greater resistance to the federal attempts to direct those resources through either negative or positive incentives can be expected. In most cases, it is the issue of priorities for the expenditure of limited funds and the allocation of limited state/local government personnel that must be understood rather than the broader issue of general program acceptance (Taddiken, 1978: 127-8).

Like the incentives strategies, recent penalty-based strategies have stimulated state attention to their error rate problems (Taddiken, 1978: 162-4; Zeller, 1981). Nevertheless, a number of real or potential problems with this approach should be noted. Many states and more neutral analysts have pointed to weaknesses in proposals to base penalties on error rates. As presently defined, error rates include technical errors (e.g., failure to register for WIN or obtain a social security number) and do not include other factors such as the quality of client service, timeliness of awards, or administrative costs which also indicate managerial effectiveness. Measuring only results (errors), they ignore real questions about the ability of agencies to comply (available resources, legal, and civil service restrictions, etc.) or the availability of the technological means to solve verification problems. Furthermore, many have questioned the accuracy and uniformity of the error measurement process (General Accounting Office, 1980: ii), and it is widely argued that further utilization of QC programs as a basis for sanctions will lead the states to hide the errors they do find, or to contest federal error findings endlessly rather than addressing

corrective action needs (Richardson, 1977: 264; General Accounting Office, 1980: Chapter Two).

While the threat of sanctions stimulates corrective action, penalties may not fall directly on those who have caused problems (although states may pass penalties on to the counties which generate high error rates; see Zeller, 1981) and may make things worse either by hurting recipients or by reducing already underfunded administrative efforts (Taddiken, 1978: 13, 147). The worst states may be able to make substantial improvements in their error rates with modest investments, but at some point, the costs of corrective action to attain error rate goals may exceed savings from improved case management (Richardson, 1977: 250). The 1980 case studies of AFDC programs concluded:

Federal, state, and local AFDC managers need a good deal more reliable information on all of the costs of quality control programs--in dollars spent by the agency, in time required of caseworkers, and the costs in quality of service to the client. Such an accounting may prove empirically what these case studies only suggest, that the utility of pursuing error becomes marginal once states and counties have taken the basic, necessary steps to control the quality of AFDC management (Zeller, 1981: 90; emphasis in original).

Finally, serious questions remain in the minds of many states as to whether the fiscal sanctions threatened in the late 1970s will ever be imposed. In the early years of the AFDC program, the Social Security Board frequently vetoed noncompliant state practices; however, the last time a fiscal sanction was actually imposed on a state was in 1951 (see Steiner, 1966: Chapter Four; ACIR, 1980). State reactions against the 1951 sanction (in which the Federal Security Agency terminated AFDC funding for Indiana because it opened relief rolls to public inspection) were so strong that Congress amended the Social Security Act to overrule the FSA position. A 1966 analysis of federal welfare policy termed the 1951 dispute a "turning point in the activities and authority of the federal agency in relation to state policymakers...Now it appeared that a state with clean hands might achieve a desired change in federal law even if that change ran contrary to the predilections of the administrative agency. The success of the Jenner amendment (overruling FSA) suggested that in the making of categorical

relief policy politicians could be no less influential than welfare professionals" (Steiner, 1966: 97).

Fifteen years later, the discretion contained in the Michel Amendment to waive penalties for "good faith" corrective action efforts may well mean that the past ritual of "threaten, negotiate, and waive" will continue. In all likelihood, a smaller penalty which actually was imposed would prove a better weapon than the massive cannons which to date have gone unfired ACIR, 1980: 34, 39). As state officials told researchers from the Center for Governmental Research in 1977,

State legislators may be less concerned about what is permissible under regulations than with what USDHEW will accept, or can be "forced" to accept. USDHEW's history of backing-off on sanctions and prior requirements tends to encourage a high degree of legislative "creativity" in some states. Departments of Social Services may be placed in compromising positions in such situations since their credibility is often dependent on ability not to interpret current regulations, but ability to foresee future DHEW decisions (Taddiken, 1978: 172).

Perhaps the only safe conclusion about the impact of federal utilization strategies concerns the variations among welfare and criminal justice systems which were so evident in our research. Some officials in some agencies have long been strongly committed to fraud reduction and have implemented extensive and sophisticated prevention and enforcement programs; limitations on their effectiveness may only suggest the limitations of control technology, the limitations of all public bureaucracies, and the inevitability of competing basic operational tasks. Other officials and other agencies have consistently displayed lower motivation, lower competence, and less interest in fraud and abuse problems. As one senior DHHS official summarized his experience, "There are perhaps three groups of states--the very best which have always been well run and innovative, the worst which don't even try, and those in the middle which are trying hard to shape up." Any federal policies which assume that states have uniform problems may, therefore, be misguided--the best states may not need help or may only be slowed down by federal involvement, and the worst states may be

incapable of using state-of-the-art techniques. As the 1980 study of AFDC programs concluded:

The threat of loss of funds... (as opposed to positive incentives) should be reserved for states with consistently high payment error. Such threats may be the last resort for states which have not proven their concern for quality control (Zeller, 1981: 90).

If welfare programs are turned over to the states, as has recently been suggested, and federal agencies lose all power to monitor them, these observations would suggest that the good ones will do better and the bad ones will become worse; if the state legislatures do not develop a capacity to oversee the expenditure of funds, program agencies will have even less incentive to control fraud.

IV SUMMARY OF CONCLUSIONS AND RECOMMENDATIONS

Fraud control involves many different issues. In some areas, fraud control is seen as an adjunct to the goals of welfare systems, e.g., as a vehicle to penalize recipients who do not deserve public assistance or providers who exacerbate the health problems of the poor. In other areas, fraud control is primarily a cost-containment mechanism, serving alongside limitations on eligibility and reimbursement rates as a way to cut total welfare costs. For some actors, fraud control is a form of political theatre, a device to appeal to anti-welfare or anti-crime constituencies. Ultimately, fraud control is all of these things and cannot be understood or improved if thought of as an isolated issue. Fraud control is part of welfare administration, is part of public budgeting, and is part of a continuing debate over the purposes of government. Even more troubling is the inescapable fact that fraud and abuse is committed both by people anyone would condemn (welfare queens and Medicaid mills) and by desperate people who cheat to survive on the margins of society. Prevention and enforcement systems aimed at the big crooks also catch the widows who conceal assets to get Food Stamps and the inner city doctors who abuse Medicaid when their private patients don't or can't pay their bills. Fraud and fraud control, in other words, are complicated moral issues.

It is a mistake, however, to assume that a complicated moral issue is beyond solution. One sign of a successful society is its ability to find satisfactory ways of dealing with complicated moral issues, such as child labor, civil rights, and the whole question of liability for damages. Particularly now, when all levels of government are finding it difficult to fund needed social programs, it is especially important that satisfactory ways be found of reducing fraud and abuse, and that the problem not be evaded or ignored.

Despite 10 years of federal and state concern about fraud control issues, our research confirms many GAO and Congressional findings that the AFDC and Medicaid programs are poorly designed to prevent fraud, that welfare agencies fail to detect most fraud and abuse, and that few detected cases lead to the imposition of effective sanctions. Improving fraud control efforts will require concerted efforts by Congress and the state legislatures, by DHHS and the state welfare agencies, and by civil and criminal justice agencies. As described, these efforts will include research into existing information to show which units and procedures are most vulnerable to fraud and what fraud-specific controls would reduce those vulnerabilities. They would also include a reevaluation of how the objective of stopping fraud and abuse can be expressed in a system of administrative procedures and civil penalties that are indeed related to stopping fraud and abuse rather than to theater.

Our research indicates that a combination of legal, resource, and policy changes will be needed to maximize the effectiveness of fraud control efforts:

- Congress should revise AFDC and Medicaid legislation to:
 - Provide that a share of recovered overpayments to recipients and providers be allocated to the control agencies that assist in recovery efforts.
 - Provide enhanced federal funding (e.g., 75%) for recipient fraud control programs similar to the Medicaid Fraud Control Units.
 - Require that state welfare agencies allocate a minimum proportion of their budgets (e.g., 0.5%) to specific fraud control efforts.
- State Legislatures should:
 - Enact legislation providing that a share of recovered overpayments be allocated to county welfare departments (in state-supervised welfare systems) and criminal justice agencies that assist in recovery efforts.
 - Establish both administrative penalties and civil fraud penalties for recipient and provider fraud.

- Provide control agencies with both subpoena powers and the authority to initiate investigations proactively (i.e., without waiting for referrals from the welfare agencies).
- Increase funding for control efforts, both within welfare agencies and in independent control agencies. (Part of this funding might come from a return to the participating agencies of a share of recovered overpayments.)
- Welfare Agencies should:
 - Assess areas of vulnerability to identify both program operations in which fraud occurs and specific recipients and providers most likely to commit fraud and devise remedies.
 - Train all staff regarding fraud-prone activities.
 - Create specialized units to respond to indications of fraud.
 - Increase fraud-specific computer-matching efforts, with expanded staff capability to investigate leads.
- Control Agencies should:
 - Designate specialized units to handle fraud cases, utilizing specially trained auditors, investigators, and prosecutors.
 - Proactively pursue potential fraud cases, while also acting on leads generated by welfare agencies and other complaints.
 - Pursue civil as well as criminal prosecution.

Finally, before decisions are made to shift federal responsibilities to states under the "New Federalism" proposals that seem to come and go, careful consideration must be given to the impact of such shifts on the fight against fraud and abuse. Our research indicates that states typically have neither the skills nor resources to control losses in benefit programs. Should states ever be expected to take full responsibility for fraud and abuse control, many of these recommendations would have to be in place first.

NOTES

Section I

1. In addition to the costs incurred by erroneous payments in the AFDC program, recipients gain access to the Medicaid and Food Stamps programs. Between October, 1979, and September, 1980, the Department of Agriculture projected from Food Stamp QC data that \$792 million was paid in error, about 8.6% of total Food Stamp issuances; 19% of households received overpayments. About 45% of variances were associated with the reporting of income data, 33% with reporting of deductions, 13% resources, 6% nonfinancial factors (e.g., household size), and 3% agency computation errors. Medicaid quality control reports for the period October 1980 through March 1981, indicated that 4.1% of the dollars spent were in error due to the recipient not being eligible for Medicaid (or the recipient's liability for payments was understated) and 0.7% of the claims processed for eligible clients were in error. HCFA, unlike Agriculture and the Social Security Administration, does not calculate a total national cost of errors.

Section III

1. Cf. Taddiken (1978: 51-52): "In many states, there are fundamental institutional roadblocks to accomplishing the objectives outlined in the federal legislation. These roadblocks derive not only from program issues--but, more importantly, from the basic management processes through which government programs are implemented. Examples here are civil service requirements, budgeting systems, and constitutional limitations on the expenditure of funds. While federal incentives can stimulate changes, they cannot, through their own existence, eliminate the roadblocks. In addition, the pressures that have produced the management processes and resulting roadblocks may be of such significant strength that they cannot be overridden merely by the availability of federal funds."
2. A 1978 study of several DHHS programs provided the following taxonomy of incentives programs (Taddiken, 1978: 182):

Section III (continued)

Orientation	Description of General Type	
	Financial	Non-Financial
Positive	Bonuses to Program	Increased Program Flexibility
	Bonuses to other Programs	Favorable Publicity
	Sharing of Savings	Technical Assistance
	Special Grants	Awards to Personnel/Officials
	Awards to Personnel	Special Conferences
Negative	Penalties against Program	Reduced Program Flexibility
	Penalties against other Programs	Bad Publicity
	Penalties against Administrative FFP	Mandatory Technical Assistance
	Mandated Payments from state general revenue funds	Civil Suits (by DHEW or Citizens)
	Performance bonds	
	Civil Money or Criminal	
	Penalties against officials	

3. One study suggests, however, that the funding structure of Child Support Enforcement units encourages waste and inefficiency, since the state, although contributing only 25% of the administrative costs of CSE, gains up to 50% (the state's share of AFDC) of recoveries from support order payments. (Maximus, 1982: VI: 3, 12-13)

REFERENCES

Section I

BENDICK, M., A. LAVINE, and T. CAMPBELL (1978) The Anatomy of AFDC Errors (Washington: Urban Institute)

CARTER, J. (1978) "Remarks" in The Secretary's National Conference on Fraud, Abuse, and Error: Protecting the Taxpayer's Dollar (Washington: Government Printing Office)

GARDINER, J., and T. LYMAN (1978) Decisions for Sale: Corruption and Reform in Land-Use and Building Regulation (New York: Praeger)

GENERAL ACCOUNTING OFFICE (1980) Better Management Information Can be Obtained From the Quality Control System Used in the Aid to Families with Dependent Children Program, HRD-80-80 (Washington: General Accounting Office)

____ (1981) Medicaid's Quality Control System is Not Realizing its Full Potential, HRD-82-6 (Washington: General Accounting Office)

HALSEY, H., F. NOLD, and M. BLOCK (1982) AFDC: An Analysis of Grant Overpayments (Palo Alto, CA: Block and Nold Economic Consultants)

HEW (1979) Office of Inspector General Annual Report: January 1, 1978 - December 31, 1978 (Washington: Department of Health, Education, and Welfare Office of Inspector General)

HOUSE SELECT COMMITTEE ON AGING (1982) Medicaid Fraud: A Case History in the Failure of State Enforcement, Comm. Pub. 97-315 (Washington: Government Printing Office)

LANGE, A., and R. BOWERS (1979) Fraud and Abuse in Government Benefit Programs (Washington: National Institute of Law Enforcement and Criminal Justice)

OFFICE OF MANAGEMENT AND BUDGET (1982) Budget of the United States Government, Fiscal Year 1983: Appendix (Washington: Government Printing Office)

RICHARDSON, J. (1977) "Quality Control Efforts," Part 7 of Congressional Research Service of the Library of Congress, Administration of the AFDC Program, a Report to the Committee on Government Operations of the United States House of Representatives (Washington: Government Printing Office)

Section I (continued)

SOCIAL SECURITY ADMINISTRATION (1980) Public Assistance Statistics, December 1980, ORS Report A-2 (Washington: Social Security Administration, Office of Research and Statistics)

(1982) Aid to Families with Dependent Children, Quality Control Findings, April-September 1980 (Washington: Social Security Administration, Office of Assessment)

Section II

BENDICK, M., A. LAVINE, and T. CAMPBELL (1978) The Anatomy of AFDC Errors (Washington: Urban Institute)

CONGRESSIONAL RESEARCH SERVICE (1977) Administration of the AFDC Program, A Report to the Committee on Government Operations of the United States House of Representatives (Washington: Government Printing Office)

FEDER, J., J. HOLOHAN, and T. MARMOR (1980) National Health Insurance: Conflicting Goals and Policy Choices (Washington: Urban Institute)

GENERAL ACCOUNTING OFFICE (1978) Attainable Benefits of the Medicaid Management Information System Are Not Being Realized, HRD-78-151 (Washington: General Accounting Office)

(1980) Federal Funding for State Medicaid Fraud Control Units Still Needed (Washington: General Accounting Office)

HEALTH CARE FINANCING ADMINISTRATION (1979) Data on the Medicaid Program, 1979 ed. (Baltimore: HCFA)

MEDICARE-MEDICAID ANTIFRAUD AND ABUSE AMENDMENTS (1977) Joint Hearings before the Subcommittee on Health, Committee on Ways and Means, and the Subcommittee on Health and the Environment, Committee on Interstate Commerce, United States House of Representatives, Serial 95-7 (Washington: Government Printing Office)

SOCIAL SECURITY ADMINISTRATION (1981) A Review of Fraud, Waste, and Abuse in New Jersey's AFDC Program (New York: Regional Commissioner, Office of Family Assistance)

STOVER, C. (1981) Finding and Forestalling Food Stamp Fraud: A Study of the Food Stamp Enforcement Activities of the Office of Inspector General-Investigations (Washington: United States Department of Agriculture Office of Inspector General)

THOMPSON, F. (1981) Health Policy and the Bureaucracy: Politics and Implementation (Cambridge: MIT Press)

Section II (continued)

WITTE, J. (1981) Welfare Errors in the State of Wisconsin (Madison: Report to the National Academy of Public Administration)

ZERENDOW, D. (1981) "MFCUs and the Single State Agency," in National Association of Attorneys General, Medicaid Fraud Report, 1 (June): 1-2

Section III

ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS (1980) The Federal Role in the Federal System: The Dynamics of Growth; Public Assistance: The Growth of a Federal Function (Washington: Government Printing Office).

FEDERAL REGISTER (1980) "Fiscal Disallowance for Erroneous Payment in Aid to Families with Dependent Children and Medicaid Programs; Calculating Reduction in Federal Financial Participation for Incorrect Payment by States after September 1980" (January 25).

GARDINER, J., S. HENTZELL, and T. LYMAN (1982) Fraud in Government Benefit Programs: Suggested State/Local Prevention Strategies (Washington: National Institute of Justice).

GENERAL ACCOUNTING OFFICE (1980) Better Management Information Can be Obtained from the Quality Control System Used in the Aid to Families with Dependent Children Program, HRD-80-80 (Washington: General Accounting Office).

(1981) Medicaid's Quality Control System is Not Realizing Its Full Potential, HRD-82-6 (Washington: General Accounting Office).

(1982) Analysis of Four States' Administration of the AFDC Program: Management Improving But More Needs to be Done, HRD-82-20 (Washington: General Accounting Office).

MAXIMUS, INC. (1982) Evaluation of the Child Support Enforcement Program: Second Year Final Report, Report to the Office of Research and Statistics, Social Security Administration.

MENDELOFF, J. (1977) "Welfare Procedures and Error Rates: An Alternative Perspective," Policy Analysis 3 (Summer): 357-374.

PILIAVIN, I. (1978) Worker-Agency Characteristics and Administrative Improvement (Madison: University of Wisconsin Institute for Research on Poverty).

RICHARDSON, J. (1977) "Quality Control Efforts," Part 7 of Congressional Research Service of the Library of Congress, Administration of the AFDC Program--A Report to the Committee on Government Operations of the

Section III (continued)

United States House of Representatives (Washington: Government Printing Office).

STEINER, G. (1966) Social Insecurity: The Politics of Welfare (Chicago: Rand, McNally).

TADDIKEN, A. (1978) Improving the Federal-State Partnership in Aid to Families with Dependent Children and Related Programs (Rochester, NY: Center for Governmental Research).

ZELLER, F. (1981) AFDC Payment Error Rate Case Studies: Comparative Analysis (Washington: National Academy of Public Administration).

APPENDIX

PROJECT SITE CONTACTS

Type of Official	State		
	Colorado	Illinois	Washington
Federal Program	6	8	4
Federal Fraud Control	2	10	4
State Legislators, staff or political leaders	4	13	5
State Program	9	13	12
State Fraud Control	6	12	5
Local Program	10	-	19
Local Fraud Control	7	1	4
Community or Other Organizations	4	4	5

END