United States General Accounting Office

GAO

Fact Sheet for the Chairman,
Subcommittee on Intergovernmental
Relations and Human Resources,
Committee on Government Operations,
House of Representatives

October 1986

MEDICAID

Results of Certified Fraud Control Units

GAO/HRD-87-12FS

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-224911

October 21, 1986

The Honorable Ted Weiss
Chairman, Subcommittee on Intergovernmental
Relations and Human Resources
Committee on Government Operations
House of Representatives

Dear Mr. Chairman:

This fact sheet is in response to your request and later discussions with your office for information on state Medicaid fraud control units. It presents the results of our efforts to determine, for states with certified fraud control units:

-- Their expenditures, including the federal and state governments' share of the expenses, for fiscal years 1984 and 1985.

-- Their results, including the number of convictions obtained, fines imposed, restitution ordered, and overpayments identified for calendar years 1984 and 1985 and their deterrent effect.

-- Changes that could strengthen their fraud control efforts.

We obtained information from two major sources: (1) quarterly statistical data submitted by the fraud units to the Department of Health and Human Services' (HHS's) Office of the Inspector General and (2) a questionnaire we sent to the 36 certified units in operation in fiscal year 1985. We did not verify the reliability of any of the data obtained from the fraud units since we did not visit them. We also obtained information from unit administrators, HHS, and the National Association of Medicaid Fraud Control Units.

In fiscal year 1984, the fraud units cost a total of about $43 million--$11 million in state funds and $32 million in federal funds. In fiscal year 1985, the units cost a total of about $47 million--$11 million and $36 million in state and federal funds, respectively.

The results of the fraud units' efforts for calendar years 1984 and 1985 are shown below.

Fraud Unit Results

	1984	1985
Cases opened	2,693	2,871
Cases closed (no merit)	1,952	2,213
Patient fraud/abuse matters reviewed	743	954
Number of providers convicted	404	440
Number of providers receiving jail sentences	68	108
Fines:		
Imposed	$1,267,067	$1,427,195
Collected	$901,746	$875,454
Restitution:		
Ordered	$3,560,445	$4,018,112
Collected	$2,283,313	$3,074,477
Medicaid program overpayments:		
Estimated	$14,713,358	$7,297,771
Judgments	$6,619,073	$2,874,757
Collected	$7,087,437	$4,281,695

Six units had analyzed or, at the time we completed our work, were analyzing the deterrent effect of their investigations on providers. Other units had anecdotal evidence suggesting their deterrent effect on providers. For example, in four cases, we were told that providers voluntarily disclosed their fraudulent activities to the units in fiscal year 1985.

In response to our questionnaire, 23 unit managers recommended changes that they thought should be considered by states or the federal government to help the units accomplish their missions. These included improving case referrals from state Medicaid agencies to the fraud units and improving patient abuse statutes at the state or federal level.

As requested by your office, we did not obtain comments on this fact sheet. Unless you publicly announce its contents earlier, we plan no further distribution of this document until 30 days from its issue date. At that time we will send copies to the Secretary of HHS, the state Medicaid fraud control units, the

National Association of Medicaid Fraud Control Units, and other interested parties and make copies available to others on request.

Should you need additional information on the contents of this document, please call me at 275-5451.

Sincerely yours,

Franklin A. Curtis

Franklin A. Curtis
Associate Director

Contents

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OIG	Office of Inspector General

MEDICAID:

RESULTS OF CERTIFIED FRAUD CONTROL UNITS

INTRODUCTION

Under the Medicaid program, the federal and state governments share the costs incurred by states in providing medical care to persons unable to pay for such care. This program, authorized by title XIX of the Social Security Act, began in 1966. Each state's Medicaid agency is responsible for designing and administering its program. The Department of Health and Human Services' (HHS's) Health Care Financing Administration (HCFA) approves the states' plans and monitors program operations. In fiscal year 1987, Medicaid will cost the federal and state governments an estimated $47 billion.

On October 25, 1977, the Congress enacted legislation authorizing a fraud unit in every jurisdiction operating a Medicaid program. The fraud units are responsible for investigating providers[1] who commit fraud and abuse in the Medicaid program. When the Congress enacted this legislation, it was concerned that sufficient efforts were not being made to control Medicaid fraud. This legislation authorized federal funding at 90 percent for 3 years, until September 30, 1980. In December 1980, the federal contribution of 90 percent was limited to a unit's first 3 full years of operations and limited to 75 percent thereafter.

Since April 1979, HHS's Office of Inspector General (OIG) has been responsible for the certification, annual recertification, and oversight of the fraud units. To be certified, a unit must meet several requirements. Two of the requirements are that the unit must be (1) an entity separate from and independent of the state Medicaid agency and (2) part of the state attorney general's office or have formal procedures established for referring cases to it.

There were 33 certified units at the end of fiscal year 1984, 36 at the end of fiscal year 1985, and 38 as of September 1986.

OBJECTIVES, SCOPE, AND METHODOLOGY

In response to a request from the Chairman, Subcommittee on Intergovernmental Relations and Human Resources, House Committee on Government Operations, and later discussions with his office, we obtained the following information:

---

[1]A provider is "an individual or entity which furnishes items or services for which payment is claimed under Medicaid."

-- Fraud units' expenditures, including the federal and state governments' share, for fiscal years 1984 and 1985.

-- Fraud units' results, including the number of convictions obtained, fines imposed and collected, restitution ordered and collected, and overpayments identified and collected for calendar years 1984 and 1985.

-- Evidence of individual fraud units' deterrent effect.

-- Changes that could strengthen the units' fraud control efforts.

Source of Information

Our fieldwork was done between August 1985 and September 1986. During this period, we obtained data from officials we interviewed in the OIG, the fraud units, and the National Association of Medicaid Fraud Control Units.

To obtain data on expenditures and results for the 36 fraud units in operation in fiscal year 1985, we relied on quarterly reports the units submit to the OIG. We used quarterly Financial Status Reports for federal fiscal years 1984 and 1985 for the expenditure data. For information on results, we used quarterly Resource and Caseload File Reports for calendar years 1984 and 1985. We did not verify the reliability of any of the data obtained from the fraud units since we did not visit them.

Our report includes data on the 36 units certified as of fiscal year 1985. For 31 of the units, we have complete data for calendar and fiscal years 1984 and 1985. The other five units--in Arizona, Mississippi, New Hampshire, South Dakota, and Tennessee--were certified in 1984. Therefore, we do not have two complete years (calendar or fiscal) of data for them. (App. I shows the certification dates for all 36 units.)

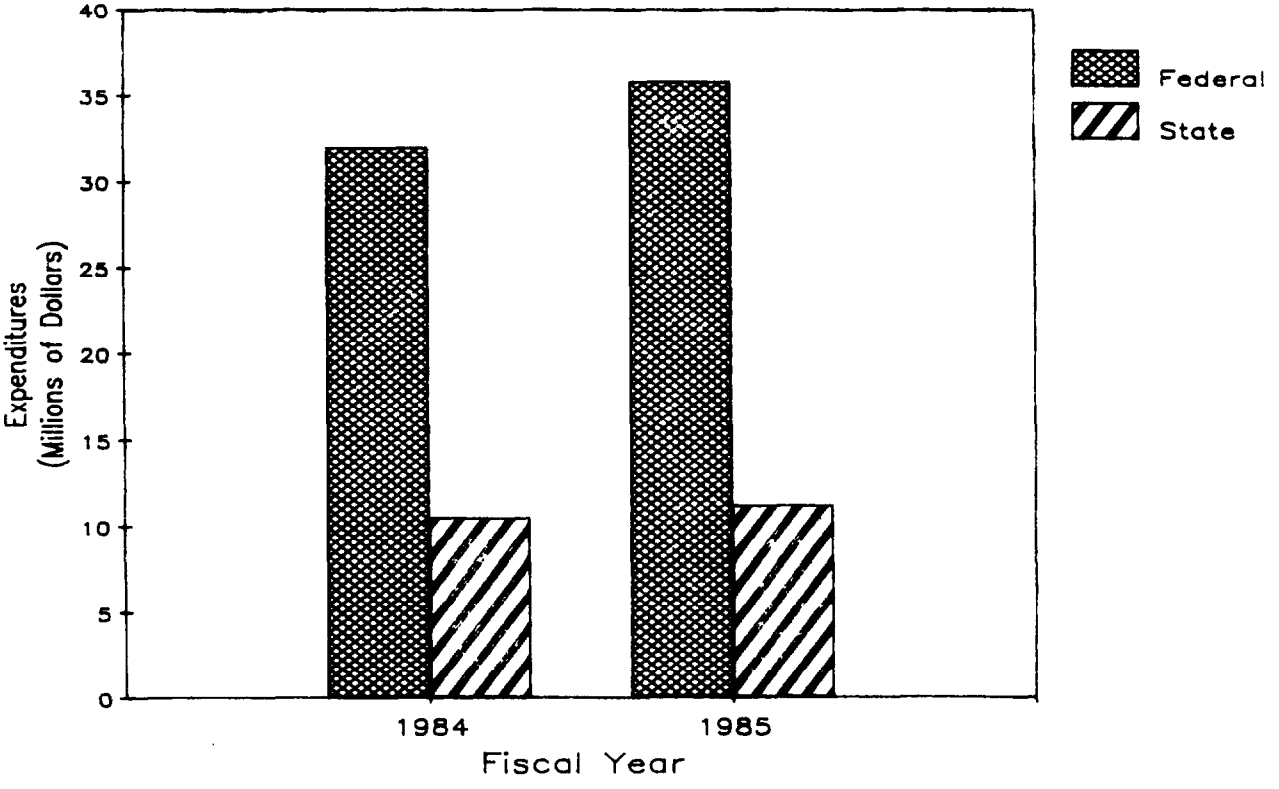
We also agreed with the Chairman's office to send a questionnaire to the fraud units. In February 1986, we mailed a questionnaire to the 36 certified units. From the questionnaire, we obtained data on where the units' cases originated and managers' views on deterrence, penalties for convicted providers, and changes that could strengthen their fraud control efforts. The response rate to our questionnaire was 100 percent. (See app. II for a sample questionnaire.)

As requested by the Chairman's office, we did not obtain comments on this fact sheet.

FRAUD UNIT EXPENDITURES

Total federal and state expenditures for the fraud units were about $43 million and $47 million in fiscal years 1984 and 1985, respectively. The federal share of the units' total expenditures was about $32 million (75 percent) in fiscal year 1984, and about $36 million (76 percent) in fiscal year 1985. A breakdown of the total expenditures by federal and state share is in figure 1.

Figure 1: Federal and State Expenditures for Medicaid Fraud Control Units
(Fiscal Years 1984 – 1985)



Of the 33 fraud units in operation in fiscal year 1984, 28 received 75-percent federal and 25-percent state funding. The other five units received 90-percent federal and 10-percent state funding. Of the 36 units in operation in fiscal year 1985, 28 received 75-percent federal funding and 8 received 90-percent federal funding. (The units' expenditures are listed by state and federal share for fiscal years 1984 and 1985 in app. III.)

FRAUD UNIT RESULTS

The fraud units' mission is to investigate and prosecute providers for committing fraud and to investigate allegations of patient physical and financial abuse.[2] The units prosecute providers who are indicted or refer them to state prosecuting authorities or the state attorney general for prosecution. If the providers are convicted, they may receive a jail sentence or probation, pay fines or restitution, or perform public service. In addition to these potential results from fraud unit efforts, many unit administrators believe their units may have a deterrent effect on other providers.

The fraud units summarize the results of their investigations and prosecutions in the quarterly Resource and Caseload File Reports that they submit to the OIG. These reports include such information as the number of convictions obtained, amount of court-imposed penalties, and amount of program overpayments identified during investigations. Table 1 highlights the units' results for calendar years 1984 and 1985. (Apps. IV to IX show these data by unit.)

Table 1:

Fraud Unit Results

	1984	1985
Cases opened	2,693	2,871
Cases closed (no merit)	1,952	2,213
Patient fraud/abuse matters reviewed	743	954
Number of providers convicted	404	440
Number of providers receiving jail sentences	68	108
Fines:		
Imposed	$1,267,067	$1,427,195
Collected	$901,746	$875,454
Restitution:		
Ordered	$3,560,445	$4,018,112
Collected	$2,283,313	$3,074,477
Medicaid program overpayments:		
Estimated	$14,713,358	$7,297,771
Judgments	$6,619,073	$2,874,757
Collected	$7,087,437	$4,281,695

Source: Certified Medicaid Fraud Control Units quarterly Resource and Caseload File Reports submitted to the OIG.

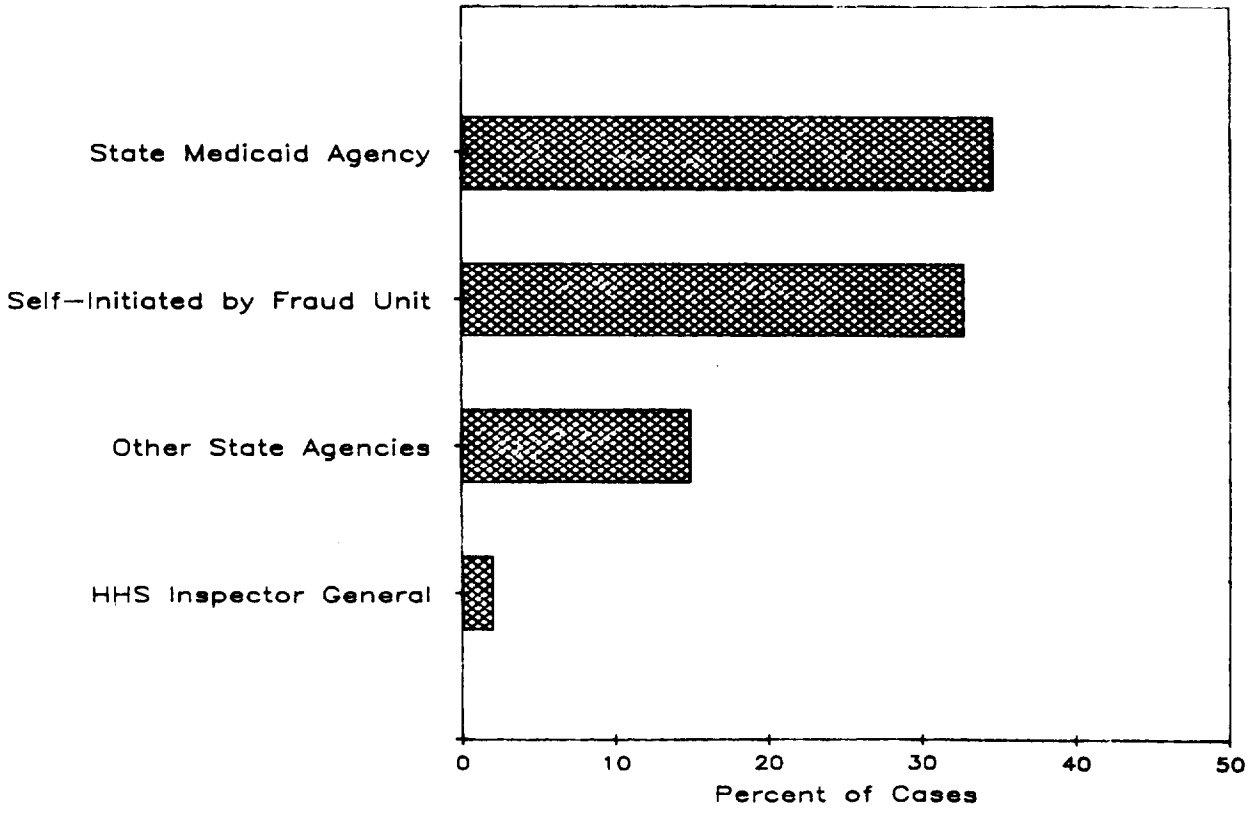
---

[2]Financial abuse refers to misappropriation of patients' private funds in health care facilities that receive Medicaid funds.

Sources and Numbers of Cases Opened

The fraud units' cases are referred to them from various sources. In fiscal year 1985, on the average, most of the cases were referred from the state Medicaid agency (34.7 percent). Figure 2 shows the sources of the units' cases for fiscal year 1985.

Figure 2: Source of Fraud Case Referrals
(Fiscal Year 1985)



During calendar years 1984 and 1985, the fraud units opened 2,693 and 2,871 cases, respectively. The number of patient abuse matters reviewed during these years were 743 and 954. (App. IV shows these data by fraud unit and year.)

Various types of health care providers were investigated for fraud and/or abuse during calendar years 1984 and 1985, including

-- institutions, such as nursing homes and hospitals;

-- practitioners, such as medical doctors and dentists; and

-- other providers of medical support, such as pharmacists and laboratories.

Convictions

The Resource and Caseload File Reports showed that the certified fraud units obtained convictions on 404 providers in calendar year 1984 and 440 in 1985. (App. V shows the number of convictions by year and fraud unit.)

Jail Sentences

In calendar years 1984 and 1985, the units reported 68 and 108 convicted providers, respectively, who received jail sentences for varying lengths of time. (App. VI shows these data by year and fraud unit.)

In response to our questionnaire, 14 of the 36 fraud unit administrators indicated that the percentage of convicted providers receiving jail sentences was higher in fiscal year 1985 than when their units were initially certified. Nine of the 14 believed that more frequent imposition of jail sentences on providers increased their ability to get convictions and helped deter providers from committing fraud.

Fifteen fraud unit administrators believed that there was no difference in the number of providers receiving jail sentences in fiscal year 1985 and the year their units were certified, while two believed that more providers received jail sentences when their units were first certified than in fiscal year 1985.

Fines, Restitution, and Overpayments

The OIG's instruction manual for completing the Resource and Caseload File Reports defines a fine as "a sum imposed by a court of law as punishment for an offense" and restitution as "money wrongfully taken which a court of law orders a convicted defendant to return." In the quarterly Resource and Caseload File Reports for calendar year 1984, the fraud units reported that the courts imposed on providers fines totaling about $1.3 million. In calendar year 1985, total fines imposed were about $1.4 million. Total fines collected were about $0.9 million in both 1984 and 1985. (See app. VII for data by unit on fines.)

The units also reported that the courts ordered restitution from the providers totaling about $3.6 million in calendar year 1984 and about $4.0 million in calendar year 1985. Total restitution collected during 1984 and 1985 was about $2.3 million and $3.1 million, respectively. (See app. VIII for data by unit on restitution.)

During their investigations, the fraud units identify Medicaid overpayments made to providers. In the Resource and Caseload File Report Instruction Manual, the OIG defines

overpayments as the amount of money that a unit has "determined from its investigative processes as having the potential of being wrongfully overpaid." According to the caseload reports, the units identified overpayments of about $14.7 million in 1984 and about $7.3 million in 1985.

In addition to reporting overpayments, the units report the amount of judgments against providers relating to overpayments. The OIG defines judgments as "the amount of money as established by the final order of a court or administrative tribunal concerning Medicaid program overpayments." The units reported judgments against providers of about $6.6 million in 1984 and about $2.9 million in 1985.

Total estimated overpayments and judgments collected were reported as about $7.1 million in 1984 and about $4.3 million in 1985. (See app. IX for data by unit on overpayments and judgments.)

Deterrence

The OIG and many fraud unit officials believe that the units have some effect in deterring providers from committing fraud. Although it is difficult to document and quantify the deterrent effect, six units have attempted to do so during their investigations. In addition, some unit officials noted examples that suggest that actions by their units have a deterrent effect on providers.

In March 1982 congressional testimony before the House Appropriations Committee and Senate Special Committee on Aging, HHS's Inspector General and a fraud unit official discussed units' deterrent effects. The Inspector General said the units represent a strong deterrent to fraud, waste, and abuse at the state level that could not be duplicated by the OIG if the units did not exist. Regarding the difficulty in measuring deterrence, the fraud unit official testified that "it is impossible to quantify the deterrent savings associated with the Medicaid fraud control units . . ." But he added that as long as fraud units exist and health care providers are aware that someone is looking at their actions and using such techniques as undercover activities, there is a greater chance of decreasing fraud and abuse.

Five units have analyzed, and one is analyzing, the deterrent effects of their investigations on providers. Each analysis includes a review of changes in providers' Medicaid billing patterns or changes in Medicaid payments to providers as indicators of deterrence before, during, and after fraud unit investigations. One difference, however, between the analyses is the type of provider they focused on. For example, New York's analysis involved transportation providers (i.e., taxi

companies that take Medicaid recipients to hospitals or other health care providers), while Ohio's focused on a pharmacist.

Four of the five completed analyses concluded that once providers became aware of ongoing investigations on them or other providers in the same geographic area or provider specialty, their Medicaid billings decreased. The following is a brief summary of each unit's analysis.

-- In Ohio, the fraud unit studied a pattern that it noticed had emerged while it investigated a pharmacist. The investigators noticed a change in the pharmacist's Medicaid billing pattern when he became aware of their investigation. Before the investigation, the pharmacist was billing Medicaid for such items as drugs other than those he dispensed and a drug prescribed for a non-Medicaid recipient. During the investigation, the fraud unit found that his Medicaid billings per month decreased by 80 percent. According to the unit's August 1, 1985, analysis, the change in the billing pattern could be attributed to the unit's ongoing investigation and the pharmacist's "fear of being found out."

-- In New York, the fraud unit's investigation of a number of Medicaid transportation providers had the effect of reducing Medicaid expenditures by some providers under investigation and others not under investigation, according to the unit's December 1983 analysis of data gathered on these providers. As the providers became aware of the investigation, their billing patterns changed, which indicated that the investigation had a deterrent effect. For example, two transportation providers reduced their billings by about 37 percent (or $140,332) once they became aware of the investigation. Another company decreased its billings by 23 percent (or $20,708) during the investigation. According to the unit's analysis, their audits/investigations have a deterrent effect and result in substantial savings of Medicaid dollars.

-- In California, in a February 1985 memo, the fraud unit noted that during one investigation, Medicaid payments to providers under investigation decreased by 54 percent (or $4.3 million). In addition, after the investigation and arrest of many of the providers, unit officials noted a 15-percent (or $1.4 million) decline in payments to providers who were not involved in the investigation as defendants.

-- In Illinois, the fraud unit did a "cost avoidance study" in August 1985 to determine the savings for the state's Medicaid program as a direct result of its investigation

and prosecution of providers associated with a complex fraud case. Payments to Medicaid providers were compared before the fraud investigation, during it, and after the initial indictments. The "study" states that the investigation and prosecutions of providers realized a cost savings of over $7 million in only a 1-year period and halted the significant growth patterns of these fraudulent Medicaid bills.

-- In the spring of 1986, the Michigan fraud unit identified savings resulting from reductions in Medicaid billings following various actions against providers (e.g., convictions, arrests, out-of-court settlements) during 1978 through March 1986. For example, savings from reductions in subsequent billings by providers who were arrested but not convicted in calendar year 1982 were $677,446. In addition, during that same year, savings from reductions in subsequent billings by providers who were not arrested but had negotiated out-of-court settlements were $172,633.

In addition, in 1986, the Massachusetts fraud unit and the Department of Public Welfare are studying the effect of the unit's enforcement activities on the billings by independent clinical laboratories, including those involved and not involved in ongoing investigations of laboratories.

There is also anecdotal evidence suggesting that fraud units and their investigations have deterrent effects on providers. For example, fraud unit managers from Connecticut and Minnesota believe that their investigations and convictions had a deterrent effect because they had been asked to speak about fraud control efforts at conferences for providers and lawyers. Similarly, in our 1980 report on the fraud units,[3] we noted an example of a fraud unit's deterrent effect. We said that an official from the Massachusetts fraud unit had attended a pharmaceutical seminar at which the pharmacists expressed concern about the unit's makeup, the types of cases being investigated and prosecuted, fines and penalties for providers convicted of civil and criminal offenses, and the unit's sources of fraud referrals.

In response to our questionnaire, unit managers in California, Maryland, New York, and Pennsylvania cited instances of providers voluntarily turning themselves in to the unit in fiscal year 1985. According to the unit manager in Maryland, a provider voluntarily reported himself to the unit out of fear of being caught and prosecuted. In our 1980 report, we noted a

---

[3]Federal Funding for State Medicaid Fraud Control Units Still Needed (GAO/HRD-81-2, Oct. 6, 1980).

similar incident in Ohio. In that case, a nursing home owner contacted the unit and tried to "make a deal" with them about some questionable charges to the Medicaid program. The owner claimed that the publicity from another case prompted him to "go straight."

REGULATORY CHANGES PROPOSED BY THE OIG

In April 1986, the OIG proposed three new rules to increase units' effectiveness. Two of the three rules are on unit staffing levels. The third is on staff training.

Two of the proposed rules concern minimum staffing requirements for states applying for unit certification for the first time. Current federal regulations do not specify the number of staff a unit must employ to carry out its duties and responsibilities effectively and efficiently. The OIG compared the performance of several fraud units to attempt to document a relationship between minimum staff size and unit effectiveness. Although the study's results were not conclusive, the OIG proposed the following rules for initial certification of units:

1. Units must have at least five professional staff members upon initial certification unless the OIG waives this requirement.

2. Units must maintain a minimum ratio of 2 to 3 investigators for each attorney on their staff.

The OIG's rationale for proposing the first rule was that it believed that the "adequacy of professional staff equates to a strong commitment to an effective Medicaid Fraud Control Program." The OIG had found that, in the past, units that started with fewer than five professional staff members usually increased the number of staff within 1 year. The OIG's rationale for proposing the second rule was that units have a better chance for successfully prosecuting cases when there are enough staff to investigate and prepare cases for prosecution.

In addition to these two rules, the OIG is proposing that "All Medicaid Fraud Control personnel must receive basic training in 'White Collar Crime' and Medicaid program regulations." The OIG believes that after receiving this training, individuals can better detect white collar crime and differentiate fraud from program abuse and more effectively culminate investigations and prosecutions into convictions or other sanctions against the providers.

As of September 1986, the rules were being reviewed by the units and the National Association of Medicaid Fraud Control Units.

ADMINISTRATORS' VIEWS ON POSSIBLE CHANGES TO STRENGTHEN FRAUD CONTROL EFFORTS

Before developing our mail-out questionnaire, we conducted a preliminary telephone survey of eight unit administrators. Using the results of that survey, we listed possible needed changes to laws or regulations at the state or federal levels to help fraud units carry out their missions, which we included in our questionnaire. In the questionnaire, we asked fraud unit administrators if their states had these provisions, laws, or regulations and if they would be useful to all units in carrying out their mission. Table 2 lists these items.

Table 2:

Administrators' Views on Possible Changes in Laws or Regulations at the State or Federal Level

	Number of states currently implemented in	Number of units believing this would be useful
Statewide criminal prosecutorial authority	26	36
Law enforcement authority	19	34
Authority to grant immunity to witnesses	20	35
Authority to use electronic surveillance	27	36
Authority to prosecute cases in the district or county where unit is located	24	30
Authority to prosecute civil cases of fraud	27	29
Require providers to return written acknowledgement to state Medicaid agency for receipt of changes in Medicaid instructions or manuals	1	34
Grand jury specializing in examining Medicaid fraud cases	7	26
Provide federal reimbursement for support staff working less than 100 percent of working hours on fraud-related activities	0	25

We also asked them to suggest changes they thought should be considered at the state or federal level. Twenty-three unit administrators provided suggestions, which are listed in appendix X. They include

-- allowing the fraud units to investigate Medicare, in addition to Medicaid, fraud;

-- improving the Medicaid reimbursement system to check for fraud before a provider's claim is paid;

-- improving patient abuse statutes at the federal level; and

-- improving potential fraud case referrals from the state Medicaid agency to the unit.

APPENDIX I

FRAUD UNIT CERTIFICATION DATES

State fraud unit[a]	Certification date
Alabama	Apr. 1978
Arizona	Oct. 1984
Arkansas	Jan. 1979
California	July 1978
Colorado	May 1978
Connecticut	June 1978
Delaware	Apr. 1980
Florida	Aug. 1980
Hawaii	July 1978
Illinois	June 1978
Indiana	July 1982
Kentucky	Apr. 1980
Louisiana	July 1978
Maine	July 1979
Maryland	Jan. 1979
Massachusetts	July 1978
Michigan	Oct. 1978
Minnesota	June 1983
Mississippi	Mar. 1984
Montana	Jan. 1980
New Hampshire	Oct. 1984
New Jersey	Mar. 1978
New York	May 1978
North Carolina	Jan. 1979
Ohio	June 1978
Pennsylvania	Dec. 1978
Rhode Island	Jan. 1979
South Dakota	Oct. 1984
Tennessee	July 1984
Texas	Jan. 1979
Utah	Oct. 1980
Vermont	Oct. 1978
Virginia	Oct. 1982
Washington	Apr. 1978
West Virginia	Oct. 1979
Wisconsin	July 1978

[a]New Mexico and Oregon are not included here because they did not become certified fraud units until fiscal year 1986.

SAMPLE QUESTIONNAIRE SENT TO FRAUD UNITS

ID____ 1-2

U. S. GENERAL ACCOUNTING OFFICE

SURVEY OF MEDICAID FRAUD CONTROL UNITS

GENERAL INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE

--Please verify that the name and address for your unit and its administrator as shown on the mailing label are correct. Make any necessary changes in the space provided to the right of the label.

--Since many of the items ask for opinions about changes that should be considered in laws and regulations governing fraud control units, we request that the form be completed by the unit's chief administrator.

--Where actual data to answer the factual questions are not available, please give us your best estimate.

****

THANK YOU FOR YOUR COOPERATION.

****

1

APPENDIX II

I. THE FY 85 CASELOAD

1. Many of the questions in this form refer to fiscal year 1985. If possible, please answer those questions for the 1985 federal fiscal year. If your records are not organized that way, use the 1985 fiscal year for your program. In either case, please indicate the dates for which you are reporting below.

Beginning date:	_____ Month	19_____ Year	5-8/8
Ending date:	_____ Month	19_____ Year	9-12/8

2. During fiscal year 1985, what was the total number of Medicaid fraud cases opened by your office? ("MEDICAID FRAUD" INCLUDES PROVIDER FRAUD, PHYSICAL PATIENT ABUSE, AND FINANCIAL PATIENT ABUSE. PLEASE INCLUDE CASES INITIATED BY YOUR OFFICE AND CASES REFERRED TO YOUR OFFICE FROM OTHER SOURCES.)

Number of Medicaid fraud cases opened in FY 85.....	_____	13-16/8

3. About what percentage of the cases that you opened in FY 85 came to your office from each of the sources listed below? (ENTER A PERCENTAGE ON EACH LINE. IF THE PERCENTAGE ON ANY LINE IS "ZERO," ENTER "0." ESTIMATES ARE ACCEPTABLE.)

Source	Percentage of Cases	
Self-initiated.....	_____%	17-19/8
State Medicaid agency.....	_____%	20-22/8
Other state agencies.....	_____%	23-25/8
HHS Inspector General.....	_____%	26-28/8
Other (include other identifiable sources not listed above).....	_____%	29-31/8
Source not readily identifiable.....	_____%	32-34/8
TOTAL.....	100%	

APPENDIX II

II. DETERRENCE

We would like information about the extent to which Medicaid Fraud Control Unit investigations of providers deter other providers **not being investigated** from committing fraud, much in the same way that, for example, IRS investigations of tax evaders might deter cheating by other taxpayers.

4. Since your unit was initially certified, have any formal studies been done by you or anyone else to determine the effect of **your unit's** activities in deterring health providers from committing fraud? (BY "FORMAL STUDY," WE MEAN A STRUCTURED ACTIVITY SPECIFICALLY DESIGNED TO ADDRESS QUESTIONS ABOUT DETERRENCE.)

   1. [ ] Yes (ANSWER QUESTION 5)

   2. [ ] No (GO TO QUESTION 6) 35/8

5. Are results of this study(ies) available?

   1. [ ] Yes (PLEASE INCLUDE A COPY WITH YOUR QUESTIONNAIRE)
   2. [ ] No 36/9

6. During FY 85, apart from providers under investigation, did any providers **voluntarily** disclose fraudulent activities about themselves to your unit?

   1. [ ] Yes (ANSWER QUESTION 7)

   2. [ ] No (GO TO QUESTION 8) 37/8

7. About how many providers not under investigation **voluntarily** disclosed their fraudulent activities to your unit during FY 85?

Number not under investigation
who voluntarily disclosed their
fraudulent activities in FY 85....._____ 38-39/9

8. Is the Medicaid agency in your state required to report to you the amount of overpayments that providers return voluntarily or because of your investigation?

1. [ ] Yes (CONTINUE WITH QUESTION 9)

2. [ ] No (GO TO SECTION III ON PAGE 5) 40/8

9. During FY 85, apart from providers under investigation, did any providers **voluntarily** return overpayments to the state Medicaid agency?

1. [ ] Yes

2. [ ] No 41/9

10. During FY 85, about how many providers not under investigation voluntarily returned overpayments to the state Medicaid agency?

Number not under investigation
who voluntarily returned
overpayments in FY 85....._____ 42-43/9

APPENDIX II

III. PENALTIES FOR CONVICTED PROVIDERS

We are interested in the differences in penalties imposed on Medicaid offenders during the year when your unit was first certified and the penalties imposed during FY 85.

11. Thinking about these two points in time, would you say that the percentage of convicted providers receiving jail sentences was higher when your unit was first certified, higher in FY 85, or about the same for both years? (USE YOUR BEST ESTIMATE IF NECESSARY. PLEASE CHECK ONE BOX ONLY.)

1. [ ] Percentage receiving jail sentences was higher when unit was first certified (ANSWER QUESTION 12)

2. [ ] Percentage was higher in FY 85 (ANSWER QUESTION 13)

3. [ ] Percentages were about the same for both years (GO TO QUESTION 14)

4. [ ] Don't know (GO TO QUESTION 14) 44/8

12. In your view, what was the general effect, if any, of the change to **less frequent** jail sentences on the ability of your unit to do its work in the following areas? (CHECK ONE BOX ON EACH LINE.)

Area	Effect of Less Frequent Jail Sentences: No Consistent Effect (1)	Increased Unit's Ability (2)	Decreased Unit's Ability (3)	
Getting indictments.....	[ ]	[ ]	[ ]	45/9
Getting convictions.....	[ ]	[ ]	[ ]	46/9
Deterring providers from committing fraud.....	[ ]	[ ]	[ ]	47/9

**********IF YOU ANSWERED QUESTION 12, PLEASE GO TO QUESTION 14**********

5

APPENDIX II

13. In your view, what was the general effect, if any, of the change to **more frequent** jail sentences on the ability of your unit to do its work in the following areas? (CHECK ONE BOX ON EACH LINE.)

Area	Effect of More Frequent Jail Sentences: No Consistent Effect (1)	Increased Unit's Ability (2)	Decreased Unit's Ability (3)	
Getting indictments.....	[ ]	[ ]	[ ]	48/9
Getting convictions.....	[ ]	[ ]	[ ]	49/9
Deterring providers from committing fraud.....	[ ]	[ ]	[ ]	50/9

14. Between the time your unit was first certified and FY 85, were there any changes in what constitutes a misdemeanor or felony that made certain types of Medicaid fraud **more serious** crimes? (INCLUDE, FOR EXAMPLE, CHANGES IN THE CLASSIFICATION OF CERTAIN TYPES OF MEDICAID FRAUD FROM LESS SERIOUS TO MORE SERIOUS MISDEMEANORS OR FELONIES.)

1. [ ] Yes (ANSWER QUESTION 15)

2. [ ] No (GO TO QUESTION 16) 51/8

15. In your view, how did classifying certain types of Medicaid fraud as more serious crimes affect the ability of your unit to get indictments and convictions, and to deter providers from committing those kinds of fraud? (CHECK ONE BOX ON EACH LINE.)

Area	Effect of Classifying Certain Types of Medicaid Fraud As More Serious Crimes: No Consistent Effect (1)	Increased Unit's Ability (2)	Decreased Unit's Ability (3)	
Getting indictments for those types of fraud.	[ ]	[ ]	[ ]	52/9
Getting convictions for those types of fraud.	[ ]	[ ]	[ ]	53/9
Deterring providers from committing those types of fraud.....	[ ]	[ ]	[ ]	54/9

**********************PLEASE CONTINUE WITH QUESTION 16*********************

APPENDIX II

16. Between the time your unit was first certified and FY 85, were there any changes in what constitutes a misdemeanor or felony that made certain types of Medicaid fraud **less serious** crimes?

1. [ ] Yes (ANSWER QUESTION 17)

2. [ ] No (GO TO SECTION IV ON PAGE 8) 55/8

17. In your view, how did classifying certain types of Medicaid fraud as less serious crimes affect the ability of your unit to get indictments and convictions, and to deter providers from committing those kinds of fraud? (CHECK ONE BOX ON EACH LINE.)

	Effect of Classifying Certain Types of Medicaid Fraud As Less Serious Crimes			
Area	No Consistent Effect (1)	Increased Unit's Ability (2)	Decreased Unit's Ability (3)	
Getting indictments for those types of fraud.	[ ]	[ ]	[ ]	56/9
Getting convictions for those types of fraud.	[ ]	[ ]	[ ]	57/9
Deterring providers from committing those types of fraud.....	[ ]	[ ]	[ ]	58/9

APPENDIX II

IV. VIEWS ABOUT NEEDED CHANGES

This section asks for your views about laws or regulations that could be implemented in many or all states to help Medicaid Fraud Control Units carry out their missions.

18. Are any of the following provisions currently part of **your** state's laws or regulations? (CHECK "YES" OR "NO" ON EACH LINE.)

Provision	Yes (1)	No (2)	
Fraud unit has statewide criminal prosecutorial authority.....	[ ]	[ ]	59/8
Fraud unit has law enforcement authority.....	[ ]	[ ]	60/8
Fraud unit can grant immunity to witnesses.....	[ ]	[ ]	61/8
Fraud unit can use electronic surveillance.....	[ ]	[ ]	62/8

19. In your view, how useful would each of the provisions listed below be to help Medicaid Fraud Control Units **across the nation** accomplish their missions? (PLEASE CHECK ONE BOX ON EACH LINE.)

	Very Useful (1)	Somewhat Useful (2)	Not Very Useful (3)	Don't Know (4)	
Giving fraud units statewide criminal prosecutorial authority.....	[ ]	[ ]	[ ]	[ ]	63/8
Giving fraud units law enforcement authority.....	[ ]	[ ]	[ ]	[ ]	64/8
Allowing fraud units to grant immunity to witnesses.....	[ ]	[ ]	[ ]	[ ]	65/8
Allowing fraud units to use electronic surveillance.....	[ ]	[ ]	[ ]	[ ]	66/8

8

20. Are providers in **your state** currently required to return a written receipt to acknowledge that they have received changes in Medicaid instructions or manuals?

1. [ ] Yes

2. [ ] No 67/8

21. In general, how useful do you believe it would be for all states to require written acknowledgement from providers when they receive changes in Medicaid instructions? (CHECK ONE BOX ONLY.)

1. [ ] Very useful

2. [ ] Somewhat useful

3. [ ] Not very useful

4. [ ] Don't know 68/8

22. Is **your unit** required to bring cases to court only in the district or county where the provider operates, or can you also bring cases to court where the unit is located? (CHECK ONE BOX ONLY.)

1. [ ] Unit must bring cases to court only in district or county where provider operates

2. [ ] Unit can bring cases to court in district or county where the unit is located 69/8

23. In general, how useful do you believe it would be for fraud units in all states to be able to bring cases to court in the district or county where the unit is located? (CHECK ONE BOX ONLY.)

1. [ ] Very useful

2. [ ] Somewhat useful

3. [ ] Not very useful

4. [ ] Don't know 70/8

24. Is there currently one grand jury in **your state** that specializes in examining Medicaid fraud cases, either exclusively or as part of a focus on white collar crime?

1. [ ] Yes

2. [ ] No 71/8

9

25. In general, how useful do you believe it would be for all states to have a grand jury specializing in Medicaid fraud cases? (CHECK ONE BOX ONLY.)

1. [ ] Very useful
2. [ ] Somewhat useful
3. [ ] Not very useful
4. [ ] Don't know 72/8

26. Apart from cases referred to the federal government for civil prosecution, does **your** Medicaid Fraud Control Unit have the authority to prosecute civil cases?

1. [ ] Yes
2. [ ] No 73/8

27. In general, how useful do you believe it would be if Medicaid Fraud Control Units in all states could prosecute civil cases? (CHECK ONE BOX ONLY.)

1. [ ] Very useful
2. [ ] Somewhat useful
3. [ ] Not very useful
4. [ ] Don't know 74/8

28. It may be possible to establish a federal clearinghouse to which all states would be required to report the names of convicted providers. This information would then be disseminated to other states. In your view, how useful would such a clearinghouse be to Medicaid Fraud Control Units? (CHECK ONE BOX ONLY.)

1. [ ] Very useful
2. [ ] Somewhat useful
3. [ ] Not very useful
4. [ ] Don't know 75/8

29. Current federal regulations say that the federal government will fund only those professional and support staff who spend 100 percent of their time in the unit on fraud-related activities. The federal government does not pay for full or part-time staff who spend part of their work week on other matters. How useful would it be to your unit to allow federal reimbursement for **support staff** who spend less than 100 percent of their working hours on fraud-related activities? (CHECK ONE BOX ONLY.)

1. [ ] Very useful

2. [ ] Somewhat useful

3. [ ] Not very useful

4. [ ] Don't know 76/8 *80/1

30. Please describe any other laws, regulations, or other changes that should be considered by the states or by the federal government to help Medicaid Fraud Control Units accomplish their missions.

****

PLEASE RETURN THE QUESTIONNAIRE IN THE ENVELOPE PROVIDED.
INCLUDE ANY AVAILABLE DETERRENCE STUDIES AS INDICATED IN Q. 5.

YOUR TIME AND EFFORT ARE VERY MUCH APPRECIATED.

****

11

APPENDIX III

FRAUD UNIT EXPENDITURES BY STATE AND FEDERAL SHARE

FOR FEDERAL FISCAL YEARS 1984 AND 1985

State fraud unit[a]	Fiscal year 1984 cost			Fiscal year 1985 cost		
	State	Federal	Total	State	Federal	Total
Alabama	$ 79,333	$ 238,000	$ 317,333	$ 152,000	$ 456,000	$ 608,000
Arizona[b]	-	-	-	39,650	356,847	396,497
Arkansas	128,156	384,465	512,621	148,000	444,000	592,000
California	1,152,348	3,457,043	4,609,391	1,051,357	3,642,038	4,693,395
Colorado	105,195	315,583	420,778	107,333	322,000	429,333
Connecticut	98,000	294,000	392,000	124,333	373,000	497,333
Delaware	60,247	180,740	240,987	62,953	188,860	251,813
Florida	323,588	970,765	1,294,353	316,068	918,000	1,234,068
Hawaii	124,132	354,250	478,382	141,500	416,000	557,500
Illinois	238,043	714,129	952,172	233,992	701,976	935,968
Indiana	20,278	182,500	202,778	55,480	337,954	393,434
Kentucky	84,475	253,424	337,899	94,594	283,783	378,377
Louisiana	127,094	381,281	508,375	131,046	393,140	524,186
Maine	50,707	152,120	202,827	58,638	175,913	234,551
Maryland	244,561	733,685	978,246	229,927	663,798	893,725
Massachusetts	476,667	1,430,000	1,906,667	521,667	1,565,000	2,086,667
Michigan	531,764	1,595,291	2,127,055	528,579	1,585,735	2,114,314
Minnesota	25,674	231,065	256,739	44,801	403,210	448,011
Mississippi[d]	14,262	128,366	142,628	39,532	273,000	312,532
Montana	38,333	115,000	153,333	45,333	136,000	181,333
New Hampshire[b]	-	-	-	11,628	104,651	116,279
New Jersey	430,677	1,292,032	1,722,709	439,264	1,317,791	1,757,055
New York	4,135,211	12,405,642	16,540,853	4,362,000	13,086,000	17,448,000
North Carolina	149,448	448,342	597,790	187,666	563,000	750,666
Ohio	246,110	738,331	984,441	287,898	863,695	1,151,593
Pennsylvania	409,603	1,228,810	1,638,413	583,989	1,751,967	2,335,956
Rhode Island	128,776	386,250	515,026	132,417	397,590	530,007[c]
South Dakota[b]	-	-	-	12,213	109,920	122,133
Tennessee[d]	1,598	14,387	15,985	61,434	552,959	614,393
Texas	432,869	1,298,607	1,731,476	331,327	993,981	1,325,308[c]
Utah	114,000	342,000	456,000	145,334	436,000	581,334
Vermont	49,306	147,917	197,223	59,594	178,782	238,376
Virginia	26,723	240,509	267,232	32,733	265,000	297,733
Washington	178,418	535,252	713,670	175,221	525,663	700,884
West Virginia	50,041	150,126	200,167	56,558	169,675	226,233[c]
Wisconsin	232,500	697,500	930,000	270,643	811,928	1,082,571
Total	**$10,508,137**	**$32,037,412**	**$42,545,549**	**$11,276,702**	**$35,764,856**	**$47,041,558**

[a]New Mexico and Oregon are not included here because they did not become certified fraud units until fiscal year 1986.

[b]Arizona, New Hampshire, and South Dakota did not have a fraud unit until fiscal year 1985.

[c]Preliminary estimates as of September 4, 1986. As of that date, the OIG had not received final Financial Status Reports for fiscal year 1985 from these states.

[d]These units were certified during fiscal year 1984.

FRAUD UNIT CASES OPENED AND CLOSED IN CALENDAR YEARS 1984 AND 1985

State fraud unit	Number of cases opened 1984	Number of cases opened 1985	Number of cases closed 1984	Number of cases closed 1985	Number of patient fraud/ abuse matters reviewed 1984	Number of patient fraud/ abuse matters reviewed 1985
Alabama	67	62	63	48	20	58
Arizona[a]	2	41	0	18	0	5
Arkansas	52	92	35	79	3	12
California	255	367	242	359	0	0
Colorado	42	35	24	8	25	16
Connecticut	12	13	9	19	0	0
Delaware	28	48	12	9	2	0
Florida	51	62	87	58	11	22
Hawaii	25	22	17	12	8	10
Illinois	92	69	22	26	13	13
Indiana	127	231	28	27	82	179
Kentucky	42	39	28	64	28	38
Louisiana	85	60	68	55	23	46
Maine	39	36	40	41	18	13
Maryland	41	53	54	38	0	4
Massachusetts	104	73	66	55	26	36
Michigan	109	48	58	94	51	28
Minnesota	47	35	30	26	15	7
Mississippi[a]	26	30	7	27	1	11
Montana	26	32	22	29	3	29
New Hampshire[a]	11	24	1	17	1	2
New Jersey	111	106	79	86	0	0
New York	586	455	508	457[b]	334	276
North Carolina	50	34	30	40	6	1
Ohio	84	70	72	73	2	9
Pennsylvania	39	29	11	8	0	0
Rhode Island	14	71	8	15	3	6
South Dakota[a]	0	14	0	4	0	0
Tennessee[a]	1	95	0	25	0	1
Texas	218	210	49	106	7	44
Utah	81	59	36	60	20	31
Vermont	38	50	63	36	3	22
Virginia	42	52	40	40	0	0
Washington	42	76	38	68	2	8
West Virginia	18	10	7	9	4	6
Wisconsin	86	68	98	77	32	21
Total	**2,693**	**2,871**	**1,952**	**2,213**	**743**	**954**

[a]Units were certified during calendar year 1984.

[b]Includes cases closed due to subjects being sentenced, arrested on other charges, or convicted.

NUMBER OF PROVIDERS CONVICTED IN CALENDAR YEARS 1984 AND 1985

State fraud unit	Number of providers convicted 1984	1985
Alabama	7	6
Arizona[a]	0	0
Arkansas	10	5
California	16	55
Colorado	12	3
Connecticut	7	3
Delaware	3	0
Florida	8	20
Hawaii	2	8
Illinois	33	50
Indiana	0	3
Kentucky	1	4
Louisiana	9	7
Maine	9	2
Maryland	16	7
Massachusetts	42	41
Michigan	35	20
Minnesota	6	13
Mississippi[a]	1	2
Montana	0	3
New Hampshire[a]	0	0
New Jersey	43	23
New York	65	98
North Carolina	14	7
Ohio	7	5
Pennsylvania	14	23
Rhode Island	3	0
South Dakota[a]	0	2
Tennessee[a]	0	1
Texas	21	7
Utah	8	9
Vermont	0	4
Virginia	2	3
Washington	1	4
West Virginia	1	1
Wisconsin	8	1
Total	**404**	**440**

[a]Units were certified during calendar year 1984.

NUMBER OF PROVIDERS RECEIVING JAIL SENTENCES IN CALENDAR YEARS 1984 AND 1985

State fraud unit	Number of providers receiving jail sentences 1984	1985
Alabama	1	3
Arizona[a]	0	0
Arkansas	1	2
California	4	37
Colorado	1	1
Connecticut	2	2
Delaware	0	0
Florida	1	1
Hawaii	0	1
Illinois	14	10
Indiana	0	0
Kentucky	1	0
Louisiana	0	0
Maine	0	0
Maryland	12	1
Massachusetts	1	0
Michigan	4	3
Minnesota	1	7
Mississippi[a]	0	0
Montana	0	0
New Hampshire[a]	0	0
New Jersey	4	0
New York	10	29
North Carolina	1	2
Ohio	4	1
Pennsylvania	1	2
Rhode Island	1	0
South Dakota[a]	0	0
Tennessee[a]	0	0
Texas	0	1
Utah	1	0
Vermont	0	2
Virginia	0	2
Washington	2	1
West Virginia	0	0
Wisconsin	1	0
Total	**68**	**108**

[a]Units were certified during calendar year 1984.

AMOUNT OF FINES IMPOSED AND COLLECTED IN CALENDAR YEARS 1984 AND 1985

State fraud unit	Amount of fines Imposed 1984	Imposed 1985	Collected 1984	Collected 1985
Alabama	$ 500	$ 3,500	$ 500	$ 2,000
Arizona[a]	0	0	0	0
Arkansas	65,000	10,950	0	0
California	86,451	259,196	45,653	259,196
Colorado	24,838	5,000	0	0
Connecticut	44,793	95,809	44,793	95,809
Delaware	6,663	0	6,662	0
Florida	53,460	40,098	38,192	29,571
Hawaii	10,600	72,000	2,600	2,222
Illinois	39,900	12,660	29,100	6,499
Indiana	0	40	0	40
Kentucky	47,000	2,000	0	2,000
Louisiana	4,550	139,369	4,550	94,500
Maine	16,100	0	13,000	0
Maryland	80,482	20,000	0	0
Massachusetts	240,927	12,500	240,927	104,300
Michigan	7,095	5,780	7,095	5,780
Minnesota	24,400	64,436	4,500	51,490
Mississippi[a]	1,088	3,400	1,088	3,400
Montana	0	50	0	0
New Hampshire[a]	0	0	0	0
New Jersey	207,750	97,050	207,750	97,050
New York	6,175	284,950	0	0
N. Carolina	97,000	104,000	97,000	11,000
Ohio	3,500	2,500	1,000	0
Pennsylvania	20,873	36,850	0	0
Rhode Island	200	0	200	0
S. Dakota[a]	0	10,000	0	10,000
Tennessee[a]	0	0	0	0
Texas	81,300	66,500	75,800	0
Utah	6,249	1,700	150	0
Vermont	0	7,500	3,813	2,600
Virginia	0	500	0	500
Washington	16,698	53,246	14,598	53,246
W. Virginia	3,090	5,611	3,090	2,451
Wisconsin	70,385	10,000	59,685	41,800
Total	**$1,267,067**	**$1,427,195**	**$901,746**	**$875,454**

[a]Units were certified during calendar year 1984.

AMOUNT OF RESTITUTION ORDERED AND COLLECTED IN CALENDAR YEARS 1984 and 1985

State fraud unit	Amount of restitution Ordered 1984	Ordered 1985	Collected 1984	Collected 1985
Alabama	$ 2,232	$ 125,616	$ 2,232	$ 5,133
Arizona[a]	0	0	0	0
Arkansas	0	1,250	0	0
California	255,047	683,646	199,066	307,466
Colorado	63,452	3,383	50,497	15,488
Connecticut	42,961	50,734	42,961	50,734
Delaware	27,835	0	14,030	4,100
Florida	65,561	31,224	18,246	41,667
Hawaii	4,354	7	4,818	5,656
Illinois	114,396	55,755	26,679	6,052
Indiana	19,456	0	19,456	0
Kentucky	0	85,228	0	53,505
Louisiana	39,010	223,033	39,010	223,033
Maine	82,000	0	27,000	0
Maryland	272,039	336,072	0	0
Massachusetts	788,969	6,668	788,969	307,400
Michigan	398,745	274,100	149,822	404,687
Minnesota	48,870	226,582	13,812	18,432
Mississippi[a]	5,765	1,767	5,765	1,767
Montana	0	0	0	0
New Hampshire[a]	0	0	0	0
New Jersey	92,987	31,653	92,987	31,653
New York	259,798	1,420,379	328,416	1,132,738
N. Carolina	291,093	139,402	171,713	210,708
Ohio	56,366	61,301	20,362	16,597
Pennsylvania	62,407	145,312	0	83,911
Rhode Island	8,551	0	8,551	0
S. Dakota[a]	0	43,820	0	43,820
Tennessee[a]	0	1,217	0	0
Texas	14,435	2,200	14,435	20,304
Utah	22,674	6,400	2,479	19,582
Vermont	0	15,000	0	0
Virginia	7,692	1,450	0	1,450
Washington	60,639	19,913	28,706	43,594
W. Virginia	0	0	0	0
Wisconsin	453,111	25,000	213,301	25,000
Total	**$3,560,445**	**$4,018,112**	**$2,283,313**	**$3,074,477**

[a]Units were certified during calendar year 1984.

APPENDIX IX

AMOUNT OF ESTIMATED OVERPAYMENTS, JUDGMENTS, AND COLLECTIONS IN CALENDAR YEARS 1984 AND 1985

State fraud unit	Amount of overpayments: Estimated overpayments 1984	Estimated overpayments 1985	Judgments 1984	Judgments 1985	Collected overpayments and judgments 1984	Collected overpayments and judgments 1985
Alabama	$ 229,594	$ 220,777	$ 0	$ 0	$ 0	$ 4,855
Arizona[a]	0	0	0	0	0	0
Arkansas	46,492	197,567	0	0	0	0
California	323,704	190,142	0	0	0	0
Colorado	129,293	134,484	35,045	40,897	91,713	15,897
Connecticut	83,415	9,684	0	0	0	9,041
Delaware	118,338	0	6,283	0	10,184	0
Florida	29,735	104,686	13,500	6,880	1,836	0
Hawaii	0	0	0	0	237,824	911
Illinois	3,590,754	514,904	2,791,325	466,604	98,113	203,026
Indiana	1,458,698	487,819	2,349	0	0	37,495
Kentucky	0	0	0	0	8,659	502
Louisiana	493,861	2,730,755	15,000	15,000	848,965	383,662
Maine	385,000	62,635	0	0	0	27,337
Maryland	2,120,778	385,585	0	0	0	269,557
Massachusetts	0	0	158,849	561,398	175,578	608,163
Michigan	195,025	4,386	[b]	[b]	122,272	313,652
Minnesota	0	0	0	0	618	0
Mississippi[a]	149,800	131,878	0	0	0	69,615
Montana	0	12,616	0	0	3,982	15,222
New Hampshire[a]	0	0	0	0	0	0
New Jersey	2,168,453	606,770	2,185,078	318,422	3,700,489	258,849
New York	219,934	48,199	533,222	1,428,550	770,976	1,324,517
N. Carolina	679,149	37,350	96,781	24,508	66,781	59,809
Ohio	66,590	117,482	0	0	0	46,593
Pennsylvania	285,585	0	9,143	0	182,867	86,895
Rhode Island	6,477	0	0	0	3,837	0
S. Dakota[a]	0	0	0	0	0	0
Tennessee[a]	0	0	0	0	0	0
Texas	124,619	319,020	0	0	0	100
Utah	79,140	52,388	0	0	10,259	75,256
Vermont	152,179	507,690	0	0	34,433	7,094
Virginia	26,097	10,792	0	0	6,686	17,162
Washington	35,000	99,059	0	0	12,013	94,977
W. Virginia	269,237	190,506	80,052	0	97,226	30,460
Wisconsin	1,246,411	120,597	692,446	12,498	602,126	321,048
Total	**$14,713,358**	**$7,297,771**	**$6,619,073**	**$2,874,757**	**$7,087,437**	**$4,281,695**

[a]Units were certified during calendar year 1984.

[b]Michigan had 4 judgments in 1984 and 2 in 1985, but these were not reflected as dollar amounts in its Resource and Caseload File Reports.

FRAUD UNIT ADMINISTRATORS' SUGGESTED CHANGES FOR CONSIDERATION BY THE FEDERAL OR STATE GOVERNMENTS TO IMPROVE FRAUD CONTROL EFFORTS

State fraud unit	Administrators' suggestions
Arkansas	Allow fraud unit attorneys to be cross-designated as federal prosecutors to permit federal prosecution by attorneys who are familiar with the state's fraud laws and the cases.
	Design a better Medicaid system to check for fraud before provider claims are paid.
California	Maintain the current level of federal matching funds.
	Let fraud units remain independent from the single state agency.
	Create an emergency fund that units can draw upon in extraordinary cases needing investigation.
	Implement federal regulations defining minimum obligations of Medicaid fiscal agents.[1] Contracts negotiated by the single state agency[2] with fiscal agents may neglect the needs of fraud units and limit cooperation from the fiscal agents.
Colorado	Enact a patient abuse statute that includes in the definition of "patient abuse" injury or danger resulting from neglect.
Delaware	Enact specific patient abuse and Medicaid fraud laws in each state.

[1]A fiscal agent is a nongovernmental entity that has a contract with a state to process Medicaid claims.

[2]Single state agencies are those agencies responsible at the state level for the Medicaid program.

Illinois	Mandate single state agencies to promptly refer all potential criminal activity to the fraud unit.
	Allow federal reimbursement for fraud unit staff who spent less than 100 percent of their time on Medicaid fraud control activities.
	Permit civil monetary penalty law judgments to be shared with the fraud units.
	Allow fraud units to share in recoveries made by the single state agencies if the recoveries result from referrals, investigations, or prosecutions made by the units.
	Enact federal criminal statutes relating to provider fraud violations.
	Maintain federal match rates for fraud unit funding at present levels.
	Keep administrative responsibility for units within the OIG.
Louisiana	Institute regulations that would permanently expel convicted providers from the Medicaid and Medicare programs.
	Require all states participating in the Medicaid program to have fraud units.
	Provide permanent federal funding for units at a minimum rate of 75 percent.
	Base minimum staff levels for fraud units on states' Medicaid program expenditures.
	Transfer surveillance and utilization review function from the state Medicaid agency to the fraud unit.
	Expand jurisdiction of fraud units to include fraud occurring in the Medicare program.
	Improve definitions pertaining to contracts between providers and vendors.

Maine	Authorize units to investigate fraud committed by Medicaid and Medicare providers and recipients. Allow fraud units to use part-time professional staff.
Maryland	Require state Medicaid agencies to notify recipients of benefits paid. Specify those records the providers are required to keep in order to fully document services rendered. Provide for waiver of doctor-patient/hospital-patient confidentiality for records needed to document services rendered by Medicaid providers.
Massachusetts	Enact at the federal level or have states consider enacting the following statutes: -- Michigan's Health Care False Claims Act (incorporates for the private health care industry the same provisions for controlling fraud as in the legislation for the Medicaid and Medicare programs). -- Massachusetts' Patient Abuse Statute (establishes methods for reporting cases of patient injury to the responsible agency and the sanctions that can be applied against a guilty provider). -- Massachusetts' Proposed Patient Funds Bonding Statute (intended to make nursing homes post bond on "patients' needs money" and establishes sanctions for providers failing to do this). -- Massachusetts' Proposed Nursing Home Waiting List Statute (intended to eliminate nursing home discrimination against Medicaid patients by requiring them to publish their waiting lists for beds).

APPENDIX X

	Authorize regulations giving fraud units direct access to Medicaid Management Information System data.
Michigan	Require single state agencies to make their experts available to assist fraud units.
	Require single state agencies to provide access to magnetically stored data.
	Broaden fraud unit jurisdiction to include the Medicare program and other third party payers.
	Require states to enter into "capitation" contracts with medical reference laboratories in lieu of paying for claims.
	Make providers responsible for supervising subordinates and employees to reduce their likelihood of submitting false claims or statements to the Medicaid and Medicare programs.
	Have state plans and laws stipulating, as a condition of participation in the Medicaid program, that providers must give fraud units access to their records, documents, etc.
	Revise section 1902(a)(8) of the Social Security Act to state that after becoming a Medicaid provider under the state plan, one may not refuse to provide goods or services.
Mississippi	Maintain current levels of federal funding for the fraud units.
New Hampshire	Continue OIG administration of the fraud units.
	Consider criminalizing patient abuse at the state level.
	Maintain current levels of federal funding for the fraud units.

New Jersey	Authorize regulations requiring all providers to relinquish patient/recipient files (including psychotherapy notes) to the unit upon subpoena.
New York	Require providers to acknowledge in writing that they have received and read the manuals and any additional changes to them. No payments should be made to providers until this is received. Set minimum federal requirements for provider certification of tape-to-tape payment submissions that pinpoint individuals responsible for supervising payment claims and the related medical services. Enforce federal regulations requiring that single state agencies include in their provider agreements a consent for fraud unit access to providers' financial records. Tighten requirements for certification and recertification of providers including more comprehensive data and background information, such as prior criminal involvements and providers' financial backers and other health care interests.
North Carolina	Assure continued federal funding of the fraud units at the current matching levels and make provisions for future growth. Stress federal criminal prosecution with less emphasis on recovering money. Deterrence can be best achieved through vigorous prosecution and sentencing of convicted providers. All single state agencies should support this mission. Mandate input, and possible veto, into Medicaid program regulations by units. Increase funding for investigation and prosecution of patient abuse and neglect cases.

	Support, at the department level, unit prosecution activities with continued oversight by law enforcement and prosecution-oriented personnel.
Ohio	Require single state agencies to (1) stop making payments to providers upon indictment for fraud-related activities and (2) permanently terminate providers from the Medicaid program upon conviction.
	Provide additional 100-percent funding to train fraud unit staff in the legal, audit, and investigative areas.
	Fund travel and living expenses so fraud units can "exchange" staff members to assist in unusual or complex cases.
Rhode Island	Encourage or require, at the federal level, state agencies to use their authority to suspend or revoke Medicaid providers' certification.
Tennessee	Maintain federal funding of the fraud units at current rates.
	Forbid state Medicaid agencies to regulate their fraud units' funding.
Texas	Provide for federal preemption of state created physician-patient privileges. Authorize regulations making it a federal crime for providers refusing to give fraud units access to their documents.
	Maintain federal funding of the fraud units at the current rates.
Vermont	Allow fraud units to remain as primarily prosecution units rather than collection agencies, since prosecution has a strong deterrent effect.
	Separate fraud units from the agencies administering the Medicaid program as these agencies are more interested in collecting overpayments than in pursuing convictions.

APPENDIX X

Virginia	Enact a federal patient abuse statute to include both physical and financial abuse as felonies, so that providers, upon conviction, would be expelled from the program.
Washington	Fund fraud units with 90-percent federal funding and regulate unit size according to the total state Medicaid budget. Maintain federal liaison/accountability for the fraud units at the OIG rather than at HCFA.
West Virginia	Either improve regulations of single state agencies' Surveillance and Utilization Review units to ensure that they are detecting fraud cases to be referred to the fraud units or provide funding for the fraud units to do this themselves.

(118146)

Requests for copies of GAO reports should be sent to:

U.S. General Accounting Office
Post Office Box 6015
Gaithersburg, Maryland 20877

Telephone 202-275-6241

The first five copies of each report are free. Additional copies are $2.00 each.

There is a 25% discount on orders for 100 or more copies mailed to a single address.

Orders must be prepaid by cash or by check or money order made out to the Superintendent of Documents.