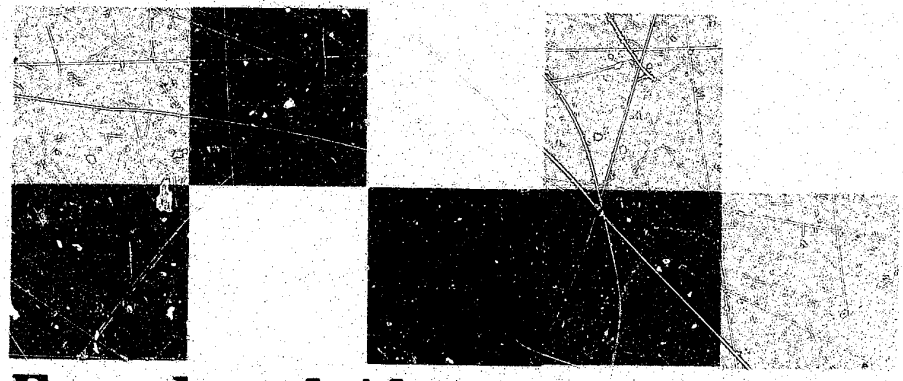
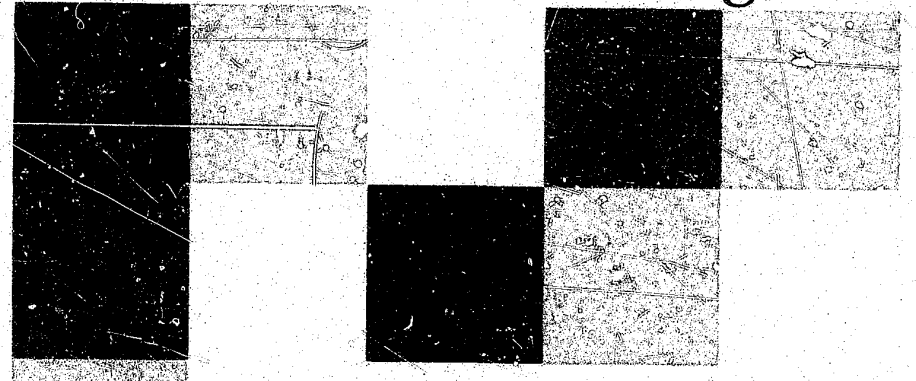


Fraud and Abuse in Government Benefit Programs



U. S. Department of Justice
Law Enforcement Assistance Administration
National Institute of Law Enforcement and Criminal Justice

Fraud and Abuse in Government Benefit Programs

Andrea G. Lange
Principal Author
Robert A. Bowers
Editor

November 1979

U. S. Department of Justice
Law Enforcement Assistance Administration
National Institute of Law Enforcement and Criminal Justice

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402

Stock No. 027-000-00855-1

Law Enforcement Assistance Administration
Henry S. Dogin
Administrator
Homer F. Broome, Jr.
Deputy Administrator for Administration

National Institute of Law Enforcement and Criminal Justice
Harry M. Bratt
Acting Director

This project was supported by Grant Number 77-NI-99-0081, awarded to University City Science Center, Washington, D. C., by the National Institute of Law Enforcement and Criminal Justice, Law Enforcement Assistance Administration, U. S. Department of Justice, under the Omnibus Crime Control and Safe Streets Act of 1968, as amended. Research on this project was completed in July 1979. Points of view or opinions stated in this document are those of the authors and do not necessarily represent the official position or policies of the U. S. Department of Justice.

TABLE OF CONTENTS

LIST OF TABLES

ACKNOWLEDGEMENTS

The preparation of this report would have been impossible without the cooperation of program administration and enforcement officials throughout the country. While they are too numerous to name individually, we would like to extend our sincere appreciation to all of them.

Several representatives of the National Institute of Law Enforcement and Criminal Justice, Division of Community Crime Prevention, deserve special mention for their support and assistance in the preparation of this report. Mr. Bernard Auchter, the Project Monitor, was most supportive of the work as was Dr. Fred Heinzelmann, Division Director.

Appreciation is also extended to the Science Center staff with project responsibilities among whom were Thomas Beall, Robert Bowers, Florence Einhorn, Carol Gay, Kimberly Matthews, Don Overly, and Stephen Schack. Special thanks is extended to Mary Blount, Carol Dill, and Violet Sewell for their patience and cooperation in the preparation of the final typing. The project staff is solely responsible for the contents of this volume.

SUMMARY

Fraud and abuse in government benefit programs is widespread, but there is no certain tally of the enormity of losses. The United States General Accounting Office (GAO), the official watchdog audit agency for the federal government, estimates total dollars lost to fraud and abuse to be in the range of one to ten percent of all program expenditures.[1] These figures, the Office admits, are conservative estimates, and the Agency's recent report on federal efforts to combat fraud concludes that probably "no one knows the magnitude of fraud against the government."[2] A ten percent estimate is only impressive when it is noted that such a loss rate would drain in excess of 7.9 billion dollars from the fifteen programs reviewed for this report.

In moving to combat losses, federal, state, and local governments are committing substantial audit, investigation, and computer resources to detection. Federal and state agencies continue to view prosecution of criminal fraud cases as a major enforcement goal. However, some jurisdictions have begun developing civil as well as non-judicial remedies for program abuses, where criminal intent cannot be proven, but some deterrent is sought.

An important control issue for the future will be establishment of uniform definitions for program offenses. In the past, the terms *fraud* and *abuse*, and categorizations of specific offenses, have been subject to varying interpretation. As one local Food Stamp administrator noted, the U.S. Department of Agriculture defines fraud more broadly than the county and uses the terms *fraudulent issuance* and *erroneous issuance* interchangeably though the county does not. For purposes of this report, abuse is broadly defined as *the improper utilization of a benefit or benefit system.* Fraud differs only in that the utilization must also be *illegal.* Ultimately, the impropriety or illegality of benefit system utilization remains a jurisdictional matter.

Program design deficiencies are also integral to control. Previously, design received little attention as a basis for combatting fraud. A "delivery-at-all-costs" philosophy pervaded much of the program operations. Where controls were in place, many program personnel either overlooked or circumvented them for the sake of expeditious processing of sizeable caseloads. Only in the past five years have auditors, investigators, and other enforcement personnel taken a proactive role in designing legislation to meet enforcement as well as delivery needs by acquainting law makers with the vulnerability of design faults.

---

[1] Federal Agencies Can, and Should Do More to Combat Fraud in Government Programs (Washington, D.C.: U.S. Government Printing Office, September 1978), p. 1.

[2] Ibid., p. 5.

The types of enforcement available and their effectiveness are basic to control. While there has been a dramatic increase in the quantity and variety of control strategies employed, there has been little evaluation of the individual or aggregate value of such strategies in reducing fraud and abuse. No major empirical testing of the strategies has been completed nor comparative studies done to determine the relative impacts of each.

The lack of study given enforcement effectiveness is perpetuated by a virtually pervasive lack of data on the size of the fraud and abuse problem, on the handling of fraud and abuse cases, and on final dispositions and recidivism. Where within-program enforcement data exist for a particular jurisdiction, it is seldom consistent with the type of data collected in other jurisdictions. Similarly, the data collected for one type of program in a given jurisdiction usually differs from the data collected in other types of programs in that same jurisdiction. The cross-program/cross-jurisdiction inconsistencies make it virtually impossible to build a single data base for fraud and abuse at this time. Efforts to detect causes of fraud and abuse and to develop economical and effective solutions are slowed immeasurably as a consequence.

Design of the Study

To address the fraud and abuse control issues, the study design was composed of two interrelated parts: on-site interviews and survey research covering fifteen benefit programs.[3] These components were chosen because a preliminary review of the existing literature on fraud offered no synthesis of current knowledge. The combined survey and interview work thus provided contact with a formidable cross-section of federal program officials and enforcement staff in all states, the District of Columbia and Puerto Rico.

Three phases of interviews were conducted with one hundred and thirty-four (134) state and local government offices during 1977-78. The study findings, therefore, reflect the views of pro-

---

[3]Programs reviewed are: from the United States Department of Agriculture (USDA), *Food Stamps (FS)*, *Summer Food Service Program for Children (SF)* and *Rural Housing;* from the United States Department of Health, Education,and Welfare (HEW), *Medicare, Medicaid, Aid to Families with Dependent Children (AFDC)*, and *Vocational Education (VE);* from the United States Department of Housing and Urban Development (HUD), *Rehabilitation Housing Loans and Federal Disaster Assistance (FD4A);* from the United States Department of Labor (DOL), *Unemployment Insurance (UI)*, also called *Unemployment Compensation* in some jurisdictions, and *Comprehensive Employment and Training Program (CETA);* from the United States Small Business Administration (SBA), *8(a) Minority Business Development*, also known as *8(a) Minority Contracting*, and *Physical Disaster Loan Assistance;* from the United States Veterans Administration (VA), *Veterans Educational Assistance (G.I. Bill)* and *Veterans Home Loan Guaranty Program.*

gram administrators, fraud investigators, auditors, prosecutors, quality control officials, and others charged with day-to-day responsibilities for program operations, integrity, and control.

The survey portion of the study included two parts. In November, 1977, a survey questionnaire was sent to all state Attorney Generals' offices[4] to collect information on the current investigative and prosecutorial activities for anti-fraud control in these jurisdictions.

Other survey work involved the administration of an "Information Resource Form" to 216 state officials responsible for program operations and/or enforcement. The survey was designed to elicit information and views on program benefit fraud and abuse and was composed of three parts including program objectives, operations and procedures, and fraud and abuse. This survey, conducted between September and November 1978, asked for data on seven benefit programs including:

- Medicaid
- Aid to Families with Dependent Children
- Vocational Education
- Food Stamps
- Summer Food Service Program for Children
- Comprehensive Employment and Training Act
- Unemployment Insurance

The survey response rate was approximately 57%[5] with one hundred twenty-three (123) responses broken down as follows on page 4..

Findings

A. Program Design

Application of a vulnerability perspective to the fifteen programs that were reviewed allowed identification of major offender categories and patterns of associated offenses. Misrepresentation of eligibility, believed by most administrators to account for a major number of program offenses, may be committed by recipients, program sponsor agencies, or by third party providers. A variety of other offense patterns were found including: creation of "ghost" eligibles, improper use of benefits, receipt of additional benefits, overcharging, withholding or providing unneeded services, accepting

[4]Including appropriate offices in Puerto Rico and the District of Columbia.

[5]The return was gratifying in this sensitive area since programs had to report on their own inability to prevent fraudulent activity. It may be indicative of the current high visibility of fraud and abuse issues and the eagerness to contribute to research on them.

SURVEY RESPONSES

Number of Questionnaires Sent	Programs	Frequency of Completed Questionnaire Returns	%
40	Medicaid	18	45
34	AFDC	18	53
10	VE	7	70
37	Food Stamps	20	54
6	Summer Food	6	100
37	CETA	16	43
34	UI	21	62
18	"Other"[6]	17	96
Total 216		123	57

or paying kickbacks, records tampering, embezzlement or theft, over- and under-payments of benefits, counterfeiting, and illegal ownership of benefit services.

The research also suggests that certain types of benefits are more susceptible to specific offense patterns than others. While cash assistance (in check form) exhibits the simplest transaction of all benefit types studied, cash benefits show vulnerability to patterns of theft, embezzlement, tampering, forgery, counterfeiting, and misuse of funds.

Scrip (showing entitlement to the bearer) is frequently a target for theft either from the recipient, or in quantities from coupon inventories. Since scrip has few identifying characteristics, it is readily transferable to other parties and has surfaced in several blackmarket-type operations.

Loan benefits present complicated transaction patterns where it appears that merely increasing the number of parties involved increases vulnerability. Since documents change several hands and validations are required for many parts of the eligibility determination, loan benefits are vulnerable to misrepresentation, forgery, tampering, collusion to defraud, and misuse of documentation and benefits.

Where service is provided to the client and an indirect financial arrangement called reimbursement is used, programs become targets for forged or falsified bills and vouchers, bill padding, overcharging, duplicate billing, bid-rigging, payment of kickbacks, and misuse of benefits.

---

[6]The category "other" includes units like audit, quality control, fraud investigation, and surveillance utilization.

Like loans and reimbursed service benefits, contract procurement presents numerous points of vulnerability. In the particular contract program studied, misrepresentation (fronting), collusive bidding, misuse of contract payments, forgery of documents and record tampering were well documented.

In addition to finding common points of vulnerability across various programs, the study also revealed two potential areas of research on the structure and functioning of programs to reduce fraud and abuse. Analyses of data on client to staff ratios and assessed rates of fraud and abuse suggested that the incidence of offenses cannot be assumed to be a simple function of program size. While factors such as budget size, client load, and number of staff did not correlate with detection, variables such as the presence and absence of statistics on fraud and abuse and the ratio of clients to staff yield data of some significance.

The study also suggests that training appears as a mediating factor in the relationship between client to staff ratios and fraud and abuse detection rates. Training, therefore, may be one avenue for further study relative to its impact on detection.

B. Enforcement

Enforcement, in general, has suffered from an *ad hoc* and reactive posture. Quality data has been unavailable for assessing proportions of fraud and abuse or planning for its control. Other factors such as an absence of legislative support, financial incentives, and alternate resolutions of cases that do not rely on criminal justice dispositions have inhibited enforcement efforts.

While large sums are now being expended for development of computer detection systems, little evaluative study has been given to the real dollar costs and benefits of these systems, the value of the data that is provided, or the use made of the data for resolution of cases. Further, the implementation of computerized welfare roll matching has raised serious concerns for the compatibility of technology used by the federal government and the states as well as for the value of the output as a detection mechanism. And while matching has been conducted for several years in some states, no follow-up to review impact on fraud reduction and recidivism has been conducted.

Training, in particular, holds some promise for curbing offenses. However, development of curricula has been limited. Cross-training of auditors and investigators has gained some momentum in federal program agencies, but has not been implemented extensively in the states.

Finally, the study identified some ten general strategies for fraud and abuse control.

- Education/Training
- Legislative Support
- Quality Control
- Investigation
- Financial Auditing
- Harassment
- Civil and Criminal Prosecutions
- Administrative Adjudications and Remedies
- Organizational Redesign
- Research

Used singularly or together, each strategy carries a different set of expectations for enforcement effectiveness. The report concludes that when enforcement units undertake strategies without careful analyses of their associated strengths and weaknesses, limited deterrence may result, and commitments may be made to solutions that are substantially burdened by opportunity costs.[7]

[7] For a more thorough discussion of methods to compare the effectiveness of various enforcement strategies, see University City Science Center, Alternative Strategies for Cost Benefit Analysis of Fraud and Abuse Enforcement: A Working Paper (Washington, D.C., July 1979).

CHAPTER 1

INTRODUCTION

Whether measured by number of programs or dollars allocated, government benefits to the needy appear to have grown dramatically in recent decades. Increasingly, however, news media reports suggest that such benefits are depleted by fraud and abuse. No program or region of the country seems immune to scandal. A Philadelphia news headline reads: "Waste Alleged in Meal Program;" a New York Times article begins, "Consumer Board, in Study, Finds Abuse Among Technical Schools;" the Columbus, Ohio Dispatch warns, "Welfare Cheating May Hit 46,000;" and in Richmond, Virginia, the Times Dispatch reports the findings of a General Accounting Office study as "United States Agencies Unprepared to Detect, Prevent Fraud."[1]

Television news media have also served to place fraud and abuse squarely before the public as a salient, national issue. Aggressive investigative reporting, like a "60 Minutes" segment on abusive collections of disability compensation by air traffic controllers, is credited by some with embarrassing government agencies into accounting for their trustee role over tax dollars obligated to benefit programs.

Despite such adverse publicity, no one seems to know the actual magnitude of lost benefits. While making this same point, the General Accounting Office (GAO) of Congress estimates that total dollar losses from fraud and abuse range from one to ten percent of all program expenditures,[2] and in a frightening evaluation of the current situation, the GAO argues that:

> Opportunity for defrauding the Government is virtually limitless because of the number, variety, and value of Federal programs . . . The involvement of so much money, and so many people and institutions makes the Federal programs vulnerable to fraud.[3]

While losses in government benefit programs are extensive and substantial tax dollars are spent to combat them, no systematic, economical or manageable solutions appear to currently exist. This is not to suggest that strategies for combating fraud and abuse are totally lacking. On the contrary, some strategies do exist and are

---

[1] Philadelphia Bulletin (July 25, 1978); The New York Times (July 24, 1978); Columbus Dispatch (March 2, 1978); Richmond Times Dispatch (April 16, 1978).

[2] U. S. Government Accounting Office, Federal Agencies Can, and Should Do More to Combat Fraud in Government Programs. Report to the Congress by the U. S. Comptroller General (Washington, D. C.: U. S. Government Printing Office, September 23, 1978), pp. 1-5.

[3] Ibid., p. 11.

one focus of this report. But as this review will show, current strategies are ill-defined and their success, at best, seems limited. Because data concerning fraud and abuse are disaggregated, inconsistently collected or entirely absent, opportunities for assessing the impacts of these strategies are severely constrained. When program fraud research has been conducted, usually at the direction of a specific program agency, the product is specific to a program or agency and lacks comparisons with other programs.

The literature concerning fraud and abuse is also limited and can generally be described as anecdotal, describing flagrant welfare cheating and extravagant program waste, or it is highly technical, directed to a specific program audience. Moreover, studies of specific aspects of program control, such as quality control sampling or compliance visits by administrative program staff to resident provider participants, treat fraud and abuse only tangentially.[4]

The lack of a solid body of knowledge about fraud and abuse further complicates the task of combating current and potential program vulnerabilities; as a result, government responses have been sluggish and reactive. Program administrators express frustration with attempts to cope with unconfirmed allegations of fraud and abuse in their daily operations. Auditors, investigators, and other enforcement officials find it difficult to plan for a rational use of personnel, caseloads, and financial resources to meet the suspicions and allegations of program misuse without reliable data. The importance of planning for fraud control, in fact, has only gained recognition in the past few years as a result of strong political pressures. Comments from the GAO report on fraud and abuse cited earlier illustrate the new emphasis on anti-fraud planning in federal agencies.

> Most of the programs and agencies (GAO studied) have said that they have recently made fraud identification a high priority and have fixed organizational responsibility, for fraud detection [5]

A statement by Attorney General of the United States, Griffin Bell before a Chamber of Commerce Advisory Panel on White Collar Crime underscores the fact that white collar crime enforcement planning

---

[4]Examples of recent works on the subject are: Marc Bendick, The Anatomy of AFDC Errors (Washington, D. C.: Urban Institute, April 1978); Touche-Ross and Company, Evaluation of AFDC-QC Correction Action. Final Report (Washington, D. C.: U. S. Department of Health, Education and Welfare, Social Security Administration, 1977).

[5]U. S. General Accounting Office, Combat Fraud, op. cit., p. vii.

is just now gaining momentum at the Department of Justice.

> The traditional response to white collar crime at all levels of government has been sporadic, reactive, and inconsistent. In the past, throughout the criminal justice system--federal, state, and local--only minimal resources have been specifically earmarked for combating white collar offenses. What is needed, and what the Department of Justice is seeking to develop and implement is a national enforcement strategy.[6]

The importance of these efforts cannot be ignored. Public confidence in government is eroded when tax dollars are wasted through fraud and abuse. Noting a recent Gallup Poll in which it was suggested that nearly half the American public believes 48 cents of every federal tax dollar is wasted, Health, Education, and Welfare Secretary, Joseph Califano argued that unless the government responds to the fraud and abuse problem, "it may not be long before the public seeks to cut back social programs in an undiscriminating way."[7]

The Purpose of This Report

Following a general assessment of fraud and abuse in government benefit programs, this report details the state-of-the-art in program enforcement. Although available program data are insufficient to allow an accounting of all cases of fraud and abuse, critical policy-related issues are addressed. Next, focusing on fifteen distinct benefit programs, the analysis identifies potential offender populations and the types of offenses which occur across programs. The state-of-the-art in preventing, detecting, and deterring offenses is then assessed. Finally, throughout the report, issues which should be addressed before effective and equitable solutions can be developed, are identified.

The programs reviewed in developing this assessment include:

- U. S. Department of Agriculture (USDA)
  1. Food Stamps (FS)
  2. Summer Food Service Program for Children (SF)
  3. Rural Housing (RH)
- U. S. Department of Health, Education and Welfare (HEW)
  1. Medicare

---

[6]"White Collar Crime Erodes Respect for Justice System," LEAA Newsletter (January 1979), p. 2.

[7]Joseph A. Califano, Jr., "Remarks to the U.S. Department of Health, Education and Welfare, National Conference on Fraud, Abuse and Error" (Washington, D.C.: U.S. Department of Health, Education and Welfare, December 13, 1978), p. 5.

2. Medicaid
3. Aid to Families with Dependent Children (AFDC)
4. Vocational Education (VD)

- U. S. Department of Housing and Urban Development (HUD)

1. Rehabilitation Housing Loans
2. Federal Disaster Assistance Administration (FDAA)

- U. S. Department of Labor (DOL)

1. Unemployment Insurance (UI); also known in some jurisdictions as Unemployment Compensation (UC)
2. Comprehensive Employment and Training Act (CETA)

- U. S. Small Business Administration (SBA)

1. Business Development; also known as 8(a) Minority Contracting
2. Physical Disaster Loan Assistance

- U. S. Veterans Administration (VA)

1. Veterans Educational Assistance (G.I. Bill)
2. Veterans Home Loan Guaranty Program

Each of these programs, organized by type of benefits (i.e., cash, script, loans, service or contract procurement), is profiled in Appendix A of this report.

The data upon which the assessment and profiles are based derive primarily from on-site interviews and mailed survey questionnaires sent to all state Attorney General's offices to collect information on the current investigative and prosecutorial activities for anti-fraud control in these jurisdictions. A list of the respondents and a copy of the questionnaire are to be found in Appendices C and G, respectively.

Based upon information obtained from these offices and other government agencies, one hundred thirty-four (134) state and local government officials were selected for face-to-face interviews. These respondents were selected because they were reputed by senior federal officials as being intimately familiar with program administration, fraud investigation, auditing, prosecution, quality control and other aspects of program operations or enforcement at the state or local level.

During the interview process, an additional two hundred sixteen state officials with senior level program or enforcement responsibilities were identified. These officials were sent an Information Resource Form (hereafter "fraud and abuse survey") to obtain additional program and attitudinal data. This survey is discussed in greater detail below.

It should be stressed that no effort was made to systematically sample either interview or survey respondents. The overriding goal of this exploratory effort was to obtain as much information from as many knowledgeable respondents as possible.

Structure of This Report

Chapter 2 defines fraud and abuse, and addresses vulnerability of benefit program designs. While some evidence suggests that people are more likely to steal from a government agency than from a private firm (or from a large firm as opposed to small firms, or a business as opposed to a person), there is no direct evidence to suggest why people are more likely to steal from one government/agency or program as opposed to another.[8] A foundation is laid for resolving this question by creating taxonomies of plausible offenders and offenses, and by reviewing other common program design vulnerabilities.

In Chapter 3, the report discusses the results of a survey of two hundred sixteen state officials responsible for program operations and/or enforcement.[9] The survey was designed to elicit information and views on program benefit fraud and abuse. It was composed of three parts: program objectives, program operations and procedures, and program fraud and abuse. This survey, conducted between September and November 1978, asked for data on the following seven benefit programs:

- Medicaid, a state operated program providing health assistance services to eligible recipients
- AFDC, a state or locally operated program offering cash assistance to eligible recipients
- VE, a state operated program offering vocational planning and assistance to eligible recipients
- Food Stamps, a state or locally operated program providing scrip benefits for the purchase of food items
- Summer Food, a federal or state operated program serving meals to eligible children during summer months
- CETA, a locally operated employment and training program for eligible recipients
- UI, a state operated program offering cash benefits to unemployed eligible recipients

---

[8]Erwin Smigel, "Public Attitudes Toward Stealing as Related to the Size of the Victim Organizations," American Sociological Review 21: 320-27, 1956; Erwin Smigel and H. Lawrence Ross, Crimes Against Bureaucracy (New York; Van Nostrand, 1979).

[9]A copy of the instrument appears in Appendix H.

The overall survey response rate was approximately 57%[10] with one hundred twenty-three respondents. Respondents broken down by program type appear in the following table.

TABLE I

SURVEY RESPONSES

PROGRAM	QUESTIONNAIRES SENT	QUESTIONNAIRES RETURNED[11]	RATE(%)
MEDICAID	40	18	45
AFDC	34	18	53
VE	10	7	70
FOOD STAMPS	37	20	54
SUMMER FOOD	6	6	100
CETA	37	16	43
UI	34	21	62
"OTHER"[12]			
TOTAL	216	123	57

Chapter 4 addresses current enforcement efforts to prevent, detect, and deter fraud and abuse and develops a typology of such strategies. Chapter 5 analyzes the deficiencies of past and present enforcement strategies.

---

[10]The return was gratifying in this sensitive area since programs had to report on their own inability to prevent fraudulent activity. It may be indicative of the current high visibility of fraud and abuse issues and the eagerness to contribute to research on them.

[11]A list of reporting agencies appears in Appendix C.

[12]The category "Other" includes units like audit, quality control, fraud investigation, and surveillance utilization.

CHAPTER 2

PROGRAM DESIGN VULNERABILITIES AND FRAUD AND ABUSE

In a 1977 study entitled Economic Offenses, the American Bar Association warned:

> In the future, all federal social programs (excluding revenue sharing funds) should be designed so as to diminish the likelihood of abuse, and that the design of any social program specifically recognize the potential for fraud. [1]

Program design has traditionally been the responsibility of legislators, regulators, and administrators only, outside the purview of auditors, fraud investigators, and other enforcement personnel. Unfortunately, problems in the design of programs appear to be affecting the ability of governments to enforce benefit regulations and laws.

Most persons interviewed believed, without supporting data, that the manner in which benefits are delivered to eligible recipients provides some explanation for the frequency and types of fraud and abuse committed and limited testing has been inadequate to *prove* association. For example, a regional HEW officer responsible for AFDC programs in a number of states told of an informal study done in the region to test whether length of time between initial certification and subsequent recertification had an impact on fraud and abuse; the premise was that shortening the time would reduce opportunities for committing offenses. Findings based on the statistical data provided by the states were inconclusive, making it difficult to persuade states that there was a need to shorten these time periods.

Others who have investigated the relationship between fraud and abuse and particular independent variables have not had opportunities to confirm their preliminary findings. For example, one state initiated an extensive study of its unemployment insurance beneficiary population using statistical techniques of discriminant analysis to learn whether certain applicants were more or less prone to commit program frauds and abuses. The study was undertaken following a massive and expensive scandal in the state's Unemployment Insurance Program.

---

[1] Economic Offenses, Recommendations of the American Bar Association, Section of Criminal Justice, Committee on Economic Offenses, (Washington, D.C.: American Bar Association, March 1977, p.7).

The findings suggested that "development of a profile for identifying claimants likely to fraudulently collect benefits" is possible, and that "propensity to commit (known) fraud was not randomly distributed among the claimant population."[2] The authors emphasize, however, that the "profile has not been operationally implemented."[3]

To date there has been no comprehensive effort to compare design characteristics across programs with similar patterns of fraud and abuse. This chapter suggests why programs are targets for misuse, why commonalities exist in the types of offenses committed, who comprises the offender population and why certain programs appear more vulnerable to fraud and abuse. Beginning with definitions for "fraud" and "abuse", this *vulnerability analysis* identifies potential offenses and offenders by employing a simple framework of characteristics which were generic to the fifteen programs reviewed. In addition, external characteristics which were commonly identified by interviewed program officials are also used as indicators of possible program weaknesses. These externalities suggest basic issues which may be addressed by legislators and regulators as well as enforcement personnel contemplating changes in the design of benefit programs.

Defining Fraud and Abuse

A significant problem in the study of fraud and abuse is finding similarities in fraud definitions and abuse definitions across various program jurisdictions. The potential for confusion about definitions was well illustrated in an interview with a local county welfare administrator who noted in a discussion of the Food Stamp Program:

> The U.S. Department of Agriculture tends to define fraud much more broadly than does the county and uses the terms fraudulent issuance and erroneous issuance interchangeably though the county does not.

To gain more information on the complexities associated with the definition of fraud and abuse, the fraud and abuse survey[4] (which will be discussed in more detail in Chapter 3) asked respondents for working definitions in the following programs: AFDC, Medicaid, Food Stamps, Summer Food Service, Vocational Educa-

---

[2]Robert D. St. Louis, Paul L. Burgess, and Jerry L. Kingston, Fraudulent Receipt of Unemployment Insurance Benefits: Characteristics of Those Who Committed Fraud and a Prediction (Arizona Unemployment Insurance Task Force, UI Bureau, Arizona Department of Economic Security, June 1978), p.1.

[3]Ibid.

[4]See Appendix H, Items 18 and 20.

tion, CETA, and Unemployment Insurance. Approximately 70% of the respondents indicated that "abuse" is considered such a catch-all term that *a single definition is not appropriate for all circumstances.*

The easiest way to categorize fraud definitions is by using legal definitions which describe whether state, federal, or both government jurisdictions have sanctioning authority. For example, federally funded programs administered primarily by federal agency personnel are governed by federal fraud statutes. USDA's Rural Housing program, VA's Education and Housing Guaranty, HEW's Medicare, and SBA's Minority Contracting and Physical Disaster Assistance are examples. Where programs are federally funded (or involve state and federal monies such as Unemployment Insurance) and are state supervised or administered, fraud definitions derive from general state fraud statutes or from what are called "welfare fraud" statutes.

Arizona illustrates a state with welfare statutes for fraud perpetrated by recipients in Food Stamps, UI, or AFDC programs.[5] Five from the group of programs reviewed in this study, USDA's Food Stamp and Summer Food Service; HEW's Medicaid, AFDC, and Vocational Education; and DOL's Unemployment Insurance, typify state sanctioning control and provide fraud definitions. It should be added that within one program there may be appreciable overlap of state or federal law enforcement responsibilities; such is the case with AFDC. On the other hand, within a single program, the states and the federal government may have jurisdiction over different parts of the program. An example of this is the Food Stamp Program, where recipient fraud is a state responsibility and retailer or wholesaler fraud is the responsibility of the federal government.

"Abuse" is a more ambiguous term than "fraud". Defined herein as *the improper utilization of a benefit or benefit system,* in practice, "abuse" rests on an official determination of *impropriety.* When such impropriety is defined by law and criminal intent can be shown, abuse is "fraud."[6] But often, administrative regulations, not laws, proscribe certain behaviors associated with obtaining or using benefits. And in other, even less clear situations, benefits are obtained or used in ways which are not intended by those who design or administer programs, but which are not specifically prohibited by law or regulation.

---

[5] Arizona Revised Statutes Annotated 142:100 (1978); 46:215; 201:360 respectively.

[6] It should be noted that laws vary across states, and that Federal statutes may differ from state statutes; thus, in practice certain actions may be defined as abuse in some jurisdictions and fraud in others.

Thus abuse is a concept which includes practices as diverse as making administrative errors on eligibility forms to the irregular and inadequate provision of "quality of life" care for elderly residents in a nursing home. Program abuse entails improper interpretations of policies and program guidelines, as well as taking improper advantage of ambiguous policies. Abuse is often more insidious than fraud; therefore, it is more difficult to combat. Most enforcement officials see abuse as far more damaging to the integrity of benefit programs than is fraud, primarily because abuse often involves "stretching" regulations to meet a desired end. And from the perspective of the potential abuser, the fact that no laws are broken, that victims have little basis for raising complaints and that sanctions are less well-defined and applied than in fraud cases, abuse may be perceived as having a lower risk calculus to commit. This risk calculus premise is confirmed by most observers, who also find that programs have more abuse than fraud.

The variety of existing programs and the inconsistencies among federal, state, and interstate definitions of "fraud" complicate the task of providing all-purpose examples of fraud. Some examples which clearly imply criminal intent and which are often defined by statute as fraud include cases wherein: scrip benefits may be counterfeited; a loan program computer may be manipulated by an administrative employee to create a fictitious borrower; serving portions of summer lunches for children may be made intentionally too small to meet government standards; or a doctor may provide unnecessary treatment to fraudulently collect reimbursement from health programs. Case histories of previously detected program fraud also lead to the generality that concealment and guile (as in other types of white collar crime) are major ingredients, i.e. a contractor may conceal fraud in bid-rigging arrangements made with subcontractors.

Finally, it should be noted that in practice "it is virtually impossible to distinguish sharply between fraud, abuse, and waste since one problem frequently involves all three.[7]

BENEFIT PROGRAM VULNERABILITY

Interview respondents noted multiple points within the benefits delivery system where program design weaknesses allow individuals or groups to take unintended or illegal advantage of the system. Identifying these points of *vulnerability*, as well as the individuals or groups with the potential to abuse the system, are

---

[7]U. S. Department of Health, Education and Welfare, Office of Inspector General Annual Report: April 1, 1977 - December 31, 1977 (Washington, D. C.: March 31, 1978), p. 1.

the first step toward developing "countermeasures which are wholly dependent upon the particular type of threat being countered."[8]

Vulnerability analysis has been used with some success in the computer security industry.[9] These assets (including facilities) are concentrated in only a few locations, and the primary purpose of vulnerability analysis is to identify the risks resulting from this concentration. When potential threats such as physical violence, equipment malfunction and human error are identified, they are then assessed for the magnitude of potential loss in terms of dollars, time, or permanency of damage. Managers may then make policy and budget decisions to minimize potential losses. For purposes of this report vulnerability analysis is limited to the identification of potential threats and offenders.[10]

POTENTIAL OFFENDERS

The fifteen benefit programs reviewed for this report include four potential offender populations. These include:

- Recipients - Those persons who directly received program benefits
- Administrators - Persons charged with management responsibility for a program
- Third Party Providers - Those persons or agencies charged with responsibility for providing benefit services
- Auxiliary Providers - Distinct from third party providers, auxiliary providers offer contracted services to third parties and administrators

---

[8]Harry Katzan, Jr., Computer Data Security (New York: Van Nostrand Reinhold Company, 1973), p. 113.

[9]Arthur E. Hutt, "Management's Role in Computer Security," in Douglas B. Hoyt, Computer Security Handbook (New York: MacMillan, 1973), pp. 1-3.

[10]It should be noted that to complete the analysis and thereby allow fully informed policy and budget decisions would require the availability of cost-benefit data. A separate report entitled Alternative Strategies for Cost-Benefit Analysis of Fraud and Abuse Enforcement: A Working Paper has been prepared which details the data requirements and alternative approaches to its analysis; the current paucity of available data makes a complete analysis impossible. Copies are available from the University City Science Center.

Program administrators and U. S. Attorneys indicated some organized crime activities in benefit programs. Only in four programs were *suspicions* mentioned, and results of the fraud and abuse survey suggested that only a small percentage (2%) of respondents believe that organized crime activity is linked to their benefits programs. While any willingness to report beliefs of organized crime involvement may be significant, the current scope and level of such involvement remains primarily a matter of conjecture.

Elements of organized crime are alleged to have used techniques such as blackmarketing, trafficking, counterfeiting, and forgery to accomplish benefit-related crimes. The one area that has recently received particular enforcement attention for program deficiencies is syndicated crime ownership of third party services participating in benefit programs. For example, several state Medicaid investigation units have begun to analyze ownership documents and disclosure forms for purposes of detecting alleged syndicate activity.

Because information concerning organized crime activities is insufficient to limit its potential role to third party providers and because information concerning its role in that sphere is also limited, this report will not focus directly on potential syndicate involvement. The following discussion first conceptualizes benefit program vulnerability; it then addresses each of the aforementioned potential offender groups and reviews the types of offenses which have been found.

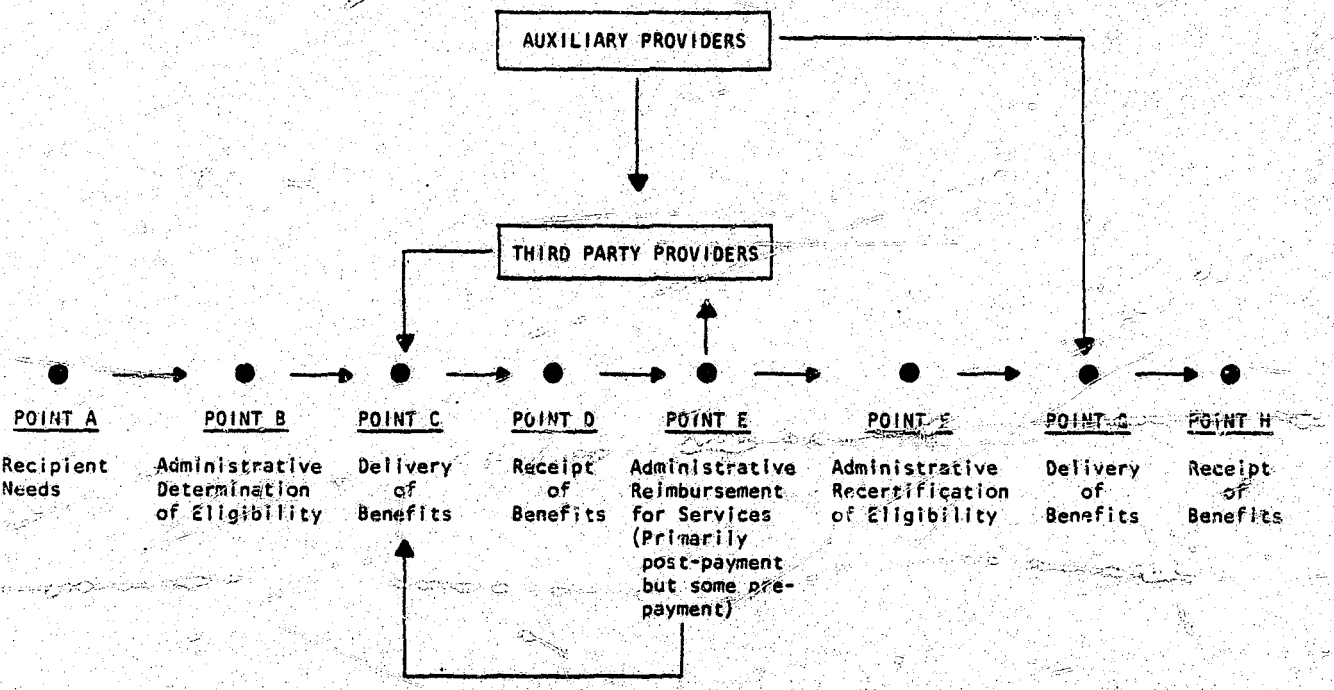
POTENTIAL OFFENSES

Visualizing a benefit system as abuse-free, the benefit process as depicted in Table II, page 19 flows along a continuum from a recipient's original need to his/her receipt of benefits.

Recipient need can be considered Point A. At Point B, recipient eligibility data, third party eligibility data, and auxiliary provider data are reviewed by program administration for purposes of determining eligibility to participate. When eligibility determination is favorable, the recipient enters the benefit system. At Point C, benefits are provided to the recipient either by administration itself, or by third parties with the assistance, in some instances, of auxiliary providers. Benefits are received by the recipient at Point D. Delivery and receipt transactions are separated into two points to emphasize that both delivery and receipt exhibit individual opportunities for fraud and abuse. At Point E, the administration reimburses third parties for their benefit services after reviewing their vouchers and billing claims. The process of delivering and receiving benefits continues until time of redetermination or recertification of eligibility. This transaction point is considered as F in the flow diagram. When a favorable redetermination is made at Point F, the delivery of benefits is renewed, and the pattern is repeated along the continuum.

TABLE II

PROGRAM VULNERABILITY POINTS



The discussions below, organized by the potential offender populations, focus on the types of risk associated with the various vulnerability points. It should be noted that while the examples of vulnerability presented here are program-specific, the vulnerability may exist for programs other than those from which the illustrations are drawn. Moreover, while the potential patterns of abuse are identified separately, they may in fact occur in association with each other in any given case. For example, a provider misrepresenting eligibility may do so to gain additional benefits from the program and kick back some of the program "profits" to an accomplice in the fraud scheme. Misrepresentation, gaining additional benefits, and payment or acceptance of kickbacks are identified here, however, as separate patterns of offenses.

RECIPIENT OFFENDERS AND OFFENSES

We begin with the premise that recipients represent an identifiable potential offender population. Recipients, including individuals, families, business entities, and local governments may

benefit directly from available programs.[11] Individual and family recipients vary in socio-economic and demographic characteristics, i.e., young and old, poor and middle income, sick and well, urban and rural, employed and unemployed. Certain of these population characteristics derive from eligibility criteria set out in statute and program regulations for each benefit.

Because eligibility determination and subsequent redetermination are at the heart of recipient participation in a program, they are basic to program design and, consequently, to program enforcement. At the present time, eligibility determinations rest on criteria and formulae established by each individual jurisdiction. As a result, there is little consistency or standardization either within or across programs.

The variety is compounded by another problem -- too much paper. As one federal official commented, "We are asking for more and more and learning less and less." In one large state AFDC program, three billion pieces of paper are handled yearly, and one city reports an average case file contains 700 application documents. The Secretary of HEW has pointed out that in some places "if you need public assistance, you may fill out 60 separate forms." An official participating on the President's Commission on Federal Paperwork commented that 85 percent of a caseworker's time in the AFDC program is spent on paperwork rather than on direct contact with clients.

Observers suggest that the lack of standardization and a preponderance of forms and documents have resulted, among other things, in fragmenting eligibility data, swamping program files with data, causing recipients and program personnel to "drop out because they can't cope" with the mass of information required, and forcing administrators to seek the support of others for the eligibility decisions they make. These difficulties suggest that these administrative weaknesses of recipient eligibility determination and recertification are highly vulnerable to recipient manipulation.

Recipient Misrepresentation of Eligibility

The research findings support the premise that misrepresented eligibility information (A) is an identifiable offense pattern used to qualify recipients not only for initial benefits where legitimately such qualification would not be possible, but also for benefits over and above those to which the recipient is entitled. Intentional and willful misrepresentation of eligibility information submitted to a

---

[11]Recipients here are considered as prime beneficiaries and should not be confused with entities which received reimbursement from program funds for services rendered to the program. For example, a physician receiving Medicare payments for services rendered to an eligible Medicare patient is not a prime beneficiary of the program. The eligible Medicare patient is the recipient.

program sponsoring agency is common to all but one of the programs reviewed.[12] Misrepresented data on acquired assets, income, birth date, social security identification, veteran status, marital status, credit worthiness, and criminal records have been documented in numerous programs.

Similarly, intentional misreporting or nonreporting of changes in eligibility status also occur frequently. For example, an AFDC recipient whose economic status changes because of the acquisition of new assets or the attainment of employment providing additional income is required to report this. Forgetfulness and ignorance of regulations may also explain some nonreporting.

Because many of the interviews indicated serious program vulnerability to misrepresentation of eligibility, respondents to the fraud and abuse survey were asked to assess the occurrence of this offense pattern among several types of fraud and abuse, using five response categories for the frequency with which it occurred: 0 to 10 percent, 11 to 25 percent, 26 to 50 percent, 51 to 75 percent, and 75 to 100 percent.[13] Only 72 (or 58.5%) of the 123 administrators responded with an estimate of the extent of

TABLE III

FREQUENCY OF PROGRAM RESPONDENTS ESTIMATING PERCENT OF RECIPIENT MISREPRESENTATION OF ELIGIBILITY

Program	0-10%	11-25%	26-50%	76-100%
Medicaid	5	2	0	0
AFDC	7	2	1	2
VE	0	0	0	0
Food Stamp	11	3	0	1
Summer Food	2	0	0	0
CETA	9	0	0	0
UI	13	0	0	3
Other	7	1	0	3
Total	54	8	1	9

[12]Misrepresentation of eligibility was not reported in the Vocational Education program.

[13]See Appendix H, Item 22.

misrepresentation of eligibility.[14] As Table III indicates, of those providing an estimate, 54 (75.0%) believed the abuse to occur in 0 to 10% of all cases; 8 (or 11.1%) believed it occurred in 11 to 25% of the cases; and 9 (or 12.5%) of those responding estimated that misrepresentation of eligibility occurred in 76 to 100% of all cases.

Recipient Creation of "Ghost" Eligibles

The transaction point of administrative determination of eligibility (B) appears vulnerable to a second recipient offense pattern where eligibility data are submitted to an agency for purposes of establishing a fictitious recipient. In this way a recipient establishes "ghost eligibility" and receives benefits other than those to which he/she is entitled. Illegal duplication or manipulation of social security identification, program identification forms, forging veteran discharge papers, or falsifying employment status data are some illustrations of how "ghosts" may be created. Observers have documented creation of fictitious eligibles in conjunction with other patterns of fraud such as counterfeiting or paying kickbacks to program administration personnel, providers, or third parties.

The fraud and abuse survey data on the assessed occurrence of recipient ghost eligibility showed even less variability than for misrepresentation of recipient eligibility.[15] For those 34 percent of the respondents who even estimated the rate of recipient ghost eligibility, only one respondent placed it above the 0 to 10 percent range. However, it should be noted that several responding fraud investigation and audit units placed creation of ghost eligibility by recipients in the low range, suggesting that they have handled "ghost" cases.

Recipient Theft of Benefits

The "benefit delivery" transaction point (C) is vulnerable to direct theft. Theft of benefits is a pattern associated primarily with programs offering cash or scrip benefits, or programs where cash or scrip must change hands in order to provide the benefits, such as Food Stamps and AFDC. Where cases of theft have been

---

[14]Other respondents either did not estimate misrepresentation of recipient eligibility or checked a "not appropriate" box. Unless otherwise indicated in subsequent analysis of estimated fraud and abuse, missing percent values represent respondents who either did not respond or who checked the "not appropriate" category. *NOTE:* Because responses to all other patterns of abuse similarly clustered in the "0-10%" category, complete breakdowns by type of abuse are not generally provided for subsequent offense patterns. Detailed presentation for each offense type would place improper emphasis on data with limited variance where the number of administratives providing estimates is often low.

[15]See Appendix H, Item 22.

documented, they entail a recipient's "inside knowledge" of program operations as to the dates and times when benefits are available. For example, an AFDC recipient knows when his or her benefit checks are sent out and when they are expected. This knowledge may be used to steal checks from other recipients' postal boxes and then to traffic the stolen checks.

Across all programs, only 26 percent of survey respondents placed this offense pattern in a percentage range at all.[16] Only two respondents estimated the rate occurrence above ten percent. The remainder found the pattern inappropriate for the types of fraud and abuse in their programs. AFDC and Food Stamp program respondents were the two groups with the greatest proportion of respondents providing any estimates of recipient theft.

Recipient Improperly Using Benefits

There is another pattern of offenses that may be associated with the benefit receipt transaction point (D): improper use of benefits. While the offense occurs in all programs, how the benefit is "improperly" used depends upon individual program regulations. This pattern is illustrated by using scrip benefits, like Food Stamps, to purchase items which are ineligible under program regulations, renting to others a residential dwelling purchased with VA loan assistance, or using Individual and Family grant money from FDAA to repair parts of the home not damaged by disaster. All of these acts are in violation of program regulations.

Only one-third of all survey respondents provided estimates on this type of fraud.[17] Twenty-three percent of the respondents estimated improper use of benefits by recipients as occurring between zero and ten percent of the time. Three percent of all respondents estimated it as occurring 11 to 25 percent of the time, and six percent of the respondents rated it as happening 25 to 50 percent of the time. Medicaid respondents were the largest group providing estimates of improper use of benefits in their programs: approximately two-thirds (64%) of these respondents provided estimates of this type of fraud and abuse.

THIRD PARTY PROVIDER OFFENSES AND OFFENSES

Third party providers (hereafter "third parties") represent a significant potential offender group. In examining program vulnerability to third party offenses, an understanding of how third parties function in the delivery of benefits is useful. In many programs third parties operationalize benefit delivery. In general, federal, state, or local government program sponsoring agencies

---

[16] See Appendix H, Item 22.

[17] Ibid.

contract with third parties for specialized goods or services to be delivered from the private sector. In Medicare and Medicaid, for example, pharmacies, physicians, hospitals, and nursing homes are also considered to be third party providers. Each state program determines reasonable fees for reimbursement of these various services based on guidelines and regulations from HEW and the states. In some states, for example, bottled oxgyen supplies to a nursing facility are not reimbursable under program regulations but instead are considered a "pass-through" cost of the nursing home. In others, it is partially reimbursed.

Other programs besides Medicare and Medicaid that involve identifiable provider/vendor participation and potential benefit delivery offenses are shown in Table IV on page 25. One of the distinguishing characteristics of providers is that they represent white collar elites in most communities. Bankers, doctors, and educators are generally considered important community members providing specialized services. As professional elites, the public generally expects them to be beyond reproach. As one prosecutor put it, "They are seen as pillars of the community because of their status, power, and authority." The community's perception of these providers helps to explain why it has been difficult to combat provider offenses. The members of the community who must sit on juries have found it difficult to convict the family doctor, lawyer, or accountant in a benefit fraud scheme because they do not perceive these individuals as normal criminals or wrongdoers. Current efforts are only at a threshold stage because of the conflict inherent in enforcing program regulations against those who are generally viewed as honest by the public. The patterns of offenses committed by some third parties include the following: misrepresentation of eligibility, receipt of additional benefits, overcharging for services, withholding services, providing unneeded services, establishing "ghost eligibles," accepting or paying bribes, kickbacks, or payoffs, and record tampering.

Third parties submit eligibility data on their own behalf and, in some programs, on behalf of those recipients they intend to serve. Many of the administrative weaknesses that marked deficiencies in recipient determinations appear in third party determinations. These include nonstandardization, excessive red tape and burdensome paperwork, inadequate verification of data, and poor quality control at the point of eligibility information intake. As with recipient fraud and abuse, some third parties see opportunities at the eligibility determination point to manipulate the system to their advantage.

Third Party Misrepresentation of Eligibility

The pattern of third party fraud through willful misrepresentation of qualifications submitted to the program agency is demonstrated in several programs. Examples of some types of misrepresentations of eligibility follow presentation of the Provider/Vendor table.

TABLE IV

EXAMPLES OF PROVIDER/VENDOR PROGRAM PARTICIPANTS

Program	Benefit Type	Type of Third Party Providers
Summer Food Service	Service	Prime Sponsors Food Management Firms
Food Stamps	Scrip	Coupon Vendors Coupon Redeemers
Medicare	Service	Physicians, Pharmacists, Hospitals, etc.
Medicaid	Service	Physicians, Pharmacists, Hospitals, etc.
Rural Housing	Loan	Contractors and Builders
Rehabilitation Housing	Loan	Contractors and Builders
Veterans Education	Loan	Vocational Schools, Universities, and Colleges
Veterans Housing Guaranty	Loan	Real Estate Brokers and Lenders
Comprehensive Employment Training Act	Service	Prime Sponsor and Employer
Vocational Education	Service	Vocational Schools
FDAA Reconstruction	Loan	Contractors
SBA 8(a)	Contract Procurement	Contractors

Major fraud and abuse occurred in the Summer Food Service program where prime sponsors claimed to establish several feeding sites within the inner-city and these sites subsequently were shown to be duplicative. Since feeding sites are created on the basis of demographic data on potential eligible children to be served, providers would create sites on paper, never serve meals at some of the sites, and yet fraudulently collect reimbursement for each meal claimed to have been served. As one federal prosecutor commenting on misrepresentation in the Summer Food Service program noted:

> When a prime sponsor represents to the government that it can feed two hundred children at a single site that has only a four burner stove, then one must begin to suspect irregularities in the applicant's service qualifications.

Misrepresentation of service abilities may occur separately or in conjunction with misrepresented eligibility data for those whom third parties intend to serve. For example, some providers serving the Rural Housing programs for the USDA have misrepresented the eligibility of recipients. Program regulations allow providers of large housing development or tenant housing to submit the applications of potentially eligible borrowers in the single package, thereby presenting a number of applications to USDA county offices at one time. As the program is currently structured, high volume offices have come to rely on "packaged applications" to speed the benefit delivery process. The problem is that falsified and misrepresented eligibility information which is submitted without verification, is frequently taken at face value by administrative personnel. Audit and investigative studies of Rural Housing packaging crimes place blame with both packagers and agency staff who carelessly process applications.

Two methods for misrepresenting eligibility from providers have been found in the CETA programs. It is reported that in some counties, prime sponsors have "coached" recipients to file application papers that meet CETA requirements, even though they in reality cannot meet such criteria. Another method falls under the rubric of "patronage." Patronage fraud and abuse by providers have resulted in individuals being hired and paid with CETA monies although they do not meet eligibility criteria.

Third Party Establishment of "Ghost" Eligibles

The point on the continuum where data are submitted for service eligibility by third parties also appears vulnerable to creation of "ghost" eligibility for those they claim to serve, e.g., a third party collects benefits for nonexistent clients.

Bogus eligibility data to create a "ghost" client may be drawn from identification from the living or deceased. Duplicate social security numbers, forged obituary data, abandoned residence addresses, or falsified wage reports illustrate ways of establishing ghosts. The Unemployment Insurance, CETA, SBA 8(a) and Vocational Education programs have documented incidences of this pattern of provider offense.

To understand how ghost claimants may be created by employers for collection of unemployment insurance, it is essential to know the distinction between a "wage reporting" and a "wage requesting" state. In some states ("wage reporting"), statutes require employers to report to the state on a timely and periodic basis, i.e. every quarter on all wages paid. In other states ("wage requesting"), wage records are requested by the state for only an annual

period without uniform records for each quarter. In wage requesting states, therefore, there is potential for employers to create ghost employees to collect illegal benefits since all the state ever sees are total aggregate salary figures for the year. This is less likely to occur in wage reporting jurisdictions where all wage records are on file.

Similar to the pattern of creating "ghost" employees is a technique called "fronting." Fronting involves a person or a group masking the identification of activity of the actual controlling agent. This strategy can be used by an unscrupulous contractor to obtain federal contracts in the SBA 8(a) minority program. He/she misrepresents or falsifies corporate ownership documents in order to create a "stand-in," e.g., a minority member, who because of race is automatically eligible for program participation. With this client, the contractor is certified by SBA to receive procurement contract assistance. The accomplishment of this offense is possible when SBA officials do not perform adequate verification of ownership data.

Data from the fraud and abuse survey for assessed occurrence of third party ghost eligibility were not statistically significant. Few respondents provided estimates and those that did (18%) placed it in the 0 to 10 percent range.

Provider Receipt of Excess Benefits

Provider schemes to obtain reimbursement over and above that to which the party is entitled may be found at several transaction points in a benefit process. Upon eligibility application, data may be misrepresented, or when reimbursement for service is claimed, vouchers and bills may be forged, mutilated, lost, or improperly submitted. Service information may also be misrepresented.

Receiving benefits in addition to those to which a provider is entitled is classified as "error" in many programs that were reviewed. Where audits or investigations find such errors, providers are usually required to repay the overpayments. However, where additional benefits are received through fraud by forging vouchers or intentionally misstating information about the work or service done, criminal actions may ensue.

Criminal prosecutions were brought against contractors, for example, who falsely notarized vouchers in an attempt to collect additional disaster assistance funding from FDAA. Double-billing, illegal upgrading of services,[18] and similar practices have provided opportunities for medical providers to gain additional health program funds.

---

[18]Upgrading of services "is the practice of billing for a service more extensive than that actually provided. A physician may treat a suspected cold and bill for treating acute bronchitis." (See HEW Inspector General Annual Report, op. cit., p. 79).

Returning again to the schematic, we asserted that "service delivery" was a key point for program vulnerability. The next three patterns of third party offenses described below are committed at this delivery point (C) in the benefit process.

Overcharging for Services Rendered

Overcharging may occur in two ways. If monitoring from the program agency is inadequate, one form of abuse is for providers to mistakenly overcharge and subsequently mistakenly receive payment; the second way involves intent to overcharge. Methods used for intentional overcharges include budget padding, voucher padding, multiple billing, or substitution of services while claiming reimbursement at a higher rate. In past Summer Food Service programs, there were instances of bid padding to include accessory items to meal service, such as trash collection. Prime sponsors in the program have padded budgets with inflated salaries and overhead expenditures. Rehabilitation Housing Loan officials have received padded bids from contractors, and one program reported problems with "frills" rehabilitation, i.e., the construction of a garden gate charged in addition to the work initially contracted for.

Medicare and Medicaid are also plagued by provider overcharging. Preliminary investigations in one state show gross overcharging by hospitals, which is difficult to detect because of the numerous "cost centers" in hospital facilities. For example, radiology treatments may be charged in the hospital laboratory and in the radiology department, thus providing potential for double-billing.

Provider Withholding Services

Another identifiable offense pattern at Point (C) involves withholding services or goods while billing the program for them. This pattern is associated with a provider's ability to either conceal the withholding by juggling books and records or by "paying off" others to hamper discovery of the offense. Many Summer Food Service programs in the mid-1970's had documented cases of partial meals being served to eligible beneficiaries. Because prepayments were allowed in the program, providers could serve inadequate portions and still collect reimbursement without being detected through an audit.

Withheld services are documented in the Rural Housing programs. Shoddy and inferior construction done by providers has led to leaking roofs, broken plumbing, electrical fires, and structural damage. The damage occurs after the homes are occupied and after the provider has received payments. In order to remedy these problems for the recipient, the program legislation provides some financial relief for repairs because of substandard construction.

Providers Offering Unneeded Services

At the other end of the spectrum from withholding services is the provision of unneeded services or goods. For example, to gain

additional benefits, a provider offers a service not originally called for in the contract and then charges the program for the service. A difficult aspect of this offense pattern is whether the client is, in fact, better served by the additional services. For example, in conjunction with health programs, only certain services are covered by reimbursement formulae. Often, however, the professional judgment of the provider indicates an uncovered service is required, and it is argued that the provider should receive payment since better health care may be the end result. As one official noted, it is a question of what is "medical necessity," who should determine its necessity, and who should pay for it.

Provision of unneeded services is also illustrated where some contractors participating in Rehabilitation Housing Loan programs have "tailored" their work. "Tailoring" involves work performance not specifically described in the contract as the same type of work to be done. A roof may be replaced in a home, because of tailoring, when the initial contract calls only for reshingling.

In Medicaid, provision of unneeded service falls under the special heading of "overutilization." States are now establishing what are called "Surveillance Utilization Review Units" (S/UR) for creation of provider and patient profiles and analyses of utilization patterns. Under present plans in one state Department of Health, providers are screened for flagrant overwriting of drug prescriptions. Approximately 50 types of drugs with high street values are the initial targets of the surveillance. Where overutilization is found, a warning letter is sent to the provider.

In another Medicaid S/UR program, physician visits to hospitals and consultations are reviewed to ascertain whether they are necessary and reimbursable, or unnecessary, and, therefore, not reimbursable. In many cases a physician bills Medicaid for a twenty minute consultation, even though a simple analysis will show that adding up all his/her reported "twenty minute consultations" would result in a twenty-hour day at the hospital.

Providers Accepting or Paying Kickbacks, Bribes

Paying or accepting kickbacks out of program funds is usually associated with the "service delivery" transaction point, although there are a few instances where misrepresented service eligibility was covered up by paying bribes.

Doctors in some Medicaid programs kickback program monies to pharmacies that they own for the purpose of perpetuating opportunities for writing and filling unneeded prescriptions. Unemployment Insurance has had cases where an employer has colluded with an employee to receive Unemployment Insurance benefits and then split the proceeds. Programs involving bid work between the provider and a specialized subcontractor have also documented cases where bribes and kickbacks were paid, i.e., Summer Food Service, SBA's 8(a), HUD's Rehabilitation Housing, USDA's Rural Housing, CETA, and FDAA's reconstruction programs.

Providers Tampering with Records

Providers have been known to fraudulently tamper with program or program-related records. For example, investigators for the VA described a case where veterans' discharge papers were fraudulently aged and backdated. The VA Housing Loan Guaranty program has documented incidences of forged or altered credit reports, affidavits, and other documents submitted by real estate brokers or lenders to VA with false information about the veteran, the proposed loan, or the property being purchased.

A regional counsel to the SBA reported several instances of record tampering in the packaged loan applications submitted to the Regional Office. The applications for loans contain a separate sheet of warnings to the beneficiary about conditions and fees for packaging, but packagers receiving the SBA forms tear off the warnings. An unsuspecting client may end up paying exorbitant fees to the packagers without understanding the conditions already set out. In one example, a packager submitted 60-70 applications charging fees of $1,500 each where the fee limit should have been around $500.

ADMINISTRATIVE PROGRAM PERSONNEL

The general view is that recipient and provider fraud and abuse represent the majority of offenses committed in programs. However, there is little reliable evidence to show the frequency with which either of these groups commit offenses.

Data from the fraud and abuse survey are equivocal on this point. The majority of respondents (71%) provided estimates on the rate of fraud and abuse among recipients across the various types of fraud and abuse.[19] Fewer respondents provided estimates of fraud and abuse for provider offenses (41%) or for program agency employees (35%). However, the estimates of the rate of occurrence of fraud and abuse made for employees by this smaller sample of respondents tended to be higher than those made for recipients or providers. Half of the respondents who estimated rates of fraud and abuse among employees categorized it as occurring more than 11% of the time. Only 28% of those who estimated the rate of fraud and abuse for recipients and 47 of those who estimated provider fraud and abuse placed the rate of estimated occurrence above this 11% rate.

In an analysis of telephone calls made to its "Fraud and Abuse Hot Line," the United States General Accounting Office found that of "957 allegations of wrongdoing, the highest proportion, 30 percent, was in the participant category called 'federal employees

---

[19]See Appendix H, Item 22.

only.'"[20] Our fraud and abuse survey findings and the General Accounting Office findings suggest that even though the magnitude of the threat to program vulnerability is uncertain, administrative program personnel can be identified as a third potential offender category.

As the flow diagram suggests, administrative program personnel have major responsibilities at the points of eligibility determination (B) and recertification (F). In fact, the scope of their responsibilities goes far beyond to quality control, quality assurance, program integrity, and timely delivery of benefits.

Regardless of specific program details or the benefits offered, staff are considered the backbone of program operations. Computers are installed and technology is used to assist staff in sorting eligibility data, storing and retrieving client files, or cataloging internal program audits. Third party providers such as bankers, doctors, or contractors offer key services in program delivery. Auxiliary providers assist program operations by assuming certain responsibilities for third party provider participation. But in the final analysis, the human staff component provides the link between program formulation and implementation. Because this link is believed to be a vital one for effective, efficient, and crime-free delivery, staffing of benefit programs continues to be controversial.

Staff size is criticized for poor staff to client ratios: the distribution may vary from one to one up to one to several thousand. Staff functions are criticized for being too general in some programs, thus allowing abuses and errors to slip by, or for being too specialized, as in the criticism that caseworkers serve only a benefit delivery role and not a fraud detection role. Staff functions are also criticized for having too many responsibilities, some of them in potential conflict. For example, many argue that eligibility workers should not be given tasks of fraud investigation, that it is impossible to "provide benefits and look over a client's shoulder." To underscore the importance of staffing, Congress inserted a provision in the Food Stamp Act of 1977 calling for establishment of staffing standards. The Department of Agriculture is currently undertaking a study to determine the most appropriate staffing arrangements for each state Food Stamp program.

These staffing controversies raise multiple research issues related to the vulnerability of programs to employee fraud and abuse.

- Staff size varies greatly from program to program as well as within program areas.

---

[20]Elmer B. Staats, U. S. Comptroller General, "Statement Before the Senate Committee on Budget, GAO Efforts Related to Fraud, Abuse and Mismanagement in Federal Programs" (Washington, D. C.: U. S. Government Printing Office, March 15, 1979), p. 23.

- Staff responsibilities are sometimes split between state and local government agencies.
- Staff turnover is extremely high.
- Part-time staffing can increase the possibility of fraud and abuse.

One, staff size varies tremendously within and across program areas. The fraud and abuse survey data show staff sizes range from two to 5,590 employees. The ratios of staff administering a program to total clients served by the program vary from a low of one to one, to a high of one employee to 32,789 clients. The higher ratios are perhaps explained by the fact that some programs rely on third parties to provide benefits. For example, the state administrative staff for a Summer Food Service program may be composed of a dozen persons, but a food management firm under contract to the prime sponsor may serve meals to thousands of needy children. Little is known about the relationship between staff size or clients to staff ratios, and the incidence of fraud and abuse. The results of a preliminary analysis of these variables using the survey data are presented in Chapter 2 of this report.

Two, staff responsibilities from programs may be split (decentralized) between state and locality. For example, 42% of the survey respondents indicated that their programs were decentralized. Knowledge of the relationship between decentralization and the rate of fraud and abuse may be beneficial for developing program designs for fraud and abuse control. For example, a study completed for HEW on AFDC error rates concludes:

> We find that state administered AFDC programs exhibit significantly lower error rates than state-supervised programs. If all state-supervised programs were converted to state administration, $90 million per year in payment errors would be saved.[21]

However, data from the fraud and abuse survey indicated that respondents from programs exhibiting split responsibilities tended to report lower average estimated rates of administrative fraud and abuse. For those programs that estimated the frequency of various types of administrative fraud and abuse, only 42% of the decentralized programs estimated administrative fraud and abuse as occurring more than 11% of the time while 74% of the programs having single staff responsibility for administration placed their estimates above 11%. Further, the majority (62%) of programs with split responsibility reported their assessed rate of fraud and abuse detection above 10% while the majority of respondents (52%) from programs with single staff responsibility placed it at 9% or less.[22] No

---

[21]Marc Bendick, Jr., Abe Lavine, Toby Campbell, The Anatomy of AFDC Errors (Washington, D.C.: The Urban Institute, 1978), p. 8.

[22]See Appendix B, Item 31.

differences were noted on recipient or provider fraud and abuse. Such data suggest that while there are advantages to centralization, they may be offset by problems of a different sort. For example, recipient fraud and abuse may be reduced under decentralization, but more administrative fraud and abuse may develop.

Third, staff turnover in programs is extremely high. One administrator suggests that turnover in state AFDC programs may run as high as 25% annually. One of the recommendations made for the AFDC program in a 1978 report on program error rates is for the federal government to undertake further research on the "subject of staff turnover, its determinants, and cost-effectiveness measures for its reduction."[23] High rates are considered a major cause for fraud and abuse because there is no consistent staffing pattern to assure careful case handling.

Fourth, the staff of programs with part-time personnel is alleged by some to create more opportunities for fraud and abuse than if only full-time staff were used. Part-time staff is usually hired during peak demand periods. For example, migrant workers' Unemployment Insurance claims increase at the end of seasonal work periods. Also, during disaster recovery operations, special emergency benefits are offered on a short-term basis to victims. These periodic upsurges in demand make it necessary to hire temporary, part-time help. The corresponding increase in fraud and abuse can be attributed to several factors. In crisis situations there may not be enough time for extensive personnel training. Poor training and a quick program start-up can leave part-time personnel confused about their jobs. During periods of heavy work load, personnel may take "short cuts" in duties. For example, applications may receive only a cursory review and recipients may be declared eligible for benefits who would, on further inspection, be declared ineligible. Previous fraud and abuse cases involving part-time personnel suggest instances of theft of benefits and services, collusion with applicants to steal benefits, and receipt of kickbacks from benefit proceeds. Whatever the method or reason for the occurrence of fraud and abuse as it relates to part-time personnel, the results are the same--heavy financial losses and violations of program regulations.

The irony of the part-time, full-time controversy lies in the fact that program vulnerability to fraud and abuse by employees derives in large measure from the very nature of their familiarity with program operations. Employees usually commit crimes successfully because they know how benefits are conveyed, the transaction points involved, and the timing and methods of delivery. Collusion with clients to defraud, creation of fictitious clients and client records, and creation of fictitious postal addresses to collect defrauded benefits are crimes committed by some employees as a result of their inside knowledge and their ability to use that

---

[23]Bendick, et al., op. cit., p. 11.

knowledge. As with recipient and third party fraud, misrepresented eligibility and creation of ghost eligibility characterize patterns of employee offenses.

Agency Misrepresentation of Eligibility

The significance of eligibility determination for program participation cannot be overemphasized. Therefore, weaknesses in program design which provide opportunities for employee misrepresentation of an applicant's eligibility are important to identify. The determination of eligibility formulae is a major area for that abuse. In one recent study of the AFDC program it is noted that:

> If all states were to adopt program rules (i.e. consolidated grants, flat grants) as simple as those in force in the most streamlined states, then the national case error rate could be cut . . . savings in payment errors avoided.[24]

Detection of misrepresented eligibility is difficult because verification is cumbersome. As an investigator of Housing Loan Guaranty fraud cases commented, investigations are inhibited because sources of employment verification have frequently gone out of business.

Misrepresented eligibility with intent to defraud may also occur in collusion with a client or with a provider. In an already documented case of employee misrepresentation, a staff member of a local housing authority, charged with responsibility for distribution of HUD Rehabilitation Housing funds, fraudulently misstated eligibility data for potential beneficiaries to qualify them for eligibility. The employee also entered into collusive agreements with a local building contractor who was to do the repair work. The contractor then kicked back a portion of his reimbursement.

Misrepresentation of recipient eligibility may also result in fraudulent collection of benefits over and above those to which the recipient is entitled, an administrative overpayment to the client, the provision of unneeded services to some recipients, or the receipt of benefits by ineligible recipients.

Agency Creation of "Ghost" Eligibles

Creation of bogus case files and fictitious benefit recipients is another employee offense pattern. Ghost eligibility may be established by counterfeiting identification already issued to a recipient, tampering with records, forging signatures, or duplicating social security numbers. In many instances where employees create ghost recipients, collected funds are either kept for themselves or kicked back to others who may have colluded in the fraud.

---

[24] Ibid., p. 7.

Agency Embezzlement or Theft

It is appropriate that embezzlement follows creation of ghost eligibility in this taxonomy of agency offenses because most program embezzlement schemes involve establishment of ghosts. For example, a computer technician, responsible for payment of health claims to providers, could manipulate the program to create a ghost provider and ghost patients and then embezzle the payments.

Agency Overpayments or Underpayments

Administrative responsibility for benefit delivery to the client is indicated at transaction Points C and G; administrative responsibility for third party reimbursement of services is shown at Point E. While prepayment has been eliminated in most programs, there are still vestiges of its use in some programs. These administrative transaction points where benefits are delivered to the client and third parties receive payments for their services are vulnerable to administrative overpayment and underpayment of benefits.

Programs offering cash benefits appear to be the most likely candidates for administrative payment error to clients. For example, AFDC's cash assistance to clients has been particularly troubled with administrative payment errors forcing the implementation of formalized quality control. The complicated nature of payment determinations, understaffed offices, and poor case management are blamed for fostering opportunities for payment abuses.

Inaccurate administrative payments have been made in most of the programs with third party participation. It appears that poor quality control, a lack of pre- and post-payment auditing, and significant pressures to get the reimbursements out quickly to providers so as to avoid their dropping out of the program are design deficiencies which lead to reimbursement abuses.

Agency Withheld Benefits

Closely associated with payment abuse is an offense pattern of withholding or misrepresenting information on services provided to a beneficiary. This pattern occurs at the transaction point where third parties are reimbursed for their services and usually is allied with other offense patterns such as accepting bribes or kickbacks from a third party.

The most blatant illustration of this pattern occurs in some housing assistance programs where agency staff either forget to submit work change orders or deliberately falsify information on the orders to represent that work has been done when it has not. Withheld or misrepresented information on work change orders has resulted in faulty and inferior construction of dwellings paid for with program funds. In addition, agency inspectors or compliance monitors perform substandard quality control. Critics of USDA's Rural Housing program find that inadequate employment criteria for hiring of inspection personnel, poor in-house training of inspection

personnel, and huge inspection caseloads which are understaffed, are to blame for faulty inspection jobs and consequent administrative abuses.

AUXILIARY PROVIDERS

Having synthesized information on patterns of offenses committed by recipients, third parties, and agency personnel, one final category of potential offenders remains to be discussed, which is that of auxiliary providers. The phrase "auxiliary providers" identifies groups and agencies offering services integral to third party provider participation in programs. In some programs, auxiliary providers are outside the scope of federal program regulations, while in others they are subject to specific provisions. From the illustrations which follow, it is fair to conclude that auxiliary providers operate in programs where third party participation is requisite for benefit delivery. Fiscal intermediaries and insurance carriers who process third party claims for Medicare and Medicaid are examples of auxiliary providers. In Medicare, the federal government contracts directly with these firms, but in Medicaid the states contract with auxiliary providers.

Offenses committed by some intermediaries and carriers appear to fall into patterns of contractual abuses, rather than intentional fraud. For example, several Medicaid contractors were dismissed because they did not meet their obligations for timely payment of third party claims. In one particular state, the backlog of claims became so great that the Medicaid program was almost forced to shut down. Critics of auxiliary providers also suggest that they are reluctant to question claims aggressively and would rather handle the problem with a "pat on the provider's wrist."

State licensure boards, state rate-setting commissions, state regulatory agencies and the like may also be placed in the category of auxiliary providers. Program third party providers are subject to their regulatory supervision and general governance and, therefore, the vigor with which they perform these functions may influence how fraud- and abuse-free a program will be. If physicians' licenses are revoked by appropriate state authorities after the conviction of criminal fraud charges in Medicare, for example, the deterrent effect of this action is presumably far reaching. Where regulatory boards do not take aggressive action, provider offenses continue and may increase since there is no deterrent.

Conflicts of interest shared by third parties and those who sit on regulatory boards, and the lack of aggressive action from these boards, has come under serious criticism in the past several years. Some critics argue that the justice system would not have to take on the responsibility for punishing third party fraud and abuse if the regulatory boards were doing a more thorough and public-minded job. Proponents of some of the boards are quick to show that not all have been delinquent in their regulatory responsibilities. At least two state boards in one federal region have aggressively

sought sanctions for third parties found misusing Medicaid funds, and regularly make referrals to HEW of alleged provider abuse practices that are brought to their attention.

Peer boards used specifically in health care programs for review of charges made by third parties for reasonable costs and for review of cost-containment in hospitals also function as auxiliary providers. Subcontractors, such as those used in CETA's program design, emphasize "local initiative" and decentralized operations; private firms which act as subcontractors are outside federal regulatory control.

Regulator and licensor patterns of offenses are difficult to identify. However, critics argue that their failure to properly inspect facilities, revoke professional licenses, and to bring improper professional practices to the attention of program administrators are an abuse of their public trustee role.

Patterns of auxiliary subcontractors' offenses have been identified as collusive bid-rigging, inferior quality benefit delivery, misuse of program funds, payment or acceptance of kickbacks from program funds, and tampering with benefit delivery vouchers, records, or files to defraud programs.

EXTERNALITIES OF PROGRAMS

This application of vulnerability assessment to benefit programs has employed a taxonomy of offenders and offenses. The taxonomy, however, only begins to explore the issue of why program deficiencies are easy marks for fraud and abuse. External factors of program operations can also be related to program vulnerability and make it easy for program crimes to be committed. These externalities include the economic structure of service delivery and aspects of supply and demand for program services.

Economic Structure of Service Delivery

To understand the ways that externalities influence program vulnerability, the economic structure of the particular "functional area" (market place) within which program benefits are delivered must be explored. The term "functional area" applies to the major objectives of the program. For example, Food Stamps provides improved diets for low-income eligibles by supplementing their food purchasing ability.[25] Similarly, loans which "restore, as nearly as possible, the victims of physical disaster to pre-disaster conditions"[26] provide disaster assistance.

---

[25]Office of Management and Budget. Catalog of Federal Domestic Assistance 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), pp. 42-43.

[26]Ibid., pp. 760-761.

The current economics of the health services delivery "marketplace" provide a useful illustration of how economic structure is related to program vulnerability. Health assistance programs rely on third party and auxiliary provider services. Their participation of necessity expands the number of financial transaction points through which program funds must pass. It has been suggested that third party reimbursement affords numerous opportunities for abuse and fraud in the claims reimbursement process. Hospital reimbursement illustrates the potential problems created by an economic structure which necessitates indirect financing with program funds. "Hospitals are reimbursed on the basis of costs incurred in patient care; thus the incentive is to run up costs, bringing enough revenue to keep the hospital going."[27]

As one federal enforcement official commented, "There is a conscious extraction of the last dollar by some hospitals for any procedure." He added, "Hospitals will attempt to create positions which can be billed directly to the health programs." Instances of billing for "phantom surgeons" have occurred for example. Once an individual has completed his/her hospital residence, he/she may stay on at the hospital as a junior surgeon and then bill Medicaid directly for the surgical services. Medicaid reimbursement, however, never flows back to the individual surgeon, but rather is used to support the hospital's program for all resident surgeons.

Supply and Demand

Another externality which should be considered for its relationship to fraud and abuse is the supply and demand aspects of functional service areas. Since program caseload is a proxy of demand, as demand rises caseload will also increase. Seasonal demand for benefits in Summer Food Service, for summer CETA employment, and for unemployment relief for farm workers is credited with increasing caseloads for short time periods, for example. The surge in demand makes it difficult to perform adequate quality control. It has created problems of understaffing and required the employment of part-time personnel who have limited knowledge of program operations. Poor quality control and inadequate staffing are, in turn, blamed for incidents of fraud and abuse.

Elasticity of supply and demand in functional service areas also appears related to fraud and abuse. Housing assistance and health assistance both illustrate this relationship.

Housing Assistance

The entire residential industry is a major credit consumer[28]

---

[27]Abigail Trafford, "Inside Our Hospitals," U.S. News and World Report, Vol. 86, No. 9 (March 5, 1979), p. 35.

[28]Veterans Administration, Annual Report, 1977 (Washington, D.C.: U.S. Government Printing Office, 1977), p. 76.

and depends on demand for homes and the availability of housing stocks. "The availability and cost of funds in the money and capital markets therefore have an impact on" the number of claims for housing assistance in government-sponsored programs.[29] The VA program, for example, keeps its interest rate ceiling competitive with the private market to assure lender support for the program.[30] Availability of mortgage money and increased demand for housing has placed heavy pressures on government loan volumes at the program agency level and has created more opportunities for lenders and real estate brokers to participate as third parties. The result has been that large caseloads have swamped understaffed eligibility offices and loan monitoring processes, affording opportunities for fraud and abuse.

Health Assistance

The relationship of price elasticity to potential fraud and abuse opportunities is also demonstrated in the health service area. However, price elasticity for health services acts in reverse to most "free market" operations.[31] On the service side, observers see that the "more hospital beds in an area, the more usage goes up --and the more costs per admission go up."[32] Hospitals find it necessary to maintain their initial capital investment purchases of beds. For physicians who offer program services, the price pattern operates similarly. The higher the number of doctors in an area, the higher the fees which are charged and must be reimbursed by program funds.[33]

On the demand side, more individuals are seeking health care assistance and demanding better care. Take the elderly population, for instance, who benefit from health assistance programs. The number of elderly persons in the nation is increasing, and they generally require 2.5 to 3.0 times as much medical care as younger people.[34] Moreover, the "elderly . . . and their diseases, usually chronic, require 50 percent more bed rest than those who are 45 to 64 years old."[35] Hospital treatments and stays are therefore increasing and "gobbling up" more health assistance dollars. With prices for health services rising, providers contend they must "defensively bill for the services that are rendered to elderly program recipients in order to meet rising costs. This results in more efforts by providers to abuse program billing regulations. For example, a physician may attempt to upgrade billing or attempt to double bill. Many physicians who are caught abusively billing consider any fines they must pay as a "cost of doing business."

---

[29] Ibid. [30] Ibid.

[31] Trafford, op. cit.

[32] "Special Report: Unhealthy Costs of Health," Business Week (September 4, 1978), p. 58.

[33] Ibid. [34] Ibid. [35] Ibid.

SUMMARY

The vulnerability assessment of fifteen government benefit programs uncovered common design deficiencies which provide opportunities for fraud and abuse. In addition, externalities were identified which make it easier for offenders to take advantage of program design deficiencies. Table V summarizes the potential offenses and offenders; see below.

TABLE V

TAXONOMY OF OFFENDERS AND OFFENSES

	RECIPIENTS	SPONSOR AGENCY	THIRD PARTY PROVIDERS	AUXILIARY PROVIDERS
MISREPRESENTING ELIGIBILITY	●	●	●	
CREATING "GHOST" ELIGIBLES	●	●	●	
IMPROPERLY USING BENEFITS	●			
RECEIVING ADDITIONAL BENEFITS	●		●	●
OVERCHARGING FOR SERVICES			●	●
WITHHOLDING SERVICES		●	●	●
OFFERING UNNEEDED SERVICES			●	
ACCEPTING OR PAYING KICKBACKS		●	●	●
TAMPERING WITH RECORDS	●		●	
EMBEZZLING OR STEALING BENEFITS		●		
OVERPAYING OR UNDERPAYING BENEFITS		●		
COUNTERFEITING BENEFITS	●	●		
ILLEGALLY OWNING BENEFIT SERVICES			●	

CHAPTER 3

SELECTED HIGHLIGHTS FROM THE FRAUD AND ABUSE SURVEY

The other portions of this report offer a number of findings from the fraud and abuse survey which are descriptive in nature, e.g., survey response data to items concerned with definitions of fraud and abuse and the ways computers are used to detect fraud and abuse.

The survey data also lend themselves to some other types of analyses. These analyses suggest some possible relationships between program structure and operation, estimated rates of fraud and abuse, and program enforcement. Concerning program structure and operations, there is some indication of a relationship between various ratios of staff to clients and assessed rates of fraud and abuse occurrence and detection. With regard to program enforcement, overall levels of training activities were observed to be related to the detection and occurrence of some types of fraud and abuse. Such results deserve further scrutiny in future efforts to reduce benefit program fraud and abuse.

Staff to Client Ratios

At present, there is very little information available on the relationship between staff to client ratios and incidences of fraud and abuse. The relationship has only begun to be scrutinized for empirical validity. A continuing problem is that tremendous variation in the way programs are operated at each management level inhibits the formulation of national standards for specifying appropriate ratios of staff to clients. There is also some controversy as to whether an appropriate formula for determining the number of staff to serve a given number of clients is attainable and workable. In addition, social welfare management literature has not dealt extensively with issues of efficiency and effectiveness expressed as a proportion of staff to clients. The closest concept appears to be work measurement. However, work measurement theory usually assumes a given error rate per worker rather than a variable rate based on other factors.

While the fraud and abuse survey does not shed light directly on issues of optimal staff to client ratio, it does provide some data which suggests that staff to client ratios may have a relationship to the detection and reporting of fraud and abuse in programs.

Examining the staff to client ratios in the reporting sample utilized the reported number of staff employed to administer the program and the reported monthly client loads.[1] From these figures,

[1] Monthly client load was chosen because it represented a conceptually manageable middle ground between gross aggregations of yearly figures and the more variable daily figures. It also represented the time frame most commonly used by programs themselves in assessing workloads.

a client to staff members ratio was computed. Although the resultant index figures represent rather gross estimates of workload because they do not exclude purely administrative personnel, certain relationships of possible interest were noted.

Initial analysis revealed a significant relationship between client to staff ratios and the average assessed rate of fraud and abuse across parties for receipt of additional benefits ($r = +.48$, $N = 43$, $p = .001$) and for overcharge of benefits provided ($r = +.33$, $N = 25$, $p = .048$). That is, survey respondents with more clients per staff member tended to estimate a greater frequency of fraud and abuse in these two areas. A further, and perhaps more reliable analysis was conducted on those program respondents who indicated that they kept statistics on fraud and abuse. The underlying assumption was that the estimated rates of fraud and abuse from these programs would be more accurate and less erroneous than those estimates made by other respondents. Despite the reduced sample size, the relationships just discussed improved considerably. The correlation between the clients per staff ratio and receipt of additional benefits was + .64 ($N = 29$, $p = .001$). For overcharging of benefits provided it became + .70 ($N = 15$, $p = .002$). In addition, one other relationship was noted which had been nonsignificant when computed on the full sample. The overall estimate of fraud and abuse by program recipients[2] was found to be positively correlated with the clients to staff ratio ($r = + .39$, $N = 39$, $p = .015$). As before, statistics-keeping survey respondents with more clients per staff member tended to report more frequent occurrence of recipient fraud and abuse than those respondents with small clients per staff ratios. One technical note which should be injected into these findings at this point is that other notable correlations were obtained but restrictions in the response range and the number of respondents in certain fraud and abuse categories statistically prohibited their inclusion.

These restrictions prevented the interpretability of similar analyses conducted using the ratio of clients to fraud and abuse detection personnel (i.e., the number of fraud investigators and internal auditors which a program has).[3] However, one finding which did emerge was a low, but significant negative correlation between this ratio and the estimated rate of fraud and abuse detection by programs which kept statistics ($r = -.29$, $N = 35$, $p = .041$). In general, survey respondents who had fewer clients per detection personnel also reported higher estimated rates of fraud and abuse detection.

---

[2]This value represents the average estimated rate of fraud and abuse by program recipients computed across each type of fraud and abuse listed (see Appendix H, Item 22)

[3]See Appendix H, Item 11.

Overall, these findings suggest that the incidence and detection of fraud and abuse cannot be assumed to be a simple function of program size. That is, as programs get larger the rate of fraud and abuse increases and the ability to detect it decreases. Excepting the statistical restrictions mentioned earlier, no significant correlations were observed between program size as measured by budget, client load, or staff size and the reporting incidence or detection of fraud and abuse. Those factors which did appear to be of some interpretative value were the presence or absence of actual fraud and abuse statistics, and the ratio of clients to staff members and detection personnel. Such results suggest that in future studies, *relative* measures of program design and functioning such as ratios or per capita may yield information of greater enforcement utility than absolute measures such as budget size, total staff, etc.

Training

A second avenue of exploratory analyses concerned the level of training a program provided to its staff. An overall level of program training activity was derived from the frequency of reported training in the survey.[4] In those programs which kept fraud and abuse statistics, these overall levels of training were found to be positively correlated with the estimated rate of fraud and abuse detection ($r = +.32$, $N = 43$, $p = .013$) and negatively correlated with the assessed rate of fraud and abuse occurrence in the category of receiving additional benefits by those declared eligible ($r = -.29$, $N = 32$, $p = .049$). In essence, those programs which reported greater levels of regularly scheduled training activities also tended to report a greater estimated rate of fraud and abuse detection and lower estimated rates of fraudulent receipt of additional benefits.

The relationship of overall levels of training with program size variables was also explored. A significant negative correlation was found with monthly client load ($r = -.26$, $N = 45$, $p = .040$). The programs that reported less overall training on a regularly scheduled basis also reported higher monthly client loads. Presumably an explanation for this would be that greater client demands on the program leave less time for other activities such as training. Partial support for this supposition comes from the finding of a marginally significant correlation between overall levels of training and the ratio of clients to staff ($r = -.27$, $N = 34$, $p = .060$). Programs with more clients per staff member also tended to report fewer regularly scheduled training activities.

---

[4]Overall training level was computed by summing values assigned to the frequency of training across all types of training and audiences (see Item 12, Appendix H). Values assigned were: 1 = Training held once, 2 = Training held annually, 3 = Training held two to four times per year, and 4 = Training held more than four times per year.

Although these correlations are low and cannot be interpreted in any causal fashion, they do tend to suggest that staff training is an area of programmatic endeavor which may be of some benefit in reducing the incidence of program fraud and abuse. The survey data indicates that greater regularly scheduled training activity is associated with higher estimated rates of detection and lower estimated rates of certain types of fraud and abuse. The fact that training levels are related to estimated detection rates whereas clients to staff ratios are not suggests that training may be an important mediating variable in assessing the value of changing client to staff ratios. Limitations in the response, detail, and refinement of the present survey preclude a more sophisticated statistical analysis of part and partial correlations among these variables. Future research should be designed to provide data on both the structure and functioning of individual programs so that analyses of the interaction between these factors will provide a better understanding of the dynamics of program fraud and abuse.

Overall, the preliminary results of the survey suggest that a greater number of detailed studies can provide useful information in the design of welfare programs to be less vulnerable to fraud and abuse. But weak program designs are only one contribution to the general problem of fraud and abuse. Deficient enforcement strategies also contribute to the on-going problem. The following chapter reviews the current commitments to enforcement of benefit program laws and regulations as they relate to design vulnerabilities.

CHAPTER 4

CURRENT ENFORCEMENT COMMITMENTS

Recognition of the relatively frequent occurrence of fraud and abuse in government benefit programs has led to the development of a variety of techniques to combat the problem. These *enforcement activities* are inextricably bound to successful benefit delivery, and in an era of fiscal restraint are destined to play an even more significant role in determinations of program viability and success. The reader will recall that Chapter 2 described the benefit delivery process in terms of a basically linear continuum. When enforcement activities are added, it may be more appropriate to view the process as circular (See Table VI below). Thus, one aim of enforcement is to recoup improper benefit payments. Recouped funds are placed back in the program for additional benefit payments. Various types of enforcement occur at different points on the circle. As an example, a strategy to recoup fraudulently collected benefits and return them to the program for determination of eligibility appears at Point B. Another enforcement strategy is to terminate participation of ineligible recipients and assure that only eligible needs are met at Point C. Strategies that punish third party providers for program wrongdoing are designed to assure appropriate and timely delivery of benefits at Points C and G.

The field investigations of the fifteen benefit programs reviewed for this study revealed a variety of enforcement *activities*. Interviews suggested that current commitments are usually thought of in terms of their primary goal, e.g., prevention, detection or deterrence[1] of fraud and abuse. Beginning with this simple goal typology, this chapter will first describe current enforcement commitments. Not all currently existing examples of a particular type of enforcement activity are included, as this would result in a prohibitively long and analytically redundant volume. Rather, one or two typical examples of the enforcement technique is/are described. It should be noted that not all of these techniques are appropriate across all benefit program types. Therefore, those *strategies* which are common to all programs will be further differentiated on the basis of the activities associated with their employment, thus creating a more detailed typology of enforcement strategies which is based on characteristic activities rather than general goals. Because each of these new strategy types is designed to reduce the incidence of fraud and abuse, and because the prevention-detection-deterrence (goal)

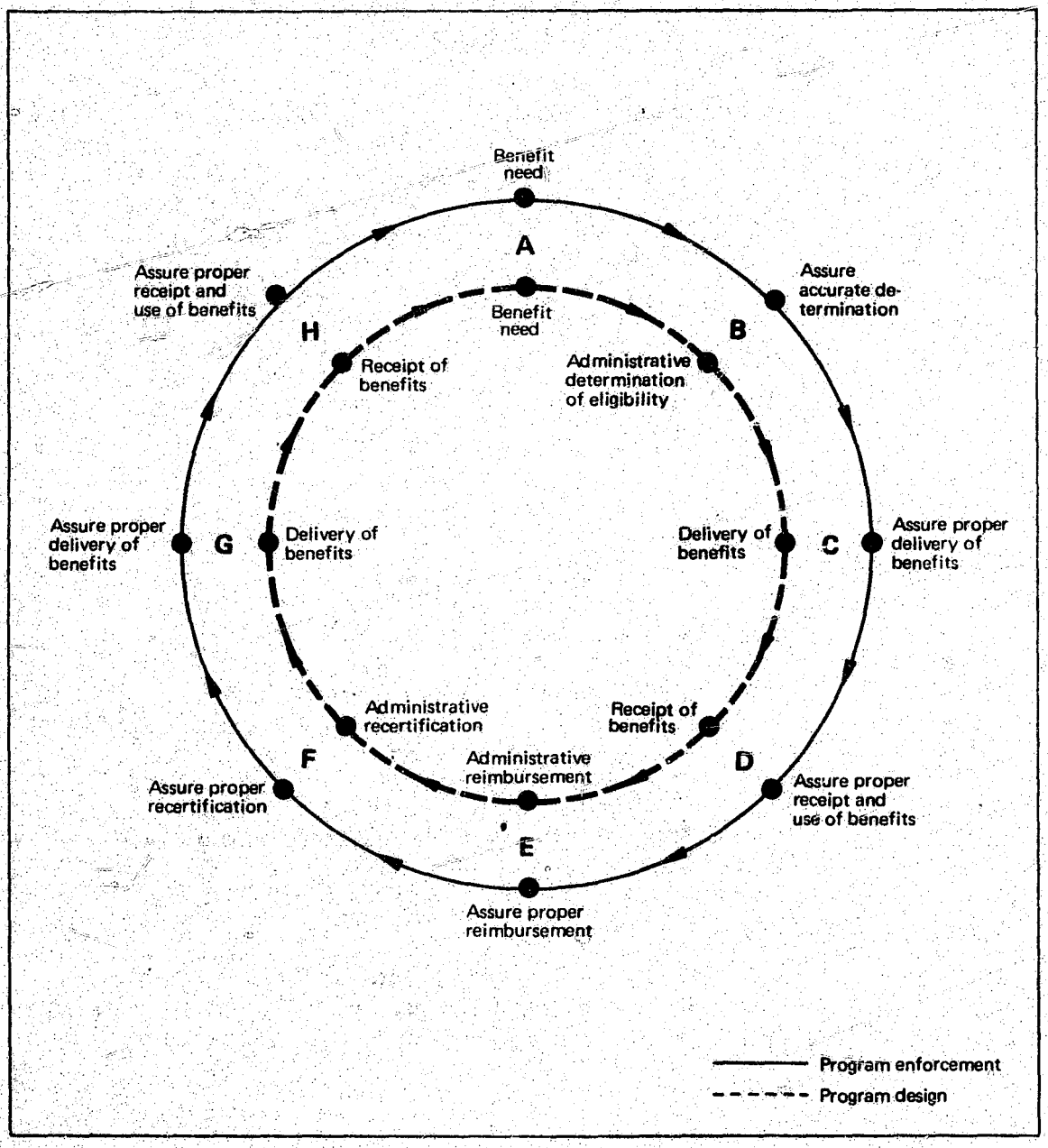
---

[1] Deterrence is here differentiated from prevention by its employment of some direct sanction to proscribed activities.

typology is conceptually slippery[2], those who are concerned about enforcement to control fraud and abuse may find the action typology to have greater utility than the goal typology.

TABLE VI

FLOW CHART OF PROGRAM ENFORCEMENT



[2]It is slippery, in part, because deterrence implies that new crimes or abuses are prevented, and detection is necessary to determine the success of either prevention or deterrence. Simply stated, reducing crime requires all three.

Establishment of State Offices of Inspector General

Coordination of investigation, audit, and sanctioning powers has been overlooked in past program enforcement efforts. This lack of coordination appears to have seriously hampered the government's ability to counteract fraud and abuse. To gain more enforcement efficiency and effectiveness, several jurisdictions have established offices of Inspector General (IG).

Three federal agencies, the United States Departments of Housing and Urban Development, Health, Education, and Welfare, and Agriculture, were forerunners in the establishment of offices of Inspector General as an independent agency unit for coordinating program enforcement (and internal security). The mandate of HUD's Inspector General, for example, is to provide an "independent review of the effectiveness and integrity of HUD operations," and the office has the authority "to inquire into all programs and administrative activities" of the agency as well as those of "persons or parties performing under grants, contracts, or other agreements with the Department."[3] The offices have staffs of auditors and criminal investigators.

Organizationally, these offices have central headquarters in Washington and regional or branch field offices also staffed with audit and investigative personnel. HUD's office had 478 personnel in fiscal year 1977, consisting of about 80 employees at headquarters and the remainder in field locations.[4] One of the unique organizational features of the IG offices is their position in the hierarchy. They are autonomous units and report directly to the agency secretary. While they do not replace established lines of operational authority, they do intervene where problems in procedures, policies, or employee conduct arise.[5]

To emphasize the importance of their role to program integrity, Congress and the agencies have appropriated fairly large sums to these offices. The Department of Agriculture office will operate in fiscal year 1979 with a $32 million budget, HEW's office with a $35 million budget, and HUD's office with a $16 million budget.[6]

---

[3]United States Department of Housing and Urban Development, Office of Inspector General, 1977 Annual Report, Schedule No. 6 (Washington, D.C.: U.S. Government Printing Office, 1978), p. 1.

[4]Ibid.

[5]Ibid.

[6]Office of Management and Budget, The Budget of the United States (Washington, D.C.: U.S. Government Printing Office, 1979), p. 349 and U.S. Department of Housing and Urban Development, Office of Inspector General, "Salaries and Expenses," Budget Activity 12 (Washington, D.C.: U.S. Department of Housing and Urban Development, 1979).

One important measurable result of the IG offices' work has been program cost savings. Annual reports for the offices provide illustrations of these savings. The Housing and Urban Development report shows sustained savings of $116,720,595 for fiscal years 1972 to 1977 and cash savings of $54,145,335.[7] The individual annual figures are shown in the next table.

TABLE VII

SUMMARY OF SUSTAINED AND CASH SAVINGS
FISCAL YEARS 1972 THROUGH 1978[8]

Fiscal Year	Sustained Findings	Cash Savings
1972	7,984,678	4,135,507
1973	9,446,571	5,052,352
1974	16,101,956	8,131,077
1975	14,807,141	7,511,005
1976	33,799,805	18,756,109
1977	34,580,444	10,550,285
Totals	$116,720,595	$54,145,335

The success of these IG offices has spurred Congress and the President to expand the concept. The House of Representatives Conference Report on offices of Inspector General concludes that consolidating existing resources in other agencies will result in substantial savings.[9] The Report also finds that "any direct costs incurred will be relatively minor and will be offset many times over through benefits attributable to the work of the office."[10]

---

[7]"Sustained Findings are not reported until we are advised in writing that program officials have concurred in our findings and have requested the grantee/borrower to make restitution or take corrective action. Cash savings are reported only after we have received evidence that HUD's costs have actually been reduced. In addition to the cash recoveries, insured mortgage reductions amounted to $1,802,326. Court awards and indemnifications received amounted to $503,046." HUD Inspector General Report, op. cit. Schedule 5.

[8]Ibid.

[9]Inspector General Act of 1978, 5 U.S.C. app. (1978).

[10]U.S. Congress, House of Representatives, Extension of Office Inspector Generals in Certain Departments and Agencies, Report 95-584, 96th Congress, first session (Washington, D.C.: U.S. Government Printing Office, August 5, 1977), pp. 16-18.

State and Local Consolidations of Audit and Investigation

Following the trend of the federal government, states and localities have begun coordinating enforcement efforts and committing funds for specific enforcement purposes. The patterns of organization for these units vary considerably from one jurisdiction to the next. In one state, the investigation unit is an arm of the state comptroller, and in another, it is an autonomous unit but under the organizational structure of the program administrative agency.

The fraud and abuse survey questioned whether state program budgets had allocations for enforcement. When such allocations were identified, the survey sought to determine the amount of money allocated to enforcement techniques, such as detection, investigation, client education, staff training, prosecution, etc.[11] More than half (51%) of the respondents said they had budgets for investigating fraud and abuse. However, when asked to identify the dollars allocated to specific techniques and percentages of the total budget for these allocations, only 4% were able to do so. Although line item breakdowns for enforcement dollars are not available, the fact that programs have monies available for enforcement allows us to suggest that state legislatures see fraud control as an important expenditure.

Enactment of State Welfare Fraud Statutes

Several states contacted during the study have enacted fraud statutes applicable to specific programs. These statutes specify penalties for program offenses and are the basis for developing state fraud investigation/prosecution units. There is no current tally of the number of states that have enacted these statutes. Presumably, however, more states will pass these laws as the public grows less tolerant of program losses. In addition, it is expected that program administrators and enforcement officials will more regularly seek legislative support for fraud statutes in response to the public's demand for action.

Legislative Support

As an enforcement technique, the search for legislative support is intended to bring about changes in program design and/or provide enforcement funding through the political process. Historically, support has been sought only by administrative and management officials. Now, enforcement interests as well are lobbying for program reform and enforcement appropriations. Part of the change has come with public recognition that careless spending of tax dollars without requisite safeguards has created "legislated waste" in many programs. The lobbying efforts are generally directed

[11] Appendix H, Item 17.

to.ard closing loopholes in program design, tightening the meaning of program definitions and terminology, eliminating ambiguous program objectives, and providing funding for enforcement manpower, resources, and technology.

The effectiveness of legislative lobbying lies in its ability to bring about compromise. Since decisions in government result from multiple, often conflicting pressures, the purpose of legislative lobbying is to bring about some general agreement. It is obvious that elected legislators cannot function without being reelected. Consequently, "they must...advocate the perceived needs of their constituency, even though satisfying those needs may not be in the best interests of the larger body which they are supposed to represent."[12]

One of the greatest weaknesses of "log-rolling" for program enforcement is that Congressional efforts to resolve deficiencies seemingly cannot account for all the variations in programs. The problem is that 50 different variations of a program complicate the task of writing legislation which meets all enforcement demands. For example, fraud, abuse and waste in Summer Food Service programs operating in large urban areas prompted Congress to write strict language about compliance monitoring of food preparation and food service sites. Strict monitoring in urban areas from a practical viewpoint proved much easier to accomplish than in geographically spread out rural areas.

In sum, the decision-maker chooses legislative lobbying as an enforcement activity when he or she seeks to change political behavior to reform programs, remove vulnerabilities or obtain funds for other techniques and strategies. While seeking legislative support can be an important enforcement tool, its effectiveness may be weakened by the very nature of benefit program administration in the states.

Organizational Redesign

Where vulnerabilities in program design are identified, remedies for the problems may be sought by redesigning the program's organization. Redesign aims to define major organizational constraints to combat opportunities for program misuse. It can be categorized therefore as an enforcement activity for benefit programs. Using the Rural Housing program for illustration, there are several program control aspects demonstrated by organizational redesign. In the past, some fraud and abuse has been attributed to organizational weaknesses concerned with staffing, volume of work, and quality control. Observers claim that inadequate staff

---

[12]Robert N. Anthony and Regina Herzlinger, Management Control in Non-Profit Organizations (Homewood, Illinois: Richard D. Irwin, Inc., 1975), p. 50.

at the county office levels, coupled with a heavy volume of loan portfolios and the additional responsibilities for other aspects of the Department of Agriculture's work, have resulted in poor loan deter inations and management.

Effor. are underway to eliminate these vulnerabilities by redesigning staff responsibilities. In a recent experimental project, an automated system will perform all accounting and servicing of housing loans as well as the handling of tax servicing and liquidation. Automating these functions, it is believed, provides county staffs with time to more carefully review housing applications and reduce reliance on packaged applications.[13] Under a reorganization plan adopted by one state, county offices will retain all housing loan responsibilities, but all other department work will be shifted to the district office level. The plan is aimed once again at focusing more time, attention, and staff resources on housing loans since these account for the bulk of the county offices' workload.

The rural housing example points to several contributions that redesign brings to program enforcement. First, redesigning the scope of tasks to be accomplished by the organization affects the span of control of county offices. By reducing the span, improved service delivery (in terms of timeliness, thoroughness and efficiency) should decrease opportunities for fraud and abuse. Second, redesign is intended to change the boundaries of the client groups serviced. By readjusting the scope of the client load, i.e., concentrating only on housing loans and reallocating other tasks, redesign is assumed to improve contacts with applicants and, for the administrative side, to provide more fraud - and abuse - free service to the eligible client.

Other redesign efforts have focused more directly on intentional fraud and abuse by administrative employees. Employee offenses appear to account for a substantial portion of fraud and abuse. While the magnitude of these offenses nationwide is not known, the experience of one federal agency is illustrative of the potential of employee crime. The U.S. Department of Housing and Urban Development reports that since 1972, 92 of its employees have

---

[13] *Packaging* is a technique (allowed under program regulations) used by housing developers and builders to combine applications for Rural Housing Loan assistance to assure purchasers for their housing and to expedite the application and determination process. Packaging has been criticized because county staff have been lax in reviewing applications submitted in this manner and some developers have abused the process by falsifying applicant information to receive a favorable loan determination.

been indicted for offenses related to their misuse of office and 74 of these were convicted.[14]

The importance of reducing such incidences cannot be overstated for insuring the integrity of programs. Several jurisdictions have implemented specific strategies to deal with employee fraud and abuse. For example, one location now uses written conditions of employment for all employees. These conditions are worded so that the fraud or abuse that occurs must be the result of "willful intention" and not merely poor judgment. Violations of the conditions are considered proper cause for dismissal. Under some of the conditions, employees are prohibited from:

- Backdating a claim without formal adjudication or approval from a superior;
- Transferring a claim retroactively without a superior's approval;
- Participating in taking, adjudicating, or paying claims from relatives by blood or marriage; or
- Receiving cash restitution payments unless the receipt is witnessed and countersigned by a superior.

The Inspector General's office at the Department of Housing and Urban Development is combatting employee misconduct by conducting briefings with new and currently employed staff on standards of conduct. The briefings aim at "promoting departmental integrity and familiarizing employees with the conduct that is expected of them"[15] under federal regulations. In fiscal year 1977, the Office conducted 79 such briefings at regional and headquarter offices.

Recipient fraud and abuse is countered directly by still other program redesign efforts. For example, under the provisions of a mail-in redetermination status form project, enrolled beneficiaries are sent a Monthly Status Report form by the sponsoring agency. The recipient must return the form before a benefit check is released to him/her. In the Monthly Status Report, the recipients submit information on income, household composition, and other eligibility factors that would affect the benefit grant. The

---

[14] HUD Inspector General Report, op. cit., p. 4.

[15] Ibid.

computations of grants are based on the beneficiaries' circumstances for the month prior to payment, rather than on estimates of future circumstances. This monthly "retrospective accounting" system reduces the amount of administrative error in the form of overpayments and underpayments because the applicant's eligibility is redetermined with more frequency than in the past.

The monthly reporting system involves the status report and relevant income reports which are designed for simple responses from recipients. These forms facilitate entry into a data processing system. The computer processing of the eligibility data enables the agency to handle the caseloads quickly and efficiently and to update the central file systems for quality control and management information purposes.

In addition to redesigning particular program elements for a reduction in vulnerability, some reorganization aims at coordination and streamlining. For example, Medicare and Medicaid were combined in the Health Care Financing Administration (HCFA), and in April 1978 the Office of Program Integrity in HEW was created to link the Inspector General with HCFA. At the state level also, the trend is to consolidate responsibilities by substituting state supervised programs (those supervised by the state but run by county governments) with total state administered programs.

Several localities are experimenting with computers to determine eligibility and the amount of assistance to which the individual is entitled. The computer systems are referred to as case financial summary systems. These systems contribute to streamlining benefit program operations and reducing the opportunities for fraud and abuse in several ways. They:

- standardize and automate all calculations of benefits paid to beneficiaries.
- reduce the amount of time caseworkers must spend on routine paperwork and increase the time available for direct contact with clients.
- make benefit client records easily accessible.
- reduce the turnaround time of processing applications and thereby alleviate hardship more quickly.
- decrease errors in agency case recordkeeping.

Caseworkers obtain eligibility data from prospective beneficiaries and then enter this data into the system. The computer calculates the amount to be awarded and simultaneously prints a case financial summary.

Finally, in the belief that simplified programs and reduced paperwork for recipients and administrators will reduce program misuse, the U.S. Department of HEW is undertaking a project to create uniform eligibility standards for programs of public assistance. The project will operate in 1979 and has three objectives.

- Standardize federal requirements across social services.
- Simplify the application process for clients.
- Implement government-wide standards.

The project is modeled on a state project conducted in one of the federal regions under the acronym SPAARS (Single Purpose Application and Automatic Referral System.) The project consisted of a SPAARS team drawn from six states. The team was responsible for maintaining contact with individual states, coordinating efforts, and providing technical assistance for the development of a single application form for 17 benefit programs. The project had several goals.

- Develop methods to simplify and reduce the cost of the application process for individuals seeking assistance from social and medical service and income maintenance programs at the state level.
- Consolidate application and eligibility forms while continuing to meet state and federal requirements.
- Design and implement a complementary referral system which would maximize client access to the appropriate state programs.
- Make certain the system would protect the confidentiality of all "personal data" provided through a single purpose application and referral service.[16]

A 24-page draft of the application was developed by the team. It was then reviewed for legal constraints which might affect determination of eligibility. Because of the differences across program lines and among state administrations of programs, questions arose regarding how best to accommodate variations in eligibility determination within the single application. The experimental

---

[16] SPAARS, The Legal Constraint Study (Denver: Colorado SPAARS Committee, Colorado Office of Human Resources, March 1977), p. A-2.

implementation of the single purpose application was limited to a small geographical area for a short time period. Currently, the SPAARS team is concentrating on standardizing terms and definitions in eligibility requirement regulations in conjunction with federal efforts to simplify program operations.

The effectiveness of redesign is dependent in large part on the human resources that process the organization's work. Management literature has dealt with problems of workers' attitudes toward the organization and change.[17] Field work for this study found similar effectiveness problems in program agencies where changes were undertaken to redesign staff responsibilities from delivery to partial enforcement. For example, the introduction of detective investigative responsibilities at the operational levels of program agencies has created serious work effectiveness problems for both benefit delivery and program enforcement. Some staff see the two roles as incompatible. They argue that one cannot provide benefits to a recipient and also monitor the recipient for potential fraud and abuse.

In summary, redesign is believed to provide program control through its capacity to readjust organizational constraints and contingencies, thus eliminating or reducing opportunities for fraud and abuse. The examples chosen to illustrate this assumed contribution have yet to be tested empirically.

Creation of Financial Incentives

In the past, many state jurisdictions were reluctant to pursue fraud control because they had to bear the costs, while the funds they recouped automatically reverted to the federal government. New legislative and appropriation initiatives recognize the lack of incentive and provide matching funds and reimbursable costs to states who undertake fraud detection. For example, the Food Stamp, Unemployment Insurance, AFDC, and Medicaid programs offer financial incentives for states to establish fraud units. The Medicaid program also provides financial assistance to states that develop management information systems which meet HEW certification.

Education and Training

Educational and training activities are used to reinforce individual behavior and to raise the level of awareness an individual has about the program. Education and training are considered

---

[17] Among this literature is: Chris Argyris, Interpersonal Competence and Organizational Effectiveness (Homewood, Illinois: Dorsey Press, 1962); Rensis Likert, The Human Organization (New York: McGraw-Hill, 1967); and New Patterns of Management (New York: McGraw-Hill, 1961).

important enforcement tools which can be applied to all participants in a benefit program - administrative staff, third party providers, auxiliary providers, recipients, and potential applicants.

Most program regulations require administrative staff to attend an orientation and receive continuing training in their area(s) of responsibility. Much of this training is provided on-the-job by supervisory staff. Instruction and casework for administrative personnel are designed to reduce errors which may lead to fraud and abuse and to enhance the overall ability of personnel to detect irregularities for follow-up investigations.

During the interviews, it was found that practically all programs have some training component for employees; however, the type and frequency of training varies considerably. Table VIII presents the percentage of respondents in the fraud and abuse survey who indicated that they provide particular types of training to specific groups of employees.[18]

TABLE VIII

FRAUD AND ABUSE SURVEY: PERCENT OF PROGRAMS PROVIDING TRAINING BY TRAINING TYPE AND AUDIENCE

Type of Training	Staff Supervisors	Eligibility Workers	Case Workers	Fraud Investigators	Auditors
Orientation	55%	50%	14%	33%	22%
In-House/ On-the-Job	68%	52%	11%	39%	21%
Specialized Courses	49%	29%	7%	30%	12%
Refresher Courses	29%	19%	6%	15%	7%

As indicated in Table VIII, although all forms of training are provided to fraud investigators and auditors, relatively few programs provide the same types of training for these enforcement personnel when compared to staff supervisors and eligibility workers. While only about a third of the programs surveyed provided a particular type of training to fraud investigators or auditors, only a tenth of the programs reported that they offered no training at all to their fraud investigators and audit staff.

[18] See Appendix H, Item 12.

Cross-training, to obtain additional or specialized skills, is also available in many programs. For example, an auditor may learn program operations, a caseworker may learn investigative skills, or a prosecutor may learn program specifics. In addition to the formalized training, administrative personnel will learn from working with persons trained in other disciplines. Such was the case when a Veterans Administration Investigative Unit worked with loan guaranty officers.[19] According to the investigators, they became "sensitive to peculiarities which may be indicators of fraud and abuse in programs."

Training for third party providers normally is conducted either by the program administrative staff or by auxiliary providers. In the Summer Food Service program, for example, prime sponsors receive training through either regional USDA offices or state Board of Education offices. In the case of Medicare training, third parties, i.e., doctors, nurses, hospitals, etc., receive informational materials from HEW and from auxiliary providers (intermediaries and carriers).

Training for auxiliary providers in Medicare and Medicaid is conducted both by the program-sponsoring agencies and by the individual providers. Intermediaries and carriers develop instructional materials for their staff members who have responsibilities in these two health programs.

Educating beneficiaries is also being emphasized to improve communications at the time of application as well as during the period of eligible participation. In several jurisdictions slide presentations are prepared in-house for preparation to prospective beneficiaries of AFDC and Food Stamps. The shows depict the types of information that will be required from the recipient to determine eligibility and the steps in the benefit process. In another program, Medicaid regulations require that beneficiaries be informed of the charges made to their Medicaid accounts. Significant work has been done in bilingual and multiple language communications to assure that recipients understand all their rights and obligations of assistance.

The aim of educating and training program participants and the general public is three-fold. First, there is prevention. Many program officials believe that the more information that is available about a program, the fewer incidences of fraud and abuse will occur. In the case of recipients, educational information is directed to alleviate anxiety about receipt of benefits. It is believed that in the past, recipient exasperation and misunderstanding about program operations have "turned" them against the system and toward its misuse.

---

[19] Officers responsible for processing applications for loan guaranties.

Second, education (particularly public information) is believed to encourage reports of suspicious program behavior to enforcement officials. This "consumer intelligence" function is demonstrated in a project undertaken by a state Medicaid prosecution unit. The unit trains coalitions of elderly citizens (i.e., Gray Panthers) to watch for unhealthy or inadequate living conditions in nursing facilities where they visit friends and relatives. This training activity has created an intelligence network which has surfaced many abuses and has placed a check on the delivery of inadequate services in these nursing homes.

To ascertain whether public information is considered a deterrent to fraud and abuse, the fraud and abuse survey asked respondents to "explain" its effects - whether it decreased incidences of fraud and abuse or increased them.[20] Sixty percent of the sample said public information had a positive impact on decreasing fraud and abuse. When responses were separated by programs, only two-thirds of respondents who administered Unemployment Insurance and CETA programs indicated that public information decreased the amount of fraud and abuse. Over half of the Medicaid and AFDC program respondents were also in agreement, as were almost all the fraud, audit, and quality control units which responded.

Third, education is believed to provide support for enforcement actions. Information is disseminated in the belief that public awareness of fraud and abuse and the harm which is caused both in human terms and in dollar losses will encourage the public to tolerate enforcement more readily. As an example, public awareness of AFDC fraud and abuse has brought enforcement officials to consider a National Recipient Data System. One of the major obstacles to creation of the system is the privacy issue. The system, as designed, accounts for privacy concerns by limiting the period of time that data may be retained and limiting the type of information which is collected. The system's implementation would be impossible without public understanding of the problems.

While education is touted as an important technique for reducing fraud and abuse, there are those who question its effectiveness in this regard. Some argue that large amounts of information tend to increase "insider knowledge" and consequently increase opportunities to defraud or abuse programs.

In another context, some program administrators question the value of education's "consumer intelligence" function. The use of "Explanation of Benefits" (EOB) forms in Medicaid demonstrates this concern about effectiveness. EOBs provide the Medicaid patient with an accounting of charges made against his account. The form is intended to be informational and to provide a check on provider charges. Where a patient finds a billing error, he/she is to report

[20] Appendix H, Item 23.

the irregularity to the appropriate enforcement authorities. Many administrators comment that either these forms are never reviewed by the patients, or if they are, they confuse, rather than help the patient. Others question the cost-effectiveness of the informational form. As one state Medicaid administrator explained:

> My Department sent out 26,000 EOBs of which 67 were sent back with questions. Of those 67, only 4 provided useful information for potential fraud cases. There is no cost-effectiveness since the postage alone was more expensive than the EOBs returned with indications of possible fraud.

There is doubt also about the effectiveness of providing investigative and detective technique training to administrative staff who are responsible for handling recipient data and claims. It is felt by some that an eligibility worker cannot adequately perform the function of deliverying benefits, if the worker must at the same time look for fraud in applications. In some of the sites that were visited, the interviews disclosed problems of tension, conflict, and early "burn-out" where persons were required to serve clients and "also look over their shoulders." At the present time, this criticism is based on administrators' subjective judgment without benefit of empirical data. However, it does raise serious questions about cross-training of workers and their abilities to do their jobs when they must also control the delivery of benefits.

Fraud and Abuse Research

The potential value of research clearly lies with its ability to explore the general phenomenon of program fraud and abuse. Research inquiries lead to better understanding of relationships among various patterns of fraud and abuse, relationships between program design and vulnerabilities, relationships among enforcement strategy effectiveness, and the impacts of benefit program offenses on society.

There has been only limited research into the causes and effects of program benefit fraud and abuse. The research that has been done, however, includes several studies employing discriminant analysis. Discriminant analysis is a statistical technique for differentiating between two groups of individuals or objects on the basis of several properties they possess. To conduct analysis, a linear combination of measurements whose distributions for the two groups do not overlap must be found. The procedure for discriminating consists of determining a critical value of the index above and below which the two groups fall.[21]

---

[21]For a more thorough discussion of multiple linear discriminant analysis see: Paul G. Hoel, Introduction to Mathematical Statistics (New York: John Wiley & Sons, Inc., 1966), pp. 179-180.

Using this technique, several states have examined program beneficiary populations for tendencies to commit offenses. The analysis in one of these studies shows that the tendency to commit (known) fraud is not randomly distributed among the claimants. Systematic identification of claimants who may commit offenses is therefore a viable enforcement tool.

Other research efforts have involved computations of estimated losses in programs based on past records. In one particular project, it was found that during the period 1950-1975, fraud charges were brought against one in every 100 beneficiaries. One out of every ten of these cases was prosecuted.

Education and training, organizational redesign, establishment of financial incentives, and research to counter fraud and abuse are techniques in wide use for prevention. Techniques associated with improving detection of fraud and abuse are discussed in the following section.

DETECTION

Creation of United States General Accounting Office Special Fraud Prevention Task Force

The United States Government Accounting Office has also established a task force to assist in its efforts to reduce fraud, abuse, and mismanagement in government agencies. In October 1978, the Comptroller General announced the creation of the GAO Special Task Force for the Prevention of Fraud, with the broad mandate of evaluating the adequacy of management control systems in federal agencies and assessing the adequacy of investigative and corrective actions taken on the GAO audit and investigation reports. Initially, the Special Task Force reviews the CETA program, Community Services Administration, Small Business Administration, and the Naval Material Command. The efforts of the Special Task Force will concentrate on identifying program operation and system weaknesses in order to discern patterns of fraud, abuse, and mismanagement that can be applied to many agencies and departments. The Comptroller General has assigned three major activities to the Special Task Force.

- Establishment of a nationwide hotline telephone to allow citizens to report fraud and abuse in federal programs.
- Conduct of "vulnerability assessments" to determine whether agencies audited have adequate internal accounting or management controls (these assessments will result in "risk profiles" of the agency or program).
- Making an overall effort to determine the extent of fraud in federal agencies and programs and its causes.

After incidences of fraud or mismanagement are identified through hotline tips, they are referred to the appropriate agencies for further action. The Comptroller General has assigned 57 person-years in each of fiscal years 1979 and 1980, to achieve the objectives of the Special Task Force.[22]

Quality Control

Quality Control is a system of monitoring the reliability and accuracy of program-related data and resources. In government, as in other complex organizations, quality control serves as a detection mechanism to spot instabilities and problems in program operations. This detection system is usually placed at successive levels within the organization's structure to allow consistent monitoring and stabilizing of workflows and to trigger changes in the organization where instabilities are present.

The growth of quality control in all organizations is attributable in part to the introduction of specialization in the workplace.

> The growth of specialization has resulted in numerous groups whose existence depends upon their ability to make appraisals, evaluations, and checks that the manager himself has neither the time nor the skills to make for himself.[23]

Additionally, the administrator "may not see trends by generally looking at single points in time."[24] Problems of disguise and deceit which may figure in the superior-subordinate role between manager and worker also may necessitate quality control.[25] The point to be emphasized about any quality control technique is how effectively or ineffectively it functions to detect problems and allows for marginal adjustments in the program or its delivery process. In the sense that quality control offers an alternative to crisis management, it is an important tool for program enforcement and integrity.

Within program agencies, quality control serves a number of enforcement purposes. Quality control provides staff support, resource management, and/or reporting systems for internal mana-

---

[22]Staats, U.S. Comptroller General, "Statement Before the Senate Committee on Budget, GAO Efforts..," op. cit., *passim*.

[23]Leonard R. Sayles, Managerial Behavior (New York:McGraw-Hill, 1964), p. 93.

[24]Ibid.

[25]Ibid.

gerial effectiveness. The equitable and humane distribution of benefits is impacted by the ability of quality control to identify eligible recipients, to assure provider or third party compliance in programs, and to maintain the quality of legitimate benefits.

The effectiveness of quality control remains open to question on several grounds. First, the cost and time savings that are claimed from quality control are almost cancelled out by the fanaticism with which it sometimes has been used. Sampling, checking, monitoring - all characteristics of quality control - have led to overreaction. In one program, it was reported that workers collected unnecessary documents from program applicants in the event that quality control specialists reviewing the caseload found irregularities. The overcompensation has produced stacks of unnecessary paper that sits in the files.

Second, some observers believe that imposing quality control (a fairly structured technique) on unstructured benefit operations has created serious obstacles to its success. The Summer Food Service program illustrates the problem. Program benefits are delivered by "grass roots," non-profit organizations. Many program administrators claim that these organizations have not had enough experience in accounting for service delivery. Some critics believe that imposing quality control on these groups and expecting it to indicate problem trends and irregularities, is a naive assumption. In their judgment, it cannot be an effective enforcement tool.

The effectiveness of quality control to detect and measure fraud in programs has come under criticism also. The ineffectiveness of data generated from state Medicaid Management Information Systems has been a source of recent concern.[26] Also, interviews with AFDC quality control staff and program supervisors at regional office levels of HEW indicate that the use of quality control to measure fraud in AFDC is inappropriate. They explain that many errors in verification and documentation are considered a liability against the state and are computed as part of the error rate. However, these rates have no bearing to the amount of fraud in AFDC. For example, if a state neglects to register an applicant for an employment program when it determines eligibility for AFDC, the case is automatically thrown out as administrative error.

Another apparent weakness of AFDC quality control rests with the sampling technique used. In the current AFDC quality control activity, a sampling of open and closed cases is taken and reviewed for errors, inconsistencies, and possible fraud. If a fraud case

---

[26] U.S. General Accounting Office, Report by the U.S. Comptroller General, Attainable Benefits of the Medicaid Management Information System Are Not Being Realized (Washington, D.C.: U. S. Government Printing Office, September 26, 1978), *passim*.

appears in that sample, then it is pursued for investigation. However, if no fraud case appears in the sample, there is no opportunity to detect fraud. Similarly, the federal government takes subsamples of the state samples of open and closed cases. If a fraud case does not appear in this subsample, it will go undetected for federal or federal and state follow-up investigation.

In conclusion, quality control's merit for enforcement is its ability to indicate instabilities in program design and operations. In a practical sense, quality control raises a "red flag," screening out problems and questionable aspects of program operations. Its effectiveness, however, is tied chiefly to its ability to accurately perform this screening and allow for marginal adjustments in program design.

Investigation

Like the detective in the police department, the criminal investigator attached to a program fraud unit is responsible for identifying and apprehending offenders and providing evidence of guilt to the prosecutor. As with several of the other activities already mentioned, investigations are brought against a variety of program participants.

Responsibility for program investigations is lodged in the administering agency, in an autonomous unit (either connected with the agency or outside), or with an auxiliary provider. No one organizational pattern for investigative units appears to dominate nationally although a preference for locating the unit apart from the purview of program staff seems to lend necessary objectivity to investigation activities.

In practice, investigations of recipient fraud and abuse are handled by the state or local investigative units. There is usually little, if any, federal investigative involvement, i.e., the Federal Bureau of Investigation. Investigations of administrative personnel are usually handled by the internal security division of the investigative units. Depending upon jurisdictional authority (as set out in statute and regulation) over third parties and auxiliary providers for individual programs, irregularities are investigated by either state or state and federal investigative personnel.[27]

While all investigative techniques encountered cannot be enumerated, a few illustrations should suffice to demonstrate that effectiveness is associated directly with the type of benefit provided. Thus, programs offering loan assistance are susceptible to analyses of default patterns and, particularly, identification of first defaults. Other indicators used in loan programs are:

[27] See individual program profiles in Appendix A.

patterns of loan application rejections, lenders' reluctance or eagerness to make marginal risk loans, and past corrupt business practices of lenders or real estate brokers.

For programs providing contract benefits, repetitive participation of individual contractors in program bidding, types of bidding controls consistently used, or coincidental contracting arrangements where several persons use the same business address or mailbox have provided leads for further investigations.

Programs offering services, such as Summer Food Service, provide opportunities for investigators to analyze the economic market structure of the particular service industry to ascertain the types of business entities involved and the length of their established service. As one investigator commented, "We look for 'para' or false economic markets where a company may jump in just for the profit that can be made from the summer program."

One of the major criticisms of benefit program investigation effectiveness has been that it is too oriented to violent street crime and criminal prosecutions. Investigation of program fraud requires a broader view of crime.

> It is important that personnel in law enforcement agencies recognize...that white-collar crime activity cannot be narrowly considered only in light of its potential for criminal prosecution. The very same activity may well be treated as a criminal violation, or as a basis for a civil claim, or as the basis for some civil or regulatory action.[28]

Investigation effectiveness also depends on coordination between the investigation and other program units. The effective use of investigative resources rests on liaison, coordination, and interface with program administration.

Financial Auditing

Financial auditing involves analysis of financial documents and records for accuracy and completeness. As a broad enforcement activity, it is also assumed to contribute to detection of financial irregularities and to the collection of evidence for proving the guilt of alleged offenders.

---

[28]Herbert Edelhertz, et al., The Investigation of White Collar Crime, A Manual for Law Enforcement Agencies (Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, April 1977), p. 6.

The use of auditing as an enforcement technique is fairly innovative. Under federal law, all agency administrators must create an internal audit capability to control agency funds, property, and other assets.[29] While this internal audit capability has been well established in program agencies for management purposes, there has been little use of it for fraud and abuse detection. Program regulations have usually provided for internal audits and external audits only; fraud audits *per se* are only beginning to occur.

Internal Audits

Internal program audits, otherwise known as operational audits, performance audits, or management reviews, evaluate the efficiency and effectiveness with which managerial responsibilities within the benefit programs are carried out. The internal audits in HUD programs, for example, determine whether management controls, policies and procedures are adequate and effective, whether the applicable laws and regulations are complied with and whether resources, such as staffing, are managed and used economically and efficiently.[30] Computer auditing, in which the agencies' computer systems are reviewed for operating accuracy, is assuming an increasingly significant role in internal audits of program administration.

External Audits

External audits of third parties and auxiliary providers, grantees, borrowers, and other program contractors include a variety of audit types: project audits, financial audits, cost audits, and cost reimbursable contract audits. The external audits may entail such evaluations as accounting and pricing proposal procedures that affect the furnishing of accurate financial reporting and cost reimbursement, e.g., certain HUD programs. The project audits ascertain the degree of compliance of the organization or individual with the statutes, regulations, and terms of agreements under which federal funds are made available, as well as the appropriateness of disposition of the funds granted, loaned or contributed. The financial audits review only the finances and transactions of the contractors, not their operations.

An example of how external audits are applied to benefit control is seen in the Medicaid program's prepayment and postpayment audit systems. The prepayment audit provides an initial monitoring of third party claims. The postpayment portion identifies patterns of health care based on the costs of reimbursing third parties.

---

[29]The Budget and Accounting Procedures Act of 1950.

[30]U.S. Department of Housing and Urban Development, Inspector General Annual Report, op. cit., Appendix No. 1, p. 1.

Fraud Audits

The new emphasis on fraud detection has created a different type of audit - the fraud audit. The fraud audit is an in-depth review of the finances and operations of the program agencies or the contractors. Fraud audits analyze and investigate irregularities and discrepancies that surface during financial audits. Fraud audits are usually conducted by audit personnel in fraud investigation and/or prosecution units.

An example of the fraud audit technique is demonstrated by audits of third party health providers' books and records. In one jurisdiction, these audits are conducted by gathering a random sample of all providers' records. The audit staff then announces to all providers that audits will be undertaken of each bill rendered. Photocopies of all bills are sent to the providers with information on the audit exceptions found. The auditors then visit individual providers whose records have irregularities.

Current Trends

Requests for additional audit personnel and the greater frequency with which audits are being performed signal a new emphasis on all aspects of program auditing. An indicator of this renewed interest in auditing for enforcement can be seen in the staffing patterns of federal agencies. The Veterans Administration with previously just a handful of audit staff was authorized 200 new audit positions in fiscal year 1978. The Office of the Inspector General at HUD has a complement of 339 auditors and expects yearly increases.[31] HEW's Office of Inspector General is requesting additional auditors to fill the unmet needs in calendar year 1977, of 1,382 staff-years of audit work.[32]

The increased emphasis on auditing can be attributed to several factors:

- The complexities presented by benefit programs with numerous financial transaction points
- The national scope of programs involving many individuals and business entities
- Program reliance on third party reimbursement to purchase services
- The introduction of computers for storing and retrieving financial and other management information

---

[31] U.S. Department of Housing and Urban Development, Office of Inspector General, Salaries and Expenses, op. cit., p. F-5.

[32] U.S. Department of Health, Education, and Welfare, Inspector General Annual Report, op. cit., pp. 12-13.

The recognition auditing is receiving for program control in the public sector is paralled by activities in the private business auditing community. At controversy now in both sectors is whether or not auditors should exercise an investigative role, how far they should go in uncovering fraud and abuse, and whether current tools are effective for detection.

> Accountants, burned by instances of management fraud they failed to uncover, are being told they now must play a much larger role in ferreting out wrongdoing...Despite auditors' repeated assertions that uncovering fraud is not their primary role, Congress, regulators, the courts, and even the accounting profession itself all are pressuring CPA's to probe more deeply...[33]

To date, auditors have shunned the investigative role because they lack the tools for specifically detecting fraud. At a recent conference held to search for new tools, participants concluded that different techniques must be developed with a broader range of skills than those of traditional auditing.[34] "Any new approaches may have to be painstakingly developed with inputs from other disciplines and professions."[35]

Given the characteristics of program crimes and the financial transactions involved, auditing appears to hold promise as a first line of defense against fraud and abuse. However, its effectiveness rests almost solely on the ability of the discipline to create appropriate financial audit fraud detection tools.

Computer Aided Detection

Several localities are experimenting with computers to determine eligibility and the amount of assistance to which the individual is entitled. The computer systems are referred to as case financial summary systems. These systems contribute to streamlining benefit program operations and reducing the opportunities for fraud and abuse in several ways:

- To standardize and automate all calculations of benefits paid to beneficiaries

---

[33] "Can Accountants Uncover Management Fraud?" Business Week (July 10, 1978), p. 92.

[34] Ibid.

[35] Ibid.

- To reduce the amount of time caseworkers must spend on routine paperwork and increase the time available for direct contact with clients
- To make benefit client records easily accessible
- To reduce the turnaround time of processing applications and thereby alleviate hardship more quickly
- To decrease errors in agency case record-keeping.

Caseworkers obtain eligibility data from prospective beneficiaries and then enter this data into the system. The computer calculates the amount to be awarded and simultaneously prints a case financial summary. The summary contains all personal, financial, and family data, in addition to computed amounts, such as the adjusted basic needs, related expenses, net and adjusted earnings, total needs, net income, applied income, and the recommended benefit award. After eligibility determination, the system prints a certificate of action for the state agency and the client which includes the award amount, effective date, beneficiaries to receive assistance, and the reason for the award. The system produces a certificate to show denial or an instance where assistance is discontinued.

The case financial summary system aids in program quality control and the detection of fraud and abuse. The computer provides listings of cases that are due for redetermination or monthly quality control study. Caseworkers also receive lists of cases which, because of administrative errors or other factors, have been delayed in processing. Agency employees verify data provided by applicants by residence addresses and name identifications placed in the system to detect duplication or irregularities in benefit delivery.

Computer Screening and Editing

For purposes of enforcement, computerization provides opportunities to verify benefit program data and analyze the data for problems. The concept of using computer "screens" to provide leads to investigators has received the greatest attention in the AFDC, Medicare, and Medicaid programs. For Medicaid, states are being encouraged by the Federal government to develop management information systems which screen out providers for false billing, double-billing, overutilization, and other offenses. These Medicaid efforts are backed by HEW certification and funding. They have grown out of a project undertaken by the agency in 1977 called Project 500 (also known as Project STAR). The HEW screening project was conducted jointly by the Office of Inspector General and the Health Care Financing Administration. All Medicaid claims

paid to physicians and pharmacies during calendar year 1976, from the 49 Medicaid states, the District of Columbia, and Puerto Rico were reviewed.[36] These analyses covered approximately 250 million transactions. Of these 250 million, 3,500 cases were selected for intensive follow-up. Half of this group eventually warranted no action, approximately 600 were referred for administrative actions (HEW places these overpayments in "excess of $2.8 million")[37] and the remainder were passed on to individual states for criminal prosecution proceedings. At present, no data are available on what action, if any, these states have taken. HEW has placed the recurring savings from Project 500 at over $3.6 million annually, and efforts are underway now to extend the computer applications to other provider service areas.

Computerized Central File

Within the AFDC program of HEW, a computerized central file bank of recipient income and identification data is being considered. The National Recipient System (NRS) will detect potential cases of fraud, abuse, and error at the federal, state, and local levels. Over time, it is believed that program misuse will be reduced as recipients become aware of the identification and verification and by word of mouth. Funding for the implementation and operation of the NRS would be shared equally by the federal and state governments.

The NRS performs three major functions in the detection of fraud, abuse, and error.

- Interstate name search
- Social Security verification
- Federal benefit payment verification

The interstate name search addresses the problems of individuals who are allegedly drawing AFDC payments in more than one state. For individuals whose name, birthdate, sex, or social security number may differ from the information on file at the Social Security Administration, the NRS provides verification. The NRS also verifies federal benefit payments with the recipient's reported income from federal benefit programs.

The system has been carefully designed to meet privacy requirements, both under current law (Privacy Act of 1974), and under draft Office of Management and Budget regulations for privacy in cross-matching. The safeguards include limiting the amount of

---

[36] U.S. Department of Health, Education, and Welfare, Office of the Inspector General, Computer Matching Programs Underway (Washington, D.C.: U.S. Department of Health, Education, and Welfare, December 13-14, 1978), p. 10.

[37] Ibid.

information that goes into the system (name, date of birth, sex, social security number, and case or client number) and allowing the data in each case to be retained only from the time of benefit application or until the recipient withdraws from the program. The computer file itself is not marked when cross-matches are found.

The National Recipient System provides accurate information to state and federal administrators which will help to eliminate duplicate payments and to adjust payment rates. Also, the validated Social Security number will enable states to search their own payroll and program rolls.

Cross-Matching of Welfare Rolls with Employment Records

The State of Michigan, along with several other jurisdictions, pioneered the concept of comparing welfare recipient rolls with state and city payroll records. Texas and Oklahoma, for example, now have the computer capability to cross-check rolls among their respective counties for several different benefit programs in addition to cross-matching with other states.

The cross-matching techniques in states gave impetus to a national effort conducted by HEW in 1977-78, not only to compare state AFDC rolls with federal employee records but also to compare rolls and records across state jurisdictions. Project Match, as the HEW effort was called, identified 33,000 matches, of which 18,000 cases are currently under review by the respective states responsible for administrative or prosecutorial actions. HEW reports that of these 18,000, the states have found close to 2,000 overpayments and close to 1,900 ineligible beneficiaries.[38] To date, there have been only 15 indictments, all of those in the District of Columbia. Project officials claim costs and savings as follows:[39]

TABLE IX

PROJECT MATCH I (1977-78)
ESTIMATED COSTS

Level	Cost	Direct Savings	Avoidance*	Total Savings
State	$1 million	$6 million	$5.9 million	$17.9 million
Federal	$1 million	$6 million		

*Estimated savings from determination of ineligibility for benefits other than those of the directly matched programs, cannot currently be broken down by level of government.

[38]U.S. Department of Health, Education, and Welfare, Computer Matching Programs Underway, op. cit., p. 1.

[39]Costs and savings estimates for Project Match I per telephone interview with John Allen, Office of Inspector General, United States Department of Health, Education, and Welfare, January 4, 1979.

HEW believes that the success of Project Match I warrants additional matches and is planning to conduct matches of Supplemental Security Income with employee rolls and interstate matches on a quarterly or semi-annual basis.

There are some major obstacles to cross-matching. Intra-jurisdictional matches are difficult to conduct, and the results are inconclusive in those states where wages are not mandatorily reported. A major stumbling block to interstate matching is the incompatibility of computer hardware and software. As several HEW staff who were involved in Project Match recalled, the states' AFDC computer systems ranged from "terrible to passable." Interviews conducted with state employment agencies also underscored the need for more compatibility of equipment and output. In some instances, states wanting to match with others had to choose jurisdictions with similar computer systems instead of jurisdictions where the results would be more meaningful, i.e., adjacent states or states with heavy streams of migrant labor.

Cross Registration for Receipt of Benefits

Cross registration requires a benefit program applicant to also register his or her employment status. Originally designed for the simple purpose of determining an applicant's employment status, this procedure has coincidently provided a potential check on fraud and abuse. Mandated by statute in many states, the provision of such information often makes it possible to determine whether an applicant is receiving benefits in violation of the work requirements of the public assistance program.

Rotation of Caseloads

To avoid employee fraud and abuse and also to provide a detection tool, many agencies have begun to rotate caseloads and job responsibilities for benefit programs. Variations of this technique appear in a number of programs that were studied. For example, fee appraisers in the Loan Guaranty programs of the Veterans Administration receive rotating appraisal assignments. In another instance, a local county welfare office reported that a floating unit of personnel is used to rotate AFDC, Food Stamps, and Medicaid caseloads. This unit also acts as a fraud and abuse detection unit with personnel trained across the various program areas.

Investigation Team Concept for Improved Detection

Many jurisdictions are finding that a team approach to investigations works effectively. Combinations include the use of a lawyer, auditors and investigators for health care program fraud and a team of three investigators on individual program fraud cases. In the latter situation, each investigator is responsible for a different aspect of the investigation. One investigator handles interrogation of witnesses, another, acquisition of evidence, and a third, the overall coordination of the investigation.

Peer Review

The technique of peer review is being used in health assistance programs to contain costs and detect overutilization. The technique involves teams of nurses and doctors reviewing patient stays in hospitals, and making recommendations for acceptance or denial of federal Medicaid payments.

Professional Standards Review Organizations (PSROs) are "medical watchdog" groups created by federal law to monitor hospital stays. PSROs thus interface between the private sector of providers and the government. An HEW report on the results of PSROs was published in 1977. A news account of the report appeared in a Washington Post article. It noted:

- Only 7 of 18 closely studied PSRO's achieved reductions in hospital stays, and the PSRO system seemed to have no effect on hospital use nationally.

- There is no evidence PSROs have saved money. Even where they have cut hospital stays, it has cost them $16 to $18, on the average, to review each patient's stay, with these federally paid administrative costs themselves adding up to millions.

- There are some indications that PSRO's have improved the quality of hospital care by requiring doctors and hospitals to keep better patient records and by creating ev... this new partial kind of review of doctors performance.[40]

The failure of PSROs to detect fraud and abuse may be traced to three factors. First, there is some confusion about the role they should play. Some argue that their mission is solely the review of utilization patterns to recommend administrative changes. Others argue that this mission should be conducted in tandem with fraud detection. Where fraud is suspected in utilization patterns, it should be pursued by the organization.

Second, the PSROs deal with several constituencies. Some of these constituencies tend to conflict with others in matters of fraud detection. The PSROs are committed to protect the interests of physicians and hospitals - their professional constituency. PSROs must meet demands from this constituency that professional

---

[40]Victor Cohn. "Watchdog Doctor Unit Says It Saved Us $3 Million," The Washington Post (November 8, 1977), Section C, p. 1.

standards be used to guide cases of alleged fraud or abuse. These professional standards may differ appreciably from what government or the public considers legitimate, particularly concerning issues of medical necessity. In addition, the PSROs operate partially within a public area. Often, discussions of fraud and abuse do not occur in a public PSRO meeting but rather in an informal setting among collegial peers.

Third, PSROs also represent the benefit recipients. In performing a form of quality control on service utilization patterns, PSROs are attempting to provide better health benefits for recipients by screening out questionable practices.

Operational Surveys

"Operational Survey" is a term pioneered (in 1972) by the Office of Inspector General at HUD to describe "fact-finding studies of an entity or activity in a relatively short period of time to determine the nature of the activity and the control which management exercises over the activity."[41] The "survey" data form the basis for planning more audits and prioritizing further actions relative to deficiencies that are found in program management.

The effectiveness and efficiency of surveys have been applauded by oversight and enforcement officials. The surveys are credited with early detection of program design deficiencies which may encourage fraud and abuse. The type of commendation "surveys" have received appears in the following excerpt from the General Accounting Office study of government benefit program fraud.

> Among the agencies we reviewed, HUD's operational surveys are the most ambitious systematic mechanisms aimed at actively seeking out and identifying fraud. The operational survey combines HUD investigators and auditors in a team which concentrates its efforts on a single HUD office. The surveys are aimed at uncovering deficiencies in program management and identifying specific irregularities, which indicated possible fraud, for investigation.[42]

The GAO report goes on to suggest that considering the merit of the survey techniques, "Not enough effort is being dovoted to them."[43]

---

[41] U.S. Department of Housing and Urban Development, Inspector General Annual Report, op. cit., p. 17.

[42] U.S. General Accounting Office, Combat Fraud, op. cit., p.20.

[43] Ibid. p.

In interviews with staff of HUD Regional Inspector General's offices it was suggested that although such surveys are time consuming, expensive, and labor intensive; they are cost-effective in the long run.

Surveys of Recipients to Prevent Third Party Offenses

Modelled on victimization surveys in criminal justice, surveys of program beneficiaries who receive third party services have been conducted by several jurisdictions. For example, a state Medicaid prosecution unit surveyed "relatives and friends of nursing home patients by mail" to solicit information on the nature of the beneficiaries' experiences, both positive and negative.[44]

Third Party Provider Surveys to Prevent Abuses

A major concern in programs which operate seasonally is the lack of pre-program preparation afforded to third parties who will participate. To meet these concerns and to anticipate possible third party abuses, jurisdictions have begun to survey needs of third parties. Agency sponsors seek information as to whether or not assistance is needed for planning, training, and recordkeeping.

Surveillance of Third Party Provider Services

Surveillance of third party services offered to program recipients is another strategy used to lessen the opportunity for fraud and abuse. In the Food Stamp program, for example, regulations prohibit the purchase of certain items with Food Stamps. To see that this regulation is enforced, the program employs "aides" from local communities to attempt to purchase these ineligible items with Food Stamps. Thus, they can detect sale abuses by retailers.

Medicaid programs in about a quarter of the states have established or are beginning to establish Medicaid Management Information Systems with components for profiling provider practices and billing patterns. After determining typical service and billing practices, investigators focus their efforts on those providers whose claims do not fit the normal pattern, in order to determine whether the claims are in fact valid. Because provider service and billing practices vary across states, the surveillance systems are designed to fit the particular needs of each state.

Community Organizing to Detect and Report Third Party Offenses

Some recipients victimized by third party providers are not aware of their vulnerability. This is especially true among elderly

---

[44]Charles J. Hynes, Third Annual Report from the Deputy Attorney General for Nursing Homes, Health and Social Services (New York, January 10, 1978), p. 9.

recipients of Medicare and Medicaid assistance. Illnesses and infirmities may leave them vulnerable to crime and equally helpless to counteract. For example, there are serious problems in some nursing home facilities when a patient's escrow account is intermingled with the operating funds of the home thus violating Medicaid regulations. The patient may have no knowledge of these transactions. Other problems in nursing facilities have stemmed from inadequate provision of "quality of life" care by facility staff, i.e., linen is not changed regularly or food served is not nutritional.

To compensate for the vulnerability of beneficiaries, state offices are working with local community groups, particularly those with elderly members. Since these groups frequently visit friends and relatives who may be institutionalized, they are in a position to note irregularities and patient abuses. The organizing has created an informant network for investigative leads and has generated a potent lobby for improving the quality of life in nursing facilities.

Third Party Provider Misconduct: Prevention Referrals

Investigators working with fraud and abuse cases of third party providers explain that many cases would be avoided if allegations of misconduct were handled expeditiously. At least one prosecution unit is putting forth an effort to accomplish this. Allegations of misconduct are referred formally and immediately to appropriate disciplinary boards resulting in actions being brought against several accountants for negligent preparation of nursing home financial statements.[45]

Rating Systems for Preventing Third Party Offenses

Several state Medicaid programs have implemented rating systems for auxiliary providers who conduct inspections of nursing homes. The rating systems provide standards of comparison for reimbursement of nursing home facilities. The ratings apply to the overall facility rather than concentrating on individual deficiencies.[46] While there have been concerns that these rating systems would be inconsistent and unworkable, one state's testing with a system showed that with "training and a properly developed format, raters could reach 90% agreement on ratings and the areas of disagreement were minor."[47]

---

[45] Ibid., p. 44.

[46] Joint Legislative Audit and Review Commission, Long Term Care In Virginia (Richmond, Virginia: The Virginia General Assembly, March 28, 1978), p. 68.

[47] Ibid.

Establishment of Anti-Fraud Hotlines

Research and experience in the detection of program fraud and abuse have shown that a significant proportion of fraud investigations are initiated by anonymous phone tips. In response to this finding, hotline telephones have been established in many jurisdictions around the country to systematically collect and evaluate allegations of benefit program fraud, abuse, and waste. On January 18, 1979, the General Accounting Office put a nationwide anti-fraud hotline into operation. Professional auditors of the GAO's Special Task Force for the Prevention of Fraud answer telephones and attempt, by questioning the informant, to establish the materiality and involvement of federal funds in the alleged wrongdoing. When reviewing the allegations, the hotline staff categorize the allegations according to six activity participant types:

- Federal employees only
- Federal employees in conjunction with others
- Federal contractors or grantee organizations
- Corporate recipients of federal financial assistance
- Individual recipients of federal financial assistance
- Other individuals or corporate entities

The allegations are jointly reviewed by Task Force personnel and the Inspector General of the agency affected. The case by case follow-up of allegations usually takes one form of three possible referral actions:

- Referral to the appropriate agency Inspector General, for investigation to determine the need for criminal justice or agency corrective action
- Referral to a GAO Regional Office when the agency involved does not have an Inspector General
- Referral to the GAO Audit Division when the allegations are of a non-criminal nature (possible mismanagement)

The GAO Fraud Task Force monitors the status of all cases regardless of the referral action. The information from "hotline" calls is considered confidential data for investigation and is retained in the GAO Fraud Task Force files.

In its first six weeks of operation, the GAO hotline yielded over 3,000 allegations from 48 states, the District of Columbia, and overseas locations that affect agencies within all executive cabinet departments as well as the legislative and judicial branches. Of the calls received, 62% appear to merit investigation or audit to determine intentional wrongdoing or agency mismanagement. In addition to the detection functions of the hotline, the GAO intends to use the data collected to assess weak areas in agency management and improve goverment operations.[48]

DETERRENCE[49]

Creation of Target Task Forces

The concept of targeting investigation and prosecution resources to combat program fraud was developed in the early 1970's following housing loan scandals within HUD programs. Staff from HUD's Inspector General Office, the Department of Justice, the FBI, Postal Service, and other agencies with law inspection and enforcement duties initially composed the task force group. At the present time, the Department of Justice reports having 23 task forces in operation and over 1,000 operationalized in the period 1972 to 1978.[50] Composition of the task forces has been increased to include a number of other program agencies.

Targeting of Prosecutional Resources

A number of activities are being undertaken to reorganize prosecution efforts, provide more program fraud training to prosecutors, and publicize successful convictions of offenders.

---

[48] Staats, U.S. Comptroller General, "Statement Before the Senate Committee on Budget, GAO Efforts..," op. cit., pp. 15-29.

[49] Prevention and deterrence are closely associated. Prevention strategies produce *activities which make it more difficult to commit crimes, regardless of perceived odds of apprehension.* Deterrence strategies invoke enforcement *activities intended to influence the perceptions of potential offenders as to the likelihood of their apprehension and punishment.* (See Theodore H. Schell, Don Overly, Stephen Schack and Linda S. Stabile, National Evaluation Program Phase I Summary Report, Traditional Preventive Patrol (Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, June 1976), p. 6.

[50] Staats, U.S. Comptroller General, "Statement Before the Senate Committee on Budget, GAO Efforts..," op. cit., *passim.*

In some jurisdictions, office reorganizations and, in others, creation of new units are bringing more and broader prosecution resources to program fraud control. Examples of restructured or newly created prosecution units include:

- Creation of economic crime units within local district attorneys' offices funded through LEAA grants to the National District Attorneys' Association.
- Establishment of program fraud units at the level of state Attorney Generals' Offices for Medicaid.[51]
- Reorganizations of U.S. Attorneys' Offices to accommodate unit expertise in program fraud litigation.

In the case of Medicaid, federal funding is available to states that establish program prosecution (HR 3) units within certain federal guidelines. These units are aimed primarily at criminal prosecutions of program providers, and secondarily, at civil recoveries of defrauded program funds.

Formal in-house white collar crime training of prosecutors is also becoming more prevalent. The American Bar Association, the National Institute of Law Enforcement and Criminal Justice, and the Practicing Law Institute have all offered coursework on program fraud. These offerings have covered such topics as:

- Common elements of white collar crimes.
- Detection of white collar crimes.
- Prosecutive evaluation of white collar crime.
- Plea-bargaining and sentencing white collar crime.[52]

Greater press coverage of recipient and provider fraud prosecution is considered a major deterrent by enforcement personnel, because of the geographical proximity of some program recipients and the collegial, close-knit relationship of providers which allows a "grapevine" effect when there is news of a successful conviction.

---

[51] Medicaid-Medicare Anti-Fraud and Abuse Act of 1977, P.L. 95-142.

[52] B. James George, Jr., White Collar Crimes: Defense and Prosecution, Criminal Law and Urban Problems Course Handbook Series 31 (New York: Practicing Law Institute, 1970), *passim*.

Civil and Criminal Prosecutions

The objectives of civil and criminal prosecutions are not only to successfully develop and present a court case against program offenders, but also to impress upon all program participants and the general public that those who defraud or abuse the system will be pursued.

At present, program prosecutions are conducted by U.S. Attorneys, the U.S. Department of Justice, state Attorney Generals, or by local prosecutors. Due to the nature of criminal and civil authority in some states, many state Attorney Generals have only civil jurisdiction and local prosecutors have only criminal jurisdiction. This jurisdictional factor has made it difficult to coordinate prosecutions of program fraud. For example, HR 3 Medicaid fraud unit regulations require that for certification and funding by HEW, units must be a part of the state prosecutor's office. The lack of criminal jurisdiction to prosecute these cases proved a major obstacle to establishing them. In one state, the problem was resolved through a compromise whereby the state unit acts in the name of the local prosecutor and presents cases to local county grand juries.

In order to learn more about the problems and issues associated with prosecution of program fraud and abuse, a survey was sent to all state Attorney Generals.[53] Respondents were asked to describe common problems they encountered in investigating and prosecuting cases of benefit fraud and abuse.[54] The responses indicated the following problems:

- Shortages of personnel to investigate and prosecute cases
- High costs of resources relative to the proportion of punitive action available
- Lack of screening mechanisms for cases referred for prosecution
- Reluctance of witnesses to provide information or to testify at trials
- Lack of a centralized coordinated effort with specific investigation and prosecution goals
- Lack of clear and understandable statutory or administrative restrictions on benefit payments and constant changes in these which make it difficult to prove intent to deceive

[53]For copy of survey, see Appendix G.

[54]Ibid., Item 3.

- Lack of administrative records and systems designed to detect fraud and abuse
- Lack of adequate legislation under which to prosecute
- Lack of a"history" of prosecution (many felt it would be helpful to have a precedent to refer to in answering questions which arise during program adjudication.)

The offices were then asked what additional resources are needed to investigate and prosecute benefit program fraud and abuse. Almost unanimously, the responses indicated a need for more manpower, more interagency coordination, and broader civil and criminal jurisdiction.

The survey also sought information on whether criminal rather than civil remedies had been generally more effective in state courts for combatting fraud and abuse.[55] For the most part, respondents believe criminal remedies more effective, although some prosecutors felt that sentences are too lenient. Relative to the ineffectiveness of civil prosecution, respondents commented: the typical welfare recipient is judgment proof; there is nothing to execute or garnish in a civil suit; civil action is not viable because funds have been spent by the recipient; or county prosecutors are reluctant to use their limited resources preparing civil cases.

Finally, the survey asked prosecutors to specify incentives that they felt should be built into benefit programs to enforce opportunities for investigation and prosecution.[56] The following suggestions indicate the variety of responses to this item:

- Standardization and simplification of procedures
- Adequate and trained personnel at caseworker level
- Statutes mandating felony sanctions for fraud
- Data processing control systems for monitoring and analyses
- Federal funds for state and local prosecutions of fraud cases

[55] Ibid., Item 5.

[56] Ibid., Item 6.

- Safeguards, checkpoints, and other built-in detection mechanisms
- Motivation for informers
- Public awareness of how tax dollars are spent
- Training aimed at caseworkers, eligibility workers, and supervisors
- Program administrator feedback on a case by case basis including the type of abuse or fraud, the dollar amount lost, and the costs of investigating and prosecuting the case

There are two important effectiveness issues for prosecution. The first concerns the measurement of its effect for special and general deterrence. The intent in mentioning the measurement issue is not to develop a broad discussion of the problems, but rather to note that little research has been done in the program fraud area.[57]

The second effectiveness issue relates to the relationship between the amount of resources committed to the prosecution as an activity and its deterrent impact. Judging from the responses to the Attorney Generals' survey, prosecution is considered an effective strategy but there is insufficient money, manpower or time devoted to it. Until research is conducted to show the relationship of resources to deterrent impact, only subjective judgments of the strategy's true effectiveness are possible.

In summary, prosecutors assume that they have a deterrent impact on program fraud and abuse. Criminal litigation is viewed by state prosecutors as more effective than civil trials from the perspectives of monetary recoupment (many defendants are indigent and therefore cannot repay fines or make restitution) and deterrence (the defendant literally buys out of trouble rather than suffering the impact of incarceration.) Empirically, prosecution effectiveness remains open to question; while the strategy is highly favored, there have not been enough resources committed to prosecution to adequately assess its relative effectiveness.

---

[57] For the reader who may be interested in the measurement problems, see Alfred Blumstein, Jacqueline Cohen, and Daniel Nagin, eds., Deterrence and Incapacitation: Estimating the Effects of Criminal Sanctions on Crime Rates (Washington, D.C.: National Academy of Sciences, 1978).

Reforming Penalties

At least one program, Food Stamps, has begun to work with the concept that swifter justice deters fraud. This is accomplished by altering the penalties for frauds committed by retailers or wholesalers. Under the 1964 Food Stamp Act, frauds were considered felonies, and therefore, prosecutable only in the U. S. Federal District Courts where felony dockets are crowded and backlogged. The 1977 Act provides for misdemeanor penalties, and cases are heard before U.S. Magistrates.

Criminal penalties for coupon issuers of Food Stamps were also increased under the 1977 legislation. Issuers now face possible fines and imprisonment for failure to report inventory levels of coupons or for falsely stating information on their inventory reports submitted to USDA.[58] Under proposed regulations published last August, HEW intends to "ferret" out evidence of fraud and abuse and prosecute offenders involved in illegal ownership of control interests in private institutions, organizations, and agencies providing health-related services to beneficiaries.[59] The new regulations would require full disclosure of ownership. Failure to disclose names of owners or managing employees previously convicted of a criminal offense may result in administrative termination of the provider from the health programs. These regulations apply to Medicare and Medicaid in addition to several other health-related programs.

Adjustments in penalties for recipient offenses are seen as another method of deterrence. Again, in the Food Stamp Act of 1977, for example, administrative penalties are stiffer than in previous legislation. A recipient faces disqualification from the program when administrative proceedings find he/she has misused the program. When a criminal conviction also attaches to a recipient, participation may be suspended for up to 24 months. Households transferring assets to become eligible to qualify for benefits may be disqualified for a year from the date the transfer is found. Several states have acted also to increase criminal penalties for recipient fraud.

Administrative Adjudication and Administrative Remedies

Perhaps the most significant contribution administrative adjudication makes to enforcement is its capacity to correct program deficiencies without the involvement of criminal justice agencies. This contribution is critical to program integrity because the

---

[58] Food Stamp Act of 1977, 7 U.S.C. 2016 (7d).

[59] HEW News, press release re: AFDC and SSI Error Rates, (Washington, D.C.: U.S. Department of Health, Education, and Welfare, August 13, 1978).

criminal justice system has been criticized for failing to cope effectively and efficiently with cases of program fraud and abuse. Often, prosecutors have given low priority to criminal litigation of fraud cases. Court dockets, already backlogged with criminal cases, are ill-equipped to process additional program fraud cases which may be lengthy or involve small amounts of money. Critics of the criminal justice system find that sentencing of criminal offenders has been inconsistent and has detracted from the deterrent effect of the criminal sanction on program fraud and abuse.

The use of administrative due process apparatus and administrative sanctions offers a viable alternative to the shortcomings of criminal prosecutions. Rather than draining prosecutorial resources on small cases or prosecutorial time on learning extensive program details to bring about a complicated program litigation, a permanent adjudicative structure may provide better allocations of resources and more uniform handling of fraud and abuse cases. Administrative adjudication is also used against a variety of offender types which enhances its appeal as an enforcement activity. Recipients, administrative agency staff, third party providers or auxiliary program providers may be subject to administrative penalties which exact restitution or suspend or terminate program perticipation. Administrative penalties may be quite effective. A legal authority recently noted that "suspension of payments is a powerful governmental weapon for controlling or pressuring those health care entities which depend on governmental reimbursement for a substantial portion of their revenues."[60] When suspension is imposed, the cash flow position of a provider may be seriously crippled.[61]

The major limitation to measuring the effectiveness of the administrative sanction has been its limited use by both government agencies and independent state regulators (i.e., professional licensing boards or rate-setting commissions), despite government support for the alternative.[62] Interview respondents consistently noted that state regulatory bodies have refused or neglected to impose administrative sanctions against providers who were found guilty of misusing benefit programs. These groups have provided a "slap on the wrist", rather than using the powers of their office to suspend or revoke a provider's license, where collegial interests have dominated the regulator's responsibility to censure providers who are their peers.

---

[60] Byron G. Lee, "Fraud and Abuse in Medicare and Medicaid," Administrative Law Review, 30:1 (Winter 1978).

[61] Ibid., p. 36.

[62] U.S. General Accounting Office, Food Stamp Program--Overissued Benefits Not Recovered and Fraud Not Punished, Report to the Congress by the Comptroller General of the United States (Washington, D.C.: U.S. Government Printing Office, July 18, 1977), p. iii-iv.

In summary, administrative adjudication punishes individuals or groups through penalties, or rewards them through prescription of certain courses of action, or through reparational awards.[63] Although ultimate adjudicative decision-making lies with the courts, administrative adjudication is a viable alternative. Effectiveness of administrative remedies, however, rests on how regularly and with what degree of determination it is used.

Administrative Collections of Overpayments

Administrative recoupment of erroneous and fraudulently collected payments has met with some success, particularly in the Unemployment Insurance program. Recoupment is handled in either of two ways: the amount of funds owed is either offset against continued payments or the amount is paid in a lump sum. The offset technique has tended to be used in times of economic recession when disposable income is reduced, and the lump sum in periods of economic prosperity (when personal incomes are higher and work is more available.)

Recoupment success is credited to funding of specialized state recoupment units by the United States Department of Labor. A Labor official estimated the success rate for collection of funds at 50 cents on every dollar, and state units provide similarly favorable recoupment statistics. Another estimate based on a state's official statistics for the priod 1977-1978 shows a recoupment success rate of closer to 25 percent. The amounts lost and recouped appear in the following table.

TABLE X

STATE UNEMPLOYMENT INSURANCE
RECOUPMENT STATISTICS

Year	Amount Lost	Amount Recouped	Percentage Success
1977	$595,304	$135,481	23%
1978	$468,152	$113,139	24%

Harassment

The negative connotations associated with the term "harassment" complicate the task of demonstrating its contributions and effectiveness to enforcement. However, for those agencies who use

---

[63] Joseph P. Champerlain, et al., The Judicial Function in Federal Administrative Agencies (Freeport, New York: Books for Libraries Press, 1972), p. 95.

harassment either as an individual technique or in conjunction with other strategies, it is considered an important tool for deterring suspected offenders.

Examples of "harassment" in program enforcement include:

- Direct surveillance of a warehouse where crates of allegedly stolen Food Stamp Authorization to Purchase cards are kept.
- Badgering of a food service provider before a grand jury to gain the details of a fraudulent bid-rigging scheme.
- Continual reviews of the records of health care providers who previously have been suspected of fraud or abuse.[64]

A factor which seriously hampers evaluation of harassment effectiveness is that law enforcement officials who employ the strategy are reluctant to acknowledge its use. Their reluctance is attributable to the public perception that the strategy is somehow "extra legal." For example, arrests of alleged offenders to "shake-out" the actual offenders while knowing that evidence is insufficient for an indictment places broad discretion in the hands of enforcement officers. The rigid application of administrative standards, that otherwise are laxly enforced, to detect alleged offenders also illustrates the discretionary aspect of its use.

Thus, the strategy's effectiveness rests on its ability to identify suspected offenders. Its effectiveness, however, must be viewed within the framework of broadened enforcement powers.

SUMMARY

A broad spectrum of enforcement activities was reviewed in this chapter. These efforts are generally believed to be effective by those who employ them.[65] The numerous examples provided from federal, state and local initiatives may serve as a catalogue for officials with specific types of problems which require enforcement solutions. But, because none of the enforcement techniques

---

[64] Lee, Administrative Law Review, op. cit., p. 37 (footnote 196).

[65] Appendix I provides a ranking of strategy types on the basis of their relative effectiveness as perceived by those who responded to the fraud and abuse survey. Because the categories ranked were developed before the research leading to the typology in Table XI, they are not identical to the most commonly employed enforcement strategies.

TABLE XI

TYPOLOGY OF STRATEGIES

STRATEGY TYPE	EXAMPLES OF INDIVIDUAL TECHNIQUES	ASSUMED CONTRIBUTION TO ENFORCEMENT EFFECTIVENESS THROUGH ITS
LEGISLATIVE SUPPORT	• Creation and funding of IG units • Enactment of state fraud statutes • Appropriation of financial incentives to combat fraud	Effect on benefit program design and program enforcement funding
ORGANIZATIONAL REDESIGN	• Consolidation of audit and investigation divisions in an IG unit • Creation of new span of administrative control to accompany program design simplification, i.e., reduce number of administrative staff • Creation of new positions in administrative agencies for specialists, i.e., quality control	Definition and ordering of major organizational constraints and contingencies
EDUCATION AND TRAINING	• Recipient educational materials • Training of administrative program staff • Creation of program manuals for providers	Reinforcement of and effect on individual behavior and the level of awareness an individual has about the benefit program
RESEARCH	• Use of discriminant analysis to develop fraud offender profiles • Use of techniques to determine dollar losses in program • Studies of past cases to detect program vulnerabilities	Capacity to gather knowledge and empirical data for improving the effectiveness of all the cited strategy types
INVESTIGATION	• Tracing flows of benefit dollars • Identifying and questioning witnesses • Identifying evidence for trial	Identification and apprehension of program offenders and provision of evidence to find guilt

TABLE XI (con't)
TYPOLOGY OF STRATEGIES

STRATEGY TYPE	EXAMPLES OF INDIVIDUAL TECHNIQUES	ASSUMED CONTRIBUTION TO ENFORCEMENT EFFECTIVENESS THROUGH ITS
QUALITY CONTROL	• Statistical sampling • Compliance visits to program delivery sites • Computer cross-matching	Monitoring of resources and information associated with provision of benefits
FINANCIAL AUDITING	• Internal program computer auditing • Operational surveys • Provision of financial records as proof of guilt	Capacity for detection of financial program irregularities and gathering evidence of guilt
ADMINISTRATIVE ADJUDICATION AND ADMINISTRATIVE REMEDIES	• Fraud hearing in Food Stamps[1] • Suspension or termination of recipient, third party provider participation • Administrative dispute resolution of program fraud claims from recipients against providers	Capacity to correct deficiencies without involving criminal justice agencies
HARASSMENT	• Badgering of witnesses during investigation or trial of program cases • Administrative review of providers' records on a continous basis • Compliance visits conducted by numerous enforcement parties at the case sites	Identification of suspected offenders
CRIMINAL AND CIVIL PROSECUTION	• Program prosecution units, i.e., HR 3 Medicaid units • Creation of special program fraud grand juries • Creation of new legal doctrine to broaden prosecutorial authority in program fraud cases	Definition and ordering of major organizations constraints and contingencies

[1]See Food Stamp profile in Appendix A.

has been subjected to rigorous evaluation, some officials may be more interested in a surrogate measure of their viability. One such measure is the extent to which the enforcement technique is applicable across all benefit programs. Ten general types of activities, or enforcement strategies, were found in all fifteen benefit programs reviewed for this report. Table XI presents these ten enforcement strategies and notes each strategy's assumed contribution to enforcement effectiveness.

In addition to uncovering common enforcement strategies and finding many examples of their apparently successful use, the research on which this report is based found several serious deficiencies in the area of enforcement. These deficiences are discussed in the next chapter.

CONTINUED

1 OF 3

CHAPTER 5

ENFORCEMENT DEFICIENCIES

INTRODUCTION

Program enforcement weaknesses which many observers believe have seriously hampered fraud and abuse control are explored in this chapter. These deficiencies stem not only from problems created by the complex nature of white collar program fraud but also from other variables in the enforcement environment.

The discussion of these deficiencies must include two cautionary notes. The first relates to the objectives of program enforcement. Over the past ten years, enforcement has placed heavy reliance on the criminal justice system as its major line of defense in combatting program fraud and abuse. Criminal convictions were considered the measure of enforcement success. In the last several years, there has been a growing trend to find alternatives to criminal prosecution of cases. This change in objectives is due, in large part, to failures of the criminal justice sanction to curb fraud and abuse and to the practical reality that it is an inappropriate penalty for deterrence of abuse cases because no specific laws were broken. Objectives like restitution, recoupment, administrative disbarment, and suspension from program activities are starting to supplement, and in some programs, supplant criminal justice objectives. Therefore, discussions must recognize that "enforcement" is in transition and that the new term now applies to a number of strategies besides criminal prosecution.

The second cautionary note concerns the state-of-the-art in program enforcement. For a variety of reasons soon to be discussed, some jurisdictions have moved more slowly than others to adopt enforcement strategies. They have also moved with varying degrees of commitment in terms of staff support, time, money, and other resources. The comments that are made about enforcement, therefore, should not be construed to suggest that all agencies or all jurisdictions are similar in their applications of strategies nor are the same deficiencies seen in every enforcement setting.

CHARACTERISTIC WEAKNESSES

The languor which has characterized much of past enforcement appears to be a basic weakness. In commenting specifically on the student loan program, HEW Secretary Califano underscored this general problem at a recent conference on departmental fraud, abuse and waste. He remarked:

> How can we fault students for not paying their student loans, when this agency (HEW), for all practical purposes, never sent them a bill for over ten years?[1]

The sluggish pace and disparate levels of resource allocations for curbing fraud and abuse were confirmed in interviews. Many administrators admitted that enforcement had always been a reactive managerial posture, and many used the words "crisis management" and "putting out fires" to describe past enforcement activity. The general pattern seems to have been that as problems arose in a particular program, oversight hearings were held, administrative or judicial actions were taken, and legislative or regulatory changes were enacted which would hopefully deter repetitions. As one agency head noted, enforcement has taken a "band-aid approach" rather than seeking a cure for program ills.

This research uncovered several characteristic weaknesses which have led to the slow, reactive approach of enforcement. These include a general lack of:

- Good quality and quantitative data on fraud and abuse
- Standard definitions for fraud and abuse
- Legislative priorities for enforcement
- Alternatives to criminal justice for enforcement
- Overall enforcement planning
- Enforcement incentives
- Consistency in the use of sanctions

Each of these deficiencies is discussed below.

---

[1]Joseph A. Califano, Jr., "Remarks to the National Conference on Fraud, Abuse and Error," as verified by tape transcript on 2/1/79 by Thomas Ruttershan, Department of Health, Education, and Welfare, Washington, D.C.

Absence of Reliable Data

One of the major limitations for enforcement has been that prevention, detection, and deterrence have operated at the edge of all social benefit programs; that is, they are often "afterthoughts" which emerge following establishment of a program. The result has been that most anti-fraud and abuse strategies are based on administrative and financial data gathered to serve the programs' apparent prime goal - provision of benefits - and not the goal of limiting fraud and abuse.

The absence of reliable empirical data concerning the extent of benefit fraud and abuse is acknowledged at all levels of government. One highly placed federal prosecutor commented that "the data bases are just not there" to begin to cope with fraud and abuse. In testimony before a Senate Subcommittee on Federal Spending Practices and Open Government, the Comptroller General of the United States made clear that:

> No one knows the magnitude of fraud against the Government. Hidden within apparantly legitimate undertakings, it usually is unreported and/or undetected.[2]

Similar concerns about the lack of reliable data were expressed in the HEW Inspector General's report which underscored the fact that "best estimates" are the only available measures for federal dollars lost to fraud, abuse, and waste in the Department's programs.[3]

For fraud and abuse data to have utility they must, of course, be regularly and accurately maintained. The fraud and abuse survey did question whether statistical data were maintained on the numbers and types of fraud and abuse cases associated with the program.[4] Of 80 program respondents, 74% claimed to keep such statistics; of 51 programs who also had investigative personnel, 82% claimed to maintain this type of data. These results would suggest that the primary problems with fraud and abuse data lie in their accuracy and consistency of collection, both within and across programs; interview respondents frequently made this criticism.

---

[2]Statts, U.S. Comptroller General, "Statement Before the Senate Committee on Budget GAO Efforts ...," op. cit., p. 5.

[3]U.S. Department of Health, Education, and Welfare, Annual Report, op. cit., p. 8.

[4]See Appendix H, Item 30.

[5]U.S. General Accounting Office, Attainable Benefits, op. cit., pp. iii-iv

The issue of data quality and its application for enforcement has been critiqued in several other contexts as well. A U.S. General Accounting Office report on the collection of Medicaid data in the states concludes:

> The Surveillance and Utilization Review subsystem and Management and Administrative Reporting subsystem are integral parts of the information systems. The reporting subsystem should provide necessary information to support sound decision-making... States generally are not reviewing the quality of care provided Medicaid recipients as required, and the subsystems are not providing the data needed to help states do so.[5]

Interviews with fraud investigators reveal that data they receive from program personnel are frequently useless because the accuracy cannot be substantiated. Federal prosecutors express discouragement with ambiguous and inadequate data supplied by program administrators for trial. As one prosecutor commented:

> For HEW cases, computer output is the pivotal source of data to present cases. However, computers give inadequate definitions, because the program regulations on which they are based are so loose. Data based on these ambiguities is (*sic*) worthless for trial.

Taken as a whole, this research strongly suggests that a lack of reliable data has substantially hampered benefit enforcement.

Absence of Standard Definitions

The difficulties associated with the lack of consistent definitions for the terms *fraud* and *abuse* were discussed in the introduction to this report. Inconsistent definitions directly hamper legal and regulatory enforcement activities by inhibiting coordinated efforts. Moreover, because inconsistent definitions affect enforcement staff perceptions of what constitutes an abusive or fraudulent situation, they also constrain enforcement by leading to across-program inconsistencies in statistical record-keeping.

Absence of Legislative Priorities for Enforcement

Enforcement has not generally been a priority concern in program legislation. Most benefit program legislation results from an adversary process which is eclectic, and frequently bitter. As legislation is marked-up, legislators are inclined

---

[5] Ibid.

to fight to include their constituents or other special interests in the pool of potential beneficiaries. They are less inclined to support the incorporation of enforcement tools which might make it difficult for their interests to receive benefits. Intentionally or unintentionally, benefit programs become so burdened that it is usually difficult and often nearly impossible for them to meet the goals for which they were originally proposed. The prices too often paid for "program delivery at all costs", are fraud, abuse, and waste.

Compounding the problem of over-burdened/under-enforced program designs, enabling legislation for many programs is intentionally vague and ambiguous, making it difficult to distinguish between criminal behavior, general lethargy or ineptitude on the part of program administrators assigned the task of designing guidelines and managing effective programs. For example, some fraud and abuse in the Small Business Administration's 8(a) Minority Contract programs has resulted from the legislation's failure to define who qualifies as "economically and socially disadvantaged." Even amended legislation for the program skirts the primary eligibility question by "limiting participation to business concerns that are at least 51 percent owned and operated by a socially and economically disadvantaged person."[6] Highlighting the legislators' own failure to come to grips with the definitional ambiguity, a report accompanying the legislation admits that:

> The Committee has not dealt with the question of who should establish these criteria or what they should be. The Committee does note, however, that the ability of both contractors and procuring agencies to comply with the subcontracting requirements can only be enhanced by the existence of an unambiguous set of guidelines.[7]

Not all legislation is ambiguous as that which establishes 8(a) Minority Contract programs. The 1977 Food Stamp reform legislation, for example, is carefully structured not only to well-define qualified beneficiaries, but to improve enforcement of program-related statutes and regulations.[8]

Food stamp reform legislation notwithstanding there is additional evidence of the lack of support for enforcement from legislators. Historically, the appropriations process has neglected management of many programs, thereby increasing to a

---

[6]Small Business Investment Act of 1978, United States Senate, 95th Congress, Second Session, Report No. 950-1140, August 23, 1978, p. 13.

[7]Ibid. pp. 9-10.

[8]See the program profile in Appendix A, p. 138.

sometimes inordinate level the burden placed on enforcement. Not only are incidences of fraud and abuse likely to increase when strong managerial control is lacking, but enforcement responsibilities for limiting and recouping losses inevitably increase as well. In USDA's Rural Housing program, for example, Congress has drastically increased program responsibilities, and, thereby, managerial demands without providing appropriations to increase either the number of staff or the available technology. As a consequence, in one state a handful of staff were responsible for over $70 billion of rural housing projects in fiscal year 1977. This particular state is the leader for rural housing volume in the nation and has been the subject of numerous fraud and abuse investigations which have concluded that inadequate staffing of the programs is largely to blame. To bridge the gap left by inadequate appropriations to meet added legislated program responsibilities, the Farmers Home Administration has established a national computerized collection service. The service will relieve staff of collection responsibilities so that more time can be spent on eligibility matters to avoid fraud and abuse at the determination point.

To counter some of the problems of legislative inattentiveness to program design and subsequent enforcement, the Department of Justice has recommended that an enforcement impact statement accompany all pieces of benefit program legislation generated by Congress. This statement would set out in dollar terms, the potential costs of enforcing programs and the problems which may be incurred in the policing efforts. Observers believe that this statement, modeled on the experiences with environmental and judicial impact statements, would provide lawmakers with needed information to enact programs that afford more safeguards in design and more opportunities for effective enforcement.

Absence of Alternatives to Criminal Justice

Many observers of program enforcement have criticized its frequent reliance on the criminal justice process to the exclusion of other alternatives. Failures of enforcement to curb fraud and abuse are attributed to this pronounced emphasis on combatting problems with criminal justice penalties. Traditionally, fraud investigation units were staffed with ex-law enforcement personnel whose training and experience many times proved ill-suited. For example, they had no training for or experience in the tasks of painstakingly reconstructing a third party provider's billings and vouchers. Criminal prosecution was considered the paramount deterrent for program fraud, and felony cases, in particular, were primarily chosen by prosecutors.

Experience in combatting program fraud and abuse suggests that limitations of the criminal justice process confound program enforcement. As one former federal prosecutor comments about the use of criminal sanctions:

> There is no reliable evidence to suggest that the criminal sanction has succeeded in controlling white collar crime. In general, deterrence has not been realized, rehabilitation has been ignored, repeat offenders have not been removed from society, and victims have not been compensated.[9]

He adds that the questionable success of the sanction for white collar offenses is due to "the ponderous character," the "infrequency of prosecution," and the "limited resources" of the criminal justice system to handle the cases.[10]

Another deficiency of criminal prosecution has been that they must operate at what several officials called "the edge of cases." For example, third party program fraud must frequently be tried under mail fraud statutes rather than under direct fraud statutes, sometimes losing the full deterrent impact of the prosecution.

Criticism of the deficiencies of criminal justice to handle fraud and abuse has begun a trend toward broadening the skills of enforcement staff and diversifying the arsenal of techniques used to combat it. As a guide in investigating white collar crimes notes, diversification is needed:

> If a unit determines that criminal prosecution is its main objective it can still retain civil, administrative, or even mediation remedies for situations where criminal actions are not feasible or wise.[11]

The manual adds that a truly experienced white collar investigator "should develop great skills for judging when to work toward one enforcement objective or another."[12]

Absence of Effective Enforcement Planning

Both within and across programs, enforcement has tended to occur on an ad hoc basis. A study concerned with the lack of federal planning for enforcement found that the Department of

---

[9]Robert W. Orgen, "The Ineffectiveness of the Criminal Sanction in Fraud and Corruption Cases: Losing the Battle Against White Collar Crime", The American Criminal Law Review (2:959), p. 41.

[10]Ibid.

[11]Herbert Edelhertz, et al., op. cit. p. 41

[12]Ibid., p. 41

Justice, for one, has been "slow to assist, coordinate, and monitor the anti-fraud efforts of federal agencies."[13]

This lack of planning and coordination has often resulted in disatisfaction between program staff and prosecutors. For example, one of the most frequently heard complaints during interviews with fraud unit personnel was the prosecutors (federal, state and local) placed such low priority on benefit cases that it sometimes "seemed not worth the time" to prepare a case. On the other hand, interviews with prosecutors revealed that many of the cases referred to them from fraud units contained "botched" witness interviews and inadequate evidence for trial presentation.

Enforcement planning is undoubtedly hampered by the absence of reliable data concerning fraud and abuse. Nevertheless, interviews and the fraud and abuse survey suggest that staffing, case screening and utilization of technology all deserve careful planning attention.

Staffing

Field investigation for this study disclosed time and again that most offices have inadequate staff to combat fraud and abuse. Comments like, "Since there just is not enough manpower for undercover assignments and investigations in every case, we must try to hit as many programs as we can for prosecution," were elicited from program and enforcement personnel. Insufficient numbers of staff are available to meet all the enforcement responsibilities which are required "to clean-up programs. Investigations of 8(a) Minority Contracts from the Small Business Administration illustrate the problem. The head of SBA was forced to seek additional investigative and audit support from the Administration in 1978 to undertake "a nationwide probe of suspected abuses involving $26 million in unpaid loans or 'advance payments' made over past years to help minority business fulfill federal contracts."[14] Over half of the (agency's) 80 investigators were involved...in a large abuse problem with 8(a) contractors, that of ineligible white-owned businesses getting contracts by using minorities as fronts.[15]

The fraud and abuse survey revealed that respondents consider staff to be one of the most effective enforcement resources; the apparent deficiencies in staffing across programs is a serious current weakness.

---

[13]U.S. General Accounting Office, Combat Fraud, op. cit., p. 5.

[14]"SBA Examining 35 Firms in Unpaid Loans Probe," The Washington Post, (November 11, 1978) p. A2

[15]Ibid.

Case Screening

Case screening involves the development of formal criteria for rating and rank ordering cases for investigation and trial. Critics of formal case screening argue that the process would reduce their flexibility to pursue cases. Given limited resources, they would generally prefer to select just a few cases based on informal judgmental criteria of potential effectiveness. Proponents of case screening frequently find it lacking in current application, but argue that it is an essential area to ensure future enforcement effectiveness. For example, they would argue that more precise care should be given to decisions about the use of audit resources in program cases. A regional Inspector General in charge of audit staff commented that too often staff time had been wasted when a 100 percent audit had been done for a case when screening would have found that only a partial audit was needed. He recommended that a review of audit resources needed for each case should be done prior to initiation of the investigation rather than after it is underway.

Practical applications of case rating in large and small prosecutorial offices have provided useful tools for planning and prioritizing resource allocations. One of the major applications undertaken is a system called the Prosecutor's Management Information System (PROMIS). It has been shown that PROMIS rankings:

> "bestow exceptional managerial leverage on the Chief prosecutor, who can now apportion his office's time and manpower according to the relative importance of pending cases, which is not only good management per se but also operatively reflects the public's concern over repeat offenders and service crime."[16]

The interviews suggest that except for those offices using PROMIS, few if any formal systems exist for prioritizing cases for enforcement attention. Only one state prosecutorial unit contacted was vigorously developing screening standards for program fraud cases, and these efforts had just begun under a newly awarded LEAA grant.

In view of the burdens placed on enforcement by inadequate staffing, formal case screening should provide an important resource allocation method. Collection of empirical data which

---

[16]Institute for Law and Social Research, Institute Briefing Paper, Uniform Case Evaluation and Rating Number 3, (Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, 1976), pp. 2-3.

evaluates practical impacts of formal case screening on benefit program enforcement efficiency and effectiveness is an important future step.

Computer Technology Usage

Another neglected planning area is coordination of computer generated program data for enforcement. Utilization of computer technology is extensive: Almost all respondents (94 percent) to the fraud and abuse survey indicated use of computers in their programs.[17] Eighty-two percent of the respondents informed us that computer data are used in some fashion for detection and surveillance of program fraud and abuse.[18] Appendix reports the open-ended responses to these items.

Despite rather extensive usage of computers, interviews suggested that they are being used effectively. Often, programs have obtained large computer systems with sophisticated software packages. But enforcement personnel tend to find the systems lacking. Frequently they argued that potential fraud and abuse cases could not be pursued because of a lack of requisite benefit program information which should have been programmed into the computer. In some programs, investigators expressed exasperation with the paucity of data that they could receive from computers, and several investigators told of losing precious hours of investigative time identifying basic case and client data because these were not readily accessible to them from the computer.

Prosecutors said they seldom use computer generated data for trial purposes. They consider it too complicated to explain to a jury; there are too many evidentiary problems standing between generation of the data and its presentation as evidence at trial; and program officials cannot testify consistently to the validity of the data nor to the parameters through which they were obtained. Given the apparent growth of computer use in benefit programs, it is important that more coordinative planning of its uses for program operations and enforcement be undertaken.

Absence of Incentives for Enforcement

Program officials continually have taken a conservation approach when requesting funds for enforcement purposes because they felt that seeking these appropriations constituted an admission that programs were failures and could not be run efficiently and effectively. Given tight budgets and small staffs, many

---

[17]See Appendix B, Items 28 and 29.

[18]While a large percentage of the sample told us they use computers, the data provide no information on the sophistication of computer usage. It should not be concluded from the survey data that usage implies necessarily that the sophistication levels of the usage are also high.

jurisdictions were not able to afford the costs of supporting enforcement activities. There was also an added impediment: jurisdictions who did pursue enforcement paid for it out of their own pockets. Most of the recouped funds were returned to the federal government and were not applied to overhead costs of enforcement.

Program experimentation with incentive schemes has led to a conclusion that incentives do stir action. A recent evaluation of the AFDC;s corrective action program to reduce error rates concludes:

> Based on results of our visits to 15 states, the DHEW threat of fiscal sanctions prompted states to redirect management attention to reduction of reported errors. There is no question that this increased management attention and emphasis placed on error reduction was a primary factor contributing to improved state performance.[19]

The evaluation report adds that even though negative financial incentives[20] have been eliminated, the Department of Health, Education, and Welfare "should seek an alternative strategy to maintain and renew the level of state management interest in error reduction."[21]

The use of financial reimbursements and formula matches to increase enforcement activities in the states appears in new provisions of several benefit programs. Under provisions of the 1977 Food Stamp Act, USDA may reimburse the state 75 percent of the costs of establishing investigation units. Medicaid, AFDC, and Unemployment Insurance programs have provisions for federal financial assistance to states establishing investigation and prosecution units, and Medicaid monies are also available for creation of information systems. The Food Stamp Act, in particular, has begun to deal with the problems of recouped funds by splitting the responsibilities and costs between the federal and state governments.

Inadequate Use of Sanctions

The basic principles of deterrence suggest that in order to be effective sanctions must be meted out with swiftness, severity, and certainty. While the requisite sanctions (criminal, civil, and administrative) for deterring program fraud and abuse are in

---

[19] Touche Ross and Company, Evaluation of AFDC-QC Corrective Action Final Report (Washington, D.C.: U.S. Department of Health, Education, and Welfare, October 31, 1977), p. 116.

[20] A negative financial incentive involves the state losing program funding unless it corrects program errors.

[21] Touche Ross, op. cit., p. 117.

place, inconsistency in their use has limited their success. This finding is not surprising given the current state of criminal sentencing in the courts. A major report on fair and certain punishment found:

> The sentencing system prevailing in the United States is flawed by profound imbalance between the severity of punishment and the certainty of punishment among those convicted of crimes.[22]

Later the report concludes that the status of sentencing is much like a

> ...nation of extremes, because sentencing is neither felt nor effective, it harms both the individual and society... Credibility is weakened further when a substantial proportion of convicted defendants haphazardly escape punishment, as also often occurs.[23]

Although there are little empirical data on the sanctions used in program fraud and abuse, minimal use of sanctions appears to characterize third party provider cases. From an adjudicative perspective, very few program agencies (with the exception of HUD) have moved swiftly to disbar third parties found abusing or defrauding programs. Part of the hesitancy in using disbarment has been the fear of putting a provider totally "out of business," thus leaving the jurisdiction without a service provider. For example, a rural physician found defrauding the Medicare programs may not be disbarred because he or she may be the only source of medical assistance available in that area. While an unusual circumstance should be of some concern, administrators argue that the impact of a sanction will be diminished if it is not consistently used.

Moreover, for sanctions to be employed requires that prosecutors accept cases for trial. But prosecutions of providers usually involve lengthy trials with hundreds of exhibits and witnesses. As one federal prosecutor noted, a trial against a prime sponsor in the Summer Food Service program would have taken almost two months to present to the jury because of the 200 witnesses that were to be called. Nursing home fraud prosecutions have consumed thousands of pages of trial transcript.

---

[22]Alan M. Dershowitz, Fair and Certain Punishment (New York: McGraw-Hill, 1976), p. 3.

[23]Ibid., p. 6.

Informing juries of sophisticated accounting arrangements, loan agreements and, in some cases, payments and acceptances of bribes and kickbacks has hampered prosecution. Most prosecutors attempt to present evidence with visual aids, flow charts, and the like which break out the various transaction points in the fraudulent schemes. As one prosecutor noted, "it takes concentration and perseverence to understand the schemes to begin with, never mind trying to explain them to someone else."

Even when cases are brought to trial, a pattern of inconsistency emerges in the criminal sentencing of third parties. Judges and juries appear hesitant to sentence. As one prosecutor put it, noting that in the "macro-sense" judges and juries understand the number of tax dollars being lost to program fraud, "judicial sanctions imposed are not strong enough in the 'micro-sense'," that is, the individual provider case.

One of the major reasons given for the inconsistency of criminal punishment rests on the nature of programs, themselves. As one prosecutor explained, "Certain types of program fraud cases are losers." It is more difficult to show damage in programs where some benefit flows to an individual even though he or she is ineligible to receive it, than it is to show where actual harm would be done by excluding the beneficiary from the project.

The CETA program provides examples of hard to prosecute program fraud and abuse where a person receives a job which he or she is technically ineligible to receive under the program. Because the beneficiary has received only a job (at which he or she presumably must work to receive money) and because one of the primary goals of the program is to provide jobs for the unemployed, the program becomes the institutional victim. Judges and juries tend to view this as less a crime than such other benefit program abuses as the horrid treatment provided by some nursing homes which are reimbursed with federal program dollars. The facts in both cases may be compelling, but it is more difficult to show "the blood of the victim" in the CETA case than in the Medicaid case.

CONCLUSION

Proof of the seriousness of fraud and abuse has been obscured by inconsistent and inadequate data and emotional media reports. The meager evidence currently available supports the finding that fraud and abuse extends into all types of benefit programs and is committed by a large cast of actors either singly or in collusion. Truly staggering is the fact that if current trends are extrapolated, losses to fraud and abuse in the fifteen programs reviewed in this study could amount to between $80 and $100 billion over the next ten years. With such an outlook for the future, federal, state, and local governments can no longer turn their backs on the problems of enforcement.

This report has focused on assessing the quality and scope of current information on fraud and abuse and its control. Techniques for arraying this knowledge in simple and manageable frameworks included a taxonomy of offenders and associated offense patterns, and a typology of enforcement strategies with underlying presumptions for their effectiveness.

In sum, the report finds that legislation and regulations must be amended to insure that benefits are delivered as intended. Current program vulnerabilities are, in large measure, a consequence of inadequate program legislation. *Legislators* must address program *design* and *enforcement* issues in a more thorough and consistent fashion.

Because considerable fraud and abuse occurs *within* program staffs, *program administrators* must review their individual staff policies, regulations, and guidelines and monitor work flows more carefully to insure efficient and effective delivery of program benefits.

Program enforcement staffs must take a broader view of their responsibilities to include civil, criminal, administrative, and other remedies and must promote greater legislative support, program operations coordination, and public concern.

Ridding programs of *all* fraud and abuse is probably an unrealistic goal, but the drain of dollars should and can be slowed substantially. With more reliable data concerning fraud and abuse and the employment of proven enforcement tools, losses could be more effectively controlled. The unusually broad scope of this report, while a necessary first step, only scratches the surface of fraud and abuse control. More extensive quantitative research of particularly important relationships related to fraud

and abuse is critical. Future attention must be directed specifically toward the development of accurate and manageable data bases and empirical research of the effectiveness of various enforcement strategies. Successfully reducing the incidence of fraud and abuse depends on such efforts.

GLOSSARY

abuse - improper utilization of a benefit or benefit system where no criminal intent can be shown or proven

administrative sanctions - provided in program regulations, penalties for fraud or abuse that are enjoined against providers or recipients rather than judicial and criminal penalties; examples are suspension or termination from program participation, recoupment procedures, warnings of subsequent action, and dispute resolutions with mediators

Attorney Generals' survey - a survey letter sent to all state Attorney Generals' offices in November 1977, to collect information on the investigative and prosecutorial activities for anti-fraud control underway in the respective jurisdictions; a list of the respondents and a copy of the letter survey are to be found in Appendix G

Authorization to Purchase (ATP) card - verification card under the Food Stamp Act of 1964 that enabled eligible households to purchase food stamp coupons at a greater face value than the purchase price

auxiliary providers - distinct from third party providers, auxiliary providers offer contracted services to third party providers and program administrators

brokering - the practice of subcontracting for services not within the capabilities of the primary institution. In Medicaid, for example, many laboratories subcontract for sophisticated testing and analysis. Problems occur in this program when the laboratory accepts Medicaid reimbursement for tests that were subcontracted to independent institutions at less than the cost of the billed service

Community Planning and Development - office responsible within the Department of Housing and Urban Development for administration of the Rehabilitation Loans (Section 312) program

Compliance Branch - created by the USDA in 1977, to assist in quality control and monitoring of Food Stamp program wholesalers and retailers. The Compliance Branch provides the initial content analysis of suspected fraud or abuse cases prior to an investigation by the Inspector General's office.

corrective action plans - state-formulated plans and implementation schedules designed to reduce AFDC program error rates, as required by HEW from state programs with unacceptable high quality control error rates

cost-benefit analysis - an estimation and evaluation of net benefits of alternative projects when the costs are identical, or of the costs when the benefits are identical

cross-match - an enforcement technique involving the comparison of wage, employee or benefit program rolls (usually a computerized process) to detect duplicate participation, ineligible recipients, or to verify data affecting eligibility. The cross-matches are conducted across agency, local, state or federal jurisdiction and are subject to the Privacy Act of 1974 restrictions

direct loans - financial assistance provided through the lending of federal monies for a specific period of time, with a reasonable expectation of repayment. Such loans may or may not require the payment of interest

direct payments for specified use - financial assistance from the federal government provided directly to individuals, private firms, and other private institutions to encourage or subsidize a particular activity by conditioning the receipt of the assistance on a particular performance by the recipient. This does not include solicited contracts for the procurement of goods and services for the federal government

direct payments with unrestricted use - financial assistance from the federal government provided directly to beneficiaries who satisfy federal eligibility requirements with no restrictions being imposed on the recipient as to how the money is spent. Included are payments under retirement, pension, and compensation programs.

discriminant analysis - a technique used to statistically distinguish between two or more groups, e.g., fraudulent or nonfraudulent cases. A set of discriminating variables, such as previous criminal history, are selected which are capable of measuring characteristics on which the groups are expected to differ. Once a set of variables is found which provides satisfactory discrimination for cases with known group memberships, a set of classification functions can be derived which will permit the classification of new cases with unknown membership (again, fraudulent or nonfraudulent)

double-billing - a practice often found in Medicaid or Medicare which involves third party provider billing more than once for reimbursement for the same service

Employment and Training Administration (ETA) - a group of offices and services established to implement certain work-experience and work-training programs. Programs are carried out through 10 regional offices under the direction of the Office of Field Operations

fair hearings - under the Food Stamp Act of 1977, state agencies must provide fair hearings to beneficiaries, upon request, to appeal any state or local agency decision affecting participation of a household in the program

Farmers Home Administration (FmHA) - within the Department of Agriculture, provides credit for those in rural America who are unable to get credit from other sources at reasonable rates and terms; responsible for administration of the Rural Housing program

fee appraiser - independent appraiser whose fee is a percentage of the appraised property value; the use of fee appraisers; rather than agency or government appraisers, in loan benefit programs created opportunities for fraud or abuse

Federal Disaster Assistance Administration (FDAA) - within the Department of Housing and Urban Development, responsible for direction, management, and coordination of federal disaster assistance program

Food and Nutrition Service - the agency responsible for federal administration of the federal-state food assistance program operated cooperatively with state agriculture, education, welfare, and health agencies

formula grants - allocations of money to states or their subdivisions in accordance with distribution formula prescribed by law or administrative regulation, for activities of a continuing nature not confined to a specific project

fraud - an intentional illegal manipulation of a benefit that is offered or of the delivery system which provides the benefit

fraud and abuse survey (Information Resource Form) - sent to 216 state officials responsible for program operations and/or enforcement; designed to elicit information and views on benefit fraud and abuse; a list of respondents and a copy of the survey to be found in Appendices C and H

fraud hearings - available to Food Stamp program retailers and wholesalers who wish to appeal disqualifications from program participation enforced by sponsoring agencies; FNS provides the appeal mechanism through the Office of Administrative Services

ganging - the practice of billing for multiple service to members of the same family on the same day when, in fact, only one person needs or received treatment

General Accounting Office (GAO) - in the legislative branch, the GAO assists the Congress, its committees and its members in carrying out their legislative and oversight responsibilities, including functions such as legal, accounting, auditing and claims settlement activities with respect to federal programs and operations as assigned by Congress, as well as to make recommendations for more efficient and effective government operations

ghost eligibles - fictitious beneficiaries created from inaccurate eligibility data in order to procure ineligible benefits; may involve collusion between agency employees, benefit recipients or other program participants

guaranteed/insured loans - programs in which the federal government makes an arrangement to indemnify a lender against part or all of any default by those responsible for repayment of loans

Health Care Financing Administration (HCFA) - established in 1977, provides direction and technical guidance in the nationwide administration of the federal effort to plan, develop, manage, and evaluate health care financing programs and policies; responsible for the Medicare and Medicaid programs

Household Issuance Record (HIR) card - verification card issued under the Food Stamp Act of 1977 that enables eligible households to receive Food Stamp coupons that are equivalent to the difference between the face value and the purchase price of the old Food Stamp coupons (under the 1964 Act)

HR 3 - Medicare-Medicaid Anti-Fraud and Abuse Amendments Act (October 1977), PL95-142 provides 90 percent federal funding to states to set up investigation and prosecution fraud units in Medicare and Medicaid program

ineligible shopping - an enforcement technique in which the Compliance Branch of the U.S. Department of Agriculture hires community members to shop for ineligible Food Stamp purchases to monitor retailer and wholesaler compliance with program regulations

intermediaries/carriers (auxiliary providers) - organizations which contract with program agencies (usually Medicare or Medicaid) to assist in benefit delivery, such as claims processing, e.g., in the Medicare program carriers handle Part B claims, while intermediaries process Part A claims for the third party providers

Law Enforcement Assistance Administration (LEAA) - created by Congress in 1968 under the Omnibus Crime Control and Safe Streets Act of 1968 "to assist State and local governments in strengthening and improving law enforcement and criminal justice at every level." LEAA provides financial and technical assistance to states, cities, and counties to improve police, courts, corrections, probation, parole, juvenile justice, and assist community crime prevention efforts

Office of Comprehensive Employment Development Programs (OCED) - has major responsibility for implementation of the Comprehensive Employment and Training Act of 1973 (CETA) and the work incentive program (WIN)

Office of Inspector General - the office in federal departments or agencies which conducts and supervises audit and investigation activities relating to programs and operations in the departments or agencies; Inspector General offices have been established, by law, in the Departments of Agriculture, Commerce, Energy, HUD, HEW, Interior, Labor, and Transportation, as well as the General Services Administration, NASA, VA, Community Services Administration and the SBA

Office of Management and Budget (OMB) - in the Executive Office of the President, responsible for federal budget development, administration, and enforcement, as well as other administrative and control activities related to executive department operations and personnel

overutilization - a fraudulent or abusive practice in the medical benefit programs in which providers or recipients make use of reimbursable services in an unnecessary or excessive manner; utilization profiles of services provided or accepted (to establish norms for utilization) are compiled by state Medicaid anti-fraud units

packaging - in housing loan programs, FmHA regulations allow developers or builders providing large developments or tenant housing to submit packaged applications to county offices

postpayment system - a form of benefit delivery in which benefit payment is made based upon actual costs incurred or resources accumulated in an established time period prior to benefit delivery

prepayment systems - a form of benefit delivery in which advance benefit payment is made in anticipation of estimated costs to be incurred or resources expected in an established time period following the benefit delivery

prime sponsor - state, unit of local government, consortium of local governments or agency (private or non-profit) that delivers benefits or contracts to delivery benefits, and deals directly with the benefit program sponsoring agency

pyramiding - the practice of masking ownership patterns (e.g., nursing home operation) to qualify for cost reimbursements under benefit programs such as Medicare and Medicaid

scrip benefits - benefits issued in the form of a certificate that entitles the recipient to exchange the certificate for a good or service; specifically, in this study, Food Stamp coupons

Small Business Administration (SMA) - provides guaranteed, direct, or lender participation loans to small business concerns to help them finance plant construction, conversion, or expansion; and acquire equipment, facilities, machinery, supplies, or materials. SBA also provides them with working capital. The agency makes, participates in, or guarantees economic opportunity loans

Social Security Administration/Social Security Insurance (SSA/SSI) - the Department of Health, Education and Welfare administers a national program of contributory social insurance whereby employees, employers, and the self-employed pay contributions, which are pooled in special trust funds. When earnings stop or are reduced because the worker retires, dies, or becomes disabled, monthly cash benefits are paid to replace part of the earnings the family has lost. SSA administers the AFDC program

Social Security Insurance (SSI) - replaced federally aided state assistance programs for the aged, the blind and disabled (see Social Security Administration) in 1977 in HEW

steering - direction of a patient to a particular pharmacy by a physician or anyone else in a given medical center; violation of the patient's freedom of choice

Surveillance Utilization Units - creates provider and patient profiles of utilization of medical services and analyzes the utilization patterns; specifically used in the Medicaid program in conjunction with state anti-fraud units

tailoring - work performance not specifically described in a contract as the same type of work to be done

taxonomy - a systematic arrangement of fraud and abuse offenders and offenses; used as a tool for identifying commonalities of vulnerability across a universe of programs

third party determinations - establishment of elibibility to participate in a benefit program as a third party provider

third party providers - those persons or agencies charged with responsibilities for providing benefit services on contract with the sponsoring agency

upgrading - the practice of billing for a service more extensive than that actually provided; a physician may treat a suspected cold, for example, and bill for treating acute bronchitis

wage reporting state - by law a state which required employers to report wages paid to employees on a regular basis, and therefore maintains wage records that may be used for cross-match purposes

wage requesting state - a state which does not require employers by law to report wages paid to employees, and the state therefore does not have employee wage records to be used for cross-match purposes

APPENDIX A: PROGRAM PROFILES GROUPED BY BENEFIT TYPES

Program design vulnerabilities were addressed in this report as a major concern in the search for solutions to fraud and abuse. At the basis of program design, however, is the nature of the benefit offered. Program design evolves in large part from the type of the benefit assistance provided. Programs offering contract services as benefits will, of necessity, be designed differently from those offering scrip as benefits. The importance of these design variabilities is that some benefits appear more susceptible to certain patterns of fraud or abuse than others. This appearance is confirmed in testimony given by the Comptroller General of the United States before Congress:

> Some of the programs that would seem to be particularly susceptible to fraud are those involving a significant amount of contracting and procurement...In addition, programs involving loans, grants, and benefit payments appear to be particularly vulnerable.[1]

In this Appendix, commonalities of fraud and abuse patterns are explored from the perspective of the benefit types involved. The generalized program profiles which follow cover aspects of program design and program enforcement for each of the fifteen benefit programs reveiwed. The benefit types which are discussed and the programs associated with them are as follows:

BENEFIT TYPE	PROGRAM
Cash	Aid to Families with Dependent Children
	Veterans Education
	FDDA Disaster Grants
	Unemployment Insurance Compensation
Scrip	Food Stamps
Loans	SBA Disaster Loans
	Rural Housing Loans
	VA Housing Loans
	Rehabilitation Housing Loans

[1]Statement of Elmer B. Staats, Comptroller General of the United States Before the Committee on Budget, United States Senate, "GAO Efforts Related to Fraud, Abuse, and Mismanagement in Federal Program," March 15, 1978, p. 11.

BENEFIT TYPE	PROGRAM
Service	Medicare Medicaid Summer Food Service CETA Vocational Education
Contract	8(a) Minority Contracting

PART A: CASH AS BENEFIT

Cash benefits are provided to eligible recipients in the form of government issued checks. These checks are either mailed to the recipient or are obtained in person depending upon program regulations or restrictions.

From a program design perspective, cash assistance exhibits the most simple organization of all the benefit types. There are only two major financial transaction points - check issuance and check cashing. Under fraud and abuse-free conditions, the check moves through only three hands - the sponsoring agency, the recipient, and the check cashier. Simplicity in this case, however, does not forestall vulnerability.

While cash benefits are not plagued with problems of third party reimbursements or complex subcontracting arrangements (from which opportunities for fraud usually evolve), they are vulnerable to patterns of stealing, embezzlement, or theft; tampering, forgery or counterfeiting, and misapplication of funds once the checks are cashed. These crimes may be committed by eligible or ineligible recipients, by agency employees, or by syndicated interests desiring to obtain profits from illegal check cashing operations.

The major detection techniques currently used for cash assistance frauds or abuses are recipient complaints to authorities about stolen or lost checks; anonymous leads, telephone tips, or formalized leads from enforcement agencies, e.g., FBI leads on check cashing and theft rings; or in instances of tampering, visual or mechanical examination of checks for authenticity of signatures. On some occasions, routine audits of program records have uncovered embezzlement schemes.

Under this heading of cash assistance benefits, programs offering income, educational and disaster support are profiled below.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Type of Benefit: Cash

Sponsor: U.S. Department of Health, Education, and Welfare

Project Administration: Federal formula grants made to states for state supervised or state administered money payments made directly to eligible families.

OVERVIEW

The Social Security Act of 1935, as amended (42 U.S.C. 601 *et seq.*, 1201 *et seq.*, 1351 *et seq.*, 24 U.S.C. *et seq.*) authorizes the Aid to Familes with Dependent Children (AFDC) program. State and local welfare agencies operate the program under HEW-approved state plans and must comply with all federal regulation governing aid and assistance to needy families with dependent children. Program objectives set general standards for state administration, provide federal financial shares to states, and monitor the performance of the state programs. The federal share for AFDC is based on a state's average monthly payment of $32 per recipient (and $100 per child in foster care). The federal share of payments is determined by individual computation and is subject to statutory ceilings.

Assistance payments from states are made directly to eligible needy families to cover costs of food, shelter, clothing and other items of daily living recognized as necessary by each state's programs. Within AFDC programs, payments are also made for the care of specified children in foster homes or institutions. In addition, federal funds may be available for home repairs for recipients (up to $250 per home). Federal funds for state and local administration of programs are for costs of interviewing public assistance applicants for eligibility determination and validation of eligibility costs of state and local personnel engaged in program direction and management and other on-going costs and activities relating to proper administration. The federal share for AFDC programs in fiscal year 1978 was $6,474,000,000, and an estimated $6,773,000,000 will be granted in fiscal year 1979.[1]

Eligibility

Assistance under the AFDC program is available for needy families with dependent children who are deprived of parental support

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance 1978, (Washington, D.C.: U.S. Government Printing Office, May 1978), pp. 350-351.

by the death, incapacity or continued absence of a parent. In certain states, a father's unemployment will qualify a family for AFDC payments. The average monthly number of AFDC recipients nationwide for FY 1978 and FY 1979 is estimated at 11, 014,000 and 11,022,000, respectively, suggesting that the program serves many needy persons. The states are responsible for the determination and validation of beneficiary eligibility. By federal program regulation, redetermination of eligibility for each AFDC case is required every six months.

Administrative Responsibilities

States are responsible for AFDC program administration and eligibility determinations. The state may administer the program exclusively on a state level or supervise the program administration by local level agencies. The Social Security Administration of HEW and its regional offices are charged with supervision and surveillance of state and/or local agencies to ensure compliance with federal regulations. Federal supervision includes reviews and analysis of the mandatory quality control efforts of each state. The states are awarded funds quarterly on the basis of their estimates of maintenance assistance and administrative costs. State estimates are based on the formula of federal and state funding as outlined in individual state plans. There is a federal average maximum of funding. The beneficiaries receive monthly assistance payments from the state and local welfare agency.[2]

AFDC Loses

AFDC losses (both state and federal) are usually ascribed to program abuse and error, rather than fraud. Error rates by state and local governments administering AFDC are measured by HEW in terms of payment errors and the percent of cases containing errors. Regular reports are made to Congress on Departmental efforts to reduce the error rates. The most recent measuring period, June to December 1977, showed a slight increase in the program error rates. Payment error rates consist of payments made to ineligible persons and overpayments to eligible beneficiaries as a percent of total payments. Underpayments to beneficiaries are not included when computing payment error rates. Case error rates are the percent of inaccurate cases out of the total number of cases. The loss to

---

[2]The amount of assistance for each beneficiary is computed by the state plans formulae certified by HEW and the determination of need.

AFDC through fraud, abuse and waste in payments (including the error rate) was estimated at $475 million for fiscal year 1977.[3]

Administrative Cost Overclaims

Another area which has been identified as a major source of loss to the AFDC program involves states overclaim for administrative costs. The overclaims findings of HEW's Audit Agency include non-compliance with federal criteria, incorrect rates of federal financial participation, and claiming ineligible costs. Recommendations for the Audit Agency to prevent the overclaims call for more aggressive reviewing and monitoring of state agencies' claims and the imposition of sanctions or other deterrents in cases of irregular claims.[4]

Program Expenditure Strategy

Since 1972, AFDC federal regulatons have required states to use quality control methods for computer sampling of error rates. The techniques assist states in targeting errors and provide administrators with error and suspected fraud profiles. The state agencies must review for eligibility determination a sample of approximately 45,000 recipients every six months. As an incentive for developing computer information systems to improve and standardize models of quality control, the federal government reimburses the state for the development of such systems. The information systems must be certified by HEW to qualify for cost reimbursement. It has been recommended that an AFDC Management Institute, modeled along the lines of the Medicaid Management Institute, be established to assist in the state's development of management information systems.

Because eligibility errors account for the major problems in AFDC, initiatives on the state and federal levels have focused on eligibility verification procedures to reduce the error rates. The most notable and widely used approaches involved computer matching of AFDC rolls with other agencies' rolls, local, state and federal wage reports and payrolls. Many states have conducted interjurisdictional matches of AFDC rolls as well as cross-agency comparisons to identify duplication of recipients (by name, social security number and address) and to verify income reporting. HEW, in 1977, instituted Project Match which locates potentially ineligible welfare recipients on federal payrolls (civilian and military) to be reviewed for eligibility. The pilot test was made in the

[3]Office of Inspector General Report, April 1, 1977-December 31, 1977 (Washington, D.C.: U.S. Department of Health, Education and Welfare, March 31, 1978), p. 18.

[4]Inspector General Report 1977, op. cit., p. 109.

District of Columbia; enlarged projects then were designed on a national scale, and are to be conducted on a continuing basis.

Computer Matching

Project match is the first national effort to cross-match AFDC rolls with employee wage records. It involves a multi-step procedure in which many safeguards are built in to guard individual privacy during the procedure. HEW makes the initial match of employees and AFDC recipients. Any "raw hits", or names found on both rolls, are then subject to employment and income verification by the federal employer and eligibility redetermination by state or local agency. The result is either prosecution by a U.S. Attorney or the beneficiary's grant is adjusted or denied. Any necessary administrative action by the federal employer is also taken. Through the process, the match records are destroyed during each phase. The original computer tape files are destroyed or returned to the respective agencies at the conclusion of each Project Match. Major obstacles to overcome, in order to extend similar match programs to the states, are the incompatibility and varying levels of sophistication in the states' computer technology and the privacy issue regulations which govern each jurisdication. From the outset of Project Match, there was considerable concern for the privacy rights of individuals being matched and for the security of the data supplied on the data tapes. At the federal level, there were limited guidelines for safeguarding the individuals' privacy and confidentiality. However, some states have well defined privacy regulations that conflicted with Project Match intentions. The Office of Management and Budget recently drafted (August 1978) more specific guidelines to the Privacy Act of 1974, to allow Project Match activities to proceed.

National Recipient System

The 1977 welfare reform legislation appropriated funds for the development of a federally operated national recipient system (NRS). The NRS will provide information on AFDC cases for purposes of detecting fraud and abuse. The functions of the NRS follow.

- An interstate name search is conducted to discover duplicate payments. Name, date of birth, sex, social security number and case or client number are checked.
- Social Security numbers are verified in conjunction with Social Security's NUMBERDENT System which lists all SSN's by verifying name, date of birth, and sex.
- Income of all federal benefit programs is verified comparing beneficiaries' income reports with federal files.

Names will be matched with agency files from HEW's Master Beneficiary System, the Social Security Income program, V.A.'s pension disability program and the Civil Service Commission. All information from the system will be turned over to the states and appropriate agents in HEW (the Inspector General, quality control, etc.) for any necessary actions. The system will not interfere with states' current quality control procedures, but will provide quality control with better data projectsion when it becomes operational.

Training

The Social Security Act authorizes federal funding to assist state and local agencies with employee training programs. The states are reimbursed for 75 percent of costs associated with educational leave and in-service education and training for persons preparing to work in public assistance programs. Workshops and seminars are also provided.

Many states provide special training for AFDC agency employees to deal with program fraud and abuse. The training programs are sponsored by Legal Services Divisions or are contracted to outside consultants. The training programs concentrate on detection and investigation techniques as well as evaluative information and assistance in establishing fraud units.

As in quality control efforts, significant attention in the prevention and deterrence of fraud and abuse is directed toward eligibility determination programs. A rigid, efficient application intake process eliminates opportunities for fraud and the redetermination procedure is a viable detection method to back up the initial eligibility casework.

Improved methods of detection of irregular payments or practices continues, but it is often difficult to determine whether a case involves actual fraud (indicated by multiple social security numbers for an individual) or administrative and system errors. The current trend in AFDC fraud and abuse control appears to be toward removing investigation responsibilities from caseworkers and developing referral processes to place suspected fraud or abuse cases in the hands of separate investigation units. There have also been requests for higher level Congressional funding for state AFDC fraud units, commensurate with appropriations in the Medicaid Program.

Although there is recourse to prosecution for individuals found to be defrauding the program, there is a reluctance on the part of the judges and jurors to penalize the beneficiaries because it seems to compound the basic welfare problem of caring for children. Similarly, it is extremely difficult, and often impossible, to recoup overpaid benefits from AFDC recipients with the meager incomes that qualify them for participation. Several court decisions stand in the way of recoupment from indigent families.

Program administrators and public welfare experts are seeking alternative methods to criminal prosecutions to preserve the program's objective of aiding dependent children. Methods focus on prevention and deterrence through fraud warnings placed on applications. Publicity regarding criminal penalties is directed to beneficiaries.

UNEMPLOYMENT INSURANCE COMPENSATION

Type of Benefit: Cash

Sponsor: U.S. Department of Labor

Program Administration: Decentralized in a federal-state partnership offering grants to states for program operations

OVERVIEW

The Unemployment Insurance (UI) program is authorized in the Social Security Act of 1935, as amended 42 U.S.C. 501 *et seq*.; 1101 *et seq*.

Its purpose is:

> to administer a program of unemployment insurance for eligible workers through federal and state cooperation and to administer payment of worker adjustment assistance.[1]

To meet these objectives, covered employers pay a payroll tax on the first $6,000 of each employee's earnings. State unemployment insurance money is held in trust funds and is allocated to the states solely for the payment of benefits. Federal unemployment insurance money is used to finance the administration of the state programs. If a state's trust fund becomes depleted, the federal government will supplement it, so that all eligible workers may receive the benefits to which they are entitled.

The original intent of the Unemployment Insurance legislation was to tide workers over during short periods of unemployment while they looked for another job. The volume of payments varies directly with the level of unemployment. Therefore, during an economic downturn, there is usually an upsurge in applications for Unemployment Insurance.

Legislation extending benefits to a maximum of 39 weeks has been passed to cover workers during prolonged periods of unemployment. When unemployment in the state reaches a specified level, there is provision for extended benefits. During prolonged periods of unemployment, extended benefits are available for half the number of weeks for which the recipient originally collected UI,

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 573.

up to a maximum of 39 weeks. When extended benefits are required, the costs are shared equally by the state and the federal government.

About 97 percent of wage and salary workers are covered by UI. Veterans with recent service and civilian federal employees are covered by a separate program in which the states pay benefits of the federal government. Railroad workers are also covered by a separate federal program.

In recent years, unemployment benefits paid have been greater than the unemployment taxes collected. However, the estimates for fiscal years 1978 and 1979 show a reversal of this trend.

TABLE XII: U.I. BENEFITS PAID

Billions of $ / Years	Taxes Collected	Benefits Paid
1976	$ 6,404	$18,348
1977	$ 9,252	$14,221
1978 (est.)	$11,600	$11,241
1979 (est.)	$13,800[2]	$10,647[2]

BENEFITS AND ELIGIBILITY

Each state sets the level and duration of benefits, as well as eligibility standards. Consequently, benefits vary widely from state to state. Maximum weekly benefits range from $80 to $183. In general, UI is financed exclusively by the payroll tax on employers. However, there are three states which require employer contribution to the UI system.

---

[2]Office of Management and Budget, Catalog of Federal Domestic Assistance (Washington, D.C.: U.S. Government Printing Office, May 1978), pp. 573 and Office of Management and Budget, Update to the 1978 Catalog of Federal Domestic Assistance, (Washington, D.C.: U.S. Government Printing Office, 1978), p. E-45.

Each state UI law must be approved by the Secretary of Labor. Criteria for approval of state plans include the following:

- Methods of administration which will insure full payment of unemployment compensation when due.
- Unemployment compensation payment through public employment offices or through other approved agencies.
- Fair hearings to individuals whose claims for unemployment compensation have been denied.
- Payment of all funds collected to the Federal Unemployment Trust Fund.
- All of the money withdrawn from the fund will be used either to pay unemployment compensation benefits, exclusive of administrative expenses, or to refund amounts erroneously paid into the fund.
- Submitting reports required by the Secretary of Labor.
- Providing information to federal agencies administering public work programs or assistance through public employment.
- Limiting expenditures to the purposes and amounts found necessry by the Secretary of Labor.
- Repayment of any funds the Secretary of Labor determines were not spent for unemployment compensation purposes or exceeded the amounts necessary for proper administration of the state unemployment compensation law.

Although each state is responsible for setting its own eligibility criteria, there are some basic elements which are common to most state programs. Under all state unemployment insurance laws, a worker's benefit rights depend on his or her experience in covered employment in a past period of time, called the base period. All states require that an individual must have earned a specified amount of wages or must have worked for a certain period of time within his or her base period, or both, to qualify for benefits. The purpose of such qualifying requirements is to restrict benefits to workers who are genuinely attached to the labor force.

All states specify a weekly benefit amount, i.e., the amount payable for a week of total unemployment as defined in the state law. This amount varies with the worker's past wages within mini-

mum and maximum limits. The period of past wages used and the formulae for computing benefits from these past wages vary greatly among the states.

Usually a week of total unemployment is a week in which the claimant performed no work and received no pay. In most states, a worker is defined as partially unemployed in a week if he or she earns less than his weekly benefit amount. The benefit payment for such a week is the difference between the weekly benefit amount and the part-time earnings, usually with a small allowance as a financial inducement to take part-time work.

All state laws provide that to receive benefits, a claimant must be able to work, must be seeking work, and must be available for work. Also he must be free from disqualification for reasons such as voluntary resignation without good cause, discharge for misconduct connected with the work, and refusal of suitable work. The purpose of these provisions is to limit payments to workers unemployed primarily as a result of economic causes.

In all states, claimants who are held ineligible for benefits because of inability to work, unavailability for work, refusal of suitable work, or disqualification are entitled to a notice of determination. Claimants also have the right to appeal the determination.

OPPORTUNITIES FOR FRAUD

Several different types of fraud and abuse have been found to occur in the UI program. They can be divided into the following categories:

- Recipient fraud.
- Employer fraud
- Administrative agency fraud.

Recipient Fraud

Recipient fraud exists when a claimant misrepresents or conceals facts for the purpose of obtaining benefits to which he or she is not entitled. Such fraud typically may involve:

- Unreported or incorrectly reported earnings.
- Fictitious employment.
- Simultaneously claiming benefits in more than one state.

- Misrepresenting employment status, especially in applications for extended benefits.
- Misrepresenting the reason for unemployment.
- Misrepresenting availability for work and efforts to find work.
- Receipt of vacation pay while collecting benefits.
- Collecting UI in one state while having a job in another state.

The role of intent is critical in proving fraudulent claims. For example, if a claimant receives benefits knowing that he or she is ineligible, then the claimant has attempted to defraud the government. However, if the claimant has received claims because of a lack of understanding, he also cannot be held liable for fraud. For example, a claimant may not understand the criteria or availability for work. Therefore, there is no intent to defraud the UI system. Once availability is explained by the UI claims officer, however, it is anticipated that the recipient will abide by those regulations.

Some recipient fraud is the result of a program design, which makes the system more vulnerable. For example, about half of the states allow mail-in claims for continued certification of UI benefit eligibility. This procedure is especially helpful during periods of economic downturns, because of the heavy pressure to turn out a high volume of UI payments. On the other hand, it does make those particular state UI programs more vulnerable to recipient fraud. It is easier for a claimant to work at a job and still apply for benefits if he can do so by mailing a form in to the office. Thus, the claimant can defraud the system of some extra weeks of benefits.

Stolen checks and forged endorsements are two other frauds which have occurred in UI. They are not necessarily recipient frauds since, theoretically, anyone can steal a check and/or forge an endorsement. However, such activities are included with recipient fraud, because the checks are intended for claimants.

Employer Fraud

The major employer frauds found in UI involve misreporting of wages and/or misrepresenting the reason(s) an employee has left a job. Such frauds generally are intended to increase the amount of benefits to which a claimant is entitled, or to gain benefits for a person who would otherwise be ineligible.

Another fraud committed by employers is the creation of a fictitious employee by falsely reporting wages and paying the unem-

ployment tax for him or her. The "ghost" employee later becomes "unemployed", and his or her UI benefits are collected by the employer.

Employers or recipients can create fictitious employers; a fraud which has as its aim to create the appearance of an "employer" having paid unemployment tax so that the "claimant" would seem qualified to collect benefits. Fictitious employers are sometimes created by activating inactive claims, that is, where a legitimate employer has gone out of business.

Administrative Agency Fraud

Administrative agency personnel have sometimes been found to collude with claimants. For example, if a claimant is not conducting as active a job search as required by state law, a claims deputy may help him or her to "pad" the information on employers contacted and so on.

Additionally, during an economic downturn, there is usually an upsurge in applications for Unemployment Insurance. In order to meet this peak demand, a state agency may add temporary employees who are not as well trained and familiar with the requirements for UI eligibility as are regular agency staff. Eligibility determinations done by temporary workers, therefore tend to have a higher rate of error, although they may not be fraudulent in intent. Also, during a peak demand period, states may shortcut established checks on eligibility. The result is qualifying ineligible recipients for benefits.

Methods of Detection and Enforcement

One of the best ways to reduce fraud is to design a program in such a way that the opportunity to commit fraud is reduced. About one fourth of all applicants for UI are determined to be ineligible, indicating strong quality control at the outset.

Another deterrence to fraud is publicizing the fact that fraud is a crime in all states and is punishable by law. Most states include in their unemployment insurance law a provision for a fine (maximum $20 to $1,000) or imprisonment (maximum ten days to one year), or both for fraudulently claiming benefits. In addition, all states have the right to disqualify recipients for fraudulently claiming benefits.

States also have provisions for recovering those benefits which have been obtained fraudulently. Agreements have been signed between state governors and the U.S. Department of Labor concerning responsibilities for dollar ceilings on recoveries. States are responsible for recoveries of monies up to $1,000. Amounts over $1,000 become the responsibility of the Department of Justice and U.S. Attorneys.

During 1976 the government was able to identify 103,300 fraudulent claims. Nationally, the detection and enforcement techniques have been fairly successful. Forty-two percent of fraudulent benefit payments have been recovered. In addition, 65 percent of the prosecutions lead to convictions. The following tabulation summarizes the results of state fraud detection efforts for fiscal year 1976.[3]

Number of fraudulent claims	103,300
Amount of fraudulent payments	$32,000,000
Amount of fraud restitutions	$13,400,000
Number of prosecutions	9,950
Number of convictions	6,430

The states employ a variety of methods to detect improper payments. Probably the most productive technique is the quarterly cross-match, which involves comparing benefit payment records with wage informaton for the same quarter. Using a sampling formula, the states select cases for further investigation to determine if the claimant failed to report wages during weeks benefits were collected.

Most states (39) maintain quarterly wage records that are used in the cross-match. Those states which do not maintain wage records, formerly used wage information provided by the Social Security Administration. However, in 1975, the Social Security Administration issued an interpretation of the Privacy Act of 1974 precluding the release of individual social security data to the state employment security agencies without the informed written consent of the claimant. As a result, these states had adversely impacted their programs for fraud and overpayment detection. The affected states include such large states as New York, New Jersey, Massachusetts, Michigan, and Ohio.

Other detection techniques include matching unemployment insurance recipient rolls with recipient rolls of other benefit programs. The latter procedure detects those who are collecting UI benefits in more than one state. However, all states use these techniques.

Claims deputies can refer questionable UI application to another section of state's Employment Security Administration or to the state's Attorney General for investigation. Program fraud units are an important part of this enforcement technique, which serves to detect and deter fraud. Preceding a full-fledged investigation, there may be further fact-finding done by the claims deputies themselves.

---

[3]U.S. Department of Labor, "Fraud and Abuse in the Federal-State Unemployment Insurance System"(mimeographed January 1977).

Employers can also help detect and report fraud. Benefits paid are reported to employers. If an employee is back at work and has not shown up in the wage-reporting system, the employer can report it to the administrative agency and stop the "double-dipping."

The number of claims in a state can be responsible for how well program controls operate to detect and prevent fraud and misuse. A large caseload makes it more difficult to provide complete quality control, especially during periods of economic recession. In fact, during recession periods, there have been direct policy guidelines from the national office that enforcement efforts should be eased in order to get unemployment insurance benefits out to those who are eligible as quickly as possible. In these cases, payments made to ineligible recipients is caused by staff error rather than an intent to defraud the system.

The U.S. Department of Justice and U.S. Department of Labor have worked together to uncover UI program misuse. State programs are audited by the U.S. Department of Labor every other year, with follow-up recommendations made to the states. Some states have task force teams of Justice and Labor people who are responsible for investigating and prosecuting fraud. A number of states participating in the task force efforts feel that public media coverage of UI investigations and prosecutions acts as a deterrent; however, they believe that there is not enough publicity given to these at this time.

VETERANS EDUCATIONAL ASSISTANCE (G.I. BILL)

Type of Benefit: Cash (Monthly stipend or loan while enrolled in school)

Sponsor: Veterans Administration

Program Administration: Decentralized to educational training institutions, with built-in procedure checks from central Veterans Administration

OVERVIEW

The legislative authority for the G.I. Bill is found in 38 U.S.C. 1661 (1944), as amended. Its purpose is:

> to make service in the armed services more attractive by extending benefits of a higher education to qualified young persons who might not otherwise be able to afford such an education, and to restore lost educational opportunities to those whose education was interrupted by active duty after January 31, 1955 and before January 1, 1977.[1]

To meet these objectives, several different types of education are supported by the Veterans Administration. They are:

- College level training
- Trade and vocational training
- Correspondence training
- On-the-job training

In addition, those veterans who have neither completed high school or received an equivalency certificate may work towards these goals, without charge to their basic entitlement.

During fiscal year 1977, almost two million veterans and service personnel participated in training programs of all types. Among them, 1.4 million (71%) were enrolled at the college level, 444,000 (23%) were at schools other than college, and 112,000 (6%) were in on-the-job training programs.

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 806.

In fiscal year 1976, over $5 billion were paid to the more than 2.8 million veterans and service personnel who undertook training programs. By FY 1977, total benefits wre down to $3.6 billion for two million students. Estimates for 1978 and 1979 indicate further declines in the number of students and a concurrent drop in total benefit payments.

ELIGIBILITY AND BENEFITS

Eligibility and benefits are determined by the veteran's length of service, the number of dependents, and his or her student status (full-time, part-time). In addition, these benefits are available only to honorably discharged veterans who have served at least six months. Benefits are paid from a minimum of nine months to a maximum of 45 months depending upon the length of time the veteran was in the military. Veterans who have served between six and 18 months are entitled to 1½ months of full-time benefits for each month served. Those who have served continuously for 18 months are entitled to the maximum 45 months of full-time benefits. Generally, veterans have ten years after discharge (but not later than December 31, 1989) to complete their education. The education assistance and subsistence allowances are shown in the following.

TABLE XIII

G.I. BENEFIT ALLOWANCES

		NUMBER OF DEPENDENTS			
		1	2	3	Each Add.
INSTITUTIONAL	Full-time	$311	$370	$422	$26
	Three-Quarter	233	277	317	19
	Half-Time	156	185	211	13
APPRENTICE-SHIP/ON-THE-JOB TRAINING	1st 6 Months	$226	$254	$277	$12
	2nd 6 Months	169	197	221	12
	3rd 6 Months	113	141	164	12
	Succeeding 6 Months	56	84	108	12 [2]

For correspondence and flight schools, the veteran's entitlement is charged at the rate of one month per each $311 and $288 paid, respectively. Those who entered the Armed Forces after January 1, 1977 may participate in a contributory payment plan for their education, whereby the Government matches the money deducted for education from the service person's pay on a two-on-one basis.

---

[2]Veterans Administration, Office of Education Benefits.

This plan is different from the G.I. Bill, and will ultimately replace it completely (by December 31, 1989).

In some situations when a veteran's educational benefits are inadequate to meet his educational expenses, he becomes eligible for a loan. These loans are available for educational needs only, not for other expenses. Therefore, they are perceived by many as hard to get, especially if a student is attending a public or other relatively low-cost school, where the benefit allowance alone more than covers the cost of education.

The procedure for applying for a loan is roughly as follows:

- The loan application must go through the educational institution
- The accuracy of the tuition, fees and supplies that are claimed are verified by the institution
- The institution must certify that the expenses are reasonable.

Normally, Veterans Administration does not follow up with verification of loan applications but assumes that the information from the institution is accurate.

In fiscal year 1977, more than 14,000 loans were granted to veterans at a cost in excess of $14 million. This was an increase from the 9,207 loans made in FY 1976 for $5.1 million.

OPPORTUNITIES FOR FRAUD

Recipient Fraud

The records of all eligible veterans are maintained on a central computer system entitled Benefit Identification Locator Subsystem (BILS). As institutions submit forms for eligible veterans who have enrolled as students, the VA regional office checks them through BILS. Thus, there may be as much as an eight week lag from the submission of forms to receipt of the first benefit check. After a student is certified, the VA assumes he or she is continuing in school for the balance of the term unless the VA is notified of a change.

As a result, it is possible for a student to change his or her curriculum or the number of hours he or she is carrying, or to withdraw completely and continue to receive benefits. In some instances, certifying clerks at non-college and technical school have entered into collusive agreements with veterans to defraud the government. The veterans then pay kickbacks to the clerks. Another way for a veteran to abuse the program is to give inaccu-

rate information on his application form, i.e., misstatements concerning the number of dependents or the number of credit hours or amount of training.

Provder Fraud

Fraudulent practices by providers are found in all types of education, although they appear more frequently in trade schools. Institutions have acknowledged that once students are certified, they can remain on the rolls indefinitely. Other schools admit to creating "ghost" enrollees, and, in fact, receive the educational benefits. Some trade schools have attested to training many more students than their physical plant can accommodate.

Occasionally, inappropriate payments are the result of administrative oversight or processing lags and are not a conscious effort to defraud the VA. These oversights and processing lags are inherent in any system which depends on providers informing a central paying authority of changes in status. When overpayments occur, they are usually recouped from subsequent payments to the veteran.

DETECTION AND ENFORCEMENT TECHNIQUES

Basically, there are two ways of reducing the incidence rate of fraud. One is through designing a program in such a way that the opportunity for committing fraud is eliminated. The other is through an efficient monitoring system of both the veteran and the educational institution.

In 1977, the law was changed so that prepayment of benefits is no longer allowed. Since then, overpayments have declined considerably. In this instance, a change in the design of the program proved to be an effective anti-fraud strategy.

The basic quality control procedure utilized by the VA to detect possible fraudulent practices is the Compliance Survey. Nationally, there is a staff of 245 VA compliance officers to inspect the institutional facilities to assure that there is compliance with VA regulations. Colleges and universities with large veteran enrollments are monitored on a regular basis. The auditors select, at random, the records of ten percent of students enrolled with veterans benefits. If problems are found, 100 percent audits are done. For correspondence and flight schools, annual inspections are required.

The general computer system (BILS) minimizes the opportunities to create "ghost" enrollees by checking the accuracy of each person's discharge and entitlement information. In addition, there are backup checks of specific attendance rosters on an on-going basis. Attendance rosters are matched with certification cards, sent to the school each semester by VA, to determine whether, in fact, the student had attended class.

If an overpayment results from an action taken by an institution, liability can be established against the institution. Presently, the VA has the authority to place a moratorium on the participation of an institution which is alleged to have defrauded the program, without what is considered proper due process proceedings. In Colorado, a court decision which held that the law as written does not provide proper constitutional procedures for due process, is not being appealed. VA is arguing that the agency does not fall within the Administrative Procedures Act, and therefore, the notice requirements that have been set down by the agency are constitutional.

DISASTER ASSISTANCE

Type of Benefit: Cash grants to individual families and to localities

Sponsor: Department of Housing and Urban Development, Federal Disaster Assistance Administration (FDAA)

Program Administration: Decentralized through Regional Offices of the FDAA

OVERVIEW

The current legislative authority for the disaster assistance program is found in the Disaster Relief Act of 1977, P.H. 93-288, 88 Stat. 143. The major objective of the disaster relief program is:

> to provide assistance to states, local governments, owners of selected private nonprofit facilities, and individuals in alleviating suffering and hardship resulting from emergencies or major disasters declared by the President.[1]

The program is designed to supplement the efforts and available resources of state and local governments and voluntary relief organizations. The Administrator of Federal Disaster Assistance allocates funds from the President's Disaster Relief Fund for use in a designated emergency or major disaster area. Besides direct grants to families, non-profit agencies, and local governments, FDAA coordinates the provision of emergency food stamps, unemployment assistance, legal and psychiatric services and temporary housing during disasters and other emergency situations. These services are generally provided by other government agencies, which are subsequently reimbursed from the Disaster Relief Fund for disaster work performed at FDAA's direction. States are responsible for distributing funds to local governments.

In fiscal year 1976, 40 major disasters were declared in 24 states and four territories; four emergencies were declared in four states; and one fire suppression grant was made. During fiscal year 1977, 18 major disasters were declared in 14 states; 36 emergencies were declared in 31 states; and six firm suppression grants were made.

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance, 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 474.

Total grants are as follows:

1977	$363,695,000
1978 (estimated)	$450,000,000
1979 (estimated)	$200,000,000

Grants have ranged from $49 to $28,613,824.[2]

Once the disaster is officially declared, FDAA personnel go into the location where the disaster has occurred and set up a "disaster assistance center", which is a one-stop center. Within this center, state and federal representatives are assigned booths to explain and accept applications for individual disaster relief programs operated by various federal and state agencies. One-stop centers are usually open ten hours a day, all day Saturday and Sunday. There are outreach operations with mobile vans and trucks. There is an aggressive public information campaign that occurs at the time of the disaster with bulletins placed on radio and television and in the printed news media. Printed flyers are distributed by Boy Scout groups, or in rural areas delivered by the postal service.

There are approximately 68 persons in the central office and 100 person in the regional offices administering the disaster assistance program. Temporary employees, such as typists and receptionists, can be hired without Civil Service status to serve in the one-stop centers. In addition, there is usually a reserve of retired persons who can move from disaster to disaster to assist where needed. All other federal agencies must provide their own staff at the disaster sites. In addition, FDAA staff may be placed on "mission assignments" to extend other agencies' staff responsibilities.

BENEFITS AND ELIGIBILITY

Once the President has declared an emergency or major disaster area, state and local governments can apply for assistance through the Governor's Authorized Representative to the Regional Director of the FDAA. Individuals apply for assistance to the appropriate federal, state and local government agencies.

Services are provided and grants and contributions are made available for suppression of forest or grassland fire, and for post-disaster assistance, including:

- Repair, restoration, or replacement of public facilities of states and local governments and selected private nonprofit facilities.
- Removal of wreckage and debris.
- Performance of essential protective work on public and private lands.

[2]Office of Management and Budget, Update ot the 1978 Catalog of Federal Domestic Assistance, 1978 (Washington, D.C.: U.S. Government Printing Office, 1978), p. E-40.

- Emergency shelter and temporary housing for displaced individuals and families.
- Assistance to unemployed individuals.
- Loans to local governments suffering substantial loss of tax and other revenues.
- Emergency transportation service.
- Emergency communications.
- Food coupons.
- Crisis counseling.
- Survey and allocation of construction materials.
- Individual and family grants to meet disaster related expenses or serious needs of persons adversely affected by a major disaster.

As soon as possible after a major disaster declaration, an estimate is made of the damage which is eligible for federal assistance. These estimates, included in initial Damage Survey Reports (DSRs), are prepared by federal and state agency representatives. The surveys set forth the scope of work and the estimated costs of repairing the damage.

The DSRs are the basis for the Project Application (PA) submitted under the Federal-State Disaster Assistance Agreement. The PA and accompanying documentation are submitted to the state by the locality. The state Governor's Authorized Representative reviews and approves the PA and forwards it to the FDAA Regional Director within 90 days of the disaster declaration date.

The FDAA also provides the Individual and Family Grants Program. These are outright grants made to families with serious needs not covered by any of the other assistance programs. In order to qualify for a grant, applicants must have been turned down by other federal agencies. Costs of these grants are borne in a federal-state formula. The maximum amount of a grant is $5,000 and the grants are administered by the states under plans submitted to FDAA. In order for a state to participate in the Family Grant Program, there must be a prior request from the Governor.

OPPORTUNITIES FOR FRAUD

When localities have used subcontractors, recordkeeping has sometimes been a problem. Applications for FDAA funds may not have been completed in a business-like manner, or the log of the work done, may have been inadequately documented. A varying percentage

of the total funds for a project may be advanced to the contractor or subcontractor, which can cause problems if the work is later found to be of substandard quality or the project is not properly documented.

Unreliable contractors and unreliable companies attempt to take advantage of the disaster situation by providing services and products that are substandard. This has been a particular problem with the mobile homes that have been sold for temporary housing.

The use of temporary employees at disaster sites has resulted in some fraudulent practices in determining eligibility for Individual and Family Grants. Temporary employees sometimes are so anxious to help disaster victims that they sometimes circumvent program regulations. When eligibility decisions for disaster relief are made by regular full-time personnel, there is less fraud, error, and abuse.

Grant funds are sometimes misused; that is, they are spent for purposes other than those intended by the Disaster Relief program. For example, the money may be used to make repairs unrelated to the disaster.

ENFORCEMENT METHODS USED IN DISASTER RELIEF

The federal coordinating officer, appointed after each disaster declaration is responsible for coordinating all federal assistance from other agencies as well as FDAA to the disaster scene. His/her responsibility entails compliance with all regulations dealing with the federal disaster effort and avoiding duplicate services. Regional directors are usually appointed positions, and during the time of a disaster, the federal coordinating officer will deal directly with the state coordinator for disaster relief. The regional offices of FDAA are on a par with the highest ranks of the Department of Labor and Small Business Administration, with whom they must coordinate.

The regional office directors are responsible for determining eligibility for funds from FDAA, and they are responsible for making advances of monies to the states. Records for all programs, particularly large construction and public works projects are kept by the locality, and inspectors are called in to examine the construction and the records at the end of the project. Final inspections of completed work are performed by state and federal inspectors to determine whether the work was done in accordance with the PA.

The audit section of the HUD office of Inspector General is composed of 300 auditors distributed among regional offices. They are full-time Civil Service personnel. All audits, no matter what their specific purpose is, look for fraud and abuse. Thus, audits are concerned with duplicate payments that may have been made, as well as procedures used for vouchering and billing. Every grant

over $25,000 made by FDAA is audited. Pre-audits are done before the release of monies; post-audits are done upon completion of the contracted work. An interim audit may be done where large sums, i.e., over $40,000 for hospitals, are involved. If regional auditors find irregularities in FDAA programs, the matter is referred to the Inspector General's Office.

Recoupment of overpayments to individuals or families has not been very effective because many of the recipients are indigent.

FOOD STAMPS

Type of Benefit: Scrip

Sponsor: U.S. Department of Agriculture

Program Administration: Direct federal payments to states for state supervised or state administered program for food assistance to eligible needy

OVERVIEW

The Food Stamp program, authorized by the Food Stamp Act of 1964, as amended by the Food Stamp Act of 1977 (7 U.S.C. 2011 *et seq.*) is a federal-state food assistance program operated cooperatively with state and local agricultural and welfare agencies. The Food and Nutrition Service (FNS) of the U.S. Department of Agriculture (USDA) is the agency responsible for federal administration of the Food Stamp program. The objective of the program is to supplement the food purchasing ability of low-income households with food coupons in order to improve their diets.[1] In FY 1977, monthly participation averaged 17.1 million persons receiving more than $5 billion. For FY 1978 and FY 1979, the Food Stamp program budgets are estimated to be $5.5 billion and $5.4 billion respectively.[2] Food Stamp coupons can be used to purchase staple foods or seeds and plants to grow food for the household's use. Elderly food stamp recipients may purchase meals from certain nonprofit meal delivery services and communal dining facilities.[3]

The Food Stamp program is operated through a network of entities including the Food and Nutrition Service, designated state agencies, food coupon issuers (formerly "vendors"), retail-wholesale establishments, and commercial and Federal Reserve banks. The Department of Agriculture promulgates national standards for the

---

[1]Other provisions of the Food Stamp Act allow for Food Stamp programs on American Indian reservations to be administered by the tribal organizations, instead of state agencies, if deemed appropriate by USDA; for "out-reach" activities to alert persons to public assistance programs and aid them in making application; and for nutrition education to inform beneficiaries of proper nutritional diets and menus and explanations of the relationship between diet and health.

[2]Office of Management and Budget, Catalog of Federal Domestic Assistance 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 43.

[3]In addition, food stamps can be used to buy hunting and fishing equipment in remote areas of Alaska.

the Food Stamp program and approves individual state plans for food assistance. The states must report to USDA periodically on their plans. FNS develops policies and procedures for administration of the program by federal, state and local agencies.

The state administering agencies receive from FNS 100 percent of the costs of coupons and 50 percent of the administrative costs, i.e., the costs of certification of households, acceptance, storage and protection of the coupons, administrative hearings, and control and accounting.

State and local agencies share the administrative task of certifying qualified households for food stamp benefits. Coupon issuers are responsible for maintaining and reporting inventories of coupons distributed and available. FNS certifies and monitors the coupon inventory levels through a computerized system and establishes standards for participation and reporting by coupon issuers, although the states actually contract with the issuers. USDA formulates the application regulations for retailer and wholesaler participation and issues certification of approval. Coupons received from beneficiaries for food purchases are redeemed by wholesalers and retailers at commercial banks, who are, in turn, reimbursed through the Federal Reserve system.

New eligibility standards in the 1977 Food Stamp Act allow more households to obtain food stamps than under the original mandate. Under the 1977 Act, households are eligible for food stamps if their income falls below the national poverty line (set annually by the Office of Management and Budget). Following certification, the household receives either a Household Issuance Record (HIR) card or an Authorization to Purchase (ATP) card that verifies a household's eligibility. New provisions also eliminate the need for beneficiaries to buy food stamp coupons of greater face value than the purchase price: they now receive coupons at no cost. The coupons, under the new law, are equivalent to the difference bewteen the face value and the purchase price of the old Food Stamps. The Food Stamp benefits for each household are based on the Department of Agriculture's Thrifty Food Plan, on household size and on income. The elimination of the purchase requirement allows those people to participate who were formerly eligible but could not afford the purchase requirement.

In the event of natural disasters, Food Stamp programs can be established in the affected area to provide temporary relief to victims. Under new regulations, the income and resources of victims are considered to determine food stamp eligibility. (Previously, they were disregarded.) States are required to develop plans to deliver disaster food assistance, and USDA is establishing a Food Stamp Disaster Task Force to assist states in conducting the disaster program. The Task Force will be available to go into disaster areas and provide direct assistance to state and local offices.

Audit Responsibilities

The Office of Audit, USDA, is responsible for the auditing and monitoring of the Food Stamp program. Several types of audits are done including audits of the Food Stamp Division and selected segments of the program, such as accountability or outreach activities. A cycle of audits for the entire administrative mechanism are phased as follows:

- Regional offices are audited annually;
- Selected state issuance agents are audited annually. Those chosen are usually the ones that do 65 percent of food stamp business - New York, Baltimore, Los Angeles, Philadelphia, Chicago, Miami, Washington, D.C.;
- Another 200 stamp agent sites are audited on the odd years; and
- Others are coordinated with state audits, but no agent goes without audit longer than a three year period.

Because of lack of funds and manpower, audits conducted in a state which show irregularities are given to the state immediately so that attention can be given to other areas in the state where the same irregularities may occur. When an irregularity in a program is cited, the Office of Audit is one of the first units called in. Audit reports go to Regional Offices, as well as to the central office. Follow-ups are done on all recommendations from audit findings. Because states are liable for over- and under-payments of food stamp benefits, state audits have great significance for recoupment.

Quality Control

The Food Stamp quality control system assists program administrators in determining the number of participating households that are eligible and receiving the appropriate amounts of benefits. Continuous reviews of statistical samples of Food Stamp households are made; however, the techniques vary from state to state. Although the quality control system is primarily a management tool, the errors detected in individual cases are referred to local agencies for adjustment and recoupment, if necessary. Any incidence

of overissuance of food stamps must be reported to the local certifying office for disposition.[4]

Other quality control tools are also in use. There are federal and state regulations governing beneficiary application and certification processes to ensure accurate eligibility information. Mandatory in-person interviews, mandatory mail updates, and various recertification requirements are examples.

Under the 1977 Act, USDA is to design a simplified uniform national Food Stamp application. State designed forms will be allowed only with special approval by the Secretary of Agriculture.[5]

Compliance Activities

In 1977, the Department of Agriculture created a Compliance Branch to assist in quality control efforts over wholesalers and retailers, and to hasten the investigation process of backlogged department cases, many of which were Food Stamp cases. The Compliance Branch provides initial content analysis of the cases. USDA regional and field offices, or the individual states may refer Food Stamp cases to the Department's Inspector General. Cases are classified by misdemeanor and felony distinctions and the amount of money involved ($99.99 is the cut-off figure.) Anything under $100 is handled by the Compliance Branch. Anything over $100 is dealt with by the Inspector General.

The Complaince Branch is involved in regional monitoring of retail stores. "Retailer checks" are used to monitor redemption of coupons. Banks are required to submit redemption certificates (records of coupons redeemed by retail stores) to the USDA Computer Center in Minneapolis. Utilization reviews are run constantly to identify abusive retailers. Warnings are issued via regional and field offices to the retailers, who may be disqualified from program participation if the abusive practices continue.

Another retailer monitoring tool that the Compliance Branch employs is the "ineligible shopping" system. Local community members are hired as "aides" to shop for ineligible Food Stamp purchases. Stores are liable for the actions of their employees who sell ineligible products or give more than 99 cents in change for the food coupons. (Under the new regulations, all change must be returned.)

---

[4]U. S. General Accounting Office, The Food Stamp Program - Overissued Benefits Not Recovered and Fraud Not Punished. Report to the Congress by the U. S. Comptroller General (Washington, D.C.: U.S. Government Printing Office, July 18, 1977), p. 11.

[5]Special consideration will be granted for states utilizing combined Public Assistance/Food Stamp forms or for states with computer systems requiring specific forms unlike the national form.

The USDA maintains computer printouts containing data on types of retail stores, positive cases (ineligible items sold to the USDA agents), number of ineligible shopping trips, and the types of ineligible items sold.

Use of Computer Technology

Some states have attempted to cross-match food stamp beneficiary rolls with welfare rolls. Interstate cross-matches continue to be hampered by the incompatibility of the states' computer systems. Only a few states have computerized their issuance and payments systems.

Training

Federal reimbursement of administrative costs to state and local agencies provides for training agency employees. Training programs emphasize interview strategies for eligibility determination and certification. Special investigative training is sponsored by the Office of Investigation (USDA) and the Compliance Branch for personnel responsible for detection, investigation and adjudication of food stamp cases involving fraud, abuse and waste. The Compliance Branch offers training to local stores who are certified food stamp retailers to acquaint them with the Food Stamp program and restrictions.

Other Strategies Including Adjustments in Penalties

In 1977, a Government Accounting Office study of food stamp overissuances noted that:

> "The Government is losing over half a billion dollars annually in the Food Stamp program because of overissued benefits resulting from errors and suspected recipient fraud."[6]

Such loss statements do not include the estimates for losses attributed to program participants other than recipients and food stamp employees, such as the coupon issuers (for example, theft of ATP's or coupons or misuse of ATP's) and the retailer-wholesaler establishments. Measures aimed at preventing and deterring program misuse by all parties were written into the 1977 Food Stamp Act to help local, state, and federal agencies reduce the opportunities and incidence of Food Stamp fraud and Abuse.

---

[6]The Food Stamp Program, op. cit., p. i.

Provisions to discourage recipient fraud or abuse include:

- Disqualification of recipient and household from program participation; terms dependent on administrative or judicial findings of fraud.
- Reduction of penalty (misdemeanor) from $5,000 to $1,000 to make prosecution easier and more timely.
- Standardized deductions to reduce abuse opportunities.
- Payment to state agencies for 75 percent of costs of state investigations and prosecutions.

New provisions relating to coupon issuers allow for monetary fines and/or imprisonment of issuers convicted of failure to report inventory levels or operations and misrepresentation of inventory information. The elimination of the purchase requirement may reduce issuance fraud because cash transactions on this level are no longer made. Provisions affecting retailer/wholesaler activities are:

- Cash change (up to 99 cents) will be given to beneficiaries rather than credit slips.
- Hot foods, or hot food products, are ineligible items (with the exception of nonprofit meal delivery services, communal dining facilities, and institutions that serve meals to drug addicts and alcoholics).
- Only stores with half their food sales comprised of food staples will be authorized to participate.
- No firm will be authorized as both retailer and wholesaler at the same time.
- Authorized institutions serving meals to drug addicts and alcoholics will be unable to redeem food stamps through banks.

The 1977 Act includes incentives for program improvement and sanctions to penalize poorly managed agencies. States which reduce their error rates to below five percent will have an additional ten percent of their administrative costs paid by the federal government and will not have to submit corrective action plans relating to error rates. States which fail to meet program standards without good cause will be penalized by having federal

funds for administrative costs withheld in an amount that USDA determines appropriate. (These states are entitled to an administrative review if they disagree with the determination.) States which do not comply with program requirements may be referred to the Attorney General who may issue the appropriate injunctive relief. Also, states which have been determined to have committed negligence or fraud in the certification of applicant households may be required to pay for coupons improperly issued. (USDA will no longer have to establish that gross negligence has occurred before billing a state.)

Financial incentives are now available to states to encourage investigation and prosecution of recipient fraud and abuse. Detection of possible fraud or abuse in the Food Stamp program results from the various audits, quality control procedures and computer checks that monitor the program participants. Referrals to the Office of Investigation or the Inspector General come from the state and local agencies. Until the new regulations, there was little interest on the states' part to follow up with their own investigations because the losses involved were federal monies, while the total cost of the investigations and prosecutions were borne by the states Currently, states are liable for the losses to the program, and are paid for 75 percent of prosecution-investigation costs. The federal government encourages states to create fraud units to work in conjunction with USDA's Regional Office investigation units.

PART C: LOANS AS BENEFITS

Money lent at interest represents another type of benefit. It is distinguished from cash assistance because of the more complicated nature of its delivery process and by the fact that the recipient has an obligation to repay part of the money to the sponsoring agency.

Benefit loan programs offer either direct loans where government monies are lent for a specific time period, with a reasonable expectation of repayment either with or without interest, or guaranteed/insured loans where the government arranges to indemnify a lender against part or all of any defaults by those responsible for loan payment.[1] Loans may be offered for a variety of benefit undertakings. Some examples are purchasing or rehabilitating a residential dwelling, repairing property damage following a disaster, or replacing real or personal property lost in a disaster.

Loan benefit processes involve numerous parties and transaction points. In the Veterans Home Guaranty program, for example, the transaction may involve

- builder or seller of the home
- lender
- real estate broker
- credit reporting agency
- title company
- insurance company
- fee appriaiser
- fee compliance inspector
- veteran, or
- Veterans Adninistration employees[2]

All these points in the program represent potential opportunities for misuse.

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. vi.

[2]U.S. General Accounting Office, Federal Agencies Can, and Should, Do More to Combat Fraud in Government Programs Report to the Congress from the U.S. Comptroller General (Washington, D.C.: U.S. Government Printing Office, September 1978), p. 11.

Some patterns of fraud and abuse associated with loan benefits include misrepresentation of information required for loan application, forged or falsely prepared loan documents, collusion to defraud from any combination of transaction points, misuse of loan benefit assistance, or defaults on loan payments that may be related to collusive defrauding activities.

Some of the indicators used to detect irregularities in loan benefits are inconsistencies in loan application information, the pattern of loans made (e.g., marginal or no risk loans), the general business practices of credit, title, real estate or lender firms, or the default pattern or rate on new loans. Recipient complaints and anonymous leads also generate investigative leads.

The programs profiled under the heading of loan benefits are disaster loans and three types of housing loans. These profiles follow.

PHYSICAL DISASTER LOANS

Type of Benefit: Loans

Sponsor: Small Business Administration (SBA)

Program Administration: Decentralized, through Regional and District Offices of the SBA

OVERVIEW

The authority for the SBA's Physical Disaster Loan program is found in the SBA Act of 1935 as amended and the Disaster Relief Act of 1979, 42 U.S.C. 4401. It's purpose is to:

> "provide loans to restore, as nearly as possible, the victims of physical disasters to pre-disaster conditions."[1]

In fiscal year 1978, loans totaling $2.7 billion were distributed. In all, 96,949 loans were granted. Additional funds are made available as guaranteed loans made by financial institutions.

Overall policy for the loan program is set in SBA's national office. It is the responsibility of the Operations Division to implement the policies in the regional and district offices.

BENEFITS AND ELIGIBILITY

Physical Disaster loans are available on a first-come, first-served basis for replacement costs of personal effects and/or real property after a disaster. Most SBA disaster asistance activity takes place at the one-stop centers set up by the Federal Disaster Assistance Administration (FDAA) when a disaster is declared. Depending on the extent and scope of a disaster, SBA staff may stay at the disaster site for as little as several months or as long as several years.

Loans are available in amounts up to $5,000 for personal property and up to $50,000 for real property. Business loans may be as high as $500,000. Individuals, business concerns including agricultural enterprises, churches, private schools, colleges and universities and hospitals are also eligible.

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance, 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 760.

Applicants for disaster loans must show or prove:

- Items that were damaged.
- Ability to repay the loans.
- Financial statement of current condition.

Loan funds may be used to repair or replace damage or destroyed realty, machinery and equipment, household, and other personal property. Funds must be used for the purpose stipulated in the authorization which is issued in connection with each approved loan. The interest rates for the loans are computed according to complicated formulae, which are sometimes misunderstood.

OPPORTUNITIES FOR FRAUD

Losses or the extent of losses can be misrepresented by applicants. The verification procedure discourages such misrepresentation. However, claims are difficult to prove or disprove; thus, the opportunity for fraud and abuse exists.

Packagers of loan applications have sometimes charged exorbitant fees for their services. SBA has attempted to inform recipients of the possibility of excessively high fees being charged for packaging. There is a separate warning sheet attached to the loan form, but some of the packagers detach the warning before giving the form to the applicant.

SBA's disaster program utilizes a cadre of "camp followers" who are temporary employees and move from disaster to disaster. There have been only a few instances of fradulent or abusive actions by these personnel. Approximately 1,000 persons are on the disaster administration program payroll.

The delinquency rate for SBA Physical Disaster loans is not presently known. SBA is currently undertaking a pilot project which will provide district SBA offices with information on the status of loans and their delinquency rates. Until 1978, the law provided for "forgiveness" of loans, which resulted in high delinquency rates. The elimination of the forgiveness provision has lowered the potential for fraud and abuse.

ENFORCEMENT METHODS USED IN PHYSICAL DISASTER LOANS

SBA "loss verifiers" are responsible for doing on-site verification in every case where personal or real property is being claimed as loss for purposes of loan assistance. The "loss verifiers" also are responsible for cross-matching addresses and names to assure that duplicate payments are not made to the same

party. A loss verification report is required by SBA. Where personal property is lost, the items being claimed must be itemized and described. Where real property is damaged or destroyed, the verification report reflects an estimate of the damage which may then be used for purposes of calculating the loan needs.

There is certain confidential information on the loan application which is necessary for verifying the applicant's character and ability to repay the loan. The ACLU and other groups have raised objections to some of these questions, claiming that they are an invasion of privacy. SBA officials believe, however, that better verification reduces the chances for fraud or abuse of programs.

Training given to full-and part-time staff is an important factor in controlling fraud. Problems can arise when not enough well-trained verification personnel are available. Verification procedures become sketchy, with the result that a higher proportion of fraudulent applications are approved.

Direct on-line computer access to credit firms for claims credit review and search has been an effective adjunct to the verification process in those regions that have been instituting it.

All claimed losses which exceed $5,000 are monitored by SBA staff, and any loan made which exceeds $5,000 must be accompanied by receipts to prove purchase of new property. Although the SBA has a computer program which indicates those loans which have been approved, the computer does not have the capability of cross-checking loan applications and approvals across inter-jurisdictional lines. In order to assure program integrity for disaster loans, the federal government, SBA, and the states may cross-match disaster assistance rolls.

SBA's Inspection and Security Office investigates problems brought to their attention by field or national office staff. If the investigation reveals that fraud is suspected and additional investigation assistance is needed, the case is referred to the U.S. Attorney and the FBI.

Administrative proceedings are sometimes used to correct or eliminate fraudulent or erroneous loans. However, if the Justice Department or the FBI has begun to investigate an alleged fraud case for possible prosecution, they are often reluctant to share their information with SBA officials, delaying the administrative proceedings. In addition, there are "attitude" problems in prosecuting disaster victims, since most juries believe people have suffered enough as a result of their disaster situation.

Annual financial statements are required on certain business loans. Borrowers are required to maintain records on the use made of loan funds for three years after the last payment has been received.

RURAL HOUSING LOANS

Type of Benefit: Loan

Sponsor: U.S. Department of Agriculture

Program Administration: Federal guaranteed/insured loans, direct loans, and project grants available to rural eligibles through decentralized USDA county offices.

OVERVIEW

Under the authority of the Housing Act of 1949, as amended, 42 U.S.C. 1480, 1485, 1474, the Farmers Home Administration (hereafter FmHA) within USDA, has responsibility to assist rural families with housing loan assistance. We reviewed three of the FmHA loan programs directed toward very low income, low to moderate income, and rural rental families.

Section 502: Low to Moderate Income Housing Loans

This section of the Housing Act assists low and moderate income rural families to obtain decent, safe, and sanitary housing through insured home loans. Application for a loan may be made by an owner of a farm or nonfarm tract of land in a rural area. An applicant must be without adequate housing at the time of application and be unable to secure credit from other sources under terms and conditions which could be readily fulfilled. The applicant must meet certain income standards.

The housing must be situated in a rural area (as defined by population criteria) which has a serious lack of mortgage credit for low and moderate income families (to be determined by the Secretary of USDA).

Section 504: Very Low Income Housing Repair Loans and Grants

Section 504 of the Housing Act provides for financial Assistance to very low income home owners (who do not qualify for Section 502 loans) to make minor repairs to their homes, to secure safe conditions, and to remove health hazards. Grants or direct loans or a combination thereof may be made to an applicant who meets income eligibility standards and whose dwelling is located in a rural area (as defined by population criteria) and where mortgage credit is unavailable. There are dollar restrictions on the amount of assistance available.

Rural Rental Housing Loans

Section 515 and 521 of the Housing Act provide for insured loans to be made to individuals, cooperatives, or non-profit organizations for the design and construction of rental and cooperative housing (multi-units) and related facilities suited for independent living for rural residents. Population and credit characteristics of the housing site are part of the eligibility criteria, and an applicant must furnish documentation which shows:

- A comprehensive market analysis indicating the need for housing.
- Legal capacity to incur the obligation.
- A sound budget.
- Credit to build and rent units at amounts within payment ability or eligible low and moderate income or senior occupants was not available elsewhere.

The value of loan business in all the rural housing programs has grown significantly in the past ten years. The increase is due in a large part to a scarcity of rural housing credit in the late 1960's and the large percentage, almost one third, of the national population residing in rural areas. The Department of Agriculture said rural America accounts for half of the national total of substandard housing. "Thus the ratio of bad housing to number of families became twice as great in rural communities as in the cities".[1]

Official federal estimates of the loans and grants to be made in each program are:

		Number of Loans or Grants	Amount of Loans or Grants
Section 502	FY 1978	110,000	$2,675,000,000
	FY 1979	104,000	$2,867,000,000
Section 504	FY 1978	4,400 (loans) 2,834 (grants)	$ 11,000,000 (loans) 5,000,000 (grants)

[1]Brief History of Farmers Home Administration. (Washington, D.C.: U.S. Department of Agriculture, February 1977), p. 12.

		Number of Loans or Grants	Amount of Loans or Grants
Rural Rental Housing	FY 1978	1,750	$6,000,000,000
	FY 1979	(N.A.)	(N.A.)[2]

Administration of all the housing loan programs is handled by Farmers Home Administration personnel through a network of state and local offices in rural areas. All loan determinations and servicing of loans are the responsibility of the county supervisor and staff in the local offices. There are 44 state offices providing program services, with staffs of a Rural Housing Chief, a Rural Housing Specialist, and an engineer and architect, dependent upon location. All state directors are political appointees, and therefore, are subject to changes in administration. Allocations for each program area are made to states based on certain formulae. The state directors determine the "rural" areas in the state based on Standard Metropolitan Statistical Area (SMSA) figures and the state director allocates monies to the counties.

Fraud and Abuse in Rural Housing

The rural housing loan programs exhibit two program design features that have created opportunities for fraud and abuse. The first of these features is the discretionary granting of "interest credits" to borrowers. Interest credits enable eligible low income families to pay as little as one percent interest and provide for subsidized loans to developers of low-priced rental housing for low-income families and senior occupants. In many instances, developers claim the "interest credits" when, in fact, their units are occupied by families not eligible for participation in the program. There are also instances where the income information for these individuals has been falsified or misrepresented by the developers in order to gain "interest credits." Another abuse of interest credits in multi-family programs derives from a lack of management continuity after units are constructed. The original builder may not tell the renter-manager about interest credits and the importance of renting to only families that qualify. Many times ineligible renters become tenants, and the developer receives interest credits just the same.

A second design feature of the program is "packaging". Packaging allows developers or builders providing large developments or tenant housing to submit packages of applications to the

---

[2]Office of Management and Budget, Update to the 1978 Catalog of Federal Domestic Assistance (Washington, D.C.: U.S. Government Printing Office, 1978), pp. 22-27, ES, E-6.

county offices for consideration as one application. This is allowed because it represents an economy for agency employees reviewing applications and for developers to assure full funding and occupancy for large developments.

Several opportunities for fraud and abuse arise as a result of using packaging. The packager can alter loan papers or falsify employment verifications. County staffs receiving the packaged applications may not have the time to verify income eligibility information. Another problem with packaging is that each county has a distinct set of requirements for packaging applications. For example, one county may want only the basic items, and others may require loan obligating documents. The central office has attempted to unify some of these procedures but only after there were serious allegations of fraud.

ENFORCEMENT STRATEGIES

Quality Control

Quality control measures in the rural housing program include monitoring and evaluation, construction site inspections, interview procedure regulations, computer utilization, and audit cycles.

The Farmers Home Administration maintains an Office of Program Evaluation to monitor programs for effectiveness and provide recommendations for changes. A small staff in the Washington office (composed of evaluators and statisticians primarily) analyzes the programs; however, the major data for these evaluations are obtained via a survey instrument, the Operations Review Questionnaire, to state and district offices. The Operations Review Questionnaire is updated bi-annually by study and analysis of audits, investigations, national reviews, evaluations, and other records.

Although the questionnaire is designed to focus on all the programs administered by FmHA, there are separate sections of the instrument dealing with Section 502 and Section 504 Housing Loans applications, servicing processes, and an inventory of all loan applications. The Evaluation Division is also involved in making projections and prioritizing future manpower needs for program administration[3] for the various counties.

The FmHA has little, if any, control over contractors' delay with their sub-contractors. As a result, there is no way of monitoring the quality of the work done by the sub-contractors. (Monitoring payments to sub-contractors is handled through payment invoice checks, but there is not a postpayment monitoring system.)

[3]The Evaluation Division of FmHA is responsible for administration and analysis of the Operations Review Questionnaire.

By federal regulation, three on-site inspections are conducted during construction of subsidized rural housing projects. The inspection visits are made when

- Footings are poured.
- House (or unit) is framed in.
- Project is completed.

Personnel in county and local offices are responsible for the inspections as well as appraisals.[4]

Computer technology is utilized to maintain coordinated management data for the rural housing programs. The central office in Washington receives information from the state directors on the number of loan obligations made and the delinquency rates on the loan payments. This information is provided on a county and state basis. The Department of Agriculture is beginning a more sophisticated computer system called Unified Management Information System (UMIS) which will provide technical information on appraisals, review of contractor plans, and related matters on housing programs. Also, computerized quality control statistical sampling is reviewed for each state annually.

Auditing

The Audit Division of FmHA, using guidelines set by USDA, handles all the audit responsibilities. The auditing process is based on a three year cycle with one-third of the counties in each state audited every year. This entire job is performed by approximately 350 auditors dispersed regionally among twenty sub-office locations.

National Collection System

The Department of Agriculture has released a solicitation to bidders for creation of a bank collection system which would cover not only accounting and servicing of loans, but also tax servicing and liquidation. This program would reduce caseloads for those county offices that are understaffed but that have responsibility for determining and servicing loans. This would allow local offices, in turn, to allocate more time to loan collection processes.

There is about a 20 percent delinquency rate nationally on all housing loan programs handled by FmHA. This 20 percent figure reflects an "aging" of delinquency rates to all accounts $10 or more behind for 15 or more days. When delinquencies occur, the borrower is allowed to miss only one payment before action is taken. When further action becomes necessary, the following steps are taken:

[4]Appraisals are based on cost of land, construction and closing.

- Personal contacts are made between the county supervisor and the client.
- After two missed payments, telephone contact is made.
- After three missed payments or more, the county supervisor writes a collection letter.

When foreclosures are necessary, they are usually handled by FmHA personnel without the use of judicial foreclosure. If court proceedings are necessary, the matter is referred to the U.S. Attorney. If judicial foreclosure is imminent, USDA usually bids on the dwelling at the foreclosure sale, inventories the dwelling, makes necessary repairs and sells it to a new eligible applicant.

Administrative Recourse

As recourse to problems associated with substandard and faulty construction, families will be able to recoup monies spent on repairs under new provisions of the rural housing legislation. The difficulty foreseen with this compensatory system is in determining whether there is liability because of contractor malfeasance or whether faulty inspections by the Rural Housing officers are to blame.

Investigation and Criminal Prosecution

In the event of fraudulent or abusive activities in the Rural Housing programs, the local or state officers refer suspected cases to the USDA's Office of Inspector General for further investigation. Cases that are found prosecutable are referred to the U.S. Attorney's offices for trial.

VETERANS HOME LOAN GUARANTY PROGRAM

Type of Benefit: Loan Guaranty

Sponsor: Veterans Administration

Program Administration: Federally administered program decentralized to 49 regional or field offices' Loan Guaranty Divisions.

OVERVIEW

The legislative authority for the G.I. Home Loan program is in 38 U.S.C. 1810 (1944). Its objective is:

> "To assist veterans, certain service personnel and certain unmarried widows or widowers of veterans, in obtaining loans for the purchase, construction, or improvement of homes on more liberal terms than are generally available."[1]

Under the conventional mortgage terms, loans are protected by substantial down payments and relatively short terms of repayment. Under the Loan Guaranty program, a veteran can obtain loans through conventional sources with a minimal down payment because the Federal Government guarantees it. Under present terms of the law, home loans may be guaranteed up to 60 percent of the amount of the loan, but not to exceed $17,500. About 71 percent of the veterans purchasing a home with a guaranteed loan were able to do so with no down payment. Thus, eligible veterans are able to finance home purchases even though they may not have sufficient down payment to qualify for conventional loans.

Although the bulk of the loans are used for purchasing traditional single family homes, loans may also be used for purchasing condominiums, refinancing loans, or renovating already purchased homes. Loans to finance the purchase of previously occupied housing accounted for over 79 percent of the primary home loans guaranteed during the fiscal year 1977. During fiscal year 1977, 379,793 home loans were guaranteed. This represents an increase of nearly 17 percent over the fiscal year 1976 total of 324,968. The value of the loans guaranteed during fiscal year

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance, 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 807.

1977 was $13.1 billion. Forecasts for fiscal year 1978 and 1979 indicate loan guarantees totaling $14.5 and $14.8 billion, respectively. Between June 22, 1944 and September 30, 1977, veterans have obtained 9.5 million loans, totaling $139 billion, under the G.I. Home Loan program.[2]

BENEFITS AND ELIGIBILITY

To determine veteran eligibility for participation in the G.I. Home Loan program, the field office analyzes the income and credit records of each applicant. The application is reviewed to insure that the veteran has an adequate income to cover his or her fixed expenses as well as the payment on the loan. In addition, credit data are reviewed to determine that the veteran has not been deliquent in honoring his or her outstanding debts.

There are additional restrictions on loan guaranty eligibility.

- The borrower must own and occupy the housing unit securing the loan.
- The unit must be suitable for dwelling.
- Units completed less than one year ago must also meet VA minimum planning and construction requirements.

There are approximately 3,000 lenders in the Home Loan Guaranty program. Life insurance companies or mortgage bankers comprise about 70 percent of all lenders. Small banks and savings and loan institutions make up the balance. The veteran is allowed to choose his own lender.

All loans provided by the VA are based on appraisals. The appraisal is designed to insure that the loan does not exceed the value of the property. Within each field office, there is a list of appraisers who receive their assignments from VA, but are paid directly by the person making the request for the appraisal. In order to avoid possible collusion between VA personnel and appraisers, the appraisal panel is rotated.

Recipient Fraud

There are several areas in the application/review procedure where fraud can occur. One is the misrepresentation of earnings and/or employment on the loan application. A veteran may claim

---

[2]Veterans Administration, 1977 Annual Report (Washington, D.C.: U.S. Government Printing Office, 1978), p. 73.

to be employed when in fact he or she is not, and therefore may be unable to adequately meet financial obligations.

Another problem area is the subjective nature of "credit-worthiness". There are no cut and dried determinants for credit worthiness. What one person may consider a good credit risk, another person may not. Therefore, there are decisions made based on personal reactions to the credit data.

Along with borrower misstatements of income, employment, or asset information on the loan application is the possibility of misrepresentation of discharge papers. For submission of an application to VA, the veteran must include his original discharge papers or a reasonable copy. This has created a number of opportunities for fraud. In some instances, the veteran has submitted someone else's discharge papers when the veteran's own would not qualify him or her for the loan. There is also the opportunity to submit counterfeit papers, sometimes to hide the fact that he or she was dishonorably discharged. Although many of the attempts at fraud are clever and time consuming, many of them can be detected through more careful scrutinizing of applications and more thorough training of administrative personnel making the decision of granting the loan guaranty.

There has been some incidence of fraud concerning the requirement that the borrower reside in the dwelling unit securing the loan. In some cases, the veteran never lived in the house at all, but rented it out for investment purposes. Occasionally, veterans have attempted to secure loans for other people, in effect, selling their "entitlements".

Default by borrowers has been a minimal problem. Loans currently (fiscal year 1977) in default represent slightly more than one percent of all outstanding loans.[3] When a loan is totally defaulted, the housing unit goes to foreclosure proceedings.

Provider Fraud

The opportunities for fraud in the provider community are multiple. The provider community for VA Loan Guarantees includes the following types of organizations.

- brokers and real estate agents
- lenders
- appraisers
- contractors

---

[3] Ibid.

The most vulnerable area where fraud can occur among program providers is "broker (or contractor) packaging." The broker or contractor is permitted to assemble all the forms needed by the veteran in order to have his or her loan approved. The packaging procedure, itself, is condoned by the agency because it streamlines the paperwork required to process a loan application. Abuses have occurred where packagers have falsified information on forms, whether with or without the veteran's knowledge. VA officials estimate that broker packaging is the area most vulnerable to fraud.

Another vulnerable area, related to the packaging process, occurs with persons who act as agents for the veteran, who make loan applications and fraudulently misrepresent application information. The Home Loan Guaranty application or other documents are sometimes signed by the veteran before they are completed by the broker or lender with false or misleading information.

Besides packaging frauds among contractors, there have been occasional problems with the quality of work done by builders on new homes. Home repairs are not always done as specified and are not up to VA standards. Required inspections may or may not have been done or their recommendations may have been ignored.

Unscrupulous lenders have forged applications and other required form verifications, and/or credit reports. Such falsifications can include the veteran, the proposed loan itself, or the property.

Some appraisers have not been honest in their appraisals. Since the appraiser's fee is a percentage of the value of the property, it would be to his advantage to claim that a piece of property is worth more than it actually is. He can then use part of his fee to pay off any officials who may have colluded with him. The result is a larger loan guaranty for the veteran, an increased fee for the appraiser and some extra money in the pockets of some dishonest officials.

Administrative Agency Fraud

In addition to fraud by recipients and providers, there have been some instances of fraud by administrative agency personnel. Field office personnel have, on occasion, forged or changed certificates of eligibility. Abuse of the program, however, is not always the result of an intent to defraud. Sometimes abuse is the result of an understaffed office - the greater the volume of work, the less thorough the review procedure.

In the interest of timeliness, cursory reviews done by field office personnel may lead to inappropriate loan guaranties. In sum, the Housing Loan Guaranty program is vulnerable to fraud and abuse because of the many transaction points and multiple participants in the loan application and guaranty process.

METHODS OF FRAUD DETECTION

There are several methods used to reduce the opportunity for fraud. These methods are aimed at recipients and their agents, providers, and administrative agency personnel.

More thorough analysis of forms helps detect forgeries and inaccurate information on applications. Telephone audits of employers are conducted to verify employment information. Bank deposits and assets are scrutinized to detect misrepresentation of financial status. Prosecuting those veterans guilty of fraud is another means of deterrence. To prevent agents, acting for veterans, from supplying inaccurate information on applications, a revised loan application was distributed in October 1977. If an agent fills out the application, this must be acknowledged on the form. In addition, the form requires the lender to verify the information provided on the application.

Several methods of deterrence used by the VA are directed at reducing fraud by the provider community. For example, recently, the VA has exercised more frequently its power to disallow further participation in the Loan Guaranty program by lenders who have not worked for the best interests of the veteran. While this seems to have a positive effect on the rate of fraud, some providers perceive quality control and investigation measures as harassment.

In order to deter fraud by veterans and providers, the VA has publicized information about its methods to detect fraud and information about actual prosecutions. There are some indications that these methods have been successful. For example, a team of investigators on the West Coast noticed an appreciable difference in the quality of applications after their investigations were publicized. There was less misrepresentation on applications and fewer forged documents, underscoring the deterrent effects of publicizing methods of detection of fraud and actual prosecution cases.

There is an ongoing program to insure the accuracy of property values reported by the appraisers. The three methods used to review and supervise them are as follows.

- All appraisal reports are reviewed by VA staff to insure completeness and accuracy.
- A minimum of five percent of all appraisal reports are subject to a field review by VA staff; selection of cases for field reviews is such that the entire active roster of appraisers is under constant scrutiny.

- A statistical sampling of appraisal reports is reviewed under the statistical quality control system on a monthly basis.

The 49 administrative field offices are structured to be evaluated on four basic points.

- Statistical quality control for 30 different work processes
- Systematic analyses of operations
- Statistical evaluation reviews
- Evaluation visits by central office personnel

Results of the randomly sampled reviews for issuance of loan commitments and appraisal certificates are submitted by each field office monthly. The results of all other reviews are submitted quarterly to the national office. Some procedures which are not suitable for statistical quality control are subjected to systematic analysis once every twelve months. Examples of these analyses include reviews of attainment of program goals and maintenance of internal control devices. Every 18 months, central office personnel, using the same statistical selection methods and review criteria as were used in field activities, make a statistical estimate of whether or not the field activities' reported findings do in fact reflect the true level of quality as reported. Finally, each field office is visited by central office personnel at least once every 18 months.

BENEFITS AND ELIGIBILITY

To qualify for a rehabilitation loan, the borrower must own the property or be buying it under an installment contract. The property must be located in a federally aided code enforcement or urban-renewal area, or in a community development area funded with Community Development Block Grant funds. The loans are also available to urban homesteaders participating in the Section 810 Urban Homesteading Demonstration Program. There are no income criteria for borrowers. Eligibility is based exclusively on the location of the property, as described above.

The loans may be used for one or more of the following purposes.

- To make the property comply with the local housing and building code in a code enforcement area.
- To make the property comply with plan requirements and objectives in a federally funded urban renewal area.
- To support activities in a community development area.

Section 312 loans frequently accompany other types of loans made by HUD in order to raise property levels to minimum code standards. Depending upon the type of application, a loan may include an amount for general property improvements in addition to those items required by the localities as a prerequisite for the loan.

Generally, loans cannot exceed the actual cost of rehabilitation or $27,000 per structure, whichever is less. In special areas, this limit may be increased. The duration of the loan is calculated according to a formula, not to exceed three-fourths of the "remaining economic life" of the property after rehabilitation to a maximum of 20 years. Loans are paid in equal monthly installments, and the buyer must include in his monthly payments an amount equal to one-twelfth of the estimated annual cost of taxes, insurance, and similar expenses of the property. The loan may be paid ahead of time without penalty. Refinancing is possible on the loans, provided the owner can show a formal title to the property.

Money is placed in escrow accounts for the loans, and checks are not released until the work has been completed. This practice often causes difficulties for the small contractors who generally work with rehabilitation loan recipients, because the contractors must make the "front-end" financial commitment of purchasing materials and paying workers prior to being paid themselves. Because they typically operate on small profit margins, some small contractors are priced out of participation in the program.

HOUSING REHABILITATION LOANS (SECTION 312)

Type of Benefit: Loans

Sponsor: U.S. Department of Housing and Urban Development

Program Administration: Decentralized through HUD Regional Offices to city or county government

OVERVIEW

The legislative authority for the Housing Rehabilitation Loan program is found in Section 312 of the Housing Act of 1964, as amended, 42 U.S.C. 1452B. The major objective of this program is to provide funds for the rehabilitation of residential and commercial properties in urban areas.

There has been substantial growth in the loan value of the program. For example, in fiscal year 1979, it is estimated that $260 million worth of loans will be granted compared to only $80 million in 1978.[1]

The funds are made available to property owners by the HUD regional offices through city or county governments or local public agencies such as housing or renewal authorities. In some areas, HUD regional offices disburse the funds directly, because local governments and agencies have been hesitant to take on the responsibility. Recently, their participation has become an explicit prerequisite for their residents to receive program funds. Therefore, the number of local governments or agencies participating will increase throughout the program.

The major responsibilities of the HUD regional offices are approving plans from local agencies and accounting for the funds spent. The regional office staff may also be called upon to settle contractual disputes, if other avenues of negotiation have been explored without success.

Interest rates on the loans are very low at three percent. The loans are served by savings and loans associations.

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance (Washington, D.C.: U.S. Government Printing Office, 1978), p. 470; and Update to the 1978 Catalog of Federal Domestic Assistance (Washington, D.C.: U.S. Government Printing Office, 1978), p. E-39.

OPPORTUNITIES FOR FRAUD

There have been some instances of collusion between owners and agency staff to misrepresent the location of the building slated for rehabilitation, especially since location is the major eligibility criterion.

The quality of workmanship is sometimes a problem when Section 312 loans are used. The local agency is responsible for negotiating a settlement between the property owner and the contractor. However, if a settlement cannot be reached, HUD personnel may be called in as informal arbiters.

Breach of contract between the developer and the borrower can also occur with a dispute over the starting date, presentation of bids which are over and above the original estimates for the work, "frills" construction, the date of completion, and other problems which are subject to arbitration.

Another problem in the area of contractor-owner relations is known as "tailoring." This is a practice whereby the work actually completed is not the same work originally specified in the contract. For example, the contract may call for repair to the roof, but the contractor replaces the entire roof. The local agency staff is responsible for inspecting rehabilitation work to assure that the work was done according to the contract.

A combined contractor-administrative agency fraud is the payment of kickbacks to rehabilitation program staff in order to improve the contractor's final inspection.

Duplicate benefits can be paid from Section 312 loans and other HUD loan programs, although duplicate payments for the same work are prohibited.

When a loan is three months in delinquency, it is placed on a special list in the HUD regional office. The regional office makes foreclosure recommendations to HUD, but there are very few foreclosures in the rehabilitation loan program. The delinquency rate overall remains low. During fiscal year 1976, about 5,000 loans were made, and only 350 had some type of delinquency problem.

ENFORCEMENT TECHNIQUES

City rehabilitation loan programs are audited by HUD regional office staff, usually annually. However, HUD does not have any control over eligibility determination of rehabilitation loans. Its concern is simply to audit the program's funds.

Financial specialists in some areas work with the applicant borrowers to verify the need for the work and the capacity to repay the loan. As previously stated, foreclosures are rare.

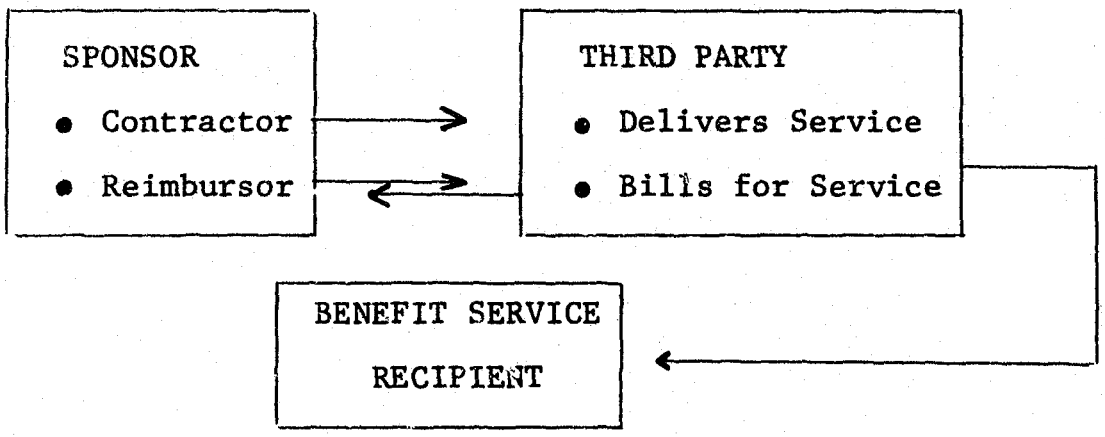
Fraud in the Section 312 program is minimal, for the following reasons.

- Funds are not released from escrow until the work is completed.
- The maximum dollar value of an individual loan is relatively small.
- Local authorities have a political stake in operating the program well and giving their administration of HUD funds a "good image."

PART D: SERVICES AS BENEFITS

The provision of services to beneficiaries and reimbursement for services provided is a common process in many benefit programs. Where a sponsoring agency is either unable (for statutory or other reasons) or does not have the capacity to provide services directly, it contracts with third party providers to deliver service benefits. This process is depicted in Diagram A.

DIAGRAM A



The specific design of each service program depends on the type of service offered and the economic market structure existing for delivery of that service.

Health service programs must, of necessity, use pharmacies, doctors, nurses, home health care agencies, hospitals, long-term facilities, and a myriad of supply vendors (i.e., linen, oxygen, surgical equipment) to provide benefits. The economic market structure requires that provider services be billed either directly to the patient and then sent to the sponsoring agency, or that they be assigned to auxiliary providers, e.g., intermediaries and carriers. In the Summer Food Service program, money for service delivery flows from the government agency sponsoring the program (either a State Board of Education or a Regional Office of the USDA) to a "non-profit" prime sponsor who then contracts with a food service management company. In sum, service benefits are the result of a process characterized by several financial transaction points with different government and business entities involved.

It follows from the characterization of the service benefit process that crimes committed involve one or a combination of the following.

- Fraudulent or abusive billing practice
- Fraudulent or abusive contract arrangements

- Fraudulent or abusive service delivery
- Fraudulent or abusive use of service

Forged or falsely notarized bills, bill padding, overcharging, duplicate billing, and services not rendered are examples of fraudulent or abusive billing practices. Bid-rigging, with or without payment of kickbacks or bribes, illustrates misuse of service contracting. Delivery of poor quality or quantity of services, withheld services, or offering services that are not necessary are fraud and abuse patterns associated with service delivery. Fraudulent or abusive use of a service is illustrated where Medicaid recipients overutilize drug prescriptions to support their drug habit.

Techniques used for detecting service benefit offenses include: compliance monitoring and inspecting of service facilities, developing service utilization profiles, and investigating economic characteristics of the service industry. Recipient complaints of poor service, anonymous leads or leads generated from investigations of other aspects of a particular service industry can also help uncover fraud and abuse in service benefit programs.

To illustrate how service benefits are delivered and their vulnerabilities to fraud and abuse, the Medicare, Medicaid, and Summer Food Service, CETA, and Vocational Education programs are grouped together. These program profiles follow.

MEDICARE

Type of Benefit: Service

Sponsor: U.S. Department of Health, Education and Welfare

Program Administration: Federally administered program offering direct payments for specified health care uses to eligible recipients

OVERVIEW

The Medicare Program, authorized by the Social Security Amendments of 1965, 42 U.S.C. 1395 *et. seq.*, as amended, is a two-part federal insurance program that includes hospital insurance (Part A) and supplementary medical insurance (Part B). Medicare Part A automatically provides hospital insurance benefits for covered services to any person 65 or above and to certain disabled persons. Part B provides medical insurance benefits for covered services to persons 65 or older and certain disabled persons who elect this coverage.*

Recent federal estimates of the financial obligations and accomplishments of Part A and Part B of the Medicare program are as follows:

Part A	FY 1978 (Est.)	FY 1979 (Est.)
Benefit Outlays	$17,529,000,000	$20,543,000,000
Persons Automatically Eligible	26,000,000	26,600,000
Part B	**FY 1978 (Est.)**	**FY 1979 (Est.)**
Benefit Outlays	$ 7,075,000,000	$ 8,411,000,000
Persons Electing Coverage	25,700,000	26,400,000

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance 1978 (Washington, D. C.: U.S. Government Printing Office, May 1978), pp. 345-46.

*Certain disabled persons entitled to Medicare benefits include, specifically, chronic kidney disease patients (CRDs). Those people under 65 who are entitled to twenty-four consecutive months of Social Security disability benefits or Railroad Retirement may receive Medicare benefits also.

Program Administrative Responsibilities

The federal agency responsible for administering the Medicare program and monitoring the many program participants is the Health Care Financing Administration (HCFA), Department of Health, Education, and Welfare. Under HCFA, the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, both maintained through contributions made by employers and employees (Social Security), are reservoirs for payments of claims. Fiscal intermediaries and carriers,[2] contract with HCFA for program operation and participation. The duties of intermediaries and carriers and the requirements of this participation are set out by statute, i.e., the states require maintenance of certain standards of operation based on statutory regulations. The states monitor the standards through state regulatory boards, providers of health services such as hospitals, long term care facilities, physicians and nurses are integral to benefit delivery. Providers must file Medicare Cost Reports annually with HEW but the intermediaries and carriers make interim payments to providers monthly. Explanations of benefits paid on behalf of or directly to beneficiaries are sent out monthly.

Eligible Services and Benefit Disbursement

Part A covers three main services with specific qualifications for each service regarding eligible services, deductibles, and benefit period limitations. In-patient hospital care, extended care, and home health services are included in Medicare Part A coverage. Part B claims generally are processed for services, such as physicians' services, not covered under Part A of Medicare. The reimbursement schedules for Part A and B are distinctive: Part A requires no monthly premium and pays "reasonable costs" (based on providers' Medicare Cost Report audits) after certain benefit periods deductible and coinsurance standards are filled (the amount reimbursed varies with the service rendered and covered). Part B charges a monthly premium for each beneficiary, then pays eighty percent of "reasonable charges" after the annual deductible and coinsurance criteria has been met. (There are exceptions to Part B payments for several different types of medical service). Reimbursement formulae for Parts A and B are determined by HCFA, but local fee schedules and conditions can affect rates of reimbursement.

Intermediaries or carriers, under contract with HCFA, make direct payments for specified uses according to Medicare standards and regulations. Under Part A, payments are made to providers on

---

[2]Intermediaries usually process Part A claims from providers; carriers generally process Part B Medicare claims.

behalf of beneficiaries, while under Part B, carriers pay physicians or suppliers under assignment for services rendered, or they make payment directly to the beneficiaries. When a provider, such as a hospital, skilled nursing facility or home health agency, furnishes Part A covered services, the provider receives payment from an intermediary.[3]

ENFORCEMENT

Program Losses

The HEW Inspector General's report of 1977 cited a $2.2 billion loss to the Medicare program in FY 1977, as the result of fraud, abuse and waste. This loss represents the second largest amount lost to any program in HEW (Medicaid has the largest). The Inspector General's report categorized the various factors comprising the loss with monetary cost values as follows:

General Description	Amount (Millions)
Excessive Nursing Differential[4]	$ 185
Renal Dialysis	153
Provider Overpayments	141
Cost Report Reviews	16
Common Audit	8
Audit Exceptions	3
Other Excessive Health Care Costs[5]	1,711
	$2,217[6]

[3]Health Care Financing Administration, A Guide to Medicare (Washington, D.C.: Department of Health, Education, and Welfare, September 1977).

[4]Medicare presently pays over one hundred percent of hospital nursing care costs allocable to Medicare patients. The excessive nursing differential cost factor was included by regulation to provide for the claim (by the American Hospital Association) that Medicare patients require more nursing care than other patients.

[5]Other excessive health care costs include hospital inpatient services (i.e., excessive hospital beds, unnecessary surgery and hospital stays, and excessive physicians costs), x-rays (unneeded and repeated x-ray orders and associated genetic defects), and nursing homes (fraudulent and abusive operative practices).

[6]Office of Inspector General Annual Report, April 1, 1977 - December 31, 1977 (Washington, D.C.: Department of Health, Education and Welfare, March 31, 1978) pp. 4, 82-90.

Quality Control

HEW established HCFA to coordinate Medicare and Medicaid in the hope of eliminating duplication and promoting economies and efficiencies for both programs. Within HCFA, the Office of Program Integrity (OPI) is responsible for quality control for Medicare (and Medicaid). The Audit Agency and the Office of Investigations also work with HCFA and the Medicare Bureau, under the aegis of the Inspector General to assist in Medicare quality control efforts. They may be called upon to do anything ranging from audit functions to investigation and criminal prosecution of participants determined to be defrauding or abusing the system.

Staff Training

All training, orientation and the refresher training for Medicare staff is handled by the main HCFA office in Baltimore, in coordination with the regional HCFA offices and the Social Security Insurance District Offices. All training materials are produced and distributed by the Baltimore office, and training staffs at the District Office levels assist in on-the-job training methods.

Orientation and training for Medicare personnel are provided to two categories of staff operating in the District Offices. Claims representatives and service representatives receive 13 weeks of required coursework. In addition, regional office personnel are trained on a semi-annual basis.

The training materials prepared in HCFA's central office for Medicare and Program Integrity staff are made available to all intermediaries and carriers participating in the health insurance program. In addition, HCFA reimburses intermediaries and carriers for the costs of any materials for training purposes that they may develop. They usually develop their own program materials and conduct coursework in which HCFA staff occasionally participate.

Audit

The Audit Agency of HEW conducts audits of the Medicare program central office, as well as audits of selected intermediaries and carriers. Recent audits have focused on determining whether the Medicare claims processing systems were producing accurate and timely benefit payments. The audits have identified many areas of possible improvement to increase economy and efficiency in the system. Specifically, in both Parts A and B, the payments systems have resulted in overpayments to beneficiaries and improper denial of claims. Another area of concern detected by agency audits involves administrative costs claimed by intermediaries and carriers. For FY 1978, the Audit Agency is allocating eleven percent of its resources to check the validity and equity of costs claimed by intermediaries and carriers concerning claims processing and provider settlements. Also, audit guides are being developed and tested that would be suitable for state or CPA audits of intermediaries and carriers.

Providers, such as hospitals, skilled nursing facilities and home health agencies, are being audited on a rotating basis by intermediaries to determine the amounts allowed to be claimed for operating Medicare. The providers are also reviewed by federal and state auditors for other programs they administer. It has been suggested that Medicare could save millions of dollars if one common audit was performed for all the programs administered by the providers.[7]

Investigation of Fraud and Abuse

The investigations and prosecutions of fraudulent or abusive participants in the Medicare program are presently handled by several agencies and staffs. The Program Integrity Office and the Office of Investigations (OI) are responsible for investigations and case development within HEW. The OI receives referrals from the Audit Agency and from Program Integrity, as well as various other sources. Regional Office investigators conduct the investigations. The scope of the investigative work includes contractor problems and beneficiary complaints; the majority of the investigations involved nursing homes, home health agencies, laboratories and clinics, and a diverse group of providers (podiatrists, therapists, chiropractors, dermatologists, opthamologists, et. al.).

Prosecution

Upon an investigative finding of probable fraud, the Inspector General, HCFA, or OI refers the case to the United States Attorney for prosecution. Criteria affecting a decision to prosecute are the dollar amount of fraud and the evidence available to prosecute the case. Successful prosecution, and therefore recovery of Medicare, provides a highly visible deterrent for fraud or abuse in the close-knit medical provider communities. Efforts are being made to coordinate the criminal investigations activities in OI and OPI in order to facilitate the prompt adjudication of the health care program cases by the Department of Justice. It has been recommended that as the Office of Investigations staff increases, it should gradually relieve Program Integrity of the responsibility for Medicare fraud investigations.[8]

---

[7]Ibid., pp. 13-14, 85, 103-04.

[8]Ibid., pp. 22-28, 69.

MEDICAL ASSISTANCE PROGRAM (MEDICAID TITLE XIX)

Type of Benefit: Service

Sponsor: U.S. Department of Health, Education, and Welfare

Program Administration: Decentralized in a federal-state partnership

OVERVIEW

The legislative authority for Medicaid is Title XIX of the Social Security Act of 1935, as amended. The program objective is:

> To provide financial assistance to states for payments of medical assistance on behalf of cash assistance recipients and, in certain states, on behalf of other medically needy who, except for income and resources, would be eligible for cash assistance. [1]

All states, except Arizona, have Medicaid programs, for which the federal government will pay out approximately $10,851 million in FY 1978 for 21,346,000 recipients of medical assistance. It is estimated that $12,065 million will be paid out for 21,378,000 recipients in FY 1979.[2] Today, health care costs in the United States represent almost 9% of the gross national product, with cost increases of 12 percent yearly since 1967. Of the estimated $186 billion spent for health care in 1978, over 10 percent is expended by Medicaid programs.[3]

Participants in Medicaid programs include benefit recipients, third party providers of medical service, auxiliary providers and administering agencies and their employees. The general criteria for establishing recipient eligibility is income standard, but specifically, persons receiving AFDC, aged, blind, or disabled persons, and others deemed in need of Medicaid benefits but not currently receiving other benefits, may participate. Third party providers delivering a broad spectrum of medical services, include physicians, dentists, laboratories, long-term and intermediate care facilities, hospitals, pharmacists, clinics and equipment and service companies (such as taxi companies). In addition, auxiliary

---

[1] Office of Management and Budget, Catalog of Federal Assistance, 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 343.

[2] Ibid.

[3] "Unhealthy Costs of Health," Business Week (September 4, 1978), pp. 58-59.

providers render services as insurance carriers, claims processing and data management intermediaries, and fiscal agents.

The Health Care Financing Administration (HCFA) of HEW is responsible for the federal aspects of Medicaid programs. HCFA, established in 1977, in place of the Social and Rehabilitation Service, provides direction and technical guidance for the nationwide administration of federal efforts to plan, develop, manage and evaluate health care financing programs and policies.[4] The Director of HCFA reports directly to the Secretary of HEW. States wishing to provide Medicaid program services must submit plans to HEW for authorization outlining the proposed management and delivery systems. The state agency responsibilities cover several areas of program administration.

- Licensing of facilities for Medicaid purposes
- Execution of records access agreement with all facilities which participate in Medicaid according to federal regulatory standards
- Eligibility determination
- Furnishing medical assistance, rehabilitation services and other services to assist families

Medical assistance services that states must provide beneficiaries are inpatient and outpatient hospital care, laboratory and x-ray services, physicians' services (including screening, diagnosis and treatment for children under 21), skilled nursing facility services, home health care and family planning services.

Optionally covered services that may be reimbursable are dental care, prescribed drugs, eye glasses, clinic services, intermediate care facility services and other diagnostic, screening, preventive and rehabilitative services.

The federal government's share of medical assistance for each state ranges from 50 percent to 78 percent according to a statutory formula based upon the relation of the state's per capita income to the national per capita income. The remaining costs in the individual programs are paid by state and local taxes.

Opportunities for Fraud and Abuse

Recipient Fraud

There are diverse opportunities to defraud and abuse the Medicaid program because of its many participants and transaction

[4]Michele Moore, ed., Public Welfare Directory, 1978/79 (Washington, D.C.: American Public Welfare Association, 1978), p. 11.

points. Among the recipient population, there have been documented problems with misrepresentation of eligibility requirements to obtain ineligible benefits and overutilization of Medicaid-covered services, such as methadone drug programs for narcotics users.

Third Party Fraud

Associated with third parties who are reimbursed for medical services provided are such frauds and abuses as:

- Establishment of "ghost" patients.
- Billing problems, i.e., over-billing, double-billing, billing for services not rendered.
- Misrepresentation of services, e.g., up-grading services and altering prescriptions or laboratory test orders.
- Overutilization of services to recipients (unnecessary or inappropriate).
- Tie-ins and interlocking ownerships among clinics, laboratories, nursing homes, etc.
- Kickbacks.
- Brokering, or subcontracting services.
- "Medicaid mill" abuses, such as ping-ponging, ganging, up-grading and steering.
- Manipulation and misuse of patient funds in skilled nursing facilities.

The various types of frauds and abuses listed above are often specific to groups within the third party provider community, such as pharmacists, dentists, podiatrists, clinics and laboratories.

Auxiliary Fraud

Among auxiliary providers who contract with state agencies to assist in data management and claims processing of Medicaid benefits, there have been occurrences of employee computer fraud. Of growing concern relative to computer fraud schemes is the need for increasingly sophisticated computer security measures to preserve data confidentially and prevent unauthorized use of computer systems by employees of auxiliary providers.

Recent criticism has been directed toward auxiliary organizations exhibiting conflicts of interest. Frequently, the decision-making groups for fee scheduling and the boards of director of

health insurance carriers are controlled by physicians and hospital representatives who may be too closely connected with the third party provider constituency and far removed from the direct beneficiary population. Auxiliary providers also come under criticism for their reluctance to take corrective actions against third party providers who are found to be abusing the program.

Agency Fraud

The occurrences of fraud and abuse by Medicaid agency employees include such activities as collusion among the employees, providers and recipients to illegally obtain benefits, the creation of ghost eligibles to draw benefits, and computer fraud. Many of the problems associated with computer systems access and security found in the private intermediary and carrier organizations are also prevalent in the program agency computer systems.

Enforcement Techniques

HEW has established various programs and offices to facilitate efficient and effective state operations of Medicaid plans. HFCA maintains the Office of Program Integrity (carried over from the Social and Rehabilitation Service) to provide management and review and case development. The authority of Program Integrity is to assure that federal and state Medicaid payments are made only on behalf of eligible recipients, only for covered services, only for appropriate services, and only in reasonable amounts. Program Integrity has a centrally headquartered staff of 50 persons and 250 field personnel in the ten nation-wide regional offices. Initially, the major focus of Program Integrity was on Medicare investigations. However, for the past few years, more attention has been placed on Medicaid problems.

Personnel in the Program Integrity sections of Regional Offices are recruited from the medical assistance programs; they require further training in investigative skills only. In 1978, there were 300 Program Integrity staff in the regional offices.

HR 3

In an effort to assist state agencies to identify, investigate, and prosecute cases of fraud in Medicaid and Medicare, Congress enacted the Medicare-Medicaid Anti-Fraud and Abuse Amendments Act in October 1977 (Public Law 95-142), hereafter known as HR 3. The new HR 3 legislation appropriates 90 percent federal funding for three years to states that wish to set up an investigative and prosecution fraud unit for Medicaid. The Program Integrity staff of the HCFA offices have been given primary responsibility for certification of HR 3 units. Recertification of units will also be handled by the regional offices.

Training

The HR 3 legislation requires that new fraud unit employees be trained annually with follow-up training provided every seven months. Experienced employees are trained annually and attend refresher courses when new legislation or regulations are put into effect which apply to their specific job tasks. HR 3 regulations also place new demands on the training of Program Integrity staff for technical assistance to states desiring to make application for funds for prosecution fraud units. Several one-day orientation sessions for regional personnel on the requirements for certifying HR 3 units have been held since the legislation was finalized in 1977.

Any training materials relating to Medicaid management and fraud control that HCFA produces are made available to all intermediaries and carriers participating in the program. HCFA will reimburse intermediaries and carriers for costs of materials they may develop for training purposes. In most instances, the intermediaries and carriers do their own development of program materials and conduct their own coursework for their own employees. The Blue Cross Association, for example, has its own staff for training purposes. In some instances, the courses have been so successful that HCFA has sent program staff personnel to participate in the intermediaries' and carriers' courses.

Quality Control

Quality control efforts are administered at the federal and state level by law, and within the auxiliary providers' organizations. There are mandatory auditing and reporting procedures for the state programs that are reviewed by the HEW office of Inspector General. By law, the Medicaid agencies must report any suspected frauds or abuses to the HR 3 unit for follow-up (if such a unit has been established), rather than conduct full-scale investigations from the administrative offices of the program.

The Office of Inspector General created a specialized quality control program, Project Integrity, in the summer of 1977. The initial work consisted of a national analysis of all Medicaid claims paid to doctors and pharmacists in 1976 (over 250 million transactions). The analysis allowed the Inspector General's staff to examine the profiles, conduct investigations and take appropriate actions for all types of irregularities discovered. The lessons learned and experience accrued from Project Integrity are being applied to other third party providers as well (i.e., laboratories, dentists, podiatrists, optometrists, chiropractors, outpatient hospital billings, medical suppliers and equipment and transport services). Increasingly sophisticated and far-ranging edit programs like Project Integrity are expected to continue.[5]

---

[5] Office of Inspector General Annual Report, April 1, 1977-December 31, 1977 (Washington, D.C.: U.S. Department of Health, Education and Welfare, March 31, 1978), p. 37.

HCFA offers technical assistance to states to set up a Medicaid Management Information System (MMIS). The MMIS will be used to create a data base for management decision-making and detection of fraud and abuse on local levels. Federal monies are available to assist in development of the system. A federal-state agency, the Institute for Medicaid Management (IMM), conducts workshops and conferences on management information for federal and state personnel, provides technical assistance and training for program managers and staff, and acts as a clearinghouse for technology transfers between states and the federal government.

Since staff turnover in state Medicaid programs is extremely high (estimated at one in six annually), the Institute provides orientation to the new staffs. Approximately 15 states have certified MMIS systems. Development has been promoted through a combination of MMIS support and state contracts with outside computer firms. The federal government pays 90% of implementation costs. Once the system is operational, the federal share is reduced.

A subsystem of the MMIS used for profiling providers and recipients in the Medicaid programs is the Surveillance and Utilization Review System (S/URS). The profiling computer screens aid program staff for fraud and abuse detection in determining:

- The client's eligibility for the program.
- The certification status of the provider.
- Types of charges made by the provider.
- Whether or not the charges claimed are within specified limits for payment.
- Whether or not rates are reasonable for various types of provider services, i.e., hospitals, nursing homes.

With increasing reliance on computer technology for management, the states can gain control of health assistance claims through prepayment and postpayment checks. Prepayment controls provide initial monitoring of the claims, while postpayment edits give information on health care patterns.

SUMMER FOOD SERVICE PROGRAM FOR CHILDREN

Type of Benefit: Service

Sponsor: U.S. Department of Agriculture

Program Administration: Formula grants provided for federal or state administration of programs with disbursement to eligible service institutions providing program services

OVERVIEW

The Summer Food Service Program for Children is authorized by the Child Nutrition Act of 1966, Section 13, as amended 42 U.S.C. 1751. At the federal level, Summer Food Service is administered by the Food and Nutrition Service (FNS) of the U.S. Department of Agriculture (USDA). At the state level, Summer Food Service is run by state educational agencies that contract with local sponsors to operate the programs at approved feeding sites. Sponsors prepare the meals themselves or enter into agreements with food vendors for meal delivery service to the sites. If the states cannot or will not administer the Summer Food Service program, the FNS will act in the state's capacity to operate the program. Within statutory limits, the costs, both program and administrative, are paid by the federal government. The Summer Food Service program is designed to feed during the summer months those children who reside in areas in which poor economic conditions exist.[1] The meal quality standards must meet USDA minimum requirements for nutritional value. In FY 1977, the Summer Food Service program served 2.7 million children, at a federal cost of $152,465,000. The estimated average reimbursement rate to sponsors for meals or food services was 75.4 cents for each meal served. Estimates for FY 1978 and FY 1979 show that federal outlays for the Summer Food Service, respectively, are $190,000,000 and $148,500,000.[2]

---

[1] "Areas in which poor economic conditions exist" are defined as (1) the local areas from which a site draws its attendance, in which at least one-third of the children are eligible for free or reduced price school meals under the National School Lunch (or Breakfast) Program; or (2) an enrollment program in which at least one-third of the children are eligible for free or reduced price school meals as determined by eligibility statements in regard to the size and incomes of the children's families.

[2] Office of Management and Budget, Catalog of Federal Domestic Assistance 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 49.

Because of the occurrences of massive abuses and fraud in Summer Food Service programs through the country, new regulations were approved in 1977 to reduce the opportunities for misuse and improve program management by all participants.

Responsibilities of the FNS and Federal Government

The Food and Nutrition Service, as the federal agency responsible for administering the Summer Food Service Program, reviews state plans entailing proposed management and administrative procedures, budget projections, compliance methods, and other program requirements. The state plans are written in accordance with guidelines and regulations established by the FNS. In the event that a state refuses to administer the Summer Food Service program, the administrative responsibilities, outlined in the regulations for state agencies, are assumed by FNS.

Responsibilities of State Agencies

The responsibilities of the state agencies cover a broad range of functions to assure proper management of the Summer Food Service. The state agency provides program assistance to sponsors. For example, the state agency conducts site visits of new sponsors or large budget sponsors prior to approval for program participation. The site inspections evaluate the capability of sponsors to serve the number of children expected, as cited in the sponsor's operation plans.

Periodic on-site evaluations must be made by state personnel during the operational months. State approval of sponsors and sites is guided by considerations of past performance in the program, capabilities to meet the needs of the child population in the site area, and limitations regarding the average daily attendance of eligible children and the number of sites a sponsor can serve. Eligibility qualifications differ for non-residential public or non-profit private institutions from those for public or non-profit private camps.

The state agencies establish accounting and reporting procedures for the sponsors and food service management companies. In addition, the state agencies are responsible for standard sponsor-vendor contract requirements, including allowances for record inspection and audits by the state agency, USDA, or the General Accounting Office. Regulations dealing with food service delivery encompass food quality standards, unitization of meals, and ineligible food service (e.g., food delivered to unauthorized sites). State agencies should encourage the use of the sponsor's own facilities or the facilities of public or non-profit private schools by the sponsors for preparation, service, and delivery of meals. Investigations of complaints or irregularities in connection with program operations are to be conducted by the state agencies, and appropriate action taken. Records and evidence gathered from such investigations must be maintained for subsequent USDA investigations. Sponsor training for administrative and supervisory personnel must

be provided by state agencies and should reflect individual sponsor needs and locations. Food service management companies (vendors) must register with state agencies administering the Summer Food Service in order to enter into contract agreements with approved sponsors.

Responsibilities of Prime Sponsors

Upon application to the state agency, or FNS, the sponsor must demonstrate its eligibility for participation by documenting such factors as its past performance with Summer Food Service (if any), its corporate status (public or private non-profit), its staff capability to supervise and operate program, and its commitment to proper training for all personnel. With their applications, the sponsors must submit information sheets for each site to be used, a proposed budget, synopsis of the invitation to bid for food service (if vendor food service is desired), and certification that the sites (camps excluded) are located in economically depressed areas. The sponsors are responsible for the nutritional quality of all meals served, as outlined in USDA regulations. Other sponsor provisions include specifications regarding the bidding process, i.e., standard contract forms and publicity for competitive bidding. Sponsors cannot contract with food service management companies that are not registered with the state.

Cost Reimbursements

The federal government reimburses sponsors for the full cost of food service operations; however, certain cost per meal rates will not be exceeded. The rates of per meal reimbursement for state agencies and sponsors are adjusted annually as specified by law. FNS makes three advance payments to the states during the summer to be disbursed to the sponsors. Determinations of fiscal needs are based on monthly reports submitted by the sponsors to states and on the cost of the state program in the preceding fiscal year.

Program Fraud and Abuse

A recent GAO report notes that:

> Before 1977, weak and inconsistent program administration and non-compliance with regulations resulted in widespread abuses in the Summer Feeding Program. Several of these abuses developed to epidemic proportions in places such as New York City.[3]

[3]U.S. Comptroller General, The Summer Feeding Program for Children: Reforms Begun - Many More Urgently Needed (Washington, D.C.: U.S. Government Printing Office, March 31, 1978), p. 2.

The abuses documented related mainly to sponsors and vendors. A large catalog of problems concerning sponsors and vendors includes ineligible food service (poor quality, not meeting USDA nutrition requirements, feeding adults, and off-site consumption of meals), collusion and kickbacks between service institutions, bidding and contract irregularities, and maintenance of incomplete and inaccurate data on the number of meals served and children fed. Inefficient site operations are attributed to the participation of incompetent sponsors and lack of close monitoring by appropriate agents. Some summer camps had provided food of poor quality. Other sponsor abuses noted were padded budgets and falsified claims for reimbursement. Vendor irregularities related to bidding and contract procedures and the lack of records to demonstrate past performance and suitability for program participation.

QUALITY CONTROL

The new Summer Food Service regulations authorized in 1977 tighten the program's quality control measures for all participants. The Summer Food Service scandals in 1976 in several areas of the country, involved extensive fraud and abuse in sponsor site management. Consequently, the new regulations limit the number of sites to be operated and the number of children that can be served at sites for each sponsor. The state agencies are required to make pre-program site inspection visits to the non-school sites in larger cities. In addition, the states may restrict the types of meals served as well as the number of meal services to be provided daily.

In the area of sponsor-vendor relationships, the federal government requires public bid openings for many sponsors who expect to receive more than $100,000 of program payments. Now, vendors who contract with sponsors for food service must maintain current health certificates and be bonded. As mentioned previously, there are standard contract forms to ensure the provision of certain base program requirements.

Increased monitoring of sponsors and sites is now required of state agencies. Monitoring takes place at sites prior to the approval of sponsors new to the program and at sites of sponsors receiving more than $50,000 of program payments per year. State personnel can monitor food vendor operations under the new regulations. Self monitoring is expected of sponsors also. However, this is not considered an effective quality control method presently, because sponsors have little reason to report and correct their deficiencies.

TRAINING

Training is an important tool of program control. Because of the short duration and structure of the Summer Food Service program,

proper training of personnel, both state agency and sponsor, tends to be haphazard. Many program employees are summer volunteers who assess the food quality and quantity at sample sites. Efforts have been made by USDA and state agencies to provide adequate training for agency and sponsor employees, particularly for administrative personnel. As noted earlier, the USDA requires states to make training available to Summer Food Service personnel in a program that is appropriate to the sponsors' individual circumstances and requirements. FNS assists in training state personnel.

AUDIT

The 1977 regulations contain specific audit procedure guidelines for the states and authorized sponsors. However, FNS resources do not allow 100% site audits; consequently, statistical samples in each state are taken for audits. USDA has automatic access to all financial records, accounts, and audit information of states and sponsors. Sponsors are subject to audits every two years by CPA's, state agencies, the U.S. Department of Agriculture or the General Accounting Office, if the states in which sponsors operate programs do not have an audit program. Additionally, sponsors who receive more than $50,000 of program payments must undergo an audit of reimbursement claims by private CPA's or independent state or local auditors. Limited personnel and budgets preclude thorough, continual audits of program participants to identify possible fraud or abuse.

Problems in the Summer Food Service Program at the state level were of an administrative nature, due to the structure of the program, rather than to an intent to defraud. The congressionally set appropriations vary from year to year, so that the states cannot calculate how much of their budgets will be necessary to cover administrative costs not reimbursed by the federal government. It is felt by state and federal GAO officials that the cost reimbursement schedules are inflexible and insufficient to pay states for program operation. As a result, states decline the administration and the responsibilities fall to the Food and Nutrition Service, which generally requires higher wages and costs for federal personnel. The "take-back" aspect of the program can cause great confusion for all participants if the state opts out at the last moment.

OTHER ENFORCEMENT

Efforts to combat the extensive fraud and abuse in Summer Food programs have been geared toward regulatory control of the opportunities for fraud or abuse. The 1977 regulations specified more stringent eligibility requirements for sponsors, outlined procedures for terminating a sponsor's contract in the event of noncompliance with service procurement requirements, and initiated enhanced quality control measures as cited earlier. A clearinghouse report, being compiled by the USDA, will list food service management companies and their summer food performance histories. Conventional

methods involving administrative or judicial penalties to reduce program abuse do not have the strength of deterrence in the Summer Food Service program as in other assistance programs. The provisions for suspending sponsors and vendors or thier claims are restricted by the guidelines in the program regulations. It is difficult to prosecute or obtain recoveries from sponsors such as churches and community and special interest organizations. The Office of Audit, USDA, has recommended the states be considered liable for any fiscal losses from sponsors or vendors, if recovery is not forthcoming. States can withhold program payments to sponsors who are delinquent in returning overpayments.[4] Fraud cases are handled by the U. S. Department of Agriculture's Office of Inspector General or the respective State's Attorney General. There are no special fraud or investigative units to accept oversight and control responsibilities for the Summer Food Service program.

---

[4] Ibid., p. 41.

COMPREHENSIVE EMPLOYMENT AND TRAINING PROGRAM (CETA)

Type of Benefit: Service

Sponsor: U.S. Department of Labor

Program Administration: Decentralized to more than 440 prime sponsors, which are either states, units or local government, or consortia of local government, and which receive either formula grants or project grants.

OVERVIEW

The legislative authority for CETA Titles I, II, and VI[1] is found in the Comprehensive Employment Act Amendment of 1978, 29 U.S.C. 801 (1963).

The overall purpose of CETA is to provide job training and employment opportunities for economically disadvantaged, unemployed, and underemployed persons and to assure that training and other services lead to maximum employment opportunities and enhance self-sufficiency. This is done through the establishment of a flexible and decentralized system of federal, state, and local programs.[2]

Title I (Now Title II-A, B, C) provides for institutional (i.e., classroom) training, as well as on-the-job training, with eligibility criteria focusing on the "hard-to-employ." Title II-A provides for supplemental vocational education assistance in addition to the basic CETA grants allotted to a jurisdiction. These special grants to governors can amount to six percent of the grants received under

---

[1]The other titles of the CETA program have not been reviewed in the Fraud and Abuse study, because either they contain the administrative provisions of the Act or they are the continuation of previous "categorical" employment programs. They are: • Title III: Special Federal Responsibilities (categorical programs; skill training and improvement program STIP for previous CETA participants who have been unable to find jobs in the private sector; and research, training, and evaluation); • Title IV: Youth Programs; • Title V: Establishment of a National Commission for Employment Policy; • Title VII: Private Sector Opportunities for the Economically Disadvantaged; and • Title VIII: Young Adult Conservation Corps.

[2]Office of Management and Budget, Catalog of Federal Domestic Assistance 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 575.

certain sections of the CETA law. Title II (now Title II-D) provides funds for the training activities covered in Title I, and adds a Public Service Employment (PSE) component. Title VI, the "Emergency Jobs Program" provides for additional PSE, as a countercyclical measure (tied to the unemployment rate), with $2.5 billion authorized initially, for FY 1975.[3] Criteria for training and employment are discussed in the following section.

In fiscal year 1978, approximately $4.2 billion were expended for Titles I, II, and VI combined. For fiscal year 1979, it is estimated that almost $8 billion will be spent for Titles I and VI. The following chart shows the number of enrollees served in fiscal years through 1978.[4]

	1976	1977	1978
Title I:	1,672,000	1,415,600	1,314,600
Title II:	252,300	352,900	210,300
Title VI:	481,200	592,900	1,008,400

BENEFITS AND ELIGIBILITY

Historically, CETA has developed from a categorical employment program. In 1969, it was changed to reflect a greater interest in local community responsibility for employment problems and to provide for a general emphasis on revenue sharing. Monies are provided on a formula basis to states and other political subdivisions (including consortia of governments) that meet a population requirement of 100,000. The formula variables, defined by statute are based on a combination of local unemployment rates and the proportion of persons with incomes less than 70% of the Department of Labor's lower living standard budget.

The states or political subdivisions must submit an employment plan to the regional offices of the Department of Labor. The offices review the plan; however, this appears to be rather perfunctory since the legislation intends local initiatives. Upon approving the employment plan the regional office enters into a contract with the elected official of the political subdivision. Each subdivision must have an advisory committee composed of labor, management, and busi-

---

[3] The Implementation of CETA in Eastern Massachusetts and Boston, U.S. Department of Labor, Employment and Training Administration, R & D Monograph 57 (Washington, D.C.: U.S. Government Printing Office, 1978), p. 6.

[4] Per January 18, 1979 telephone conversation with CETA administrative staff, Washington, D.C.: U.S. Department of Labor.

ness representatives from the community. This advisory group reviews applications from employers seeking to provide jobs. Administrative costs of the program are covered in the total allocation made to the political entity prime sponsor, but they are not to exceed 15% of the total funds allocated.

The political subdivision is responsible for training administrative and program personnel. A "Federal Representative" from the regional office is assigned to monitor each program. The Federal Representatives can also offer technical assistance to the prime sponsors, and can be a valuable liaison between the regional offices and the sponsors.

In order to qualify as a CETA candidate, a job or training recipient must meet at least one of the following criteria:

- Have received unemployment compensation for 15 weeks or more.
- Have exhausted unemployment compensation benefits.
- Not be eligible for unemployment compensation, but be unemployed.
- Be a member of a family receiving AFDC under state plan (Part A of Social Security Act, with family income less than 70% of the BLS lower living standard budget).
- Have been unemployed for 30 days prior to application, except in areas of excessively high unemployment, in which case persons need only be unemployed 15 days (applies to 50% of the non-project jobs under Title VI and Title II, if residing in an area of substantial unemployment)

These criteria, particularly the one concerning family income, have given rise to complicated formulae and extensive paperwork, for which local program administrators have had to be trained. Where state agencies train CETA administrators, the situation is complicated by the fact that each prime sponsor may run its CETA program differently.

The benefits, which are subsidized jobs, may be renewed on an annual basis. The precise amounts received by each prime sponsor vary according to the area's share of unemployment. Individual recipients may continue in their jobs if they are unable to find unsubsidized positions in the private sector.

Provider Fraud

Prime sponsors in CETA may include the following organizational structure:

- States
- Units of local government which meet certain population requirements (usually 100,000 persons)
- Combinations of units of local government
- Some cooperative rural area employment programs

These sponsors, in turn, may elect to run their own employment and/or training programs, or may subcontract all or part of them to private providers or to other government agencies.

Distribution of funds from the prime sponsors to actual program operations takes different forms, particularly in view of the emphasis on local decision-making. For example, some balance-of-state (BOS) consortia (groupings of counties which do not meet the minimum population criteria) have elected to run their CETA programs through state Departments of Education, Labor or Commerce, while others have subcontracted the funding to each individual county. Still others may hire private organizations to run the programs.

Every time funds are transferred, an opportunity for fraud or abuse exists. From this, the major types of provider fraud are:

- Embezzlement of federal funds by creating "ghost" eligibles who are fictitiously reported as working at jobs or in training. The provider then pockets the money which had been earmarked for paying recipients.
- Allowing enrollment in the program by persons known to the provider to be ineligible according to the legislated criteria, often for political patronage considerations.
- Coaching of recipients to make fraudulent claims.
- Using CETA funds to pay for positions which would otherwise have been funded from local sources. This is called "maintenance" of effort", because federal funding is being used for maintenance of public services and public employment.

Recipient Fraud

Recipients, themselves, can misrepresent their eligibility by under-reporting their family income of their length of unemployment. However, there is a very low proportion of ineligibles certified compared with other abuses of the program. The worst cases of eligibility abuse are in the summer employment programs where large numbers of applications must be processed within a short period of time. The countercyclical PSE program (Title VI) would also be subject to the problem of a large number of applications during an economic downturn.

ENFORCEMENT TECHNIQUES USED IN THE CETA PROGRAMS

Recipient eligibility and certification are handled by the state employment agency in conjunction with the prime sponsor. Usually, there is no computerization of eligibility rolls since it is too costly for local government. However, some states do cross-match their CETA rolls with Unemployment Insurance and Public Assistance rolls.

The representative from the regional office of the Department of Labor is responsible for monitoring prime sponsor procedures and auditing contractors' books to assure consistency of wage records and compliance with CETA requirements. Additionally, prime sponsors can audit their contractors' books and performance.

The decentralization of CETA makes enforcement difficult, although the Department of Labor requires an enormous amount of paperwork from the prime sponsors, as follows:

> In addition to the planning document, the prime sponsor must supply the Regional Office of the Department of Labor with an incredible array of reports, e.g., program planning summaries, program status summaries, PSE occupational summaries, financial status reports, etc. Occasionally, the prime sponsor must even provide "assurances" and "certifications" that it is adhering to all regulations. Persons connected with the day-to-day CETA operations are not surprised that the President's Commission on Federal Paperwork determined that the amount of paperwork required under CETA "prevented the program from serving its intended beneficiaries." The report went further to say that the Department of Labor tended to "legislate through the issuanc of guidelines and regulations." Whether or not the volumes of reports and paperwork are necessary to assure that the funds are used in an honest manner and do get to the persons designated as target groups

in the legislation is hard to determine. There are good arguments on both sides of the issue.[5]

The new CETA law passed in October 1978 addresses the issue of "maintenance of effort" and tightens the regulations restricting it. The term "maintenance of effort" refers to the practice of using Title VI (PSE) monies to provide those services which the local government is mandated to provide as part of its basic function, using regular municipal employees rather than CETA enrollees. It is anticipated that the new Office of Inspector General in the Department of Labor will follow-up on allegations of serious abuse involving "maintenance of effort." Presumably, prime sponsors which flagrantly violate "maintenance of effort" or other regulations, or those who ignore eligibility criteria, could be dropped from the CETA program. Realistically, this is unlikely to happen. Under the current organization of CETA, without the prime sponsors, there would be no way to get the money to those recipients who need it.

[5] The Implementation of CETA in Eastern Massachusetts and Boston, op. cit., pp. 35-36.

VOCATIONAL EDUCATION - BASIC GRANTS TO STATES

Type of Benefit: Service

Sponsor: U. S. Department of Health, Education, and Welfare

Program Administration: Decentralized in a federal-state partnership

OVERVIEW

The Vocational Education program of the Office of Education, Department of Health, Education, and Welfare, is authorized by the Vocational Act of 1963, as amended, P.L. 94-482, 20 U.S.C. 2301 to 2461.

The program objective is:

> To assist states in improving planning and in conducting vocational programs for persons of all ages in all communities who desire and need education and training for employment.[1]

The Vocational Education program provides for the funding of vocational education programs, construction of vocational education school facilities, placement services for students successfully completing vocational education programs, support services for women entering traditionally male-oriented vocational programs, day care services for children of vocational students, and state and local expenses for the administration of the program. States are required, under federal law, to allot certain portions of their services for vocational education for the disadvantaged, the handicapped, and persons of limited English-speaking ability, as well as for post-secondary and adult vocational education. The program can be administered in conjunction with other federal assistance programs that are considered suitable for joint funding according to federal regulations. Any individual requiring vocational training may participate in the program.

States desiring to provide the Vocational Education program services must submit a five-year state plan and annual program plan to the Commissioner of Education for approval. Funding for the state programs is determined by a set formula relative to the age

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance 1978 (Washington, D. C.: U. S. Government Printing Office, May 1978), p. 266.

distribution of state populations as compared to the national distribution and the previous year's allotment. The funding formula allows more funding for the lower income states than for higher income states. The federal share of funding for fiscal year 1978 and fiscal year 1979 is estimated at $413 million and $430 million, respectively. An estimated 16 million students enrolled in Vocational Education programs in fiscal year 1978.[2]

Opportunities for Fraud and Abuse

The area in which fraud and abuse of the Vocational Education program may occur is in the contractual relationship between the schools providing vocational training and the administering state agencies. The Inspector General Annual Report for 1977 noted that there was no systemic assurance that the appropriated funds were being furnished to the appropriate agencies and training programs. Some institutions received funding when the local employment opportunities were unavailable or insufficient to warrant such training programs.[3] There have been instances also in which vocational schools and training institutions have received funds for fictitious students, for students who never enrolled, or for students who dropped out prior to completion of the programs.

Enforcement Methods

Vocational Education programs are subject to continuous evaluation by the state boards for vocational education and annual evaluation by State Advisory Councils (required to assist in administering the programs). The annual plans and annual program reports are reviewed by HEW with the states. On-site management evaluation reviews are conducted periodically to assess the compliance and quality of program administration. Audits of the state and local agencies are conducted in accordance with HEW regulations; each state agency is audited by HEW at least once every five years. As a result of the findings regarding program abuse, as cited in the 1977 Inspector General report, the Office of Education plans to strengthen the guidance, monitoring and evaluation of all levels of Vocational Education administration.[4]

---

[2]Ibid., p. 267.

[3]Office of Inspector General Annual Report, April 1, 1977-December 31, 1977 (Washington, D. C.: Department of Health, Education and Welfare, March 31, 1978), pp. 14, 107.

[4]Ibid., p. 107.

PART E: CONTRACT PROCUREMENT AS BENEFIT

The method by which governments most frequently obtain services is through contracts with private enterprise. These contracts serve a dual function of providing needed services to an agency and providing income to the individual business firms. Under the 8(a) Contracting programs from the Small Business Administration Minority monies flow from the Federal agency to minority-owned small businesses for either professional, e.g., research centers, or non-professional, e.g., food service to military installations. The steps involved in a typical procurement include the following:

> The agency develops a contract solicitation, which describes its purchase requirements and sets forth conditions which the contractor must meet. That solicitation is publicized and businesses submit bids or responses to it. In negotiated procurements, the agency is able to evaluate and discuss the components of each response with the company who submitted it; in formally advertised procurements, the agency checks each bid to see if it meets the terms and conditions of the solicitation. The agency then selects the apparent winner. In negotiations, the apparent winner is the firm whose proposal, after evaluation of price, technical and other factors, best meets the terms of the solicitation. In formal advertising, the winner is the firm which responded to the terms of the solicitation and submitted the low bid. After selection but before the actual signing of a contract, the agency looks at the apparent successful firm to determine if it has adequate financial resources, will be able to meet delivery schedules, has adequate technical capabilities, a satisfactory past record of performance and is otherwise qualified for the award. The purpose of this review, which is called a responsibility determination, is to determine if the contractor who has been responsive to the terms of the solicatation and has submitted the best offer is responsible to be awarded the contract.[1]

Contract procurements appear vulnerable to several patterns of misuse. The one most publicized in the 8(a) program has been "fronting" where non-minorities use a minority front to obtain

---

[1]Small Business Investment Act of 1978, United States Senate 95th Congress, 2nd Session, Report No. 95-1140, Calendar No. 1059, August 23, 1978, p. 5.

contract benefits. The program has seen problems with defaults, with the misuse of advance loan payments (advances used to open savings accounts and draw interest); and a tendency to continue on the program and not "graduate" to a status where it could obtain its own contracts without government assistance.

Audits and investigations following complaints of problems in individual programs have detected these patterns of offenses.

MINORITY CONTRACTING
(Minority Business Development - Procurement Assistance)

Type of Benefit: Government Contract

Sponsor: Small Business Administration

Program Administration: Decentralized to SBA's district offices with regional office supervision

OVERVIEW

The authority for the Minority Contracting program is found in the SBA Act as amended 15 U.S.C. 631, 637 and 698 (1953), and the Economic Opportunity Act of 1964 42 U.S.C. 2901, 2902, 2906b and 2906c as amended. The purpose of the Minority Contracting program, which is also known as "8(a), is to:

> insure participation of businesses that are owned and controlled by 'disadvantaged' persons, in federal contracting, and to establish small manufacturing service and construction concerns, that will become independent and self-sustaining in a normal competitive environment.[1]

Federal agencies offer selected contracts to SBA, which subcontracts the work to firms owned by persons who are "socially or economically disadvantaged." The SBA, therefore, is considered as the prime contractor, and the minority firms are the subcontractors.

During fiscal year 1977, 2,727 contracts with a total value of $547.6 million were awarded to 1,061 disadvantaged companies. Considering that a purpose of the legislation is that the companies become independently viable in their marketplace, very few have actually been "graduated" from the program. Some have been "terminated" because the SBA has subsequently concluded that the firms will never be able to achieve self-sufficiency. But many "limp along," surviving solely on the basis of their SBA contracts. As of 1977, only 112 of the more than 3,000 companies involved with 8(a) since 1968 had gone on to achieve self-sufficiency. This situation may stem from the fact that the demand for some of the services, e.g., keypunching, provided by 8(a) firms is slightly outside the government sector. Or, the lack of self-sufficiency

---

[1]Office of Management and Budget, Catalog of Federal Domestic Assistance 1978 (Washington, D.C.: U.S. Government Printing Office, May 1978), p. 759.

may stem from the disadvantaged firms' need for technical and marketing assistance, along with the dollars provided by the contracts themselves. Therefore, the 8(a) program has recently begun to emphasize provision of technical and marketing assistance to firms with 8(a) contracts.

BENEFITS AND ELIGIBILITY

The primary criterion for program eligibility is qualification as a "disadvantaged person." These are persons who, because of reasons beyond their control, have been deprived of the opportunity to develop and maintain a competitive economic position because of social or economic disadvantage. In many cases, persons in the following minority groups have been so deprived: Black-Americans, American Indians, Spanish Americans, Oriental Americans, Eskimos, and Aleuts. However, the class of socially or economically disadvantaged is not limited to members of these groups.

In order to apply for the program, the firm must show that it is "economically and socially" disadvantaged. The burden of proof for sustaining the claim of deprivation is placed on the firm. The regional office of the SBA must verify the information supplied by the applicant, but the term "disadvantaged" is often subject to varying interpretations.

Contracts run from 30 days to a year and are usually renewed. Originally, there was a time limit of three years for program participation. It was later lengthened to five years, and now there is no time limit. Each firm must send an up-date of its business plan to the SBA office annually. The business plan is developed by the entrepreneur with the guidance of a SBA business development specialist and defines the mutual responsibilities of both SBA and the 8(a) firm.

OPPORTUNITIES FOR FRAUD

The major fraud in the 8(a) program has been "fronting," where an apparently eligible person has "headed" a firm which, in reality, is not disadvantaged. The "front" usually does nothing for or with the firm, other than signing the papers to apply for the SBA-sponsored contract. Where analyses of the ownership, i.e., the stock distribution of the company are made by the SBA regional or district office, fronting is less likely to succeed. In addition to blacks acting as fronts for white-owned businesses, contracts have sometimes been let to blacks who did not appear to be disadvantaged.

Misuse of contract funds by 8(a) firms has occurred, but can be minimized through the use of quarterly audits. District and

regional office directors have sometimes accepted kickbacks and bribes for letting contracts to certain firms or making other "political" decisions.

ENFORCEMENT METHODS USED IN MINORITY CONTRACTING

The minimum proportion of minority ownership of a company which is required for an 8(a) contract is set by law, but the maximum varies among the regional offices. Analysis of the claim of minority ownership is central to the elimination of fronting. Some of the techniques used by SBA to analyze ownership are as follows:

- Determination of who are stockholders in "disadvantaged" companies
- Determination of whether the firm is, in fact, "disadvantaged" or whether it is just poorly managed and, therefore, not eligible
- Examination of joint ownership in arrangements to see who, in fact, controls the company
- Determination of whether or not "management agreements" will result in bettering the firm economically.

Each 8(a) contractor must submit quarterly financial statements to SBA in order that the progress of the firm can be monitored effectively.

Most of the district and/or regional offices hold meetings to determine eligibility for the program, to review the firms annually, to assess balance sheets, and to evaluate management and technology absorption rates for "weaning" from the program.

Since district offices are the prime contractors, most are audited by their regional office on a quarterly basis. Audits of subcontracts, that is, the 8(a) contractors, are not done on a regular basis, but rather as needed. The agency does send out a questionnaire to all contracting agencies asking about performance standards and whether there is a need to have a special site visit from SBA personnel. Each 8(a) firm is visited by regional or district office staff approximately once a year; in some instances, they are visited more frequently. Some program administrators believe that more on-site visits would improve the record of contracting firms, because they would identify the areas requiring technical assistance, or they would become aware of those firms which are not functioning properly under the terms of their contracts.

In addition, there is a surveillance team available from the SBA national office, which can be called upon to investigate irregularities found by regional or district office staff.

APPENDIX B: LIST OF RESPONDENTS TO ATTORNEY GENERAL SURVEY

State of Alabama
The Attorney General

State of Alaska
Department of Law
Criminal Division

State of Alaska
The Legislature
Budget and Audit Committee

State of Alaska
Department of Health and
Social Services
Office of the Commissioner
Office of Internal Review

State of Arkansas
Office of the Attorney General

State of California
Department of Justice
Office of the Attorney General

State of Florida
Department of Legal Affairs
Office of the Attorney General

State of Georgia
Department of Law
State of Illinois
Attorney General

State of Indiana
Office of the Attorney General

State of Iowa
Department of Justice

Commonwealth of Kentucky
Office of the Attorney General

State of Maryland
Office of the Attorney General

The Commonwealth of Massachusetts
Department of Attorney General

State of Mississippi
Department of Justice
Office of the Attorney General

State of Missouri
Office of the Attorney General

State of Nevada
Welfare Division
Office of the Attorney General

State of New Hampshire
The Attorney General

State of New Mexico
Department of Justice
Office of the Attorney General

State of New Mexico
Health and Social Services
Department
Office of the Executive Director

State of New York
Department of Labor

State of North Carolina
Attorney General

State of North Dakota
Attorney General

State of Ohio
Office of the Attorney General

Commonwealth of Pennsylvania
Department of the Attorney
General

Commonwealth of Puerto Rico
Office of the Attorney General

State of South Carolina
Department of Social Services

State of Texas
Attorney General of Texas

State of West Virginia
Office of the Attorney General

APPENDIX C: LIST OF RESPONDENTS TO FRAUD AND ABUSE SURVEY (INFORMATION RESOURCE FORM)

ALABAMA

Bureau of Public Assistance for Aid to Families with Dependent Children, Department of Pensions and Security
Bureau of Food Assistance, Department of Pensions and Security

ARIZONA

Assistance Programs Bureau, Department of Security*
Manpower Grants Management Section, Program Operation Division, Department of Employment Security
Unemployment Insurance Bureau, Department of Economic Security

ARKANSAS

Utilization Review Section, Office of Medical Services, Division of Social Services
Division of Unemployment Insurance, Division of Employment Security, Department of Labor
Division of Vocational, Technical and Adult Education, Department of Education

CALIFORNIA

Fraud Prevention Bureau, Welfare Program Operations Division, Department of Social Services*
Vocational Education Unit, Department of Education
Audits and Investigation Division, Department of Health Services

COLORADO

Appeals and Recovery Section, Division of Medical Assistance, Department of Social Services
Child Nutrition Unit, Department of Education
Division of Food Assistance, Department of Social Services
Division of Income Maintenance, Department of Social Services
Office of Quality Control, Administrative Support Division, Department of Social Services*

CONNECTICUT

Division of Vocational Education, Department of Education

---

*Multiple responses received from these offices.

DELAWARE

Assistance Payments Section, Division of Social Services, Department of Health and Social Services
Division of Unemployment Insurance, Department of Labor
Food Stamp Section, Division of Social Service, Department of Health and Social Services
Medical Assistance Branch, Division of Social Services, Department of Health and Social Services

DISTRICT OF COLUMBIA

Employment Security, Department of Labor

IDAHO

Bureau of Financial Assistance, Division of Welfare, Department of Health and Welfare*
Division of Vocational Education, Board of Education

INDIANA

Benefit Administration, Employment Security Division

IOWA

Food Stamp Unit, Division of Community Services, Department of Social Services
Fraud Control Unit, Job Service
Income Maintenance Section, Bureau of Benefits Payments, Department of Social Services

KANSAS

Unemployment Insurance Service, Division of Employment, Department of Human Resources

KENTUCKY

Bureau for Manpower Services, Department of Human Resources
Bureau for Social Insurance, Department of Human Resources*

LOUISIANA

Comprehensive Employment and Training Act Bureau, Department of Education

---

*Multiple responses received from these offices.

MAINE

Bureau of Social Welfare, Department of Human Services*
Division of Medicaid Surveillance and Utilization Review, Department of Health and Welfare
Unemployment Compensation Division, Employment Security Committee, Department of Manpower Affairs

MARYLAND

Child Nutrition Section, Food and Nutrition Bureau, Office of Administration, Department of Education
Social Services Administration, Department of Human Resources
Division of Quality Control, Office of Program Planning and Evaluation, Department of Human Resources
Unemployment Insurance Division, Employment Security Administration, Department of Human Resources

MINNESOTA

Assistance Payments Division, Income Maintenance Bureau, Department of Public Service
Income Maintenance-Client Eligibility Unit, Department of Public Service
Surveillance and Utilization Review Division, Income Maintenance Bureau, Department of Public Service
Tax Branch, Division of Unemployment Insurance, Deprtment of Economic Security

MISSISSIPPI

Division of Assistance Payments, Department of Public Welfare
Food Assistance Division, Department of Public Welfare
Security and Fraud Division, Office of Legal Services, State Medicaid Commission, Division of Payments Assistance, Department of Public Welfare

MISSSOURI

Division of Investigation, Department of Social Services
Employment Services Operation, Division of Employment Security, Department of Labor and Industrial Relations
Overpayment and Fraud Control, Unemployment Insurance Operation, Division of Employment Security, Department of Labor and Industrial Relations

*Multiple responses received from these offices.

NEBRASKA

Division of Medical Services, Department of Public Welfare

NEVADA

Food Stamp Program, Welfare Division, Department of Human Resources
Summer Food Services Program, Child Nutrition Program, Field Services Division, Department of Education
Welfare Division, Department of Employment Security*

NEW HAMPSHIRE

Office of Assistance Payment, Division of Welfare, Department of Health and Welfare*

NEW JERSEY

Assistance Investigation Unit, Division of Public Welfare, Department of Human Resources
Bureau of Medical Care Surveillance, Division of Medical Assistance and Health Services, Department of Human Services
Division of Unemployment and Disability Insurance, Department of Labor and Industry
Fraud Unit, Office of Program Integrity, Division of Medical Assistance and Health Services, Department of Human Services
State Manpower Services Council, Department of Labor and Industry

NEW MEXICO

Comprehensive Employment and Training Act Bureau, Employment Service Division, Department of Human Services
Benefit Payments Control, Unemployment Insurance Bureau, Employment Division, Department of Human Services

NORTH DAKOTA

Economic Assistance, Social Service Board
Employment Development Division, Employment Security Bureau
Food Services, Economic Assistance, Social Service Board
Public Assistance and Supplemental Security Income Liaison, Social Service Board
Board of Vocational Education, Social Service Board
Unemployment Compensation Division, Employment Security Bureau

---

*Multiple responses received from these offices.

OHIO

Unemployment Compensation, Internal and Administrative Audit Department, Bureau of Employment Services

OREGON

Adult and Family Services Division, Income Maintenance Section, Department of Human Resources
Career and Vocational Employment Section, Department of Education
Family Assistance Program Unit, Adult and Family Services Division, Department of Human Resources
Manpower Instructional Services, Vocational Education Section, Department of Human Resources

PENNSYLVANIA

Food Stamps and Work Incentive Program, Bureau of Employment Security, Department of Labor and Industry
Internal Audits and Fraud Control, Department of Labor and Industry
Medical Assistance Unit, Office of Family Assistance, Department of Public Welfare
State Manpower Planning Council, Department of Labor and Industry

RHODE ISLAND

Division of Fiscal Affairs, Department of Employment Security

SOUTH CAROLINA

Bureau of Economic Service, Division of Assistance Payments, Department of Social Services*
Division of Food Stamps, Bureau of Economic Service, Division of Assistance Payments, Department of Social Services

SOUTH DAKOTA

Division of Job Services, Department of Labor
Division of Unemployment Insurance, Department of Labor

---

*Multiple responses received from these offices.

TENNESSEE

Division of Vocational-Technical Education, Adult and Continuing Education Section, Department of Education*
Food Stamps Program Section, Department of Human Services
Public Assistance Division, Department of Human Services*

UTAH

Benefit Payments Control, Unemployment Insurance Division, Department of Employment Security
Division of Adult and Vocational Education, Board of Vocational Education, Board of Education
Office of Health Care Financing, Department of Social Services
School Food Services Section, External Support Service Division, Board of Education

VERMONT

Child Nutrition Programs, Department of Education
Division of Vocational Education, Department of Education
Unemployment Compensation Division, Department of Employment Securiy

VIRGINIA

Surveillance and Utilization Review, Bureau of Medical Assistance, Department of Health
Unemployment Insurance, Employment Commission

WASHINGTON

Claims Investigation Branch, Division of Unemployment Insurance, Department of Employment Security
Employment Service Division, Department of Employment Security*
Employment and Training Division, Department of Employment Security
Office of Special Investigations, Department of Social and Health Services

WEST VIRGINIA

Division of Medical Care, Department of Welfare
Employment Service Division, Department of Employment Security

---

*Multiple responses received from these offices.

WISCONSIN

Bureau of Benefits, Unemployment Compensation, Job Services Division, Department of Industry, Labor and Human Relations
Food and Nutrition Services, Division of Management and Planning and Federal Assistance, Department of Public Instruction

WYOMING

Medical Assistance and Services, Division of Health and Medical Services, Department of Health and Social Services

APPENDIX D: LIST OF FEDERAL INTERVIEWEES

UNITED STATES DEPARTMENT OF AGRICULTURE

UNIT	LOCATION
Office of Secretary	Washington, D.C.
Office of Investigation	Washington, D.C.
Office of Audit	Washington, D.C.
Office of Inspector General	Washington, D.C.
Compliance Branch, Family Nutrition Program	Washington, D.C.
Food and Nutrition Service, Family Nutrition Program	Washington, D.C.
Administrative Services, Food and Nutrition Service	Washington, D.C.
Security and Special Investigation Office of Investigation	Washington, D.C.
Child Nutrition Services, Summer Food Service Program for Children	Washington, D.C.
Office of Program Evaluation, Farmers Home Administration	Washington, D.C.
Compliance Branch, Food Stamps, Area Office	New York, New York Atlanta, Georgia
Rural Development, Audit Division Farmers Home Administration	Washington, D.C.
Technical Services Division, Farmers Home Administration	Washington, D.C.
Single Family Housing, Farmers Home Administration	Washington, D.C.
Child and Nutrition Program, Regional Office	Chicago, Illinois
Office of Investigation, Regional Office	Atlanta, Georgia

UNIT	LOCATION
Office of Rural Housing, Farmers Home Administration	Austin, Texas Oklahoma City, Oklahoma Raleigh, North Carolina Phoenix, Arizona
School Food Services, Summer Food Service Program for Children	Denver, Colorado
Summer Food Service Program for Children, Food and Nutrition Services, New England Regional Office	Burlington, Massachusetts

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

UNIT	LOCATION
Office of Inspector General	Washington, D.C.
Office of Program Integrity, Health Care Financing Administration	Baltimore, Maryland
Program Integrity, Health Care Financing Administration, Regional Offices	Denver, Colorado Dallas, Texas San Francisco, California Seattle, Washington
Aid to Families with Dependent Children Program	Washington, D.C.
Medicaid Management Institute	Washington, D.C.
Social Security Insurance, Region #3	Philadephia, Pennsylvania
Medicaid Training, Regional Office	Dallas, Texas
Aid to Families with Dependent Children, Regional Office	San Francisco, California
Office of Family Assistance, Social Security Administration	Washington, D.C.

UNITED STATES DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

UNIT	LOCATION
Office of the Inspector General	Washington, D.C.
Office of Program Support, Federal Disaster Assistance Administration	Washington, D.C.
Relocation Program Community Planning and Development	Washington, D.C.
Office of the Inspector General of Audit, Federal Disaster Assistance Administration	Washington, D.C.
Office of Counsel, Federal Disaster Assistance Administration	Washington, D.C.
Section of Rehabilitation Housing Loans	Philadelphia, Pennsylvania
Federal Disaster Assistance Administration, Regional Office	San Francisco, California
Office of the Inspector General, Regional Offices	San Francisco, California Denver, Colorado Seattle, Washington
Community Planning and Development, Regional Office	Los Angeles, California
Area Office	Seattle, Washington
Rehabilitation Housing Loans and Community Planning and Development, Regional Office	Denver, Colorado
Service Office	Phoenix, Arizona

UNITED STATES DEPARTMENT OF JUSTICE/UNITED STATES ATTORNEYS

UNIT	LOCATION
Fraud Section, Criminal Division	Washington, D.C.
United States Attorney's Office, Northern District of Texas	Dallas, Texas
United States Attorney's Office, Western District of Oklahoma	Oklahoma City, Oklahoma

UNIT	LOCATION
United States Attorney's Office, Northern District of Georgia	Atlanta, Georgia
United States Attorney's Office, Eastern District of Virginia	Richmond, Virgina
United States Attorney's Office, District of Columbia	Washington, D.C.
United States Attorney's Office, Western District of Washington	Seattle, Washington
United States Attorney's Office	Denver, Colorado
United States Attorney's Office, Western District of Arizona	Phoenix, Arizona

UNITED STATES DEPARTMENT OF LABOR

UNIT	LOCATION
Office of Program Management, Unemployment Insurance	Washington, D.C.
Office of Investigation and Security	Washington, D.C.
Employment and Training Administration	Washington, D.C.

UNITED STATES GOVERNMENT ACCOUNTING OFFICE

Office of Supervisory Management Auditor, Justice and Law Enforcement Matters	Washington, D.C.

SMALL BUSINESS ADMINISTRATION

UNIT	LOCATION
Office of Inspection and Security	Washington, D.C.
Office of Field Operations	Washington, D.C.
Office of Business Development	Washington, D.C.
Office of Disaster Assistance	Washington, D.C.
8(a) Minority Contracting Program, Regional Office	Philadelphia, Pennsylvania

UNIT	LOCATION
Office of Disaster Assistance, Regional Office	Philadelphia, Pennsylvania
Office of Procurement, Regional Office	Dallas, Texas
8(a) Minority Contracting Program District Office	Richmond, Virginia
Office of Procurement, Regional Office	Atlanta, Georgia
Office of House Counsel	Atlanta, Georgia
Regional Office	Boston, Massachusetts

VETERANS ADMINISTRATION

UNIT	LOCATION
Office of the Inspector General, Director of Investigation and Security	Washington, D.C.
Office of Benefits Control	Washington, D.C.
Office of Special Investigation, Office of the Inspector General	Washington, D.C.
Office of Veterans Housing Loans Service	Washington, D.C.
Office of Veterans Educational Assistance	Washington, D.C.
Office of Veterans Housing Loans and Office of Veterans Educational Assistance, Regional Office	Washington, D.C. Los Angeles, California
Special Unit for Investigation	Los Angeles, California

APPENDIX E: LIST OF STATE AND LOCAL INTERVIEWEES

UNITED STATES DEPARTMENT OF AGRICULTURE SPONSORED PROGRAMS

UNIT	LOCATION
Food Stamp Program, Department of Social Services	New York, New York
Department of Education	Albany, New York
Food Stamp Section, Department of Health and Rehabilitation Services	Tallahassee, Florida
Bureau Child Nutrition Services, Department of Education	Sacramento, California
Summer Food Service Program for Children, Department of Education	Phoenix, Arizona

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SPONSORED PROGRAMS

UNIT	LOCATION
Department of Social Services, Division of Medical Assistance	Albany, New York
Office of Special State Prosecutor for Nursing Homes, Health and Social Services	New York, New York
Office of Standards and Investigations, Department of Social Services	Lansing, Michigan
Medicaid Fraud Unit	Lansing, Michigan Denver, Colorado
Office of Consumer Protection, Office of the State Attorney General	Austin, Texas
Medical Unit, Department of Human Resources	Austin, Texas
Investigation and Compliance Division, Department of Medical Assistance	Atlanta, Georgia

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE SPONSORED PROGRAMS

UNIT	LOCATION
Office of Special Administrative Services, Legal Services Division, Department of Human Resources	Atlanta, Georgia
Welfare Fraud Unit, Department of Welfare	Richmond, Virginia
Medi-Cal, Fraud Unit	Sacramento, California
Office of the State Attorney General	Sacramento, California
Welfare Fraud Unit, Medical Division, Department of Health	Denver, Colorado
Office of Investigation, Department of Social Services	Denver, Colorado
Special Prosecution Section, Office of the State Attorney General	Phoenix, Arizona
Provider Review and Sanction Unit, Medicaid Program, Department of Public Welfare	Boston, Massachusetts

UNITED STATES DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT SPONSORED PROGRAMS

UNIT	LOCATION
Division of Disaster Preparedness	Tallahassee, Florida
Office of Civil Defense, Disaster Assistance	Atlanta, Georgia

UNITED STATES DEPARTMENT OF LABOR SPONSORED PROGRAMS

UNIT	LOCATION
Department of Labor	Albany, New York
Department of Education	Albany, New York

UNITED STATES DEPARTMENT OF LABOR SPONSORED PROGRAMS

UNIT	LOCATION
Office of Unemployment Insurance Payments and Tax Accounting, Department of Social Services	Albany, New York
Employment Commission	Austin, Texas
Office of Insurance Programs and Staff, Unemployment Security Commission	Oklahoma City, Oklahoma
Unemployment Security Commission	Oklahoma City, Oklahoma
Division of Unemployment Compensation, Bureau of Employment Services, Department of Commerce	Tallahassee, Florida
Unemployment Insurance Unit, Office of the State Attorney General	Phoenix, Arizona
Employment Security Administration District Office	Phoenix, Arizona

ENFORCEMENT UNITS

UNIT	LOCATION
Investigation Division, Department of Human Resources	Austin, Texas
Office of Investigation, Department of Social Services	Columbia, South Carolina
Office of the Acting Welfare Inspector General	New York, New York
Bureau of Audit Operations, Office of Audit and Quality Control, Department of Social Services	Albany, New York
Income Support Unit, Department of Social Services	Albany, New York

ENFORCEMENT UNITS

UNIT	LOCATION
Office of Audit and Quality Control, Department of Social Services	Albany, New York
Office of Auditor General, Fraud Division, Division of Public Assistance	Tallahassee, Florida

HUMAN SERVICES OFFICES

UNIT	LOCATION
Social and Rehabilitation Services, Department of Institutions	Oklahoma City, Oklahoma
Public Assistance Program, Department of Health and Rehabilitation Services	Tallahassee, Florida
Division of Social Services and Staff, Department of Human Resources	Raleigh, North Carolina

LOCAL

UNITED STATES DEPARTMENT OF AGRICULTURE SPONSORED PROGRAMS

UNIT	LOCATION
Office of the Food Stamp Program	New York, New York

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE SPONSORED PROGRAMS

UNIT	LOCATION
Wake County Department of Social Services	Raleigh, North Carolina

UNITED STATES DEPARTMENT OF LABOR SPONSORED PROGRAMS

UNIT	LOCATION
Offices of Unemployment Insurance, Aid to Families with Dependent Children, and Food Stamps for Maricopa County, Employment Security Administration	Phoenix, Arizona

VETERANS ADMINISTRATION SPONSORED PROGRAMS

UNIT	LOCATION
Office of Veterans Affairs, George Washington University	Washington, D.C.
Office of Veterans Clerk, Northern Virginia Community College	Annandale, Virginia
Office of Veterans Administration, Northern Virginia Community College	Annandale, Virginia
Office of Veterans Certification, University of Maryland	College Park, Maryland
Office of Veterans Counselor, Montgomery College	Rockville, Maryland

APPENDIX F: TELEPHONE INTERVIEWS

FEDERAL

UNITED STATES DEPARTMENT OF AGRICULTURE

UNIT	LOCATION
Office of Rural Housing, Farmers Home Administration	Woodland, California Denver, Colorado

UNITED STATES DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

UNIT	LOCATION
Office of Community Planning and Development, Area Office	Kansas City, Kansas

University City **Science Center**

3624 Science Center
Philadelphia
Pennsylvania 19104
215 387-2255

APPENDIX G: ATTORNEY GENERAL SURVEY

November 28, 1977

ADDRESS

Dear Sir:

The University City Science Center has been awarded a grant by the Law Enforcement Assistance Administration to study fraud and abuse in government benefit programs. The underlying objective is to identify strategies for prevention and deterrence for fraud and abuse in present and future benefit programs. The study will examine a number of different transaction patterns and the opportunities afforded for fraud and abuse across the states.

Recently completed studies by both the American Bar Association, Section of Criminal Justice, Committee on Economic Offenses, and the National District Attorney's Association, Economic Crime Project, document the need for effective coordination of investigative and prosecutorial resources at all levels of government to combat fraud and abuse in public benefit programs. Clearly, offices of Attorney General play a major role in this coordination effort.

In order that we may have a better understanding of the investigation and prosecution activities presently underway in your office in this regard, we are seeking your comments concerning appropriate measures and procedures for dealing with fraud and abuse. Specifically, we would appreciate your view on the following.

1. What programs or transaction types particularly lend themselves to fraud and abuse in your state jurisdiction and why?

2. What programs or transaction types afford the most opportunities for large scale fraud and abuse in your state jurisdiction?

3. What common problems are encountered in investigating and prosecuting cases of benefit fraud and/or abuse in your state jurisdiction?

4. In your view, what additional resources are needed to investigate and prosecute benefit program fraud and abuse, i.e., increased personnel, improved methods for case weighting and screening; more funds for benefit program prosecution?

5. Within your jurisdiction, have criminal rather than civil remedies been generally more effective in combatting fraud and abuse?

6. In your view, what incentives should be built into benefit programs to provide opportunities for detection, prevention, and prosecution?

At a later time, we will be making site visits to a number of state and local jurisdictions to talk directly with prosecutors, investigators, administrators, and program personnel. We would appreciate your suggestions about others whom you believe should be contacted in the course of the study.

Please be assured that responses to these inquiries will be treated confidentially and not released. We ask that all comments be returned by December 20, 1977. If you wish further information about the project, do not hesitate to contact either myself or my colleague, Ms. Andrea Lange at (202) 483-7600 or Mr. Bernard Auchter, the project monitor in LEAA, at (202) 376-3994.

Your assistance and cooperation is very much appreciated, and we look forward to hearing from you.

Sincerely,

Don H. Overly, Director
Program Development & Management

DHO/meb

APPENDIX H

FRAUD AND ABUSE IN GOVERNMENT

BENEFIT PROGRAMS

INFORMATION RESOURCE FORM

INTRODUCTION

The University City Science Center is currently conducting a national study of fraud and abuse in government benefit programs. The study will provide information on benefit program administration, patterns of fraud and abuse, and prevention and deterrence strategies undertaken by federal, state, and local governments. The following questions cover aspects of benefit programs, operations, and fraud and abuse detection and prevention efforts. Your cooperation in responding to the questions in full is critical to the objectives of this national study.

ALL RESPONSES WILL REMAIN TOTALLY CONFIDENTIAL AND WILL NOT BE ATTRIBUTED TO ANY STATE OR LOCALITY.

I. BASIC PROGRAM OBJECTIVES

IF YOUR OFFICE ADMINISTERS MORE THAN ONE PROGRAM IN THE FOLLOWING LIST. PLEASE XEROX AND FILL OUT A SEPARATE INFORMATION FORM FOR EACH PROGRAM.

1. Please check which program you will be describing in this resource form?

_____ MEDICAID	_____ SUMMER FEEDING
_____ AFDC(ADC)	_____ CETA
_____ VOCATIONAL EDUCATION	_____ UNEMPLOYMENT COMPENSATION
_____ FOOD STAMPS	

2. Could you briefly describe the objective(s) of the program your office administers?

_____

_____

_____

3. Please check all the characteristics which apply to the ultimate beneficiary served by your program?

- MEDICAID: Young____ Old ____ Unemployed ____ Urban Resident _____

  Rural Resident ____ Disaster Victim ____ Income Standard _____

  Other (Specify) ____

- AFDC(ADC): Young ____ Old ____ Unemployed ____ Urban Resident ____
  Rural Resident ____ Disaster Victim ____ Income Standard _____
  Other (Specify) ____
- VOCATIONAL EDUCATION: Young ____ Old ____ Unemployed ____ Urban
  Resident ____ Rural Resident ____ Disaster Victim ____ Income
  Standard ____ Other (Specify) ____
- FOOD STAMPS: Young ____ Old ____ Unemployed ____ Urban Resident ___
  Rural Resident ____ Disaster Victim ____ Income Standard _____
  Other (Specify) ____
- SUMMER FEEDING: Young ____ Old ____ Unemployed ____ Urban Resident ___
  Rural Resident ____ Disaster Victim ____ Income Standard _____
  Other (Specify) ____
- CETA: Young ____ Old ____ Unemployed ____ Urban Resident ____ Rural
  Resident ____ Disaster Victim ____ Income Standard ____
  Other (Specify) ____
- UNEMPLOYMENT COMPENSATION: Young ____ Old ____ Unemployed _____
  Urban Resident ____ Rural Resident ____ Disaster Victim _____
  Income Standard ____ Other (Specify) ____

4. What type(s) of benefits does the program that you administer provide? Check all that apply.

- MEDICAID: Food ____ Medical Assistance ____ Income Suport _____
  Education ____ Disaster Assistance ____ Employment ____
  Employment Training ____ Other (Specify) ____
- AFDC(ADC): Food ____ Medical Assistance ____ Income Support ____
  Education ____ Disaster Assistance ____ Employment _____
  Employment Training ____ Other (Specify) ____

- VOCATIONAL EDUCATION: Food ____ Medical Assistance ____ Income Support ____ Education ____ Disaster Assistance ____ Employment ____ Employment Training ____ Other (Specify) ____
- FOOD STAMPS: Food ____ Medical Assistance ____ Income Support ____ Education ____ Disaster Assistance ____ Employment ____ Employment Training ____ Other (Specify) ____
- SUMMER FEEDING: Food ____ Medical Assistance ____ Income Support ____ Education ____ Disaster Assistance ____ Employment ____ Employment Training ____ Other (Specify) ____
- CETA: Food ____ Medical Assistance ____ Income Support ____ Education ____ Disaster Assistance ____ Employment ____ Employment Training ____ Other (Specify) ____
- UNEMPLOYMENT COMPENSATION: Food ____ Medical Assistance ____ Income Support ____ Education ____ Disaster Assistance ____ Employment ____ Employment Training ____ Other (Specify) ____

5. Do third party providers participate in the program you administer e.g., doctors, teachers?

   Yes _____ If "Yes", specify which providers _____

   No _____ _____

   _____

   _____

II. PROGRAM OPERATIONS AND PROCEDURES

6. Please provide the full name of your section/division and organization.

   _____

7. Are responsibilities for administration of your program split between the state and the localities, e.g., city, county.

   Yes _____ No _____

   If "Yes, please go to question 8. If "No, please go to question 9.

8. Please check which responsibilities are those of the localities and which are those of the state? Check all that are appropriate.

	STATE	LOCALITY
Administration	___	___
Establishment of Eligibility	___	___
Casework	___	___
Fund Disbursement	___	___
Recertification of Eligibility	___	___
Benefit Appeals	___	___
Audit, Accounting	___	___
Quality Control	___	___
Fraud/Abuse Detection	___	___
Fraud/Abuse Investigation	___	___
Fraud/Abuse Prosecution	___	___
Other (Specify)	___	___

9. In approximate numbers, how many staff are employed to administer the benefit program? _____

10. In approximate numbers, how many of the staff who administer the program are full-time state employees? _____

11. What specific functions does the staff administering the program perform? Please check "Yes" or "No" where applicable and provide an approximate number of employees.

FUNCTION	YES	NO	NUMBER OF EMPLOYEES INVOLVED
Staff Supervisors	_____	_____	_____
Eligibility Workers	_____	_____	_____
Caseworkers	_____	_____	_____
Fraud Investigators	_____	_____	_____
Internal Auditors	_____	_____	_____
Other (Specify)	_____	_____	_____

12. Please describe the training practices used by your office for various categories of personnel, e.g., eligibility worker receives two weeks orientation training, annual refresher courses. Check all that are appropriate and provide frequency.

Staff Supervisors
- Orientation _____ Frequency _____
- In-House/ On-the-Job _____ Frequency _____
- Specialized Courses _____ Frequency _____
- Refresher Courses _____ Frequency _____
- Other _____ Frequency _____

Eligibility Workers
- Orientation _____ Frequency _____
- In-House/ On-the-Job _____ Frequency _____
- Specialized Courses _____ Frequency _____
- Refresher Courses _____ Frequency _____
- Other _____ Frequency _____

Caseworkers	· Orientation	_____	Frequency	_____
	· In-House/ On-the-Job	_____	Frequency	_____
	· Specialized Courses	_____	Frequency	_____
	· Refresher Courses	_____	Frequency	_____
	· Other	_____	Frequency	_____
	· No Training	_____	Frequency	_____
Fraud Investigators	· Orientation	_____	Frequency	_____
	· In-House/ On-the-Job	_____	Frequency	_____
	· Specialized Courses	_____	Frequency	_____
	· Refresher Courses	_____	Frequency	_____
	· Other	_____	Frequency	_____
	· No Training	_____	Frequency	_____
Internal Auditors	· Orientation	_____	Frequency	_____
	· In-House/ On-the-Job	_____	Frequency	_____
	· Specialized Courses	_____	Frequency	_____
	· Refresher Courses	_____	Frequency	_____
	· Other	_____	Frequency	_____
	· No Training	_____	Frequency	_____
Other (Specify): _____ _____	· Orientation	_____	Frequency	_____
	· In-House/ On-the Job	_____	Frequency	_____
	· Specialized Courses	_____	Frequency	_____
	· Refresher Courses	_____	Frequency	_____
	· Other	_____	Frequency	_____
	· No Training	_____	Frequency	_____

13. Does your office utilize outside consultant assistance for program operations? Yes_____ No _____

14. If the answer to #13 is "Yes", what types of services do the consultants perform, e.g., fiscal agents, training of program personnel?

_____

_____

15. In approximate numbers, what is your average program client-load?

Per week _____ Per month _____ Per year _____

16. What was the approximate size of your budget in dollar figures for:

FY 1977 _____

FY 1978 _____

FY 1979 _____

III. BENEFIT PROGRAM FRAUD AND ABUSE

17. Is any of the FY 1979 budget earmarked for combating fraud and abuse in benefit programs? Yes _____ No _____
If "Yes", then identify techniques:

	DOLLARS	PERCENT
Detection _____	_____	_____
Investigation _____	_____	_____
Audit _____	_____	_____
Quality Control _____	_____	_____
Client Education _____	_____	_____
Staff Training _____	_____	_____
Prosecution _____	_____	_____
Administrative Proceedings _____	_____	_____
Other (Specify) _____	_____	_____

18. Does your program have a working definition of what constitutes benefit program fraud? Yes _____ No _____

19. If the answer to #18 is "Yes", please provide the definition.

_____

20. Does your program have a working definition of what constitutes benefit program abuse? Yes _____ No _____

21. If the answer to #20 is "Yes",please provide the definition.

_____

22. What types of fraud and abuse have occurred in the program administered by your office? Please answer with a check in the appropriate space. Where no answer is appropriate check "Not Appropriate".

- MISREPRESENTATION OF ELIGIBILITY (approximate frequency; % of the time)

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Recipient					
- By Administering Agency					
- By Third Party or Authorizing Party					

- RECEIPT OF ADDITIONAL BENEFITS BY THOSE DECLARED ELIGIBLE

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Recipient					
- By Third Party or Authorizing Party					

- OVERCHARGE FOR BENEFITS PROVIDED

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Administering Agency					
- By Third Party or Authorizing Party					

- WITHHELD SERVICES OR MISREPRESENTATION OF SERVICES PROVIDED

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Administering Agency					
- By Third Party or Authorizing Party					

- PROVISION OF UNNEEDED SERVICES

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Administering Agency					
- By Third Party or Authorizing Party					

- MISUSE OF BENEFITS RECEIVED

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Recipient					
- By Administering Agency					
- By Third Party or Authorizing Party					

- ESTABLISHMENT OF "GHOST" ELIGIBLES

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Recipient					
- By Employee(s) of Administering Agency					
- By Third Party or Authorizing Party					
- By Private Organizations					
- By Others					

- MISUSE OF PROGRAM FUNDS: KICKBACKS, PAYOFFS

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Recipient					
- By Employees of Administering Agency					
- By Third Party or Authorizing Party					

- COUNTERFEITING OF SCRIP, FORMS, OR IDENTIFICATION

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Recipient					
- By Employees of Administering Agency					
- By Third Party or Authorizing Party					
- By Others					

- MISUSE OF BENEFIT THROUGH EMBEZZLEMENT, STEALING

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Recipient					
- By Employees of Administering Agency					
- By Third Party or Authorizing Party					
- By Others					

- TAMPERING WITH BENEFIT RECORDS

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Recipient					
- By Employees of Administering Agency					
- By Third Party or Authorizing Agency					
- By Others					

Only check if your agency administers Medicare or Medicaid programs.

- DISCLOSURES OF CONFLICTING OWNERSHIP PATTERNS FOR PROVIDER SERVICES

Not Appropriate ☐	76%-100%	51%-75%	26%-50%	11%-25%	0%-10%
- By Direct Providers					
- By Third Party or Authorizing Agency					
- By Subcontractors					

23. How do you believe that public information, e.g., knowledge about the program, effects deterrence of benefit fraud and abuse?

Positively _____ (e.g., decreases amount of fraud and abuse)

Negatively _____ (e.g., increases amount of fraud and abuse)

Has No Impact ____

Don't Know _____

24. Do you have any knowledge or reason to believe that organized criminal activity is linked to the benefit program administered by your office? Yes _____ No _____

25. Does the program your office is administering utilize prevention and deterrence measures to combat fraud and abuse?

Yes _____ No _____

26. If the answer to #25 above is "Yes", please specify the measures being utilized, e.g., training of eligibility workers to discern fraud, computer editing, random sampling for quality control.

_____

_____

_____

_____

27. Where appropriate, please rate the effectiveness of the following for preventing and deterring fraud and abuse in the benefit program your office administers.

	Very Effective	Effective	Somewhat Effective	Not Effective	Don't Know
Quality Control	____	____	____	____	____
Administrative Sanctions	____	____	____	____	____
Organizational Changes	____	____	____	____	____
Education	____	____	____	____	____
Investigation	____	____	____	____	____
Prosecution	____	____	____	____	____
Harrassment	____	____	____	____	____
Legislative Lobbying	____	____	____	____	____
Evaluation	____	____	____	____	____
Research	____	____	____	____	____

28. How does your office use computer technology?

_____

_____

29. If your program generates detection and surveillance information by computer, what use(s) are made of the information?

_____

_____

30. Does your office maintain statistical data on the numbers and types of fraud and abuse cases which have been associated with your program? Yes _____ No _____

31. How would you assess the rate of fraud and abuse detection in the program administered by your office?

Less than 10% of cases identified _____
10 - 29% of cases identified _____
30 - 49% of cases identified _____
50 - 69% of cases identified _____
70 - 89% of cases identified _____
90% or above of cases identified _____

32. How do you measure this success rate? Answer by checking the appropriate item(s).

Number of convictions _____

Number of administrative suspensions of participation in the program _____

Number of administrative terminations of participation in the program _____

Amount of monetary recoupement _____

Type of professional association actions taken against defrauder or abuser _____

Other (Specify) _____

None of the Above _____

33. What do you see as the costs of benefit program fraud and abuse detection? Check the appropriate scaled item.

	Very High	Moderate	Very Low	None	Don't Know
Manpower and Personnel Costs					
• Audit	___	___	___	___	___
• Investigation	___	___	___	___	___
Reduced Participation of Program Eligibles	___	___	___	___	___
Computer Technology Costs	___	___	___	___	___
Critical Peer Group Review Costs	___	___	___	___	___
Public Perception of Benefit Programs Costs	___	___	___	___	___
Criminal Justice Costs	___	___	___	___	___
Administrative Proceedings Costs	___	___	___	___	___
Other Costs (Specify)	___	___	___	___	___

34. How would you assess the effectiveness of <u>additional</u> detection and prevention resources in the program administered by your office? [Rank in the order of preference, 1-8].

Manpower and Personnel

Audit _____
Investigation _____

Computer Technology _____

Critical Peer Group Review _____

Public Education About Benefit Program _____

Criminal Justice _____

Administrative Proceedings _____

Other Resources (Specify) _____

35. What types of benefit program reform do you believe have come from detection and prevention of fraud and abuse?

_____

_____

36. How and where have the reforms been implemented?

_____

_____

37. What types of reforms do you believe should be contemplated for future detection and prevention of fraud and abuse?

_____

_____

38. From an administrative viewpoint, please assess the relative effectiveness of the following judicial and administrative deterrence strategies for preventing fraud and abuse. Check where appropriate.

	Very Effective	Effective	Somewhat Effective	Totally Ineffective	Don't Know
Civil Court Dispositions	___	___	___	___	___
Criminal Court Dispositions	___	___	___	___	___
Administrative Dispositions, e.g., suspension, termination	___	___	___	___	___

39. In your view, are there any other agencies that should receive this form?

Yes _____ No _____

40. If yes, please provide the name._____

_____

41. Please feel free to make any additional comments about fraud and abuse in the program that your office administers.

_____

_____

_____

_____

Please print name and title of individual completing "FORM".

_____ _____

NAME TITLE

- WOULD YOU PLEASE INCLUDE WITH THIS RESOURCE FORM A COPY OF THE REGULATIONS WHICH GOVERN ELIGIBILITY, PARTICIPATION, AND RECERTIFICATION OF BENEFICIARIES.

- PLEASE INCLUDE WITH THIS INFORMATION FORM A COPY OF ENABLING STATUTES, GUBERNATORIAL EXECUTIVE ORDERS, ETC., WHICH GOVERN THE OPERATIONS OF YOUR AGENCY.

THANK YOU FOR YOUR COOPERATION

RESOURCE FORMS SHOULD BE RETURNED TO:

University City Science Center
1717 Massachusetts Avenue, N.W.
Suite 101

Washington, D.C. 20036

BY OCTOBER 15, 1978

APPENDIX I

RELATIVE EFFECTIVENESS OF ENFORCEMENT STRATEGIES

The fraud and abuse survey contained several items which may be used to compare respondents' perceptions of the utility of various enforcement strategies. It should be noted that the list of enforcement strategies used in the survey is similar, but not identical, to the final typology of strategies developed in Chapter 3. Moreover, the list of strategies is not identical across all items. This is because the list of strategies used in the survey was developed relatively early in the research process; the final typology was developed only after all research was completed.

The fraud and abuse survey asked respondents to rate ten strategies on a four point scale of effectiveness for preventing deterring fraud and abuse.[1] The average ratings and standard deviations for each strategy are provided in Table . It should be noted that these enforcement strategies divide themselves into three major groupings. Prosecution and investigation are clearly perceived as the most effective strategies with ratings falling between effective and very effective. Legislative lobbying and harassment are viewed as least effective with ratings between not effective at all and somewhat effective. The remaining six strategies occupy the middle ground between somewhat effective and effective. While prosecution was a most favored strategy, further analysis of the effectiveness of various types of case dispositions indicated some diversity.[2] Criminal court dispositions received a mean effective rating of 3.11 while civil court dispositions were rated at 2.54. Administrative dispositions (e.g., suspension, termination), rated at 2.82, exceeded civil court dispositions in terms of perceived effectiveness as a deterrent strategy.

---

[1] See Appendix H, Item 27. The values for this item were: 1 = not effective, 2 = somewhat effective, 3 = effective, 4 = very effective.

[2] See Appendix H, Item 38.

TABLE XIV

RANK ORDERING OF ENFORCEMENT STRATEGY EFFECTIVENESS MEAN RATINGS[3]

Enforcement Strategy	Mean Rating(s.d.)
Prosecution	3.30 (.86)
Investigation	3.29 (.68)
Quality Control	2.84 (.88)
Education	2.80 (.73)
Administrative Sanctions	2.75(1.04)
Evaluation	2.72 (.90)
Organizational Changes	2.45 (.93)
Research	2.15 (.84)
Legislative Lobbying	1.63 (.76)
Harassment	1.14 (.41)

To probe the relative value of increasing different enforcement strategies, respondents were asked to rank the effectiveness of eight different types of detection and prevention resources to their current programs.[4] Table XV , displays the mean ranking and standard deviation values.

TABLE XV

MEAN RANKING ORDERING OF THE EFFECTIVENESS OF PROVIDING ADDITIONAL DETECTION AND PREVENTION RESOURCES*[5]

Enforcement Strategy	Mean Rank(s.d.)
Investigators	2.50 (1.68)
Auditors	2.73 (1.70)
Computer Technology	3.17 (1.78)
Administrative Proceedings	4.36 (1.58)
Criminal Justice	4.66 (1.88)
Public Education about Benefit Program	5.04 (1.54)
Critical Peer Group Review	5.91 (1.79)
Other Resources	6.16 (2.57)

* Lower values represent higher ranking in effectiveness relative to the other strategies listed.

[3] N = 95

[4] See Appendix H, Item 34. Respondents were instructed to rank order strategies by placing a value of 1 by the strategy they felt would be most effective down to an 8 for the least effective.

[5] N = 93

As can be seen from Table XV , the addition of manpower in the form of investigators and auditors is ranked as being more effective than the other strategies. Overall, these findings suggest that survey respondents tend to perceive maximum effectiveness in the utilization of manpower for investigation and prosecution of fraudulent activity.

An inherent difficulty in assessing the effectiveness of any strategy is the considerable diversity in the way rate of detection is measured. Respondents to the fraud and abuse survey were asked to indicate the various criteria they used to determine the success of their fraud and abuse detection efforts.[6] Table XVI, presents the percent of respondents who checked each type of criteria.

For those respondents checking various measures, 83% checked two or more measurement criteria. Taken as a whole, the data indicate that the current situation ranges from a complete lack of measures (or administrator ignorance of their use) to utilization of multiple indicators.

TABLE XVI

RESPONDENTS UTILIZING VARIOUS MEASURES OF FRAUD AND ABUSE DETECTION[7]

Detection Measures	Percentage of Respondents Utilizing Measures
Amount of Monetary Recoupment	(55)
Number of Convictions	(46)
Number of Administrative Terminations of Program Participation	(42)
Number of Administrative Suspensions of Program Participation	(40)
Type of Professional Association Actions Taken Against Offenders	(17)
Other Measures	(12)
No Response	(34)

A truly adequate assessment of the relative efficacy of different enforcement strategies must await comparative studies across sites and program types using standard measures. However, the results of this survey generally suggest that detection and deterrence strategies are generally perceived as more effective than prevention strategies; use of concrete measures for detecting fraud and abuse seems limited.

---

[6] See Appendix H, Item 32.

[7] N = 123

APPENDIX J

SURVEY RESPONSES TO UTILIZATION OF COMPUTER PROGRAM DATA ITEM[1] FOR FRAUD AND ABUSE DETECTION

MEDICAID

Generates field investigations
Identify practices and patterns of providers
Reviews by health professionals; referral to peer Review Commission for criminal/civil actions
Reviews by health professionals, investigators; on-site visits to providers, recipient lock-in or restriction program
Determines field audits, educational needs, provider comparison
Site visits to providers, recipients for audits
Identification of abuse in prior authorization of beneficiaries, and overuse/abuse/fraud by providers
Cross-agency quality control information on employment, addresses, social security from other agencies.
MMIS; detect potential fraud and abuse by providers; refer to Attorney General fraud unit
Corrective action; planning purposes
Identify cases for investigation; policy change considerations; pre-payment controls
S/UR fraud and abuse detection

AFDC PROGRAM

Edits that initiate full scale investigations
Cross-agency quality control
Project MATCH
Reports non-compliance, misrepresentation
Follow-up to determine eligibility; report ineligibilities to legal authorities
Investigative follow-up; case reviews; reporting
Notifies local administrative agencies of periodic case actions due
Corrective action; planning purposes

FOOD STAMP PROGRAM

To recover any losses
Research to investigators
Cross-agency quality control
Investigation resulting in prosecution or termination or surveillance
Eligibility worker evaluates computer information, reports, takes appropriate action
Rejection of documents with already active case number (unless an interim change); duplicate purchase list to detect illegal purchases made on allegedly lost authorizations
Audit purposes
Provides indicators for possible fraud

---

[1] Open-ended responses to Item 28, Appendix H.

FOOD STAMP PROGRAM (cont'd)

Corrective action; planning purposes

CETA PROGRAM

Cross-checking to prevent duplicate payments
Audits, quality control evaluation
Summer program; identify duplicate wage checks for time, attendance, client verification
Sub-contractor auditing
Identification and collection of overpayments; adjust budgetary expenditures
Cross-match CETA/UI
Comparison of records and contracts

UNEMPLOYMENT COMPENSATION PROGRAM

Match with benefit payment records
To recoup overpayments
Establish overpayments and investigate flagrant fraud cases
Identify improper benefit payments; statistical data; management data
Investigation; determines amount of overpayment; recoup overpayments
Cross-match data for investigations; verify earnings with employers
Investigation of employer wage records and claimant benefits paid
Investigations; initiate prosecutions
Quality control to indicate claimant violations for reported work and earnings
Investigation; interstate records, cross-match

VOCATIONAL EDUCATION PROGRAM

Detect audit exception

QUALITY CONTROL PROGRAM

Used by investigators-heavy reliance
Quality control; eligibility and error rate established

FRAUD UNITS PROGRAM

Investigation
Turn information over to county units for investigation

BIBLIOGRAPHY

PROGRAM ADMINISTRATION

ADP Requirement Study for the Department of Health, Eduction and Welfare's Aid to Families with Dependent Children Program: Assessment of Existing AFDC System. Washington, D.C.: Booz, Allen and Hamilton, Inc., September 1978.

ADP Requirement Study for the Department of Health, Education, and Welfare's Aid to Families with Dependent Children Program: Assessment of Welfare Systems. Washington, D.C.: Booz, Allen and Hamilton, Inc., September 1978.

Community Services Administration, Geographic Distribution of Federal Funds in Summary. Washington, D.C.: U.S. Department of Commerce, National Technical Information Services, March 1978.

Congressional Budget Office of the U.S. Congress. Proposition 13: Its Impact on the Nation's Economy, Federal Revenues and Federal Expenditures. Washington, D.C.: U.S. Government Printing Office, July 1978.

"Constitutional Right to Timely Processing of Welfare Applications." New York University Review of Law and Social Change, 5:183 (Spring 1975).

County Health Services Survey, County Indigent Medical Programs, Arizona Fiscal Year 1975-76. Phoenix, Arizona: Department of Health Services, Medical Assistance Division, June 1977.

The Budget of the United States, Fiscal Year 1979. Washington, D.C.: U.S. Government Printing Office, 1978.

"Crisis of Coupons: Evaluation of the Food Stamp Program." Connecticut Law Review, 8:657 (Summer 1976).

Denvir, J. "Controlling Welfare Bureaucracy: A Dynamic Approach."Notre Dame Law Journal, 50:457 (February 1975).

"Due Process Rights of Welfare Recipients." St. Louis University Law Journal, 21:551 (1977).

Food and Nutrition Service. Characteristics of Food Stamp Households, September 1976. Washington, D.C.: U.S. Department of Agriculture, September 1977.

--------.Summary of the Food Stamp Act of 1977. Washington, D.C.: U.S. Department of Agriculture, November 1977.

Health Care Financing Administration. A Guide to Medicare. Washington, D.C.: U.S. Department of Health, Education and Welfare.

Kurtz, Howie. "Medicaid Files Not Uniform, Panel Says," The Washington Star (December 19, 1978), p. A-3.

Moore, Michel , ed. Public Welfare Directory 1978/79. Washington, D.C.: American Public Welfare Association, 1978.

Office of Management and Budget. Catalog of Federal Domestic Assistance 1978. Washington, D.C.: U.S. Government Printing Office, May 1979.

---------. Update to the 1978 Catalog of Federal Domestic Assistance. Washington, D.C.: U.S. Goverment Printing Office, 1978.

Rich, Spencer. "Figures Show End of Era in Social-Program Growth," The Washington Post (February 14, 1978).

Salaries and Expenses, Housing and Urban Development, Budget Activity 12. Washington, D.C.: U.S. Department of Housing and Urban Development, Office of Inspector General, 1979.

Social Security and Medicare Simplified, A U.S. News and World Report Book. New York: McMillan Company, 1970.

Summary of Reviews Made of Food Stamp Fiscal Accountability Operations, Food and Nutrition Service, Washington, D.C., As of March 30, 1976. Hyattsville, Maryland: U.S. Department of Agriculture, Office of Audit, Office of the Secretary, 1977.

Trafford, Abigail. "Inside Our Hospitals," U.S. News and World Report, Vol. 86, No. 9 (March 5, 1979), pp. 33-38.

U.S. Commission on Civil Rights. The Age Discrimination Study, Washington, D.C.: U.S. Government Printing Office, December 1977.

U. S. Congress. House of Representatives. Small Business Investment Act of 1978. Report No. 950-1140. 95th Congress, second session. Washington, D. C.: U. S. Government Printing Office, August 28, 1978.

U.S. Department of Health, Education and Welfare, Social Security Administration. State Plans for Aid to Families with Dependent Children Under the Social Security Act, Title IV-A. Washington, D.C.: U.S. Government Printing Office, 1976.

Waxman, J. Mark. "An Introduction to Medicare." Los Angeles Bar Journal, 52:338 (January 1977).

"An Anti-Fraud Computer Nods Over Medicaid Outrages," The Washington Post (November 13, 1978), p. A-4.

Bacon, Don. "Mess in Welfare -- The Inside Story," U.S. News and World Report, No. 84 (February 20, 1978), pp. 21-24.

Bendick, Marc Jr., Abe Levine, Toby N. Campbell. The Anatomy of AFDC Errors. Washington, D.C.: The Urban Institute, April, 1978.

"Bilking the FHA -- Way of Life to Some Mortgage Firms," Congressional Record (July 8, 1975), pp. H6403-H6408.

Bonner, Alice. "Food Stamp Activists, Officials Clash Over Mississippi Program," The Washington Post (September 5, 1978).

Bonventure, P. "Rx for Medifraud," Newsweek, Vol. 89 (May 9, 1977), p. 92.

Bumstead, R.A., "Scandal in the Use of Vocational Education Funds: The Case of P.J. Weagraff," Phi Delta Kappan, No. 59 (March 1978), pp. 477-78.

Butler, F.J. "Medicaid Fraud," America, Vol. 8, No. 6 (May 7, 1977), pp. 414-15.

Califano, Joseph A. "Remarks to the U.S. Department of Health, Education and Welfare, National Conference on Fraud, Abuse and Error." Washington, D.C.: U.S. Department of Health, Education, and Welfare, December 1978.

"Carter Tax Reform to Combat Abuses," The New York Times (February 3, 1977), p. 22.

"Catching Double Dealers: Welfare Fraud," Time, Vol. 110 (June 4, 1977), pp. 12-13.

"Chicago 'Welfare Queen'," The New York Times (March 19,1977),p. 8.

Cohn, Victor and Peter Milius. "New Medical Science: Reimbursement, How to Make Computers Pay More," The Washington Post (January 8, 1979), pp. A1, A4.

"Compensation Frauds to be Probed," The Washington Post (November 21, 1977).

"Computer Uncovers 13,584 Collecting Double Benefits," The New York Times (February 8, 1978), p. 8.

"Crackdown on Cheaters Who Draw Jobless Pay," U.S. News and World Report, No. 84 (May 15, 1978), pp. 81-83.

"Dreams for Sale: Federal Housing Programs" Newsweek, Vol. 86 (September 23, 1975), p. 65.

"Federal False Claims Act: Potential Deterrent to Medicaid Fraud and Abuse." Fordham Urban Law Journal, 5:493 (Spring 1977).

"$440 Million Is Said to Be Misspent in Welfare Program," The New York Times (January 16, 1978), p. 19.

"Fraud and Abuse Are Twin Plagues of Welfare," Nation's Business, No. 67 (January 1979), p. 38.

"Fraud and Abuse in the Federal-State Unemployment Insurance System." Mimeographed report. Washington, D.C.: U.S. Department of Labor, Janurary 1977.

HEW News. Press release re: AFDC and SSI error rates. Washington, D.C.: U.S. Department of Health, Education and Welfare, August 13, 1978.

"Inefficiency and High Cost," U.S. News and World Report, Vol. 83 (August 8, 1977), p. 49.

Karp, Richard. "Physician, Heal Thyself. Blue Cross, Blue Shield Are Taking Their Medicine." Barron's (September 11, 1978), pp. 11-18.

Lee, Byron G. "Fraud and Abuse in Medicare and Medicaid," Administrative Law Review, 30:1 (Winter 1978).

"Let's Stop Medicare-Medicaid Frauds," The AARP News Bulletin. Washington, D.C.: The American Association of Retired Persons, September 1975.

McNeil, Donald G., Jr. "Consumer Board, in Study, Finds Abuse Among Technical Schools," The New York Times (July 24, 1978).

Mack, E.E. "Fundamentals of Jointly Managed Health and Welfare Fraud Operations," Chartered Life Underwriters Journal, 23:36 (January 1969).

"Minor Excesses Add Up to Major Waste," The Washington Post (November 21, 1978), p. B-15.

Mitgang, Lee. "Favoritism, Kickbacks Found in Public Jobs Program," The Washington Post (April 19, 1978).

"One More Plan to End Fraud in Welfare," U.S. News and World Report, Vol. 84 (January 9, 1978), pp. 41-44.

Otis, A., and M. Zielenziger. "Oh, Arlene, You Welfare Queen," New Times, XI (August 21, 1978) p. 18.

Pies, Harvey E. "Control of Fraud and Abuse in Medicare and Medicaid," American Journal of Law and Medicine, 3:323 (Fall 1977).

Raab, Selwyn. "1.5 Million in Medicaid Is Found Misspent in New York Agencies," The New York Times (December 12, 1977), pp. 1, 65.

Reed, Roark M. "Welfare Fraud: The Tip of the Iceberg," Journal of Criminal Defense, 3:163 (1977).

Rich, Spencer. "Discrepancies in Jobless Pay Studies," The Washington Post (December 27, 1978), p. A3.

Robinson, D. "Billion-Dollar Scandal at the S.B.A.," Readers Digest, No. 112 (June 1978), pp. 130-33.

St. Louis, Robert D., Paul L. Burgess, and Jerry L. Kingston. Fraudulent Receipt of Unemployment Insurance Benefits: Characteristics of Those Who Committeed Fraud and A Prediction Profile. Phoenix, Arizona: Department of Economic Security, Unemployment Insurance Task Force, U.I. Bureau, June 1978.

"SBA Examining 35 Firms in Unpaid Loans Probe," The Washington Post (November 11, 1978), p. A2.

"Special Report: Unhealthy Costs of Health," Business Week (September 4, 1978), p. 58.

Thomasson, D., and C. West. "Medicaid Scandal," Readers Digest, Vol. 110 (May 1977), pp. 87-91.

U.S. General Accounting Office. Lack of Coordination Between Medicaid and Medicare at John J. Kane Hospital. Report to the Senate Special Committee on Aging by the U.S. Comptroller General. Washington, D.C.: U.S. Government Printing Office, May 6, 1977.

-------. The Food Stamp Program - Overissued Benefits Not Recovered, and Fraud Not Punished. Report to the Congress by the U.S. Comptroller General. Washington, D.C.: U.S. Government Printing Office, July 18, 1977.

-------. Ohio's Medicaid Program, Problems Identified Can Have National Importance. Report by the U.S. Comptroller General. Washington, D.C.: U.S. Government Printing Office, October 23, 1978.

"Welfare Cheating May Hit 46,000," Columbus Dispatch (March 2, 1978).

"Waste Alleged In Meal Programs," The Philadelphia Bulletin (July 25, 1978).

CONDUCT OF PROGRAM ENFORCEMENT

Aikman, A.B. and J.B. Berger. "Prosecution of Welfare Fraud in Cook County: The Anatomy of a Legal System," Journal of Urban Law, 45:287 (Winter 1967).

Argyris, Chris. Interpersonal Competence and Organizational Effectiveness. Homewood, Illinois: Dorsey Press, 1962.

Baldus, D.C. "Welfare As a Loan: An Empirical Study of the Recovery of Public Assistance in the U.S.," Stanford Law Review (January 1973).

Bloom, Benjamin S. "Learning for Mastery," Reprint from Evaluation Comment, I, No. 2 (May 1968).

Blumstein, Alfred, Jacqueline Cohen, and Daniel Nagin, eds. Deterrence and Incapacitation: Estimating the Effects of Criminal Sanctions on Crime Rates. Washington, D.C.: National Academy of Sciences, 1978.

Brooke, David Bray and Charles E. Lindblom. A Strategy of Decision, Policy Evaluation As a Social Process. New York: The MacMillan Co., 1963.

Brown, Warren. "SBA Probes Overdue Minority Loans," The Washington Post (November 22, 1978).

Burnham, David. "New York State Fails to Seek Aid for Prosecuting Medicaid Fraud," The New York Times (April 24, 1978), p. D5.

Cattoni, J.A. Medicaid Fraud and Abuse Control: A Review of Selected Literature. McLean, Virginia: General Research Corporation, September 1976.

Causey, Mike. "Hot-Line Tip Phone for GSA," The Washington Post (November 15, 1978), p. C-2.

Chaiken, Jan J. The Criminal Investigation Process, Volume II: Survey of Municipal and County Police Departments. Santa Monica, California: Rand Corporation, October 1975.

Chamberlain, Joseph P. The Judicial Function in Federal Administrative Agencies. Freeport, New York: Books for Libraries Press, 1972.

"Computer Matching Programs Underway." Prepared for the Secretary's National Conference on Fraud, Abuse and Waste. Washington, D.C.: U.S. Department of Health, Education and Welfare, Office of the Inspector General, December 1978.

"Concepts in the Economic Analysis of Criminal Justice Systems." Draft paper submitted to the Police Foundation, 1978.

Constantine, Jean. "Recoupment of Overpayments in the Aid to Families with Dependent Children Program," Unpublished paper, Catholic University Law School, 1978.

Corsetti, Paul and Earl Marchand. "Fraud Squad Probes Medicaid," The Boston Herald American (November 19, 1978), pp. A1, A6.

"Defense in Welfare Fraud," San Diego Law Review, 10:83 (January 1968).

Dershowitz, Alan M. Fair and Certain Punishment. Report of the Twentieth Century Fund Task Force on Criminal Sentencing. New York: McGraw-Hill, 1976.

Frank, Alean. "Lack of Evidence Causes Dismissal of Several Cases in Welfare Crackdown," The Washington Star (December 5, 1978), pp. DC-1, DC-2.

Hazard, G.R. "Social Justice Through Civil Justice," University of Chicago Law Review, 36:699 (Summer 1969).

Hershey, Alan M. and Robert G. Williams. Colorado Monthly Reporting System: Design and Operations. Denver, Colorado: Mathematica Policy Research, February 1978.

--------. Colorado Monthly Reporting System: Design and Operations Summary. Denver, Colorado: Mathematica Policy Research, February 1978.

Hoel, Paul G. Introduction to Mathematical Statistics. New York: John Wiley and Sons, Inc., 1966.

Hornik, John. "Medicaid and AFDC Fraud and Abuse Control and Restitution Efforts by States and Localities," "Best Practices" Case Study: Washington AFDC Program. McLean, Virginia: General Research Corporation, October 1976.

Hynes, Charles L. Third Annual Report from the Deputy Attorney General for Nursing Homes, Health and Social Services. State of New York, January 10, 1978.

Institute for Law and Social Research. Institute Briefing Paper, Uniform Case Evaluation. Number 3. Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, 1976.

Joint Legislative Audit and Review Commission. Long Term Care in Virginia. Richmond: The Virginia General Assembly, March 28, 1978.

Kobrin, Solomon, et al. The Deterrent Effectiveness of Criminal Justice Sanction Strategies Summary Report. Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, September 1972.

Likert, Rensis. The Human Organization. New York: McGraw-Hill, 1967.

--------. New Patterns of Management. New York: McGraw-Hill, 1961.

Maltz, Michael. Evaluation of Crime Control Programs. Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, April 1972.

"Miranda Warnings in Welfare Investigations," Washington University Law Quarterly, 455 (Spring 1973).

Office of Inspector General Annual Report: April 1, 1977 - December 31, 1977. Washington, D.C.: U.S. Department of Health, Education, and Welfare, March 31, 1978.

O'Neill, Robert. Investigative Planning. Seattle, Washington: Battelle Law and Justice Study Center, undated.

Pear, Robert. "Justice Department, Carter Gear Up for Attack on Fraud in Government," The Washington Star (December 4, 1978), pp. A-1, A-9.

"Recoupment of Welfare Overpayment." Houston Law Journal Review, 7:635 (May 1970).

Rottenberg, Simon, Ed. The Economics of Crime and Punishment. Washington, D.C.: American Enterprise Institute, 1973.

Rule, Sheila. "Assembly Votes Bill to Check Employees with Welfare Rolls," The New York Times (March 3, 1978), p. A1.

Sayles, Leonard R. Managerial Behavior. New York: McGraw-Hill, 1964.

Sawyer, Kathy. "$7 Million a Year in Overtime Paid to 600 U.S. Workers, Probers Say," The Washington Post (October 27, 1978), pp. A1, A4.

Schechter, Susan B. and Robert E. Oshel. Medicaid and AFDC Fraud and Abuse Control and Restitution Efforts by States and Localities, Options for Reducing Fraud in the AFDC Program. McLean, Virginia: General Research Corporation, March 1977.

--------. Medicaid and AFDC and AFDC Fraud and Abuse Control and Restitution Efforts by States and Localities, Options for Reducing Fraud in the Medicaid Program. McLean, Virginia: General Research Corporation, April 1977.

Schell, Theodore H., Don Overly, Stephen Schack, and Linda S. Stabile. National Evaluation Program Phase I Summary Report, Traditional Preventive Patrol. Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, June 1976.

Schumiatcher, M C. "Welfare Fifty Years Hence," Canadian Bar Review, 51:40 (March 1973).

Silver, C.R. "Practical Guide to Your First Welfare Case," Practical Lawyer, 16:77 (October 1970).

SPAARS Legal Constraints Study. Denver: Colorado SPAARS Committee, Colorado Office of Human Resources, March, 1977.

Staats, Elmer B. U.S. Comptroller General. "Statement Before the Senate Committee on Budget, GAO Efforts Related to Fraud, Abuse and Mismanagement in Federal Program," Washington, D.C.: U.S. Government Accounting Office, March 15, 1979.

State of Florida Office of the Auditor General. Report on Investigations of Possible Public Assistance Fraud Cases for the Period January 1, 1977 - December 31, 1977. Tallahassee, Florida: State of Florida, March 8, 1978.

Thompson, James D. Organizations in Action. New York: McGraw-Hill, 1967.

Touche - Ross. Evaluation of AFDC-QC Corrective Action, Final Report. Washington, D.C.: U.S. Department of Health, Education and Welfare, Social Security Administration, October 31, 1977.

"Unemployment Compensation: Waiver and Recoupment of Overpayments," Memphis State University Law Review, 7:683 (Summer 1977).

"U.S. Agencies Unprepared to Detect, Prevent Fraud," The Richmond Times Dispatch (April 16, 1978), pp. 1, 14.

U.S. Congress. House of Representatives. Extension of Office of Inspector Generals in Certain Departments and Agencies. Report 95-584. 96th Congress, first session. Washington, D.C.: U.S. Government Printing Office, August 5, 1977.

U.S. Department of Health, Education and Welfare, The Institute for Medicaid Management. Patient/Provider Profile (S/UR) Conference Report. Washington, D.C.: Pacific Consultants, June 1977.

U.S. Department of Justice, Law Enforcement Assistance Administration. Evaluation of Crime Control Programs. Washington, D.C.: U.S. Government Printing Office, April 1972.

U.S. Government Accounting Office. Attainable Benefits of the Medicaid Management Information System Are Not Being Realized. Report by the U.S. Comptroller General. Washington, D.C.: U.S. Government Printing Office, September 26, 1978.

--------. Computer Auditing in the Executive Departments: Not Enough Is Being Done. Report to the Congress by the U.S. Comptroller General. Washington, D.C.: U.S. Government Printing Office, September 28, 1977.

--------. Federal Agencies Can and Should Do More to Combat Fraud in Government Programs. Report to the Congress by the U.S. Comptroller General. Washington, D.C.: U.S. Government Printing Office, September 23, 1978.

--------. Further Improvements Needed in Investigations of Medicaid Fraud and Abuse. Report to the Congress by the U.S. Comptroller General, Washington, D.C.: U.S. Government Printing Office, March 10, 1978.

--------. Investigations of Medicare and Medicaid Fraud and Abuse. Report to the Subcommittee on Finance by the U.S. Comptroller General. Washington, D.C.: U.S. Government Printing Office, May 23, 1977.

--------. The Summer Feeding Program for Children: Reforms Begun--Many More Urgently Needed. Report by the U.S. Comptroller General. Washington, D.C.: U.S. Government Printing Office, March 31, 1978.

--------. Ways the Department of Health, Education and Welfare Can Increase Benefits from Auditing. Washington, D.C.: U.S. Government Printing Office, October 25, 1977.

Veterans Administration. Annual Report 1976. Washington, D.C.: U.S. Government Printing Office, June 30, 1976.

--------. Annual Report 1977. Washington, D.C.: U.S. Government Printing Office, 1978.

WHITE COLLAR CRIME

"Can Accountant Uncover Management Fraud?" Business World (July 10, 1978), p. 92.

Douglas, C.H. "White Collar Crime - Proposed Solutions," Public Law Quarterly, 7:11 (January 1978).

Economic Crime Digest, Vols, 3, 4 Nos. 5, 6, 1. Chicago, Illinois: National District Attorneys Assocation.

"Economic Crime Project, First Annual Report 1973-74." Chicago, Illinois: National District Attorneys Association, 1974.

Economic Offenses. Recommendations of the American Bar Association. Washington, D.C.: American Bar Association, Section of Criminal Justice, Committee on Economic Offenses, March 1977.

Edelhertz, Herbert, et al. The Investigation of White-Collar Crime, A Manual for Law Enforcement Agencies. Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, April 1977.

Finn, Peter and Alan R. Hoffman. Exemplary Projects: Prosecution of Economic Crime. Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, March 1976.

George, Jr., B. James. White Collar Crimes: Defense and Prosecution, Criminal Law and Urban Problems Course Handbook. Series 31. New York: Practicing Law Institute, 1970.

Hagen, Roger E. The Intelligence Process in White Collar Crime Investigation. Seattle, Washington: Battelle Law and Justice Study Center, undated.

"In Pursuit of Corruption." America, No. 139 (September 16, 1978), p. 149.

Meyer, Lawrence. "Scourge of White Collar Criminals Tells New U.S. Probers How He Did It," The Washington Post (November 30, 1978).

National District Attorneys Association. Economic Crime Digest, Volume 3, No. 5; Volume 3, No. 6, Volume 4, No. 1, Chicago, Illinois.

Ogren, Robert W. "The Ineffectiveness of the Criminal Sanction in Fraud and Corruption Cases: Losing the Battle Against White Collar Crime," The American Criminal Law Review, 2:959 (Summer 1973).

Smigel, Erwin. "Public Attitudes Toward Stealing As Related to the Size of the Victim Organizations," American Sociological Review, 21:320-27, 1956.

--------. and H. Lawrence Ross. Crime Against Bureaucracy. New York: Van Nostrand, 1970.

"White Collar Crime Erodes Respect for Justice System," LEAA Newsletter (January 1979), p. 2.

White Collar Crime: A Selected Bibliography. Washington, D.C.: U.S. Department of Justice, Law Enforcement Assistance Administration, July 1977.

"White Collar Crime Seminar." Seminar Papers Compiled September 16, 1976, in conjunction with the 1976 Annual Convention of the Federal Bar Association.

COST BENEFIT ANALYSIS

Aldine Annuals on Forecasting, Decision-Making, and Evaluation. 1974 and 1972 Editions. Chicago : Aldine Publishing Company, 1972, 1974.

Andrieu, M. "Benefit Cost Evaluation." Evaluation Research Methods: A Basic Guide (Leonard Rutman, ed.). Beverly Hills, California: Sage Publications, Inc., 1977.

Anthony Robert N., and Hertzlinger, Regina. Management Control in Non-Profit Organizations. Homewood, Illinois: Richard D. Irwin, Inc., 1975.

Bolle, Mary Jane. Cost-Benefit Studies for OSHA Standards: Use and Misuse. Washington, D.C.: Library of Congress, Congressional Research Service, August 22, 1977.

Brown, Howard A. Benefit-Cost Analysis of Water Resource Projects. Washington, D.C.: Library of Congress, Congressional Research Service, August 12, 1976.

Cauthorn, L. Terry. "Whatever Happened to Social Accountants?" Management Accounting, Vol. 58, No. 10 (April 1977), pp. 55-60.

Due, John F. Government Finance: Economics of the Public Sector, 4th Edition. Homewood, Illinois: Richard D. Irwin, Inc., 1968.

Joehnk, Michael D. and McGrail, George R. "Benefit-Cost Ratios for Family Practice Residency Centers," Management Accounting, Vol. 58, No. 8 (February 1977), pp. 41-46.

Kendall, M.G., ed. Cost Benefit Analysis. New York: American Elsevier Publishing Co., Inc., 1971.

Livingstone, John L. and Sanford C. Gunn. Accounting for Social Goals. New York: Harper and Row, Inc., 1974.

Magee, Robert P. "Cost Control with Imperfect Parameter Knowledge," Accounting Review, Vol. 52, No. 1 (January 1977), pp. 190-199.

Sassone, Peter G., and Schaffer, William A. Cost-Benefit Analysis: A Handbook. New York: Academic Press, 1978.

Stokey, Edith and Zechhauser, Richard. A Primer for Policy Analysis. New York: W.W. Norton and Co., Inc., 1978.

Taylor, Bernard W., and North Ronald M. "The Measurement of Economic Uncertainty in Public Water Resources Development." American Journal of Agricultural Economics, Vol. 58 (November 1976), pp. 636-643.

University City Science Center. Alternative Strategies for Cost-Benefit Analysis of Fraud and Abuse Enforcement: A Working Paper. Washington, D.C.: University City Science Center, July 1979.

COMPUTER SECURITY

Babcock, Charles R. "Compromise Is Offered on Bank Record Privacy," The Washington Post (May 18, 1978).

"Computer Files Are Called Safe," The Philadelphia Inquirer (November 16, 1977).

"Computerization of Welfare Recipients: Implications for the Individual and the Right to Privacy," Rutgers Journal of Computers and the Law, 4:163 (1974).

"The Growing Threat to Computer Security," Business Week, No. 2494 (August 1, 1977), pp. 44-45.

Hoyt, Douglas B., ed. Computer Security Handbook. New York: The MacMillan Company, 1973.

Katzan, Harry, Jr. Computer Data Security. New York: Van Nostrand Reinhold Company, 1973.

Shapley, D. "Social Security Computers Vulnerable, GAO Says," Science, Vol. 201, No. 4351 (July 14, 1978), p. 142.

"Social Security's Computer Security Is Found Lax," The New York Times (March 8, 1978).

☆U.S. GOVERNMENT PRINTING OFFICE: 1979--281-380:1679

END