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United States General Accounting Office

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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



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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

| | <u>1984</u> | <u>1985</u> |
|---|--------------|-------------|
| 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

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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,

A handwritten signature in cursive script that reads "Franklin A. Curtis". The signature is written in dark ink and is positioned above the typed name and title.

Franklin A. Curtis
Associate Director

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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 providers¹ 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:

¹A 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.)

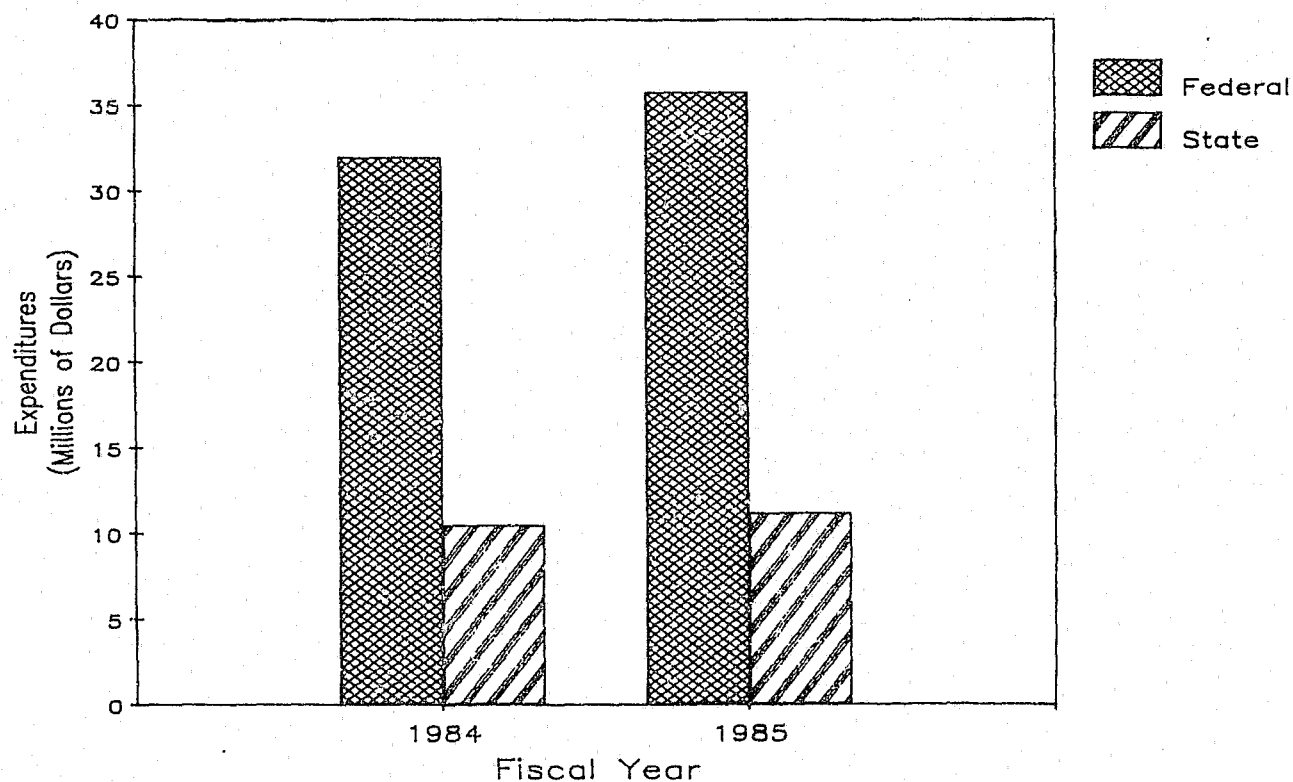
We also agreed with the Chairman's office to send a questionnaire to the fraud units. In February 1986, we mailed a questionnaire to the 36 certified units. From the questionnaire, we obtained data on where the units' cases originated and managers' views on deterrence, penalties for convicted providers, 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

| | <u>1984</u> | <u>1985</u> |
|--|--------------|-------------|
| 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 |
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| 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 |

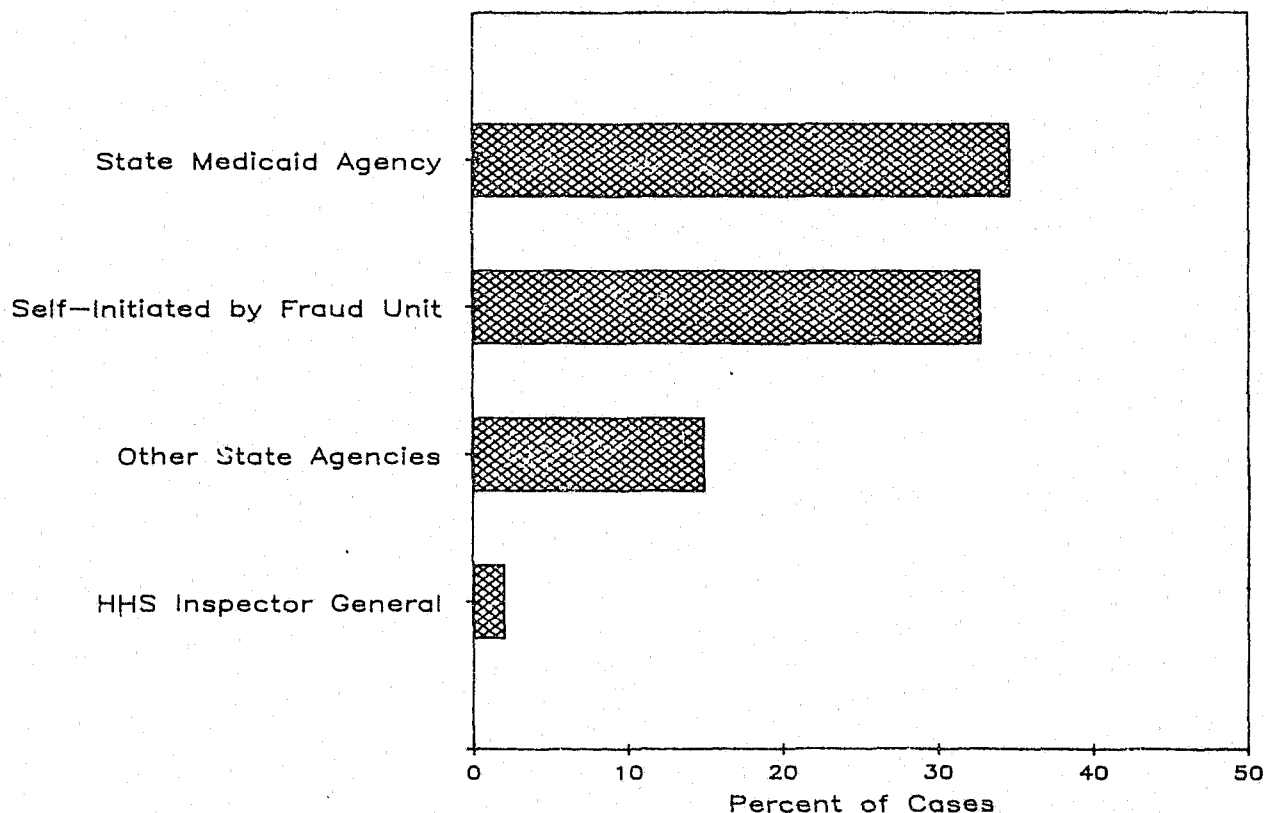
Source: Certified Medicaid Fraud Control Units quarterly Resource and Caseload File Reports submitted to the OIG.

²Financial 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 per cent). 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

³Federal 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

| | <u>Number of states currently implemented in</u> | <u>Number of units believing this would be useful</u> |
|---|--|---|
| 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.

FRAUD UNIT CERTIFICATION DATES

| <u>State fraud unit^a</u> | <u>Certification date</u> |
|---|-------------------------------|
| 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 |

^aNew 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.

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

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.)

| <u>Source</u> | <u>Percentage of Cases</u> | |
|--|----------------------------|---------|
| 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% | |

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

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..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 45/9 |
| Getting convictions..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 46/9 |
| Detering providers from committing fraud..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 47/9 |

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

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 | Increased Unit's Ability | Decreased Unit's Ability | |
| | (1) | (2) | (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 | Increased Unit's Ability | Decreased Unit's Ability | |
| | (1) | (2) | (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*****

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.)

| Area | Effect of Classifying Certain Types of Medicaid Fraud As Less Serious Crimes | | | |
|---|--|---------------------------------------|---------------------------------------|------|
| | No Consistent Effect (1) | Increased Unit's Ability (2) | Decreased Unit's Ability (3) | |
| Getting indictments for those types of fraud. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 56/9 |
| Getting convictions for those types of fraud. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 57/9 |
| Deterring providers from committing those types of fraud..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 58/9 |

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.)

| <u>Provision</u> | <u>Yes</u> <u>(1)</u> | <u>No</u> <u>(2)</u> | |
|--|--------------------------|-------------------------|------|
| 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.)

| | <u>Very</u> <u>Useful</u> <u>(1)</u> | <u>Somewhat</u> <u>Useful</u> <u>(2)</u> | <u>Not</u> <u>Very</u> <u>Useful</u> <u>(3)</u> | <u>Don't</u> <u>Know</u> <u>(4)</u> | |
|--|--|--|--|---|------|
| 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 |

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

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.

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 |

^aNew Mexico and Oregon are not included here because they did not become certified fraud units until fiscal year 1986.

^bArizona, New Hampshire, and South Dakota did not have a fraud unit until fiscal year 1985.

^cPreliminary 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.

^dThese units were certified during fiscal year 1984.

FRAUD UNIT CASES OPENED AND CLOSED INCALENDAR YEARS 1984 AND 1985

| State fraud unit | Number of cases opened | | Number of cases closed | | Number of patient fraud/ abuse matters reviewed | |
|----------------------------|---------------------------|--------------|---------------------------|------------------|--|------------|
| | 1984 | 1985 | 1984 | 1985 | 1984 | 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 |

^aUnits were certified during calendar year 1984.

^bIncludes cases closed due to subjects being sentenced, arrested on other charges, or convicted.

NUMBER OF PROVIDERS CONVICTED IN
CALENDAR YEARS 1984 AND 1985

| <u>State</u> <u>fraud unit</u> | <u>Number of providers convicted</u> | |
|-----------------------------------|--------------------------------------|-------------|
| | <u>1984</u> | <u>1985</u> |
| 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 |

^aUnits were certified during calendar year 1984.

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

| <u>State</u> <u>fraud unit</u> | <u>Number of providers</u> <u>receiving jail sentences</u> | |
|-----------------------------------|---|-------------------|
| | <u>1984</u> | <u>1985</u> |
| 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 | <u>68</u> | <u>108</u> |

^aUnits were certified during calendar year 1984.

AMOUNT OF FINES IMPOSED AND COLLECTEDIN CALENDAR YEARS 1984 AND 1985

| State fraud unit | Amount of fines | | | |
|----------------------------|--------------------|--------------------|------------------|------------------|
| | Imposed | | Collected | |
| | 1984 | 1985 | 1984 | 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 |

^aUnits were certified during calendar year 1984.

AMOUNT OF RESTITUTION ORDERED AND COLLECTEDIN CALENDAR YEARS 1984 and 1985

| State fraud unit | Amount of restitution | | | |
|----------------------------|-----------------------|--------------------|--------------------|--------------------|
| | Ordered | | Collected | |
| | 1984 | 1985 | 1984 | 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 |

^aUnits were certified during calendar year 1984.

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

| State fraud unit | Amount of overpayments | | | | | |
|----------------------------|---------------------------|--------------------|--------------------|--------------------|---|--------------------|
| | Estimated overpayments | | Judgments | | Collected overpayments and judgments | |
| | 1984 | 1985 | 1984 | 1985 | 1984 | 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 |

^aUnits were certified during calendar year 1984.

^bMichigan 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 agency² 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.

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

²Single 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).

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.

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.

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