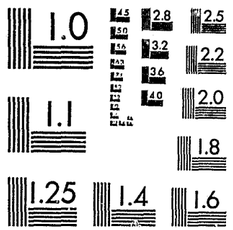

RESPONSES TO FRAUD AND ABUSE IN AFDC AND MEDICAID PROGRAMS

January 1983

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CONTENTS

CONTENTS (concluded)

LIST OF FIGURES

LIST OF TABLES

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INTRODUCTION

Emphases in public debates over America's social programs change over time. In the Great Depression of the 1930s and again during the Great Society optimism of the 1960s, the central issues before Congress and the state legislatures were expansionist in nature--how should programs such as health, welfare, nutrition, and housing be expanded to meet social needs? How should delivery systems be changed to improve "outreach" to the clients the programs are intended to serve? How should bureaucratic styles be altered to respect the dignity of clients, their privacy and humanity, their status as citizens rather than as objects of official charity?

By the late 1970s, these emphases had subsided, not because the problems had been solved but because more vocal and powerful forces were attacking the excesses of social programs. While a 1961 survey found a plurality of respondents feeling that government was spending "too little" on welfare, a 1977 survey found a plurality indicating that government was spending "too much." A 1976 poll by Louis Harris found 85% of 1500 respondents agreeing with the statement, "Too many people on welfare cheat by getting money they are not entitled to." (Harris, 1976). General Accounting Office reports and Congressional hearings began to publicize mismanagement of social programs, Inspectors-General were appointed to oversee federal agencies, and the agencies themselves began to emphasize savings as major indicators of their accomplishments. By the start of the Reagan administration in 1981, reducing expenditures and transferring programs from federal to state control became the major social program proposals before Congress.

As anti-government movements and taxpayer revolts brought social programs under attack, the issue of "fraud, waste, and abuse" came to play a central role in the controversy. Perhaps echoing Gresham's Law that bad

money drives out good money, debates over ways to improve the effectiveness of social programs were overshadowed by exposes of welfare queens, Medicaid mills, poverty pimps, and nonexistent school lunches. By 1978, a defensive President Carter was appearing before a conference of 1200 officials to proclaim, "This Administration has declared war on waste and fraud in government programs....We are concerned with more than saving dollars, crucial as that is today. We must restore and rebuild the trust that must exist in a democracy between a free people and their government." (Carter, 1978: 21)

Responding to these charges, fraud control (a generic term we shall use to describe efforts to prevent fraud and abuse and to punish violators) became a widespread concern. Congress provided funding for federal and state fraud control efforts, revised social programs to facilitate fraud control, and threatened to punish agencies which did not improve their performance. Federal agencies began to analyze their fraud and abuse problems and sought to stimulate comparable efforts by the state and local agencies which were spending federal funds.

State agencies, also facing attacks from their own legislatures, pushed their local offices to pay more attention to accuracy in program administration. The issue of fraud had advanced from isolated public grumblings at the beginning of the 1970s to specific legislative mandates, administrative reforms in federal, state, and local agencies, and the formation of specialized fraud control procedures and bureaucracies.

The development of fraud control programs has been a conflict-ridden process. Critics continue to charge that administrators are failing to supervise programs effectively. Administrators argue that they have not been given the tools to wage effective control campaigns, and that the criminal justice system refuses to take fraud cases seriously. Prosecutors charge that the agencies are giving them weak cases, and that they have other, more important things to worry about. All claim that they are trying hard, that they don't have enough resources, and that someone else should do

something about fraud and abuse. From an opposite perspective, some supporters of social programs argue that <u>too much</u> is being done--that fraud control efforts are making it difficult for those who are, in fact, eligible to receive aid, and that the fraud and abuse issue is being used as a smokescreen to disguise efforts to dismantle social programs.

This is a book about fraud control programs of the late 1970s and early 1980s. We will provide neither a criminological analysis of those who defraud the government nor a textbook on the technology of fraud control, although both topics deserve more serious attention than they have as yet received. Rather, we will focus on a number of political and public policy issues surrounding fraud control. While, in the abstract, no one has opposed the development of fraud control efforts, specific control programs have led to conflicts within program agencies between those charged with delivering services and those given control responsibilities; conflicts between program agencies and criminal justice agencies over enforcement priorities and responsibilities; and conflicts among federal, state, and local agencies over fraud control responsibilities. Many of these conflicts also involve disputes over the relative importance of different control problems and over resources for fraud control--how much should be spent, and who should pay for it? Finally, the implementation of fraud control programs has often led to charges that they are threatening either to immobilize the operations of the social program agencies or to violate the privacy and civil liberties of program beneficiaries. Agreement that fraud should be controlled, in other words, has not produced agreement on who should do it, how it should be done, or how intensively it should be pursued.

* * *

The issues of fraud control might be explored in many ways. Each government program provides different opportunities for fraud and abuse (Lange and Bowers, 1979; General Accounting Office, 1981), and each administrative and criminal justice system responds to these problems in different ways. While our analysis of fraud control issues will utilize

materials from many different sources, we will focus on two major programs, Aid to Families with Dependent Children (AFDC) and Medicaid. Both programs involve a combination of federal and state (or federal, state, and local) funding, and both are primarily administered by state agencies. The two programs, however, face substantially different problems. The AFDC program faces problems of recipient fraud, deception which affects recipient eligibility and the size of the grant each will receive. (Similar problems are faced by Food Stamps, Medicaid, Supplemental Security Income, and general assistance programs.) In the Medicaid program, the major control problems are fraud and abuse by the providers (hospitals, nursing homes, physicians, pharmacies, etc.) who are paid to give services to recipients.

Selecting AFDC and Medicaid programs for analysis involves both advantages and limitations. Since both programs are administered by states, they offer opportunities for comparative analysis which are not presented by federally-administered programs. Furthermore, they permit a comparison between programs to control fraud by recipients and programs to control provider fraud. Yet, they leave us with no information about fraud and fraud control in federal programs or in programs whose beneficiaries are middle- or upper-class Americans and businesses. We do not know, in short, whether state agencies are more or less competent and motivated to control fraud and abuse than their federal counterparts, and we do not know whether the poor or Medicaid providers are more or less likely to commit fraud than other recipients of government funds. Studies of fraud and fraud control in the Social Security program, defense contracting, and the income tax system, for example, would shed light on these issues. Finally, we must stress that we are <u>not</u> suggesting that either AFDC or Medicaid be curtailed or eliminated simply because they have fraud and abuse problems; while much can be done to improve these programs, they offer essential benefits to millions of Americans.

Our analysis proceeds in three parts. Part I sets out basic background information. Chapter One provides brief descriptions of the processes and organizations involved in the AFDC and Medicaid programs. Chapter Two then surveys conflicting definitions of fraud and abuse and estimates of their

nature and extent. Part II presents six case studies of fraud control efforts, the responses of Colorado, Illinois, and Washington to AFDC and Medicaid fraud and abuse problems. Part III seeks to explain the development of fraud control programs in terms of the perspectives of program recipients and providers, administrative agencies, and fraud control specialists. In the concluding chapter, we analyze alternative approaches to improving fraud control programs.

REFERENCES

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

GENERAL ACCOUNTING OFFICE (1981) Fraud in Government Programs: How Extensive is it? How Can it be Controlled? Volume I, AFMD-81-57; Volume II, AFMD-81 73; Volume III, AFMD-82-3 (Washington: General Accounting Office)

HARRIS, L. (1976) "Majority Ambivalent on Welfare" Chicago Tribune, June 10.

LANGE, A., and R. BOWERS (1979) Fraud and Abuse in Government Benefit Programs (Washington: Government Printing Office).

PART I

BACKGROUND

CHAPTER ONE

PROCESSES AND ORGANIZATIONS: OPPORTUNITY STRUCTURES FOR WELFARE FRAUD AND FRAUD CONTROL

Why do I rob banks? Because that's where the money is!

--attributed to Willie Sutton

If my worst enemy was given the job of writin' my epitaph when I'm gone, he couldn't do more than write: "George W. Plunkitt. He Seen His Opportunities, and He Took 'Em." (Reardon, 1963: 6)

In Fiscal Year 1981, 3.8 million American families received payments totaling $12.5 billion under the Aid to Families with Dependent Children (AFDC) program. In the same year, 22.5 million people received services under the Medicaid program totaling $22.8 billion. (Office of Management and Budget, 1982) The two programs are, clearly, among the largest and most costly of government efforts to serve the poor. As they have evolved since 1935 (AFDC) and 1965 (Medicaid),[1] the programs have developed detailed procedures both to determine who is eligible for benefits and to govern relationships among government agencies, individual recipients, and health care providers. To begin our analysis of problems of fraud and abuse in these programs, and responses to those problems, this chapter provides a general description of how the programs work--how individuals apply for and receive benefits, how providers are reimbursed for Medicaid services, and how the programs are funded and administered.

The Administration of State AFDC Programs. When Congress enacted the AFDC program (Title IV-A of the Social Security Act) in 1935, the federal government began funding state programs which complied with federal guidelines. Since poor relief or welfare historically had been a state and/or local function in the United States, AFDC gave the states substantial

latitude to define who would be eligible for benefits, what level of benefits would be provided, and how the program would be administered. As a result, instead of one AFDC program, there are 54 (covering all states, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands).

To qualify for federal funding, each state must designate a "single state agency" to receive AFDC funds, and must prepare an annual state plan. In the plan, the state determines a "standard of need" which "represents the cost of those basic living needs which the State recognizes as essential for all applicants or recipients under the assistance program." (DHHS, 1981: xii) In 1981, the standard for a family of four (one needy adult and three children) ranged from $187 per month (Texas) to $753 (Vermont). The state need not, however, award benefits equalling the standard; actual assistance payments for a family of four with no income ranged from $120 (Mississippi) to $563 (California).

Once a standard of need and maximum payment levels have been established, the actual amount paid to a family is determined by the composition of the "assistance unit" and its resources. The unit or family must have at least one dependent child ("a needy child who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent.") States may also elect, to include children, under the AFDC-UP program, who are "deprived of support by reason of the unemployment of a parent." Children must live with a specified relative and be under eighteen, or, if full-time students, between eighteen and twenty-one. If an applicant is categorically eligible (there is an eligible child), the state then determines "need" by comparing the applicant's resources with the standard of need. In general, the state looks at both property resources and income resources (wages, pensions, child support payments, other government benefits), although some assets and some income are excluded from the calculation ("disregards"). (Fischel and Siegel, 1980: Chapter Two) A family with no resources will receive the full amount provided for a family of its size; payments will be reduced if resources are available, or an application will be denied if countable resources exceed the standard of need.

Once a state plan has been approved by the Office of Family Assistance of the Social Security Administration, the federal government pays 50% of the program's administrative costs and between 50 and 65% of the costs of benefit payments, depending on the per capita income of the state. In eleven states, counties pay a share of the non-federal costs; the rest is paid by the states. Apart from certain monitoring efforts to be discussed later, the federal goverment plays no role in the administration of AFDC programs. The day-to-day handling of the application and payment process follows one of two basic patterns. Thirty-six states have "state-administered" AFDC systems, in which local offices of the state welfare department process applications and issue checks; eighteen states have "state-supervised" systems in which the state only supervises the operations of local (usually county) welfare agencies. In the state-supervised systems, counties have some discretion in interpreting program guidelines, setting benefit levels, and handling individual cases. In both systems, local welfare offices process Food Stamp and Medicaid as well as AFDC applications, and may also handle non-federally-funded general assistance programs for persons who do not meet the requirements of the federal programs. All AFDC recipients also receive Food Stamps and Medicaid benefits; some persons qualify for the latter programs without being eligible for AFDC.

Procedures used to handle applications for AFDC and the other programs vary from state to state, and probably from office to office.[2] All applicants must complete an application form; a 1977 report by the Congressional Research Service found that states varied in terms of this requirement from a minimum of one form (ranging in length from four to thirty-seven pages) to a maximum of twenty-one forms (ranging from twenty-seven to forty pages). (Congressional Research Service, 1977: 30) In addition to completing the application form(s), the applicant may be asked to provide documentation of age, family composition and relationships, citizenship, residence, social security number for each member of the unit, school attendance of the children, resources, and expenses. Unless exempt, the applicant will also have to register, usually at another office, for the Work Incentive Program, to cooperate (if necessary) in efforts to establish

paternity and collect child support payments from the child's father, and to assign support payments to the state.

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

Once AFDC eligibility is established on the basis of the information provided at application, the recipient family becomes part of the AFDC client caseload and starts to receive periodic cash payments. Case records are maintained at local welfare offices on AFDC families and their members. These records contain all eligibility information received at application and are supposed to be continuously updated to include changes in the status of a family, the amount of benefits paid, and other information which may affect a family's eligibility or be necessary for the provision of benefits. Typically, information from these case records is summarized in other files, both at the local welfare office and at the state welfare agency. The most common of these condensed records is a master beneficiary record file which is an inventory of basic information about current

recipients. This file usually includes information such as name, date of birth, address, date of eligibility and benefit payment amount for each program recipient. Depending upon the state, AFDC benefit checks are distributed by the state or the local agency and may be either mailed directly to recipients or mailed for pick-up at local banks or welfare agencies.

Eligibility for AFDC assistance and the amount of assistance available to a family can change substantially over time. Changes in circumstances, such as an increase or decrease in income, change in family composition, or change in living expenses may not only affect the amount of the AFDC grant, but may also render a family ineligible for the program. Federal regulations require states to establish procedures to ensure that alterations in circumstances are systematically brought to the attention of welfare agencies so that eligibility adjustments can be made.

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

State practices with regard to reporting vary widely. Some states systematically mail AFDC recipients a change of status/reporting form periodically (monthly or quarterly). In those states that utilize periodic reporting forms, some require that it be returned to the welfare agency only

if a change in status has occurred, while others require that the form be returned regardless of any change. Failure to submit the form in the latter case is often reason for the agency to terminate or delay payment of AFDC benefits. In practice, reporting procedures in most states usually focus on recipients' income because of the high potential for change and the prevalence of abuse by recipients when reporting this information. (Congressional Research Service, 1977: 88)

Eligibility for benefits under the AFDC program is not a permanent condition. Regulations require that AFDC eligibility be formally redetermined at least every six months. The intent of these regulations is to insure that AFDC cases are comprehensively reviewed so that those in error not continue for long periods of time. The redetermination process, like the application process, also differs significantly among the states. For example, redetermination procedures often vary in the degree to which specific information is reviewed, the kind of documentation required, and the extent to which and methods by which information is verified. The redetermination procedures in a state may involve practices as complete as the process of initial application or they may involve a simpler procedure in which only certain facts are checked and reverified. (Congressional Research Service, 1977: 40-44; Bendick, Lavine, and Campbell, 1978: 41-51)

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

Redetermination of AFDC eligibility is considered to be one of the most important aspects of AFDC program administration. It is crucial to the maintenance of program integrity, especially with regard to fraud prevention and detection. For the typical AFDC case, redetermination is the only

instance in which AFDC eligibility is critically scrutinized by welfare staff after an application is approved. Unless a case is singled out for review by other means (i.e., a recipient's report of status changes, a quality control review, or a tip from another source), redetermination is often the first routine opportunity for an examination of case accuracy and the possible existence of fraud. For example, if an AFDC recipient is defrauding the program, benefit checks for six months are almost assured before there is a risk of detection via a redetermination. If this fraud is undetected during the first scheduled redetermination, the period of fraud may extend to a year.

State Administration of Medicaid Programs. The Medicaid program (Title XIX of the Social Security Act) provides federal funding for health care services delivered to persons who are receiving cash assistance from AFDC or Supplemental Security Income (aid to aged, blind, or disabled persons), or who are "medically needy" (persons who fit within AFDC or SSI categories and have enough income to pay their basic living expenses but not enough to pay for their medical care.) All states cover AFDC and SSI recipients in their Medicaid plans; thirty-three states also provide for the medically needy. All states must cover certain basic services: Inpatient and outpatient hospital services, laboratory and X-ray services, skilled nursing facilities for persons 21 or older, home health care services for persons eligible for skilled nursing facilities, physicians' services, family planning services, rural health clinic services, and early and periodic screening, diagnosis, and treatment of individuals under 21. States may also elect to include drugs, eyeglasses, private duty nursing, intermediate care facilities, inpatient psychiatric care for the aged and persons under 21, physical therapy, dental care, etc. (Health Care Financing Administration, 1979: 2-3)

In addition to specifying which services will be provided for Medicaid recipients, each state's annual Medicaid plan specifies how providers will be reimbursed. Federal regulations require that hospitals and nursing homes (skilled nursing facilities and intermediate care facilities) be reimbursed on a reasonable-cost basis,[3] but the states can establish their own

systems to reimburse other providers. The federal government pays 50% of the states' administrative costs, and between 50 and 78% of benefit costs, again depending on the states' per capita income. In addition to these basic cost-sharing arrangements, the federal government (the Health Care Financing Administration in the Department of Health and Human Services) will pay 90% of the costs of developing automated claims processing and management information systems, and 75% of the costs of operating such systems. The costs of professional medical personnel used in program administration are matched at a 75% rate, and the costs of skilled nursing facility inspectors are matched at a 100% rate. Of particular concern to this study was the 90 percent offer of federal financing (reduced to 75% in 1981) for states that operate Medicaid fraud control units.

Each state designates a "single state agency" to plan and implement its Medicaid program. Medicaid recipients are enrolled by the local welfare offices which process AFDC applications: these offices may or may not be part of the Medicaid agency. The agency contracts with hospitals, nursing homes, physicians, pharmacies, and other providers to accept Medicaid patients (requiring that they accept Medicaid fees as full reimbursement for services). While it directly arranges for provider participation and sets reimbursement rates, the Medicaid agency also may contract with an insurance company or fiscal agent to process claims submitted by providers. The agency must provide for monitoring and auditing of providers' costs, and establish a system to refer appropriate claims to other sources ("third party liability"), e.g., insurance companies, the Veterans Administration, or Medicare, since Medicaid is designed to be only a "payor of last resort."

The Medicaid program presents two very different opportunities for fraud--like the AFDC recipient, the Medicaid recipient may misrepresent facts at the time of application or redetermination, e.g., concealing assets or income which would exceed eligibility limits. More significant in terms of total financial loss are fraudulent claims by providers--claims for services never delivered, duplicate claims, inflation of hospital and nursing home costs, overclassification of services to qualify for higher fees, etc. Administratively, recipient fraud problems are the concern of

the welfare offices which handle applications and redeterminations, while provider problems are the concern of the central Medicaid agencies.

The Federal Role in AFDC and Medicaid Programs. As has been indicated, state agencies have substantial freedom to determine eligibility for AFDC and Medicaid benefits, the scale of those benefits, reimbursement rates for Medicaid providers, and systems for administering the two programs. Thus in most ways they are state programs, even though they involve substantial federal financial participation (FFP). While state AFDC and Medicaid administrators have this freedom to adapt their programs to state needs, priorities, and resources, federal agencies (the Social Security Administration and the Health Care Financing Administration) have a number of opportunities to influence state decisions. In the process of reviewing annual plans and reports, federal agencies can determine that state practices are not in compliance with federal guidelines and threaten to disallow FFP for non-compliant activities. Audits conducted by the Inspector General of the Department of Health and Human Services identify "exceptions," specific non-compliant expenditures which lead to the denial of FFP.

Of particular interest to our analysis of fraud control in AFDC and Medicaid are federal efforts which began in the 1970s to pressure states to take action against erroneous payments. While the states control all decisions regarding eligibility and payment levels, the Department of Health, Education, and Welfare (later DHHS) created a quality control process to provide estimates of the nature and extent of eligibility and payment errors in each state. As will be detailed in Chapter Two, the "QC" process reviews a sample of AFDC, Medicaid, and Food Stamps files in each state and calculates the proportion of cases and payments which are in error. Semi-annually, each state is required to submit a "corrective action plan" indicating how it will reduce identified types of errors. Late in the 1970s, Congress attached fiscal sanctions (the "Michel" amendment) to the error rate system, threatening to reduce FFP for states with high error

rates. (The fiscal sanction strategy will be discussed in Chapter Fifteen.) While no fiscal sanctions had been imposed by 1982, their threatened imposition led many states to review their management practices.

Supplementing the diagnostic process created by the quality control and corrective action systems have been limited technical assistance efforts by SSA and HFCA; regional office and national-level officials have sought to provide information for state agencies on techniques which might address error and/or fraud and abuse problems. Finally, in addition to the Congressionally-authorized programs which provide 75% federal funding for Medicaid Management Information Systems, Child Support Enforcement units, and Medicaid Fraud Control units, the federal agencies can award discretionary funds for "demonstration projects" to address state fraud control problems.

Responses to Fraud Problems. Finally, a few words are in order about the range of responses which may follow when fraud is detected. We will use the generic term "fraud control" to encompass all responses to fraud problems. Fraud prevention refers to efforts to make sure that fraud will not take place in the future (revising program requirements, improving administrative procedures, etc.).[4] Fraud enforcement programs involve responses to specific events which have already occurred: what should be done with Mrs. Smith or Dr. Jones? In many cases, as will be seen in the following chapters, nothing is done because the fraud either cannot be proved or is trivial in scale. A second level of response is to cut the agency's losses by taking Mrs. Smith off the AFDC rolls or terminating Dr. Jones' contract to serve Medicaid patients. Third, the welfare agency can try to persuade defrauders to give the money back voluntarily; overpaid AFDC recipients who remain on the rolls may also find their grants reduced (recoupment).

All of these responses to overpayments, whether innocent or fraudulent, can be accomplished by the welfare agency acting on its own (although the recipient or provider might contest the action in an administrative hearing

or court proceeding). Efforts to impose additional civil or criminal penalties on defrauders, however, involve the participation of judicial agencies. AFDC and Medicaid fraud involve violations of both federal and state laws, although there are differences in coverage and penalties. As a result, fraud cases may be prosecuted through either judicial system, using state and federal investigators (state police, the FBI, and the DHHS Inspector General), prosecutors (county prosecutors, state Attorneys-General, United States Attorneys), and judges. These agencies may initiate enforcement actions on their own (e.g., via grand jury investigations) or as a result of case referrals from welfare agencies. Perhaps as important, as we shall see, is the fact that they can decide not to act, either choosing to concentrate on other matters or specifically declining referrals for prosecution. While state and federal judicial systems can serve to implement the fraud control goals of the welfare system, they also have the freedom to direct their attentions elsewhere.

In conclusion, Table 1 summarizes basic aspects of AFDC and Medicaid costs, beneficiaries, funding, administration, major fraud and abuse problems, and control responsibilities. We turn now to estimates of the extent of these problems.

Table 1

AFDC AND MEDICAID PROGRAMS

	AFDC	Medicaid
Total Costs, FY 1981	$12.5 billion	$22.8 billion
Beneficiaries, FY 1981	3.8 million families	22.5 million persons
Federal Financial Participation:		
Program Costs	50-65%	50-78%
Administrative Costs	50%	50% of basic costs; 75-90% of special program costs
Administrative Structure:		
Determination of eligibility	State or county welfare offices	State or county welfare offices
Payments	State or county treasurer	State or county treasurer, or fiscal agent
Major Control Problems	Recipient fraud regarding income or family structure	Recipient fraud; provider fraud and abuse
Fraud Control Responsibilities:		
Prevention	Local offices	Local offices (eligibility): claims processors (provider fraud and abuse)
Enforcement	State or local investigators	State investigators

NOTES

1. The development of federal poverty programs is described in Advisory Commission on Intergovernmental Relations (1980); Handler and Hollingsworth (1971); Piven and Cloward (1971); and Steiner (1966). The development of Medicaid is described in Stevens and Stevens (1974) and Thompson (1981: Chapter Four). Federal consideration (or lack thereof) of fraud prevention and enforcement issues in the development of these programs will be discussed in Chapters Eleven and Twelve.

2. In the text, we discuss variations in official application procedures. In subsequent chapters, it will become apparent that there are very substantial variations arising both from the competence and motivation of local administrators and caseworkers, and from policies toward applicants; some offices and some caseworkers tend to give the benefit of the doubt to the applicant, processing applicants as quickly as possible and checking the details later, while others tend to stick to the letter of the regulations, delaying approval until all papers are in order, all facts verified, etc.

3. States, in general, are required to follow the Medicare reasonable cost payment system for reimbursements for hospital care unless they have approval from the Secretary of DHHS to use an alternative payment system. For all other services, with the exception of skilled nursing facility and intermediate care facility services, the only federal requirement is that the state Medicaid reimbursement rate may not exceed the amounts paid under Medicare; thus, there is a ceiling on payment, but no corresponding floor. In the case of skilled nursing facility and intermediate care facility services, a state's payment level must be reasonably related to cost. This does not mean that a state is required to use the Medicare reasonable cost system, but that they must relate their reimbursement rates to the cost of care in some reasonable way.

4. Potential fraud prevention strategies for state and local benefit programs are analyzed in depth in Gardiner, Hentzell, and Lyman (1982).

REFERENCES

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

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

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

DHHS (1981) Characteristics of State Plans for Aid to Families with Dependent Children (Washington: Government Printing Office)

FISCHEL, M., and L. SIEGEL (1980) Computer-Aided Techniques Against Public Assistance Fraud: A Case Study of the Aid to Families with Dependent Children (AFDC) Program (McLean VA: MITRE Corporation)

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

HANDLER, J., and E. HOLLINGSWORTH (1971) The "Deserving Poor": A Study of Welfare Administration (Chicago: Markham)

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

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

PIVEN, F., and R. CLOWARD (1971) Regulating the Poor: The Functions of Public Welfare (New York: Random House)

REARDON, W. (1963) Plunkitt of Tammany Hall (New York: Dutton)

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

STEVENS, R., and R. STEVENS (1974) Welfare Medicine in America: A Case Study of Medicaid (New York: Free Press)

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

CHAPTER TWO

ESTIMATES OF THE NATURE AND EXTENT OF FRAUD AND ABUSE PROBLEMS

Fraud, waste, and abuse in HEW programs amount to $5.5 to $6.5 billion dollars each year.

--DHEW Inspector General, May 1978
(HEW, 1979: 150)

We never could figure out how they came up with that figure. We got a call from the Secretary's office saying he would be giving a speech in nine days, and wanted an estimate of fraud, waste, and abuse. We sure didn't know about our program, and I doubt that any of the people in other programs had better figures. We sent in some figure--we had to--and I guess the Secretary's people just added up all the guesses. We've been stuck with the $6.5 billion figure ever since.

--Assistant DHHS Inspector
General, March 1981

What's the Problem? Definitional Issues. Debates over improper expenditures in government benefit programs have long been marked by vague and conflicting definitions and by questionable data. At the low end of the spectrum are estimates based on cases of fraud which have been proven in court; at the high end are estimates which include any expenditure which does not further the aims of the program (to reduce poverty, improve health and nutrition, etc.). A 1981 analysis of twenty-one federal agencies by the General Accounting Office utilized a very elastic definition of "fraud and illegal activities":

> . . . any willful or conscious wrongdoing that adversely affects the Government's interests. It includes, but is not limited to, acts of dishonesty which contribute to a loss or injury to the Government. The following are some examples of fraud or other unlawful activity: falsification of documents, such as time cards or purchase orders; charging personal expenses to Government contracts; diversion of Government property or funds for unauthorized uses; submission of false claims, such as invoices for services not performed or materials not delivered; intentional mischarging or misallocation of contract costs;

deceit by suppression of the truth; regulatory or statutory violations, such as bribery, theft of Government property, graft, conflict of interest, and gratuities; and any attempt or conspiracy to engage in or use the above devices. (General Accounting Office, 1981: 2)

In contrast with this emphasis on the effects of the behavior in question, other definitions are formalistic in emphasis (Does it violate a law or regulation?) or morally judgmental (Does the person "deserve" some extra help? Is it in a "good cause"?).

Because of varying definitions such as these, conflicting estimates of the scale of improprieties in government activities often are due to the fact that people are talking about different things. Before describing different methods which are used to measure improprieties, we should note at least five different problems which are often lumped together:

- Fraud usually refers to a violation of a civil or criminal statute, and involves intentional misrepresentation of facts for the purpose of obtaining unauthorized benefits from a program; the misrepresentation may involve either the provision of incorrect facts or the failure to provide correct facts.

- Errors involve program decisions which violate relevant rules, and may be intentional or unintentional, substantial or technical, and may be caused by the official (e.g., not knowing the rules, or incorrectly applying the rules to the facts) or the client. A decision involving an error could either incorrectly award benefits or incorrectly deny them.

- Abuse most frequently is used in a circular fashion to refer to "improper utilization of a program." While intentional fraud and unintentional error would also constitute "improper utilization," the term abuse usually refers to situations in which "benefits are obtained or used in ways which are not intended by those who design or administer programs, but which are not specifically prohibited by law or regulation" (Lange and Bowers, 1979: 15). Since there are no definitions of behaviors which were not "intended," apart from those which have been specifically prohibited, perceptions of abuse are quite elastic.

- Waste is a concept even more vague than abuse. In general, it refers either to ineffective expenditures (expenditures which do not accomplish programmatic goals) or inefficiencies, things which cost more than is necessary.

- Corruption, unlike the previous terms, specifically refers to actions by officials. Some definitions are formal in nature ("behavior which deviates from the formal duties of a public officer for private wealth"); others are broader (e.g., "behavior of public officials which deviates from accepted norms in order to serve private ends.") (Definitions of corruption are discussed in Gardiner and Lyman, 1978: Chapter One). In some agencies, corrupt activities are termed "employee fraud."

Measurement Systems. Measurement is a multi-stage process involving data collection, the classification or labeling of that data, and the extrapolation or projection from that data to some assumed universe. If we want to measure how many murders occurred, for example, we would have to count the number of deaths, utilize a definition of murder to classify the deaths, and then make an assumption that these known murders constitute some proportion of the total number of murders. In this example, we usually assume that the initial counting process is fairly simple, since most bodies and most missing persons are reported. The labeling process is somewhat more complicated, since we must make judgments that the death was caused by someone else, that the act which caused it was intentional, etc. Finally, if we have data on only part of the population we are interested in (e.g., if we have data on California and want to know about murder in the entire United States), we would need to make assumptions about the relationship between our sample and the universe. If we conclude that the two are similar and California constitutes 10% of the population, then we can simply multiply California's murders by ten; if we guess that Californians are half as murderous as others, we might multiply by twenty.

Attempts to measure the nature and extent of fraud and abuse suffer from very serious counting, labelling, and projection problems. Since misrepresentation and deception are central to the crime, counting only occurs when someone goes looking (defrauders are rarely so guilt-ridden as to turn themselves in, although they may be inept enough to provide conflicting or incredible information which invites investigation). Labeling the events we have counted is clouded both by the necessity to infer intent (Did Mrs. Jones forget to report her babysitting job, or was she intentionally concealing this income?) and by ambiguities in applicable

rules (Had a teen-aged son "left the family" if he spent only ten days at home last month? Was it improper for the pediatrician to give every member of the family a physical examination when one child had a sore throat?). Projecting from a sample of AFDC recipient or Medicaid provider files to the universe is beclouded by several problems. Are the people of State X more likely to try to cheat than other states' AFDC applicants? Are the welfare workers of State X more likely to spot the deception at the time of application so that fewer of those who try will succeed? Is the sample selected in a way which will over- or under-represent defrauders? (I.e., if we pick files which have certain characteristics, such as those with teen-age children or unemployed fathers, the proportion of errors may be unrepresentative of the total caseload). Compounding all of these methodological problems may be problems of bias--do the counter, the labeler, and/or the projecter overstate or understate the existence of fraud and abuse?--and of variations among the individuals or organizations which produce data (looking at similar "facts," State X may report "fraud" while State Y reports "unintentional error" in reports to a federal agency). These problems are especially important when the estimates are used to serve some overt or covert purpose of the estimater: supporters of a program and the program's administrators will estimate low ("Almost all of our clients are really poor; it is only a few welfare queens who try to cheat the system"), while opponents of a program or those who seek to justify control emphases will estimate high ("Most of those people are cheating, and all of those poverty pimps are padding their bills").

Finally, we must recognize the important of systems to record data. Air pollution, discrimination, and industrial accidents have always existed, but it is only recently that official systems were established to measure them. Newspaper headlines and dramatic prosecutions of welfare queens and Medicaid mills tell us not that these cases are representative of welfare cases but only that the newspaper or the prosecutor found them worth publicizing or prosecuting. The General Accounting Office report cited earlier surveyed twenty-one federal agencies and found that they knew of 77,000 cases which fit the GAO definition of "fraud and illegal activities." Since each agency had different systems for locating,

labeling, and processing cases, it is hard to say what proportion of each agency's problems was captured by the GAO data; some systems may retain all information which has been received while others may record only the cases which remain at the end of the process.[1] As Albert J. Reiss, Jr., and Albert D. Biderman note in a major study of data sources on "white-collar law-breaking": "Conceptually and empirically, the records of individual events themselves are products of socially organized means of perceiving, defining, evaluating, recording, and organizing information" (Reiss and Biderman, 1980: 1xx).

Auditing Approaches: The Federal Quality Control Systems. We have indicated that the "horror stories" presented in newspaper exposes or prosecutions may be simply exotica which fit publishing or legal needs, and that agency records may only reflect the cases that they have learned about and classified according to their own criteria of significance. Neither source purports to cover the entire scope of a benefit program, and both sources systematically exclude lesser offenses. A more valid methodology requires systematic auditing of all program decisions or a random sample of them. As the costs of welfare escalated in the 1970s, federal agencies, with substantial prodding from Congress, sought to develop ways to determine whether federal funds were going to overpaid or ineligible recipients. Whether the purpose was selfish (to reduce federal matching of overpayments) or benign (to assist state administrators to improve their programs), the federal agencies wanted a statistically valid way to identify payments in violation of federal and state regulations. The results have been the Quality Control (QC) systems established for Food Stamps (1971), AFDC (1973), Supplemental Security Income (1974), and Medicaid (1975). All four QC systems look at problems of recipient eligibility;[2] we will focus on the system used in the AFDC program as an illustration of QC issues.

The AFDC QC system uses both federal and state analyses. Every six months each state welfare agency draws a sample of cases to be reviewed (about 150 in the smaller states, and about 1,200 in states with more than 60,000 AFDC families). State QC reviewers look at these case files to

determine the accuracy of the grant amount and the recipient's eligibility; factors such as family income, resources, and other grant requirements are verified through contacts with persons such as recipients, landlords, and employers. The reviewers calculate "case error rates" (proportion of ineligible cases, overpaid but eligible cases, and underpaid cases) and "payment error rates" (the proportion of erroneous payments in each case error category). (A smaller set of cases in which the agency has denied applications--"negative case actions"--is also reviewed.) QC staff from the regional offices of DHHS then select a subsample of the cases reviewed by the states, and re-review them to assess the accuracy of state conclusions. After federal-state differences on individual cases have been resolved (DHHS has the final word), official state error rates are computed.

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

Quality Control Findings vs. "True" Rates of Recipient Fraud: Implications of Recipient Surveys. Quality control systems have been attacked for a variety of reasons. In Chapter Fifteen, we will discuss the attacks which focus on their fiscal sanction implications, including proposals that states with high error rates will receive reduced federal cost-sharing and their potentially dysfunctional effects (that pressures on the welfare agencies to reduce errors will cause them to give short shrift to other goals such as service to recipients, speedy processing of applications, efficiency, etc.). At this point, we will note that for both

substantive and methodological reasons, quality control surveys are only imperfect measures of the extent of recipient fraud in a benefit program. Substantively, their focus on "errors" (awards in violation of regulations) avoids the issue of intent: client errors may correctly indicate causality but mingle intentional concealment with such things as forgetfulness, ignorance, and laziness. Methodologically, the QC process may encourage intentional data suppression by state reviewers who want to make their agency look good, an overrepresentation of errors which are easy to find (regular jobs reported to the Department of Labor, school attendance, etc.) and, most importantly, underrepresentation of more easily concealable assets, income, and family structure factors. Since the reviewers do not conduct full-scale criminal-type investigations of the recipients whose files they are examining, they are heavily dependent upon official records, statements by banks or employers they know about (e.g., present or past employers identified by the recipient), and the statements made by the recipients themselves. (Richardson, 1977; General Accounting Office, 1980 and 1981b)

A unique opportunity to go beyond the findings of the QC reviews was provided by the Seattle and Denver Income Maintenance Experiments (SIME and DIME). SIME, running from 1970 through 1976, and DIME, running from 1972 through 1977, were the largest of four income maintenance experiments conducted by the federal government to simulate conditions in which there was a universal negative income tax. In the experiment, a treatment group received grants similar to but more generous than AFDC; a control group received no grant but was allowed to participate in other welfare programs, including AFDC. During the experiments, both treatment and control households were interviewed approximately three times a year by interviewers from Stanford Research Institute (SRI); respondents' statements were not reported individually to the local welfare agencies or to the federal sponsors.

Extensive efforts were made in the interviews to record the structure of the family and each member's earnings and employment. Data was also collected directly from the welfare agencies on control families who

reported participation in AFDC. Thus it is possible to compare the data reported to AFDC with the data reported to the SRI interviewers. (Since SIME/DIME and AFDC defined family units differently, it was necessary to reconstruct the SIME/DIME data to match the AFDC families.) Analysis of 848 households in Seattle and 1,294 households in Denver produced the following findings (Halsey, Nold, and Block, 1982):

(1) About one-half of the households in each city had reportable income. Of these, one-quarter of the Seattle households and one-third of the Denver households reported no income to AFDC. The average amount of monthly earnings not reported to AFDC by households which reported income to SRI was $322.36 in Seattle and $354.45 in Denver. The earnings of male heads of households were far less likely to be reported than female heads; income by non-head members of the family was rarely reported. About one-quarter of non-wage income (primarily alimony and other government benefits) was reported in Seattle, and about one-half in Denver.

(2) With regard to family structure, 47% of the Seattle households and 42% of the Denver households failed to report the existence of male heads, and 8% (Seattle) and 9% (Denver) overreported children (i.e., reported children who either did not exist or did not live in the household).

(3) Aggregating the effects of income and family structure misreporting, Halsey, Block, and Nold concluded that the total amount of annual overpayments in Seattle was between $1.4 and $7.1 million; in Denver, the range was between $2.0 and $9.9 million.

(4) In terms of types of misrepresentations, they concluded that AFDC recipients tend to overstate the number of non-income earning dependents but understate the number of family members capable of earning income (male heads, teenagers), and to report only a fraction of wage and non-wage income. When the family acknowledges a particular source of income (e.g., a specific job), it tends to report a high percentage of the income from it; other sources are not reported at all.

As we have indicated, the SIME/DIME data are a unique source of recipient-reported data on income and family structure. It is likely that the SIME and DIME households concealed some information from the SRI interviewers, so Halsey, Nold, and Block's conclusions probably miss some fraud. We have no way of knowing whether Seattle and Denver families are more or less likely than other American AFDC families to misrepresent facts in reporting to AFDC agencies. However, if we make the assumption that there is a nationally constant proportion of overpayments in AFDC caseloads, then national estimates such as those presented in Table 2 are possible. Dividing the Halsey, et al., estimates of overpayments by the number of AFDC families in the two cities, we can produce low (line D) and high (line E) estimates of overpayments per AFDC family. Multiplying these estimates by the total number of AFDC families in 1980, we can derive low (line G) and high (line H) estimates of the national overpayment problem: AFDC overpayments may range from $376 million to $3.2 billion annually.[3]

Provider Fraud and Abuse. Unlike the problem of recipient fraud and error, no statistically valid surveys of provider fraud and abuse exist. The Medicaid quality control system checks a sample of Medicaid claims, but error findings only indicate that a payment violated a program rule (e.g., by paying for a service not covered, by paying an incorrect amount, etc.); QC reviewers do not check to see if the service was provided as claimed. While Medicaid agencies annually report "overpayments identified" and the penalties levied on participating providers, they do not systematically seek to measure which types of provider services are most frequently abused and to what extent. As will be seen in Chapters Six through Eight, the agencies which audit and investigate Medicaid providers concentrate their attention on those providers who receive the most payments (hospitals, nursing homes, and poverty area group practices, or Medicaid mills) and on those whose billing practices are significantly different from their peers; such

Table 2

NATIONAL ESTIMATES OF AFDC OVERPAYMENTS
BASED ON SIME/DIME DATA

	Seattle	Denver
A. City AFDC Families, Avg. 1974-75[1]	14,500	11,400
Annual Overpayments:		
B. Low Estimates	$1,420,236	$1,975,032
C. High Estimates	$7,101,178	$9,875,175
Overpayments/Families:		
D. Low Estimate (B/A)	$ 97.95	$ 173.25
E. High Estimate (C/A)	$ 489.74	$ 866.24
F. National AFDC Families, 1980[2]	3,842,534	
Total Annual Overpayments:		
G. Low Estimates (FxD)	$376,376,205	$665,719,015
H. High Estimates (FxE)	$1,881,842,601	$3,328,556,652

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

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

emphases increase the opportunities for agencies to recover overpayments and to apprehend particularly greedy providers, but they do not lead to representative data on fraud and abuse problems. In 1979, the Inspector-General of DHHS estimated that "Medicaid fraud and abuse, including unnecessary nursing home costs" in 1977 amounted to $668 million, with the notation "Number is incomplete and probably low" (HEW, 1979: 192). No indication was given as to how the estimate was derived, or the distribution of fraud and abuse among different types of providers. State-level data on provider problems will be presented in Part II.

Conclusion. This chapter has suggested the variety of definitions which have been given to fraud, abuse, and related concepts. No data systems exist which specifically measure fraud. The "client errors" identified by quality control systems indicate that misrepresentations by recipients amount to many millions of overpaid dollars each year; the unique SIME and DIME data suggest that many cases are not discovered by the QC review process. While no similar data exist on Medicaid provider fraud and abuse, many insiders in welfare agencies believe that its scale far exceeds losses due to recipient fraud in the program. We turn now to case studies of state responses to these problems.

NOTES

1. Table 15 in Chapter Thirteen illustrates the shrinkage which takes place during the various stages of the enforcement process. In FY 1979, state welfare agencies concluded that 133,847 cases involved "facts indicating fraud." Of these, 52,037 were referred for prosecution. In the same year, prosecutors looked at 42,300 cases and initiated prosecution on 17,263.

2. Since 1978, the Medicaid QC system has looked at payment errors and third party liability errors as well as recipient eligibility errors.

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

REFERENCES

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

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

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

_____ (1981a) Fraud in Government Programs: How Extensive is it? How Can it be Controlled?, AFMD-81-57 (Washington: General Accounting Office)

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

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

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

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

REISS, A., and A. BIDERMAN (1980) Data Sources on White-Collar Law-Breaking (Washington: National Institute of Justice)

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

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

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

PART II

CASE STUDIES OF FRAUD CONTROL PROGRAMS

INTRODUCTION

Welfare and criminal justice systems in the United States, as has been indicated, are predominantly state and local, rather than national in nature. When Congress enacted the AFDC, Food Stamp, and Medicaid programs, it explicitly provided for substantial state latitude in defining program eligibility, benefit levels, and implementation systems. Fraud in these programs, while violating both federal and state statutes, was to become primarily the responsibility of state and local prosecutors and judges. To understand fraud and fraud control in welfare programs, we must therefore begin our story in the states, using individual states' experiences as the basis for our analyses, in Part III, of general problems of fraud control.

In a research project, it usually is desirable to select research subjects on the basis of a pre-established taxonomy--to select, for example, one state "representative" of Type X, one of Type Y, etc. Unfortunately, no such taxonomies of fraud, fraud control, or welfare systems exist. Neither federal welfare officials nor leaders of professional associations have detailed understandings of what goes on in all states, although personal contacts may lead them to conclude that Smith in State A is a good administrator and Jones in State B is incompetent. Such positive and negative reputations exist, but it is impossible to judge whether they reflect more than such things as personality, presentations at conferences, or cooperativeness.

Lacking a predetermined basis for selecting our case studies, we chose the states of Colorado, Illinois, and Washington on the simple ground that we had worked with them in previous research, and thus expected few problems of access. In addition to the variations caused by differences in geography and population, the states have different administrative systems (Colorado's AFDC program is administered by counties, while Illinois and Washington are

state-administered; Illinois processes its own Medicaid claims, while the other states contract with fiscal agents for claims processing). Illinois' programs are larger than Washington's, which are larger than Colorado's. Table 3 summarizes basic aspects of the three states' AFDC and Medicaid programs, and their primary fraud and abuse control emphases.

To identify the states' responses to their fraud control problems, we visited each state in the Spring and Summer of 1981, interviewing federal and state officials (and, in Colorado, county officials) and collecting written materials on its programs. The availability of written source materials varied. Each state had formal plans describing AFDC and Medicaid policies and procedures, and provided up-to-date Quality Control statistics and reports on Medicaid Fraud Control Units. The Illinois and Washington AFDC programs had also been the subjects of detailed studies in 1979 and 1980 by Abt Associates and the National Academy of Public Administration. In all states, we interviewed federal regional office officials, administrators of the AFDC and Medicaid programs, and enforcement officials. These respondents identified other agency officials, legislators, and others interested in fraud control issues to be interviewed. Approximately four person-weeks were spent in on-site interviews; other respondents were interviewed by telephone. During the Winter of 1982, officials in each state were asked to comment on drafts of the following chapters; their reactions have been included in the final versions presented here.

Several factors should be kept in mind in reading the following chapters:

(1) Federal and state regulations and procedures are constantly in flux. We have sought to portray the policies in effect as of mid-1981.

Table 3

CHARACTERISTICS OF CASE STUDY STATES

	Illinois	Colorado	Washington
AFDC Program (December 1980)			
Recipients (number)	691,434	81,031	173,339
Total Payments ($000)	$ 62,904	$ 7,592	$ 23,435
State administered?	yes	--	yes
State supervised?	--	yes	--
*Error rate (percent)	8.6%	10.1%	9.8%
Medicaid Program (FY 1981)			
Recipients (number)	1,110,676	145,514	331,375
Vendor Payments ($000)	$1,322,176	$215,712	$424,147
Claims processed by state?	yes	--	--
Claims processed by fiscal agent?	--	yes	yes
Primary Control Emphases			
Improved local office management	yes	--	yes
Staff training	--	yes	--
Computer cross-matches	yes	--	yes
Information systems	--	yes	--

* 10/80-3/81, includes both ineligible and eligible but overpaid.

Table 3 (concluded)

CHARACTERISTICS OF CASE STUDY STATES

	Illinois	Colorado	Washington
Recipient Fraud	Recovery of excess benefits	Monthly reporting	Case detection and investigation
	Termination of ineligibles	Restitution	Recoupment and penalties
Provider Fraud and Abuse	Pre-delivery controls	Pre-payment claims review	Audits-vendor reviews
and Abuse	Computer edits	Explanation of medical benefits	Medical Services Verifications
	Postpayment audits	Patients lock-in	
	Administrative recovery		

(2) Our case studies are based on interviews and written materials. We did not observe welfare field offices to determine whether official policies were followed in practice, although we have included materials from other sources which address this issue. Similarly, we did not examine the files of individual recipients and providers, so we do not have independent quantitative data on the states' fraud control practices. Finally, we did not interview welfare recipients or Medicaid providers.

(3) In our interviews, we agreed not to attribute quotations to specific individuals. Quotations in the following chapters are thus attributed only to a type of respondent ("a county prosecutor," "a legislator," etc.).

(4) Our six case studies describe fraud control efforts from the point of view of the people in each state. Each chapter will provide their (at times conflicting) perspectives on fraud control issues; our interpretation of these issues will be presented in Part III.

(5) Finally, it must be emphasized that we have no way of knowing whether these three states are "typical" of other states, or whether AFDC and Medicaid are "typical" of government benefit programs. In at least one respect, all three states are atypical: none of the states' Medicaid Fraud Control Units correspond to the model desired by the federal government, since none are housed in the office of the state attorney-general. Our field research showed problems and practices in these states which are cited in other literature, and also showed personality and agency conflicts which may be unique to a particular state or program.

Our case studies show both differences among states and differences between recipient and provider fraud problems. We will first outline the three states' recipient fraud control programs, and then turn to provider fraud and abuse issues. In each series of case studies, Illinois is

presented first, followed by Colorado and then by Washington. The Illinois cases are presented in somewhat greater detail than the others to provide the reader with basic information about AFDC and Medicaid program administration; the four Colorado and Washington case studies emphasize characteristics and practices which differ from Illinois.

CHAPTER THREE

CONTROLLING RECIPIENT FRAUD IN ILLINOIS

The Department of Public Aid is overprotective of recipients and their own employees. Some employees are on the take and some are just there for the paycheck. If you don't watch them, some recipients will rip you off any chance they get.

--Illinois legislator

I don't know anybody who wants to be on welfare. The big abusers of the welfare system are the medical providers, not the individual recipients. The central issue should not be how much fraud and abuse there is, but rather whether people are getting a decent standard of living.

--Illinois legislator

Within the Department of Public Aid, our programmatic goals necessarily compete with our law enforcement goals. Making sure each intake and redetermination decision we make is correct is more important than prosecuting individual cases; our basic philosophy is that a soundly managed system will have the best chance to reduce fraud and abuse over time.

--Public Aid official

Since the early 1970s, the AFDC program in Illinois has faced problems of high error rates; frequent scrutiny by DHHS, the state legislature, and other state auditors and investigating commissions; challenges by welfare lawyers to agency policies and procedures; condemnation by liberals for "inadequate" benefit levels and by conservatives for "coddling welfare" queens;" and repeated efforts by insiders and outsiders to combat fraud and abuse problems. In short, AFDC in Illinois has been a highly visible program whose problems have received widespread attention.

Administration of the AFDC Program. Illinois has been participating in the AFDC program since 1941. The scale of the program has fluctuated with

economic and social changes; the number of persons receiving AFDC assistance rose from 484,000 in 1970 to 687,000 in 1980, when Illinois had the fourth highest unemployment rate in the nation. Of the 233,000 families on AFDC in 1981, over 60% lived in Chicago's Cook County. The Illinois Department of Public Aid (IDPA)[1] administers all medical assistance programs and most income assistance programs in the state. Fifty percent of AFDC's benefits and administrative costs are paid by the federal government; the remainder comes from state funds. In 1973, a system based on 51 "special allowances" was replaced with a "modified flat grant" system in which monthly benefits are based on the composition of the family unit, deducting net income from a need standard calculated for three groups of counties in the state.[2] In the largest counties, including Cook County, an AFDC family with one adult and one child receives $250 per month; a family with one adult and three children receives $368.

Figure 1 indicates the agencies involved in the administration of the AFDC program. Within the Department of Public Aid, the Division of Policy and Planning is responsible for both the development of departmental policies and procedures and their interpretation in individual cases. Caseworkers who have questions about applicants, eligibility, or appropriate benefit levels are encouraged to call Policy and Planning in Springfield to get answers. The Office of the Chief Auditor administers the federal quality control program, conducts program audits, and investigates allegations of employee misconduct. The Office of Hearings and Recoveries holds fair hearings on all appeals by recipients or persons denied aid; investigates allegations of excess assistance, fraud, and abuse; and recovers excess assistance from recipients.

For individual applicants and recipients, the most important part of IDPA is the Division of Operations, whose 6,100 employees staff ten regional offices (used primarily to implement central office policies and monitor local office performance)[3] and 124 local offices. Each county has at least one local office; 25 offices are located in Cook County. IDPA appoints an advisory welfare services committee for each county, with both public members and representatives of the county board of supervisors.

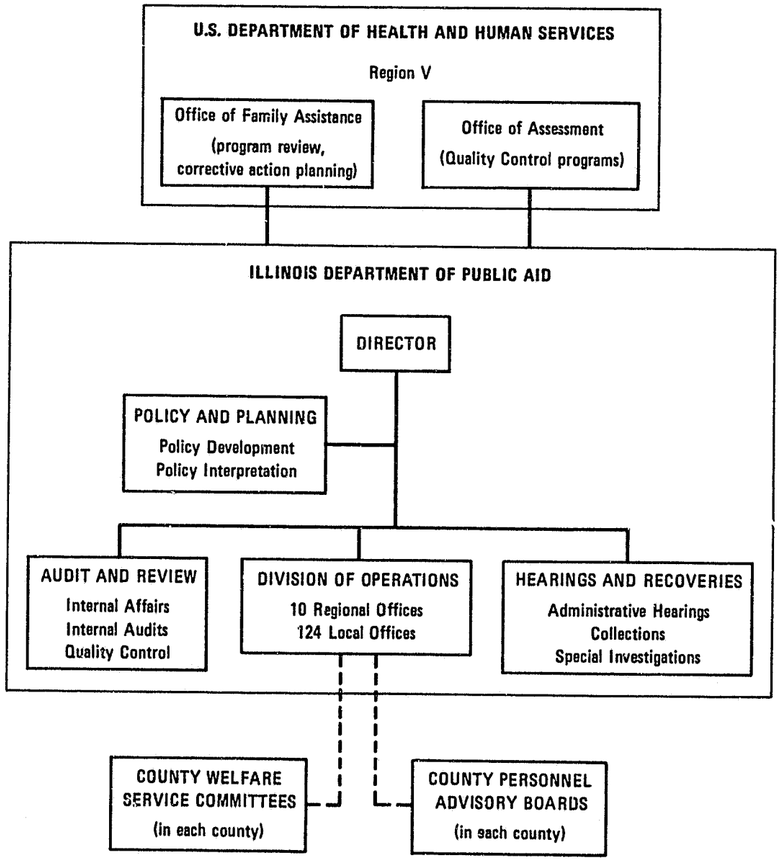

FIGURE 1 ADMINISTRATION OF THE ILLINOIS AFDC PROGRAM

Under the state's public aid code, each county personnel advisory board can recommend to IDPA candidates for staff vacancies and for the position of County Superintendent of Public Aid from among persons certified as eligible by the state Department of Personnel.[4] Internal promotions and job assignments, however, are controlled by a union contract.

Each local Public Aid office administers the AFDC, Food Stamp, AABD (Aid to the Aged, Blind, and Disabled), Medicaid, General Assistance in the City of Chicago,[5] and Aid to the Medically Indigent programs. While IDPA does not provide direct social services, it counsels applicants and recipients on the availability of services offered by other state and county agencies, and on personal, employment, training, and household management matters. Nonexempt applicants are also instructed to register at a local office of the Illinois Department of Labor for participation in the Work Incentive program or the Illinois Job Service.

When people apply at the local IDPA office for AFDC benefits, they fill out an extensive application form and are scheduled for a personal intake interview. At the interview, a caseworker goes over the application with the applicant, filling in additional information and specifying the documents (birth certificate, social security numbers, WIN registration forms, divorce decrees, etc.) which will be required to establish eligibility and benefit levels. Following a home visit and receipt of the necessary documents, intake workers verify eligibility and compute the appropriate level of benefits. Under a federal court ruling in 1977, IDPA must act on all applications within 45 days of receipt, although an application may be denied if the applicant fails to submit needed documentation; failure to meet the 45-day deadline can subject the Department to a $100 per month penalty (Custom v. Trainor, 74 F.R.D. 409, N.D. Illinois, 1977).

The level of contact between AFDC recipients and the local IDPA office following an initial award varies. Department policy requires redetermination of every case within 45 days after the first award, and every 6 months thereafter, but some redeterminations are based on a review

of the file and telephone contacts with the recipient; home visits are expected at least once per year, however.[6] Since 1979, all recipients who have reported earned income are required to submit a monthly report of earnings, which leads to a budget redetermination based on recent earnings history.[7] (In October, 1981, the reporting and rebudgeting system was revised to match new federal guidelines.) In August of 1981, the Department launched a demonstration project in one Cook County office and one downstate office in which all recipients in the test group, whether they have earned income or not, are required to report monthly on all eligibility factors.[8] IDPA hopes that monthly reporting will uncover changed circumstances more rapidly than the regular redetermination process.

Procedures for Handling Nonfraudulent AFDC Errors. Cases found to involve fraud or abuse constitute only a small proportion of the total number of AFDC cases with ineligible recipients or excess assistance. While special procedures have been established to investigate and take action against fraud cases, the routine procedures of IDPA focus on the more frequent problem of identifying cases of ineligibility or excess aid, revising benefits, and recovering past overpayments. Their emphasis, therefore, is on the improper receipt of benefits; the pursuit of fraud is a secondary concern.

Every determination by IDPA that a client has received excess assistance is expected to lead to a revision of the grant award to reflect the proper benefit level, or to cancellation if the client is no longer eligible. What other actions are taken depends on the amount and source of the error, the agency's past experience with the recipient, and whether fraud may have led to the error. The steps in the process are outlined in Figure 2 .

(1) If the amount of excess assistance received is less than $200 and there are no aggravating circumstances (e.g., that the recipient secretly held a government job or had been found receiving excess aid before), the caseworker handles the problem directly by asking

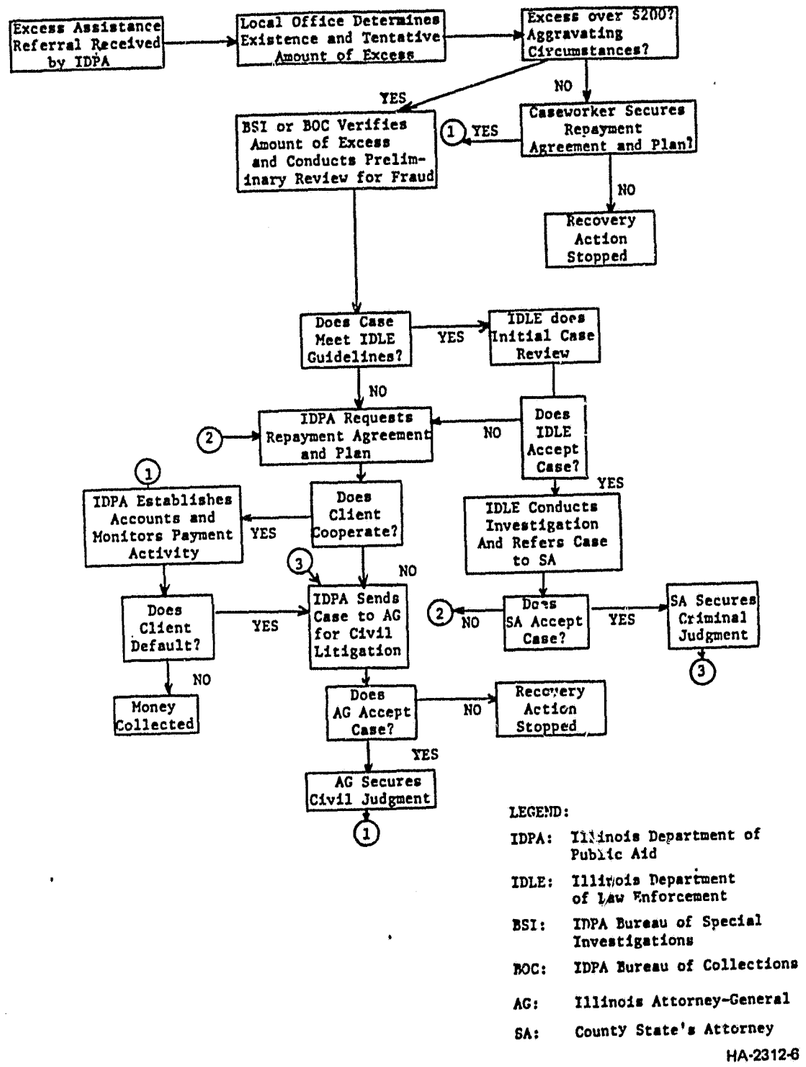

FIGURE 2 PROCESSING OF EXCESS ASSISTANCE CASES IN ILLINOIS AFDC PROGRAM

the recipient to sign a "repayment agreement and plan," a promissory note to repay the excess. Payments on these notes are handled by the Bureau of Collections.[9] If the recipient refuses to sign the note and ignores follow-up efforts, the matter is dropped, since the department feels further collection measures will be a waste of time.

(2) If the amount involved exceeds $200 or if there are aggravating circumstances, and the client refuses to sign a promissory note, the case is referred[10] to the Bureau of Special Investigations (BSI, for counties outside the Chicago area) or the Bureau of Collections (BOC, for Chicago's Cook County and three suburban counties).[11] After verification of the amount of excess assistance, BSI and BOC once again try to settle the matter with a promissory note unless there are aggravating circumstances or the amount involved exceeds $1,000.

(3) If the amount of excess assistance exceeds $1,000, or if a client defaults on a repayment agreement, the case is referred to the Welfare Litigation units in the Illinois Attorney General's Springfield or Chicago offices. If sufficient documentation is available, civil suits are filed against the recipients, and enforcement actions are brought against defaulters.

These procedures for handling nonfraud cases have been a source of some controversy in recent years. Because of the volume of cases involved, there is a clear desire to handle problems as simply as possible, with BSI and BOC trying to keep petty cases in the local offices, and the Attorney-General's office trying to keep as many cases out of court as possible. There have also been charges that the promissory note procedure is not really voluntary. In 1980, the Legal Assistance Foundation of Chicago filed suit in federal court charging that IDPA caseworkers were harassing clients, falsely threatening them with the loss of aid if they refuse to sign notes; the case was still pending in 1982 (Taylor v. Miller, N.D. Illinois).

It should be noted that, prior to Congress' 1981 amendments to the AFDC program, IDPA rarely used recoupment procedures to recover excess assistance, having elected not to follow federal recoupment requirements. When the excess occurred as a result of agency error, IDPA could only recoup the excess which was given over a 12-month period, and could not reduce the amount of the grant below the proper level (i.e., recoupment could only be taken from nonexempt assets or earned income). When the error was caused by the client, however, recoupment could cover an unlimited period, with a reduction in the amount of the grant, although IDPA was required to make an individual determination of the hardship which reductions would work on the client. Following the 1981 AFDC amendments, IDPA adopted standard federal recoupment policies, going after nonexempt assets and reducing monthly payments by up to 10% to recover excess aid. Local offices handle recoupment on grants which remain active; BOC initiates recovery efforts for terminated grants.

Fraud and Abuse Problems in the Illinois AFDC Program. It was noted in Chapter Two that estimates of the nature and extent of fraud and abuse in state AFDC programs are very unreliable. Like other forms of crime, incidents only become known--and part of a statistical data base--when someone discovers and reports them; estimates therefore are as likely to reflect the characteristics of data sources as they are the "true" nature and extent of problems within an AFDC program. Finally, it must be stressed that most--and the most accurate--sources of information focus on errors, cases where a recipient was ineligible or received excess assistance, rather than on the legal question of whether the recipient committed an act of fraud. Before describing what is known or believed about Illinois' problems, therefore, we will first indicate the various sources of fraud and abuse data and the biases or limitations which they present.

The most statistically reliable source of error data on the Illinois AFDC program is the quality control (QC) program. IDPA began a QC program in the early 1970s, before it was mandated by DHHS; until standardized in 1973 to meet federal requirements, the emphasis was on assessment of local

office administrative practices and office effectiveness in responding to area welfare needs. Currently, the Illinois QC staff reviews 1,200 AFDC cases every 6 months for federal reporting purposes, and an additional 1,000 cases in an "expanded state sample" which permits the Department to analyze error trends in larger offices. During the state and federal reviews, the QC reviewers audit files, interview recipients personally, and check collateral sources for eligibility and appropriate benefit levels. While they will look for suspicious indicators during the interview with the client (e.g., signs of an unreported adult, or the absence of signs of children who are supposed to be living in the home), and follow-up on any leads they receive, the QC reviewers do not conduct formal investigations; they do not, for example, interview neighbors or watch the home.

Error findings are grouped according to whether the agency or the client caused the error; client errors are further classified to indicate whether the client made a willful misrepresentation of facts. While a good source of data on fraud, the "willful client misrepresentation" data are necessarily limited by the reviewers' ability to locate relevant information and to determine whether the misrepresentation was "willful." Both IDPA and DHHS Regional Office QC officials also report recurrent disputes over the application of federal and state regulations in the labeling of cases as errors; these disputes will be discussed at the end of this chapter.

A second opportunity to identify fraud is provided by case redeterminations. Within 45 days after the initial award, and, every 6 months thereafter, caseworkers are expected to review each active AFDC case to determine whether assistance should be continued, and at what level. (Department records indicate that 85% of AFDC cases were "current," i.e., had been redetermined within the expected time limits as of September 1981). During the 4-month period from May to August 1981, IDPA caseworkers redetermined an average of 35,000 cases per month; 81% of the grants were unchanged following redetermination, 8.0% were cancelled, 6.3% were increased, and 4.4% were decreased.

Cases are also redetermined more frequently if the recipient reports a change in circumstances (e.g., a change in family structure or earned income), or if the Department has reason to believe that changes have occurred. Caseworkers are provided with a detailed listing of verification data which should be secured during redeterminations, but opportunities to discover errors and fraud are limited both by time constraints (each caseworker must complete at least 30 redeterminations per month as well as handle other case maintenance duties) and by the lack of investigative resources; unless the local office asks the Bureau of Special Investigations to check suspicious cases, the caseworker must act on the basis of information provided by the recipient, computerized data bases, or a few telephone calls.

A third source of leads on potential fraud cases is an extensive data exchange program in which IDPA matches recipients' names and social security numbers with a variety of sources of information. First used in 1973, crossmatches are regularly run with the state's wage and unemployment insurance data systems, and periodically with the employment rosters of federal, state, and local government agencies (particularly in Chicago) and of major private employers who agree to cooperate. Crossmatches are also used to identify persons receiving welfare benefits from other states; births, deaths, school attendance, and marriages which would change the composition of the family unit; and reviews of IDPA records to check out recipients with similar names, social security numbers, or addresses. Since 1977, the data exchange program has identified 77,000 cases where AFDC recipients' names appeared in other data bases. Forty thousand cases were reviewed by IDPA staff members, leading to 14,000 grant cancellations and 2,600 grant reductions. IDPA believes that its sources of information on employment cover about 70% of the state's work force, with little or no information on smaller employers, workers who are paid in cash (and are not paying social security or unemployment insurance taxes), workers with out-of-state jobs, or workers who use multiple names or social security numbers. The data exchange program also suffers from a problem of timeliness, since many listings reflect conditions as of six to twelve months before, conditions which may already have been reported to IDPA.

Referrals from outside the agency are the final source of leads about fraud or error problems. In 1975, IDPA established a welfare abuse hotline; during the 4-year period from 1977 through 1980, about 10,500 calls were received per year, leading to a total of 3,400 grant reductions or cancellations. Other tips come from law enforcement agencies, the media, and the state legislature's Legislative Advisory Committee on Public Aid, which, until 1979, employed off-duty police officers to investigate welfare fraud allegations. (In 1979, a new committee chairman decided to de-emphasize recipient fraud issues.)

What do these sources indicate about the nature and extent of Illinois' AFDC fraud problems? QC reports, summarized in Table 4 , show that the most frequent problems of client misrepresentation are earned income, the composition of the family unit (whether a child is in fact living with a specified relative or caretaker, whether the proper persons are included in the budget, and whether the father is "continuously absent"), and other sources of support, including bank deposits, contributions, and benefits such as Retirement Survivors Disability Insurance (Social Security) and unemployment compensation. These error/fraud problems are confirmed by other data sources, although they are not reported in such error-specific detail. Data exchange programs identify unreported jobs or income different from that reported to the Department, receipt of other benefits, or discrepancies in the composition of the family unit. Hotline tips tend to focus on unreported income ("Mrs. Smith got a job working at the Acme Corporation") or family composition ("Mr. Smith moved back in the house last month," or "Mrs. Smith has remarried," or "Jimmy dropped out of school and left home"). Earned income, family composition, and other sources of support, therefore, are the primary potential fraud problems which must be addressed.

Administrative Responses to Fraud and Abuse Problems. In recent years, while welfare fraud issues have been a matter of state and national concern, IDPA has taken a number of steps which have increased its ability both to prevent fraud and to respond to identified cases. Some are specifically

Table 4

CLIENT ERRORS IN ILLINOIS AFDC QUALITY CONTROL SAMPLES

Program Area	Reporting Period		
	4/79 - 9/79	10/79 - 3/80	4/80 - 9/80*
Basic Requirements			
School Attendance	2	1	8.9
Living with Specified Relative	12	13	
Incapacity	1		
Continued Absence	12	10	4.0
Unemployed Father	2		
WIN/Job Service Registration		2	
Residence	2	1	
Resources			
Bank Deposits or cash	5	6	2.0
Other		1	
Need-Income			
Earned Income	23	29	32.9
Work-related expenses disregards	1		
RSDI benefits	6	6	2.9
Veterans Benefits		2	
Unemployment compensation	4	4	2.0
Workmen's compensation	1		
Contributions	9	10	5.0
Other	3	2	1.0
Other			
Proper persons in budget	3	5	5.0
TOTAL	86	92	63.6

* Weighted to estimate state-wide averages.

Source: IDPA reports to DHHA, Form SSA-4341

targeted at the three types of fraud problems noted above; some deal with administrative practices which affect fraud control efforts. In order to understand current IDPA policy, however, we must begin with its basic assumption that sound management has the greatest potential for reducing fraud and abuse. This orientation was stressed in IDPA's 1980 Corrective Action Report to DHHS: "Of primary importance to this agency is the overall improvement of public assistance administration. The result of improved administration is better service to clients. The Quality Control system measures only eligibility determination. It does not fully measure the performance of a State in executing its total regulatory responsibilities."

To improve management, IDPA sought in the late 1970s to clarify its various missions, to focus administrative responsibilities in the local offices, and to develop a way to monitor local performance. The Local Office Performance Indicator (LOPI) system, begun in 1979, is the focal point of this effort. Following extensive discussion with regional and local office managers, LOPI spelled out central office "expectations for the performance of local offices," including "goals, which set the general directions for program management; objectives, which specify the activities, events, or outputs which must occur in order to achieve the goals; and standards, which prescribe levels of performance pursuant to each objective." IDPA then constructed scales to measure office intake activities, case management, office management, and program integrity, with different performance expectations for different size offices (somewhat higher standards were set for the smaller offices). In the summer of 1980, IDPA began quarterly publication of each office's LOPI scores, reporting both individual offices' scores on each scale and groupings for the five classes of offices.

The LOPI system sets eight objectives relevant to fraud prevention and control:

I-B: Ensure proper determination of eligibility and proper level of benefits for all applicants.

II-A: Determine continued eligibility on a timely basis for all recipients of assistance.

II-C: Update case record information, reflect special client needs or update assistance/support levels and provide timely notice to clients on changes in levels of assistance.

II-G: Ensure that levels of assets do not exceed those specified in agency policy.

VIII-D: Minimize agency-generated errors involved in paying financial and/or medical assistance to, or on behalf of recipients for which they are not eligible.

VIII-E: Take all necessary steps for timely corrective action in areas where appeal decisions or quality control identified errors are indicative of local office errors in policy application or interpretation.

VIII-F: Take all necessary corrective actions where client or vendor fraud is suspected, or where there is reason to believe that low quality or vendor service exists.

VIII-G: Take necessary action to assist agency in recovering any excess financial or food stamp benefits, whether the reason for such excess benefits is client or agency error.

To reinforce central office expectations, IDPA has taken a number of steps to facilitate and encourage implementation by both caseworkers and local office managers. In April 1980, to supplement the data provided by the federal QC system, the Department initiated a stratified QC sampling system covering 50 of the largest offices. A desk auditing system begun in 1980, now called the Quality Assessment and Improvement Planning Program, is also used to review random samples of documents in case files in 38 of the largest offices, leading to a report called the Quality Assessment Document. The central office expects local managers to use its findings and the regular QC findings as bases for planning operational improvements.

To focus the attention of caseworkers on specific factors which may generate error or fraud, IDPA has developed systems to enumerate cases which may present problems, to specify data sources and interview techniques which may be used to verify eligibility and budget items, and to push caseworkers to use these sources in intake and redetermination decisions. In 1975, the Department initiated the Integrated Criteria List (ICL),[12] which on a

monthly basis lists for each local office the cases which are due for a routine redetermination, or which may involve earnings, unemployment compensation, or Social Security benefits; cases where monthly checks have been returned undelivered or voided; and cases involving WIN or Social Security enumeration problems. Caseworkers are expected to take action, and report to the central office, on all ICL-listed cases which are delinquent or currently due for redetermination; other ICL listings such as lack of a Social Security number, children reaching age 18, or "exhibiting factors indicating the probability of error" are intended simply for the information of the caseworker. At various times in the past, IDPA has mounted crash efforts to get caseworkers to act immediately on every indication of potential error; the current philosophy of IDPA management emphasizes improving the quality and currency of regular redeterminations rather than asking caseworkers to drop everything when one of their cases shows up on an ICL printout.

In response to repeated QC indications that caseworkers were not following the verification procedures which had been developed in 1976, IDPA revised its redetermination forms in 1980. Under each item in the form, the caseworker must record how verification was accomplished; e.g., "explain how the worker verified at this redetermination that the child 'lives with' the caretaker relative"; "Complete and attach Automated Wage Verification System inquiry" on all persons 16 or over in the home whether in the assistance unit or not; explain how earned income, contributions, other benefits, etc., were verified. In a 1980 Corrective Action Report to DHHS, IDPA concluded that "the new form provides for better organization of the redetermination process and encourages reference to required prior documentation."

Finally, to encourage applicants and recipients to provide accurate information to the Department, IDPA prepared a brochure describing the AFDC program. The brochure emphasizes that it is the applicant's "responsibility to furnish the information needed to establish that the family meets the eligibility requirements for assistance. . . . Full information must be given about income, assets, and means of support at the time of

application. Any change in circumstances must be reported within five working days." The brochure then states:

FRAUD

> Under Illinois law, persons who make false statements or who willfully deceive and misrepresent their circumstances to the Department of Public Aid, or persons who willfully fail to report changes in income, property, or need which affect the amount of assistance they are entitled to are subject to penalties.
>
> Persons found guilty of fraud will be required to repay the state the amount of assistance received and, in addition, may be fined, imprisoned, or both. Anyone who helps or encourages misrepresentation of a case by any means, is, by law, also guilty of fraud.
>
> Cases in which recipients received $200 or more by deliberate fraud will be considered for prosecution.

These changes discussed above focus broadly on case intake and redetermination processes. Other changes have been targeted more directly on the specific causes of fraud and errors identified in QC studies. Since 1975, the senior managers of the Department have met as a Corrective Action Panel, reviewing staff analyses of identified QC errors and discussing proposed options for change. A 1980 Corrective Action Report to DHHS summarized the process as follows:

> Information on the causes of payment errors and suggested corrective action alternatives are presented to this Panel by the Bureau of Research and Analysis and the Corrective Action Coordinator. Error analysis reports are element specific. These internal reports include not only an analysis of all Quality Control data but also information concerning Agency procedures that are contributing to errors. Additional reports, studies, and centrally available data are also utilized in determining causes of errors. Suggested alternatives include a description of the present system, the proposed changes, and the anticipated results of the proposed change.

Major error-specific administrative changes deal with problems of family composition, earned income, other sources of support, and lost and stolen warrants.

(1) Family Composition. The major error elements are the persons included in the family assistance unit, the continuous absence of the father, whether children are living with the family, and whether older children are attending school. The Department expanded its Child Support Enforcement efforts, both to increase support payments and to identify parents who might in fact be living at home. Crossmatches of marriage records and school attendance records can identify recipients who have married and children who have dropped out of school or are not living at home. In 1979, IDPA also expanded the number of verification sources to be used regarding continuous absence. By 1980, "living with" errors had been reduced by 24% and "continuous absence" errors by 62% as compared with a year before.

(2) Earned Income. Somewhat different problems exist for recipients who report earned income (EI) and those who report that they have none. Historically, recipients who have worked before are more likely to resume working than those who have never worked; administratively, earned income cases involve complex problems of verification and budgeting. The Department has therefore had to work both to expand its sources of information about income not reported by recipients and to improve processing of the information it has received. To address processing problems, IDPA established specialized local office EI caseloads in 1979; EI caseworkers are given special training and smaller caseloads than their colleagues. At intake and redetermination, caseworkers check the Illinois Department of Labor's Automated Wage Verification System, using CRTs in each Public Aid

office. Data exchange programs with public and private employers, and the state's records of unemployment insurance and workmen's compensation give additional information about earned income sources. In 1980, the prevalence of EI problems in the QC samples led IDPA to make action on ICL cases with indicators of earned income a priority for local office administrators.

The most extensive change which has been made by IDPA to combat EI problems involves a change from the standard 6-month redetermination policy to a system of monthly reporting by recipients of their earned income, with budget revisions based on past earnings. Based on a modification of the Colorado system described in Chapter Four, IDPA required all recipients with earned income to report monthly. One year after the program began, IDPA reported that its average monthly EI caseload had dropped from 17,349 to 15,640; the rate of cancellations in EI cases rose from 4.2% to 6.3%, and the rate of decreases in grant amounts rose from 12.9% before the policy change to 26.3% a year later. The Department concluded that monthly reporting/retrospective budgeting has been a major source of the decline in its EI QC error rates. In 1981, IDPA also began a DHHS-funded experiment in two local offices in which all recipients, whether they have reported earned income or not, must report monthly.

(3) Other Sources of Support. A variety of information sources have been developed to identify assets, contributions, and benefits from government programs. Since 1975, each local office has had access to

the BENDEX system, showing benefits from the Social Security Administration; IDPA reported that Social Security errors promptly fell by 68%. Data exchanges on unemployment insurance and workmen's compensation were used to identify those sources of income, and efforts to locate absent parents identified unreported contributions.

(4) Claims of Lost or Stolen Warrants. In the mid-1970s, many recipients, particularly in the Chicago area, filed reports, some of which may have been fraudulent, of lost or stolen warrants (benefit checks). The problem almost totally disappeared when the state began in 1977 to send warrants directly to currency exchanges designated by recipients.[13]

Enforcement Responses to Identified Fraud Cases. It was indicated earlier that cases in which it is discovered that a client has received excess AFDC aid lead to administrative recovery procedures, supplemented in larger cases by civil court proceedings; Figure 2 described the steps involved in the recovery process. From the point at which the issue of fraud enters the picture, the two additional decisions to be made are whether IDPA will refer the case to the Illinois Department of Law Enforcement (IDLE) for investigation and whether IDLE will refer the case to a (county-level) State's Attorney for prosecution.[14] Each decision involves two issues, an evidentiary issue of whether fraud can be proved, and a resource allocation issue of how many recipient fraud cases IDLE, the State's Attorneys, and judges want to handle.

The resource allocation problem pervades the entire enforcement process, from the initial referral decision by a caseworker through the prosecutor's filing of criminal charges. At the caseworker level, for example, referring a case to the Bureau of Collections or the Bureau of Special Investigations for recovery or enforcement action requires extra

work beyond the steps involved in cancelling or revising the grant award. Until 1981, caseworkers were responsible for calculating the amount of excess assistance and initiating recovery efforts, and there were many complaints about the paperwork involved. In March of 1981, however, IDPA changed its procedures; the caseworker now only fills out a simple referral form and, if the amount of excess assistance is more than $200, forwards the form and supporting documents to BOC or BSI. Over the 8 months before this change, the local offices referred an average of 227 cases per month; over the 4 months following the change, they averaged 922 referrals per month.[15]

During Fiscal Year 1981, BOC and BSI received a total of 8,565 referrals regarding excess assistance in AFDC cases. Five thousand, five hundred and seventeen came from the local offices, 2,773 from crossmatch programs, 117 from Quality Control, and 158 from other sources (e.g., the FBI, the Legislative Advisory Committee, or IDPA investigations of other cases).

The processing of referrals has changed substantially in recent years. The first step in all cases is a review of the file to verify that excess assistance was given, and in what amount; the second step is to determine whether there is evidence of criminal fraud.[16]

Until 1978, investigators on the staff of BSI analyzed case files, interviewed recipients, employers, and other sources, and packaged cases of suspected fraud for direct submission to the appropriate State's Attorney. In 1978, however, following massive federal indictments of AFDC recipients, a Fraud Prevention Commission appointed by Governor James Thompson concluded that BSI did not possess "specially trained investigators who know how to gather evidence and prepare a case for successful prosecution," and recommended that criminal investigations of recipient fraud be centralized in the Department of Law Enforcement. BSI, however, was to continue to have responsibility for "investigation of all reported fraud and abuse cases to the point of criminal investigation, and development of new technology for defining the highest dollar risk potential for system abuse or fraud." This change was made effective July 1, 1978. IDLE's Bureau of Financial Fraud

and Forgery now employs 15 investigators to handle "white collar crime" cases; of these, the equivalent of 10 full-time person-years are devoted to AFDC fraud and stolen warrant cases.

The transfer of investigative powers to IDLE led to substantial policy and implementation problems. When IDLE began operations in 1978, BSI and BOC sent all of their current fraud cases to IDLE, overwhelming the IDLE staff with thousands of cases, almost all of which were promptly returned to IDPA for administrative action. In 1979, IDPA and IDLE established guidelines to control the referral process; cases were to be referred for investigation only when (1) there was a misrepresentation; (2) the fraud occurred within the state's three-year statute of limitations; and (3) at least $1,000 was involved, or a State's Attorney requested action on a case involving a lesser amount. Even where those conditions were met, IDLE stated that it would not open a case where (1) it is likely that the recipient had fulfilled all reporting requirements, (2) IDPA had continued to allow the client to receive assistance after learning of ineligibility, (3) documentation was insufficient to support fraud (where documents are unavailable or IDPA did not redetermine eligibility for the period of alleged fraud), or (4) a prosecutor had indicated in advance that he would not treat the case as a felony and seek criminal prosecution.

In FY 1979 BOC and BSI reviewed 5,803 cases, and referred 1,995 to IDLE; 246 cases were referred to State's Attorneys for prosecution and 335 were sent to the Attorney-General for civil action. In FY 1980, BOC and BSI reviewed 7,884 cases and referred 1,999 to IDLE; prosecution was initiated on 131 cases. From October 1980, to March 1981, IDPA reviewed 5,266 cases and referred 806 to IDLE; IDLE sent 74 cases to State's Attorneys for prosecution.

In general, IDPA and IDLE officials feel that downstate prosecutors and judges are willing to take any recipient case which is given them, but that Cook County people want only major cases. Both IDLE and county prosecutors have informally "lobbied" judges to encourage them to hear more fraud cases

and to impose stiffer sentences; their general impression is that while the number of cases has remained low, the sentences imposed have gone up.[17]

In reaction to the federal indictments in 1977 and the publicity surrounding the number of public employees found on the welfare rolls, Cook County State's Attorney Bernard Carey formed a welfare fraud unit in November 1977. In the first year after the unit was formed, 211 people were indicted for defrauding the state of more than $2.1 million. Eighty of those indicted were public employees, including fifteen IDPA employees. Carey's welfare fraud unit obtained 85 convictions; 52 defendants were given jail sentences. The courts also ordered restitution of more than $250,000. From 1977 until 1980, the unit brought 631 indictments, totaling more than $7.3 million in alleged fraud. Convictions were obtained in 473 cases; 305 resulted in jail sentences (Brodt, 1980).

Carey's successor, elected in 1980, reduced the size of the unit and indicated to IDLE that he wants to handle only provider and major recipient fraud cases. IDLE investigators reported that the declining interest in recipient cases might reflect a change in prosecutorial philosophy, or might indicate that the recent heavy emphasis on recipient fraud had exhausted the supply of major cases.

Assessments of Illinois' Response to AFDC Fraud Problems. The quotations presented at the beginning of this chapter suggest the variety of perspectives which Illinois residents and officials have regarding AFDC fraud problems. For many who are primarily concerned with improving the conditions of the poor, fraud problems are either minor embarrassments or indications of the inadequacy of benefit levels--"What's wrong with someone making a little bit of money on the side? They can't live on what the state gives them." Those who basically dislike welfare and its costs to taxpayers, however, are more likely to see fraud as a crime problem--"They took public money that they weren't entitled to. Let's get the money back and put them in jail!" Managers of welfare programs are inevitably caught in the middle--while they know that fraud exists, wastes money, and can be

politically costly, they are fundamentally concerned with the delivery of welfare programs; the prevention or reduction of fraud must be accomplished without hindering routine case intake and maintenance activities.

One indication of the impact of the administrative changes which IDPA has made in recent years can be found in the quality control error rates. Table 5 shows a substantial decline in recent error rates over the high levels of the mid-1970s. The 1980-81 error rates were low enough to enable the Department to avoid fiscal sanctions, although Department officials fear that the increased caseload generated by the recession will lead to higher error rates.[18]

The leadership of IDPA is satisfied with its recent rate of progress, and feels that it is on the right track with its emphasis on general management improvement. Officials reject the argument that fraud control should be a major focus in and of itself; providing service to the poor, controlling waste and mismanagement, terminating ineligible recipients, and recovering excess assistance are viewed as higher priorities. The Department's enforcement efforts, they feel, are better directed at provider problems in the Medicaid program than at recipient problems in AFDC. The various indicators of "quality" built into the LOPI system will serve as a reminder to local office managers of the importance of the issue, and the simplification of the referral process will encourage caseworkers to take action on the problems they encounter.

The Regional Office of DHHS appears satisfied with IDPA efforts. It concluded in a 1980 administrative review that "The State is interested and able in its pursuit of activities to curb fraud and abuse." It recognizes the constraints imposed by IDPA's union contract (setting limits on the number of redeterminations which can be required of a caseworker each month), understaffing, high caseloads, court requirements on the processing of applications, and active scrutiny by the Legal Assistance Foundation.[19] The AFDC program director in the Regional Office praised the efforts made to reduce error rates, although her staff often disagreed

Table 5

QUALITY CONTROL ELIGIBILITY ERROR RATES

IN THE ILLINOIS AFDC PROGRAM

(Payment/Case)

April-Sept. 1973	Jan.-June 1974	July-Dec. 1974	Jan.-June 1975	July-Dec. 1975
9.6%/11.7%	10.8%/12.7%	12.8%/15.1%	8.7%/11.4%	6.1%/8.2%
Jan.-June 1976	**July-Dec. 1976**	**Jan.-June 1977**	**July-Dec. 1977**	**Jan.-June 1978**
6.9%/8.0%	4.8%/6.0%	10.2%/11.8%	9.6%/11.0%	8.0%/9.7%
April-Sept. 1978	**Oct., 1978-March, 1979**	**April-Sept. 1979**	**Oct., 1979-March, 1980**	**April-Sept. 1980**
6.7%/8.5%	7.0%/7.7%	5.7%/7.0%	5.2%/5.6%	3.1%/3.5%
Oct., 1980-March, 1981				
3.8%/4.4%				

Source: Illinois Department of Public Aid, AFDC Corrective Action Report October, 1980--March, 1981, submitted to DHHS October, 1981. It should be noted that this table reports QC error rates as measured by the state QC process; the "final" figures established following the federal re-review are higher than these "original" figures.

with some details of IDPA implementation activities and found IDPA not always receptive to federal offers of technical assistance.[20]

A 1980 study conducted by the National Academy of Public Administration for DHHS similarly concluded that the changes developed in recent years would be sufficient to reduce AFDC errors to a satisfactory level of tolerance although it recommended that computerization and training efforts be increased (Zashin and Summers, 1980: V-7--V-10).

While declining error rates and the approval expressed in the DHHS administrative review and the NAPA study suggest that IDPA management is taking the right steps, two substantial obstacles to further progress remain, obstacles which may prove insurmountable. The first concerns the local offices of IDPA and their caseworkers; the second concerns IDLE, prosecutors, and judges, the officials involved in criminal justice responses to fraud cases.

Many of the administrative reforms which have been discussed were changes which the IDPA central office could effect on its own--redefinitions of eligibility policies; the creation of data systems such as ICL, BENDEX, and data exchanges with employers; the separation of earned income caseloads and the requirement of monthly reporting by EI clients; the reassignment of recovery duties from the local offices to central office bureaus, etc. Other changes, however, require implementation by local office administrators and their staffs. As one senior IDPA administrator stated the problem, "We are now at a point where we have grown more sophisticated than our caseworkers are ready for. We're not sure how to use all the tools we have developed. While we can improve on our utilization of information sources about earned income and on our simple interviewing techniques, we can only go as far as caseworkers, skill, and motivation permit."

Our 1981 interviews with central office officials and 1980 interviews conducted in local offices for the NAPA study suggest the complexity of this "skill and motivation" problem. With regard to fraud and abuse, the basic questions are whether intake and income maintenance caseworkers will follow

prescribed procedures to verify data and whether they will take steps to recover excess assistance--whether, in short, the "official" policy described in Figure 2 accurately reflects what happens in the local offices.

At one level, there is a problem of competence--can caseworkers perform the steps necessary to identify and react to fraud and abuse problems? The NAPA study found some minor "glitches" in the local offices such as CRTs which were out of service or unavailable when needed, and forms which were repeatedly out of stock. More significantly, it found problems of high staff turnover (about 10% of the local office people leave every year), high caseloads resulting from a state hiring freeze in the midst of a recession, salary levels (particularly in Cook County) which were not keeping pace with inflation, limited training, and frequent reassignment of caseloads. Finally, a career ladder established in the early 1970s permits an entry level caseworker with a high school education to rise to a Caseworker IV position merely on the basis of seniority, without necessarily having the skills or training needed for the higher position (Zashin and Summers, 1980: I-20, I-22, and III-10). For numerous reasons, therefore, many caseworkers may be new to the job and not understand the rules, or new to their caseloads and not know their clients.

More broadly, there is a question whether local office personnel--at both the caseworker and administrator levels--are motivated to work on fraud and abuse problems. For caseworkers, simply "keeping up"--handling redeterminations, routine changes, and other paperwork--can more than fill their work day; investing extra effort in verifying client-reported data may be seen as service above and beyond the call of duty. Openly challenging clients' statements ("Is Jimmy really still living at home?" "Has your husband been gone 6 months?") can exacerbate tensions between client and caseworker (Zashin and Summers, 1980: III-19). Finally, there were many indications that some caseworkers viewed the central office emphasis on fraud and abuse as a sham--"Why should we make an effort to report this stuff? We know that BSI and BOC don't follow up on the leads we give them. The Department doesn't get the money back and only the real welfare queens

get prosecuted. Besides, many of the Department's rules are nonsense anyway." Since fraud and abuse efforts are not used to evaluate employees' performance--there are no bonuses for extra effort and no penalties so long as caseworkers perform a minimum number of redeterminations each month--they have little incentive to hustle themselves into this line of work.[21]

Similarly, local office administrators must decide how much of their caseworkers' time should be invested in enforcement activities, or how much of their own time should be devoted to carrying out the central office's enforcement expectations. The goals and standards articulated in the LOPI system include attention to ineligibility and excess assistance issues, but many other office management responsibilities are also cited. Even if the administrator has an incentive to excel, either to win a performance award for the office or for personal advancement, performance on "quality" indicators counts for no more than performance on other parts of the LOPI system. While the administrator may be more exposed to central office pressure than are the caseworkers, increased attention to fraud and abuse problems may not be the inevitable result.

The tension between fraud problems and other issues which confront caseworkers and administrators within IDPA becomes more pronounced when we turn to the criminal justice agencies which must handle fraud prosecutions. While IDPA's Bureau of Collections and Bureau of Special Investigations have been able to develop about 2,000 potential fraud cases in each of the last three years, only a few hundred are sent by IDLE for prosecution. IDPA investigators understandably are unhappy with this situation, feeling that IDLE does not devote sufficient effort to welfare fraud cases. IDLE investigators, on the other hand, claim that many of the cases referred by IDPA either lack clear documentation of fraud or involve negligence by IDPA (such as failing to redetermine a case on schedule, or continuing a grant after learning of fraud) which will create a poor impression if the case goes to trial. As one IDLE investigator put it, "They should do a better job of going over their files before they send cases to us--if IDPA doesn't have the documentation we need, we can't go for prosecution."

While the lack of adequate evidence may provide a partial explanation for IDLE's high rate of rejection of IDPA cases (although many of these problems could presumably be solved by investigations to supplement the papers in the files), a far more serious problem concerns the relatively low priority given welfare cases vis-a-vis other crimes. The Director of the Department of Law Enforcement stated the issue succinctly. "The real question is where you want to invest your resources. As compared with other kinds of law enforcement duties, fraud cases are neither fun nor satisfying. Recipient fraud cases, for a prosecutor, are like shooting fish in a barrel. In addition to being unsatisfying from a technical point of view, they are less satisfying to the public. But IDLE has a duty to a brother agency (IDPA) to handle some of its cases, and we would like to maintain some type of general deterrence, so that people won't think they can get away with fraud. Beyond that level of effort, however, we can't handle many cases." Prosecutors and judges seem to share this perspective, acting on the major fraud cases but declining others in favor of what they regard as more serious crimes.

The Director of IDPA was not dissatisfied with the level of effort provided by IDLE and the courts, recognizing that recipient fraud is only one of many responsibilities which they have. He was not interested in having investigative authority returned to IDPA, arguing that enforcement powers would increase its role conflicts with recipients; the ability to terminate recipients and recover excess assistance, he argued, is sufficient to serve the Department's needs. While the two departments seem to recognize each other's divergent priorities, they are willing to negotiate about individual cases; if IDPA has a special interest in prosecuting a particular case, it can lobby with IDLE or a State's Attorney to take it.

Conclusion. Illinois has made substantial progress in its administrative efforts to prevent AFDC fraud and abuse and to recover excess assistance, but little is being done by the criminal justice system.[22] Changes in 1981 in the excess assistance referral process and the initiation of recoupment measures should greatly increase the dollar volume of

recoveries, but it is unlikely that criminal investigations and prosecutions will increase significantly. The monthly reporting requirements built into the processing of earned income cases will make it easier for prosecutors to prove that willful misrepresentation occurred, but will do little to solve the basic problem presented by investigators' and prosecutors' feeling that they have more important things to worry about.

Ultimately, policies about AFDC fraud and abuse in Illinois reflect the divergent goals and interests of organizationally separate entities. DHHS, armed with the threat of fiscal sanctions, has succeeded in pushing IDPA to reduce error rates but cannot dictate the specific steps which are taken to administer the AFDC program. IDPA, trying to conserve limited resources, has been able to revise many of its policies and procedures to focus attention on excess assistance problems, but may be unable to get further progress out of its local offices. Independent investigators, prosecutors, and judges, however, are faced with substantial backlogs of street crime cases, and have little time for fraud cases. Despite occasional newspaper write-ups of welfare queens and minor grumbling in the legislature, there appears to be little pressure to increase criminal justice efforts. "Except for the feds with their fiscal sanctions and the legislators who want to cut welfare costs any way they can," one legislator concluded, "there simply isn't an 'anti-fraud' lobby in the state." In the words of another legislator, "No one is emphasizing enforcement against welfare fraud because there is no political mileage in it unless you catch a welfare queen."

NOTES

1. The organizational structure and administrative processes of the Illinois Department of Public Aid are described in detail in Bateman (1979) and Zashin and Summers (1980).

2. In calculating financial eligibility, items such as income, resources, assets, contributions from legally responsible relatives, and other sources are considered; "allowable disregards" deducted from these resources include expenses related to earning income, income earned by full-time student children, WIN incentive payments and work expense reimbursements, and the first $30 and one-third of the remainder of income earned each month by other members of the family. Certain other income, assets and resources are exempt from consideration. Income, disregards, and exemptions are then used to calculate "net countable income." See Bateman (1979: II-28 to II-31) and DHHS Office of Family Assistance. (1980: 57-60)

   Changes in Illinois AFDC policies to match federal changes in 1981 led to the termination of benefits for over 25,000 recipients. The major changes were to limit the "$30 and one-third" disregard to four months, to include the income of step-parents in calculating eligibility, and to exclude 18- to 21-year olds unless they were full-time students. (Frantz, 1982)

3. "In addition to monitoring case processing in the local offices, the regional offices deal with union grievances, complaints about local offices from organizations representing clients, outreach to commuunity organizations, and staffing problems. Corrective responses to QC audits are also the responsibility of the regional offices." (Zashin and Summers, 1980: IV-14)

4. Despite this authority, IDPA officials report that the county personnel committees take little interest in lower level vacancies; senior positions such as the local office administrator and deputy administrator, however, command more attention.

5. General Assistance outside of Chicago is locally funded and administered.

6. In 1981, IDPA changed its home visit policy, leaving it to the discretion of the local supervisor as to whether a visit is necessary in an individual case.

7. Like other AFDC recipients, earned income recipients must come to an IDPA office for a personal annual redetermination conference.

8. Several months after initiation of the demonstration project, recipients were reporting that the reporting forms were hard to understand, that IDPA offices were misplacing forms, and that checks were being delivered late. Spanish-speaking recipients were particularly suffering, since the reporting forms were printed in English, and IDPA offices had few bi-lingual assistants to help the clients. (White, 1981)

9. The actual rate of payments into BOC accounts varies. During FY 1981, 43% of the persons who had signed voluntary repayment agreements made payments averaging $29.30 per month. Of those who lost in a civil court suit, 40% paid at an average of $44 per month. Twenty-six percent of the persons who were convicted of criminal fraud paid an average of $253.11 per month. (Since court orders required payments to the county probation office, prior to forwarding to IDPA, the supervisory power of the probation officers assisted in the collection effort.)

10. As will be noted later, there were many indications that caseworkers do not refer all excess assistance findings to the central office for recovery action.

11. In October of 1981, BOC took over BSI's excess assistance referral processing functions, although BSI continued to handle any necessary investigations on cases.

12. While the ICL identifies individual cases containing factors which might indicate errors, IDPA has not developed "error-prone-profiles" to classify types of high-risk cases.

13. A 1982 evaluation of the direct mailing program by the DHHS Inspector General, however, concluded that the program made it difficult for the elderly or handicapped to pick up their checks, that forged photoidentification cards made it still possible to steal checks, and that the photo ID system was expensive to operate (about $300,000 per year). (Coates, 1982a)

14. While AFDC fraud also violates federal laws, federal agencies rarely become involved in the investigation and prosecution of Illinois AFDC cases. The Regional Office of the DHHS Inspector-General concentrates almost exclusively on provider fraud. The FBI office in Chicago, acting on guidelines set by the United States Attorney, will not investigate a recipient case involving less than $20,000 (referring such cases to the state for action), although it will act on interstate violations exceeding $5,000 and on some types of aggravated-circumstance cases. In 1977, for example, a federal grand jury probe of government employees receiving welfare payments led to the indictment of 94 persons. Almost all were convicted. Crossmatches located an additional 1,500 government employees who were receiving illegal aid from IDPA, leading to grant cancellations or reductions. Complaints by some federal judges about the burden posed by the 1977 mass indictments led to an agreement between the U.S. Attorney and the

state that anything under $20,000 will be referred to state agencies. Arrangements have also been made to appoint prosecutors from the Illinois Attorney-General's office as special Assistant United States Attorneys to handle some prosecutions.

The 1977 investigation was conducted by a task force of the Federal Bureau of Investigation, Illinois Department of Law Enforcement, IDPA, and Postal Inspectors. The task force used computers to match public agency work records against IDPA records of public aid recipients. Although IDPA had established a computerized crossmatch program in 1973, efforts to expand it to local government units were unsuccessful until 1977, when the federal grand jury requested a special government employer data exchange. Government agencies such as the Chicago Housing Authority, Chicago Post Office, City of Chicago, and the Chicago Board of Education were subpoenaed by the grand jury to prepare tape files of payroll information in a format specified by IDPA. (DHHS, 1980: 2-31)

Federal involvement in Illinois recipient fraud problems revived in 1981. A joint investigation by the FBI, the regional Inspector-General of the Department of Agriculture, the United States Attorney, and the Cook County State's Attorney led to county and federal indictments of eighteen persons on Food Stamp fraud charges. (Crawford, 1981) The DHHS Inspector-General conducted computer checks of AFDC, Food Stamps, and Medicaid recipients in Illinois, identifying 152 families which were registered at least twice to receive the same benefits, and reported various failings in IDPA efforts to verify social security numbers, birth certificates, etc. (Coates, 1982b) In 1982, a combined federal and county investigation led to 22 AFDC indictments and 19 Food Stamp indictments (Crawford, 1981).

It should also be noted that a few AFDC fraud cases are processed outside of the BOC/BSI--IDLE route. Some tips are sent directly to county prosecutors or other officials; of these, some are passed on to IDPA or IDLE for analysis while others are independently investigated. The procedures discussed in the text, however, account for the overwhelming majority of AFDC fraud investigations and prosecutions in Illinois.

15. IDPA officials were uncertain whether the increase in referrals was due to the simplification in the caseworkers' referral tasks or to the pressure exerted on office managers by the LOPI system.

16. Under Section II-21 of the Illinois Public Aid Code, recipient fraud occurs when "Any person who by means of any false statement, willful misrepresentation, or failure to notify the Department of a change in his status ... or through other fraudulent device obtains or attempts to obtain public assistance." Offenders are subject to penalties for perjury, and may be ordered to refund the amount of the excess assistance, to pay a penalty up to the amount of excess aid, and/or be sentenced to imprisonment for periods ranging from six months to twenty years, depending upon the amount of excess aid.

17. While no statewide data are collected on the sentences imposed in AFDC fraud cases, IDLE and IDPA reported that many convictions led to either probation or to a combination of probation and restitution. Some judges were said to avoid restitution orders, concluding that the civil courts are better able to enforce restitution with their remedies of attachment and garnishment.

18. While they of course like the decline in their error rates, IDPA officials are quick to challenge the validity of the DHHS error rate system as a full measure of a state's effectiveness in administering its AFDC program. Given the diversity of states' implementation problems, IDPA officials reject any conclusions that a state with a low error rate is necessarily performing better than a state with a high error rate, or that high error rates should lead to fiscal sanctions.

Three problems in the use and interpretation of the QC data were cited by IDPA. First, the federal QC data provide a statistically valid picture of errors for the state as a whole, but do not tell individual offices what their problems are or what corrective actions would be appropriate for them; IDPA hopes that its own expanded state sample (not used for federal QC calculations) will provide valid and useful error rate data for larger offices. Second, IDPA reports a lack of coordination within the Regional Office of DHHS. "We'll clear a program change with their program people and then their quality control people will stick us on the six month quality control reports and tell us that what we'd done with prior approval was incorrect--that what we'd done is not permitted, and they count it as an error. They just don't talk to each other over there." (Quoted in Zashin and Summers, 1980: I-11)

Third, many of the reductions in error rates were attributed by IDPA not to their administrative reforms but to policy changes which defined errors out of existence. In 1975, for example, QC reviewers stopped counting changes in recipients' status, unrecorded by the caseworker, which occurred during the review month or the preceding month. The requirement that clients register for the WIN program was altered--reregistration requirements were changed from every thirty days to every six months. An affirmative requirement that the file show that a child was in school was changed to a negative requirement; a case was only in error if IDPA had received a "drop notice" from the child's school. To get around a problem caused by individual recipients who had not signed forms promising assistance in enforcing child support agreements, IDPA persuaded the legislature to make such assistance a matter of law; as a result, the absence of an individual form in a file no longer counted as a QC error.

Finally, IDPA officials point out that error rates lump together significant substantive problems and meaningless technical errors; if a client has not reregistered for WIN or obtained a social security number for a new child, for example, "real eligibility" is not affected--the caseworker simply sends the client off to get the right forms and payments continue uninterrupted.

19. The activities of the Legal Assistance Foundation and predecessor legal services programs in Chicago are detailed in Katz (1982).

20. Zashin and Summers (1980: I-13--I-15). On the topic of relationships with the DHHS Regional Office, IDPA officials suggested that DHHS was rarely obstructive, but often was a less valuable source of helpful information than other state welfare agencies or officials in Washington. By way of comparison, they reported that regional HCFA officials were more helpful about Medicaid than OFA officials were about AFDC.

21. Zashin and Summers note that caseworkers have "limited incentives to seek out instances of clients' not reporting changes. Wage increases for superior performance can be earned, but performance is evaluated on a variety of activities; there is no direct reward system for superior 'investigative' work. Increasing cancellations by uncovering ineligibility factors may help in keeping the total caseload under control for a local office, but it is not clear that this works to the caseworker's advantage except in the short run because caseloads are periodically redistributed. On the negative side is the time required to pursue such inquiries, the possible unpleasantness of confronting clients about a sensitive matter, and the added hardship to clients that might result from attempts to recoup excess assistance." (1980: III-8)

22. A 1980 staff report by the Legislative Advisory Committee on Public Aid concluded that criminal justice approaches to recipient fraud were unlikely to be very important, since IDLE was not equipped to handle many IDPA referrals and effective prosecution would require extensive pretrial investigations. As a result, LACPA recommended continued emphasis on voluntary recovery and/or civil suits through the Attorney-General's office. While this recommendation corresponded with IDPA policy, the LACPA report concluded that IDPA was not doing an adequate job in enforcing recovery agreements or in monitoring the handling of excess assistance cases both within IDPA and by IDLE and the Attorney-General's Office. (Stein, 1980)

REFERENCES

BATEMAN, P. (1979) Administration of AFDC in Illinois: A Description of Three Local Offices (Cambridge: Abt Associates)

BRODT, B. (1980) "41 Indicted on Theft Charges in $700,000 Welfare Fraud" Chicago Tribune, September 30.

COATES, J. (1982a) "Flaws Found in County's Welfare Reforms" Chicago Tribune, June 20.

_____ (1982b) "Computer Finds Heavy Welfare Cheating Here" Chicago Tribune, August 22.

CRAWFORD, W. (1981) "18 Are Indicted in Welfare Plot" Chicago Tribune, October 1.

_____ (1982) "U.S., county indict 40 in huge welfare fraud" Chicago Tribune, September 23.

DHHS (1980) "The Illinois Department of Public Aid's Data Exchange Program," State Management Practices, AFDC, pp. 2-31.

DHHS OFFICE OF FAMILY ASSISTANCE (1980) Characteristics of State Plans for Aid to Families with Dependent Children (Washington: Government Printing Office).

FRANTZ, D. (1982) "Rule Changes Push 25,000 Off State Welfare" Chicago Tribune, February 28.

KATZ, J. (1982) Poor People's Lawyers in Transition (New Brunswick: Rutgers University Press).

STEIN, M. (1980) "Welfare Fraud--An Overview" Staff report to the Illinois Legislative Advisory Committee on Public Aid.

WHITE, J. (1981) "New Report Stalls Aid to Peoria Needy" Chicago Tribune, November 24.

ZASHIN, E., and S. SUMMERS (1980) "Case-Processing and Error Rates in the Illinois AFDC Program: A Case Study of Two Local Offices in Cook County and Downstate," a report to the National Academy of Public Administration.

CHAPTER FOUR

CONTROLLING RECIPIENT FRAUD IN COLORADO

"Fraud in AFDC isn't a serious problem in Colorado. There have only been a handful of jail sentences in the past 10 years. I believe the number of fraud prosecutions pretty accurately mirror the amount of AFDC fraud out there."

Colorado State AFDC Official

"I am so constrained by lack of resources and the problem the state has in being out of compliance with its own rules that I only have 40 cases in my backlog."

County Welfare Fraud Attorney

"On occasion, I can get a case worked up for the attorneys but the pressures of my job are severe. I feel that I'm batting 1.000 if I can just motivate the Eligibility Technicians to keep blatant ineligibles off the rolls."

County Welfare Investigator

As in most other states, AFDC in Colorado is seen as a complex and expensive welfare program--necessary but unpopular. But Colorado's AFDC program, unlike that of other states, has escaped the highly visible, highly emotional controversy that so often surrounds welfare programs. Instead, the AFDC rolls and program expenditures have quietly and slowly been reduced since 1975. This downward trend is no doubt due to a number of factors, not the least of which is Colorado's economic health and relatively low unemployment rates. Instead of having to fight soaring welfare costs, Colorado's officials can concentrate on such matters as balancing economic development with protection of the environment.

However, as this examination of the State's AFDC program will illustrate, the problem of AFDC recipient fraud looms in many ways as an iceberg--just below the surface lies a very significant problem. The key question might be, why is there no controversy?

Administration of the AFDC Program. Colorado maintains a state-supervised, as opposed to a state-administered AFDC program.[1] Fundamentally, the two approaches are different in the location of responsibility for day-to-day operation of the program. Colorado's 63 counties are responsible for running the program. County workers staff the program, determine eligibility, establish individual AFDC grant amounts, handle redeterminations, distribute checks, serve as recipients' first level of appeal, and perform nearly all fraud control functions. The state legislature sets county staffing levels for program administration. The state is also responsible for promulgating general rules, monitoring, auditing, conducting quality control reviews, and providing training and general technical assistance to the counties. County governments contribute 20% of the cost of the program, the state 30%, and the federal government 50%.

The Colorado Department of Social Services (DSS) coordinates the AFDC activities of the 63 county departments of social service. A nine-member State Board of Social Services, serving at the pleasure of the Governor, oversees the Department. An Executive Director, also appointed by the Governor, is the top administrator. DSS, in addition to AFDC, also supervises Medicaid and Food Stamps; these programs, like AFDC, are administered on a day-to-day basis by the counties. DSS also directly administers a wide variety of other social service programs such as those for veterans and the aged. DSS has the third largest budget in the state, after higher education and primary/secondary education. The total cost of AFDC in Colorado was $7.5 million in 1981.

Figure 3 presents the organization of DSS. The Division of Income Maintenance (DIM) promulgates rules guiding county operations. Training of county employees, information systems support, planning, statistics, and other management assistance are provided to the counties by the DSS operations branch. Quality control and field audits are performed by an administrative branch. A small Office of Investigations, handling audit reviews and recoveries, reports to the Executive Director. There is no

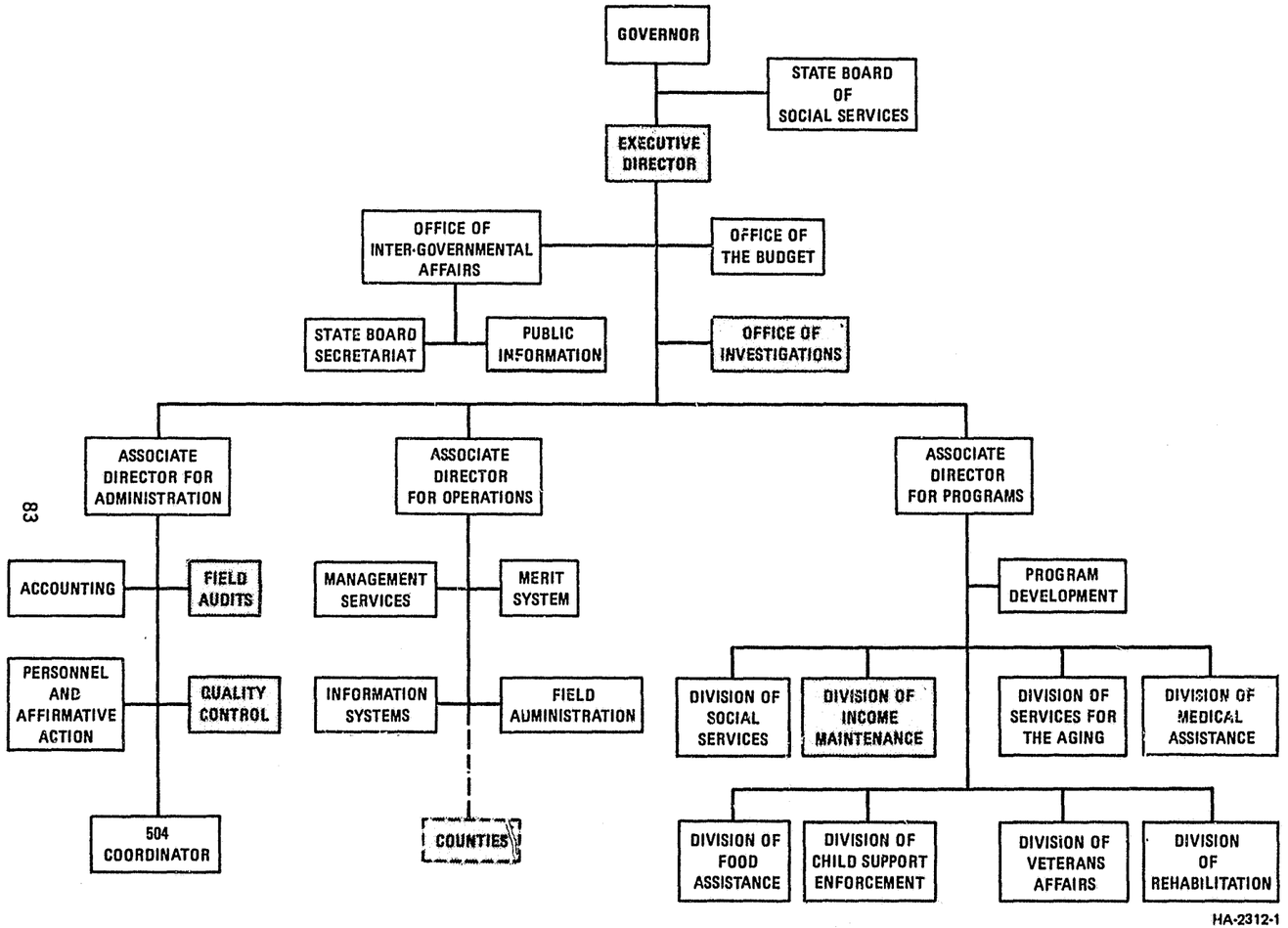

FIGURE 3 COLORADO DEPARTMENT OF SOCIAL SERVICES ORGANIZATION
(as of April 1, 1980)

requirement that counties have such an investigative capability, although several of the larger counties have investigators.

It is within the county departments of social services that applicants queue up to fill out forms, technicians[2] interview clients and fill out forms, and primary efforts to prevent or detect welfare fraud occur.

Denver County serves as a useful illustration, although this county is atypical in size. In area, it is Colorado's smallest county (118 square miles), although it has the largest population (nearly 500,000). It also has nearly 40% of Colorado's AFDC case load (and its error rate is more than twice that of the rest of the state). It is in the Denver County Department of Social Services (DDSS) that eligibility is determined and AFDC grants are issued. DDSS has approximately 1,000 employees and a total annual budget of $63 million. Its Income Maintenance Division performs AFDC intake, redetermination, and Food Stamp application processing functions. Social services and administrative services are provided by two other major units within the department. From the perspective of DDSS, the federal government's Office of Family Assistance is not relevant in any major sense, and the state is relevant only with regard to quality control, rules and regulations, and funding for program staff.

There are approximately 8,000 active AFDC cases in Denver County at a total annual cost of $30 million. The annual AFDC cost to the county, 20% of the total, is approximately $6 million. As in the state as a whole, the Denver County AFDC caseload and total AFDC costs have been dropping steadily since 1975 (see Figure 4).

To reach citizens throughout the county, DDSS has opened a number of district offices. These offices are staffed primarily by Eligibility Technicians (ETs) and their supervisors. District staff members accept AFDC applications, determine eligibility and the AFDC grant amount and, every six months, redetermine eligibility. Other investigative staff and the welfare fraud attorneys are located in the DDSS headquarters building, where program officials have offices. (DDSS recently disbanded the headquarters unit that

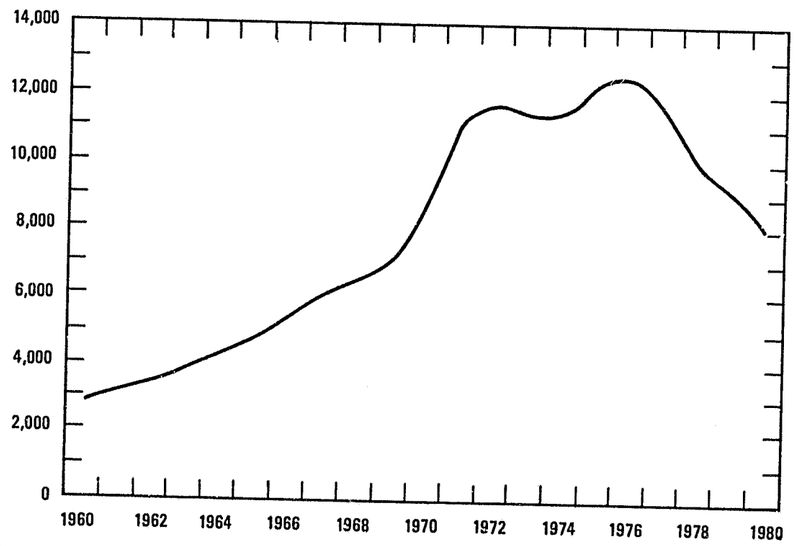

FIGURE 4 AVERAGE MONTHLY AFDC CASELOAD, 1960-1980, DENVER DEPARTMENT OF SOCIAL SERVICES

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assisted ETs by researching such things as employment data, birth verification, motor vehicle checks, bank and mortgage accounts.) In addition to AFDC, the DDSS staff also handles Food Stamps, Medicaid (except for fraud control), family services, and a host of related activities.

Applying for AFDC benefits in Colorado is a relatively straightforward procedure. Generally, a new AFDC client files an application at a district office and completes an interview with an Eligibility Technician. The application is reviewed (and completed, if needed) and a process is started by technicians to determine eligibility. A great deal of judgment is allowed, but typically the technician makes telephone calls to banks, schools, credit bureaus, etc. If time is limited, the intake technician may perform this validation only in cases where there are suspicions of misreporting. State rules require that a home visit be made for every new application. Again, this is reported to be a difficult rule to follow in counties, like Denver, where the caseload is heavy.

If the technician suspects misreporting, an investigator can be asked to follow up with records checks and/or make the home visit. For redeterminations, investigators are often called on to determine if a man is living in the house and contributing income to the family. No state rule requires home visits at the time of redetermination, so visits are typically made in suspicious cases only.

Once all necessary information has been assembled, and eligibility is determined, the size of the AFDC grant is established. To minimize possibilities for error, technicians overlay a plastic ruler-like template on the highly formatted application and, by reading off a scale, determine the size of the grant. Supervisors randomly review these calculations.

Procedures for Handling Nonfraudulent Errors and/or Fraud. Because AFDC regulations are both complex and changing, nonfraudulent errors find their way into the program. Recipients may confuse time periods when income

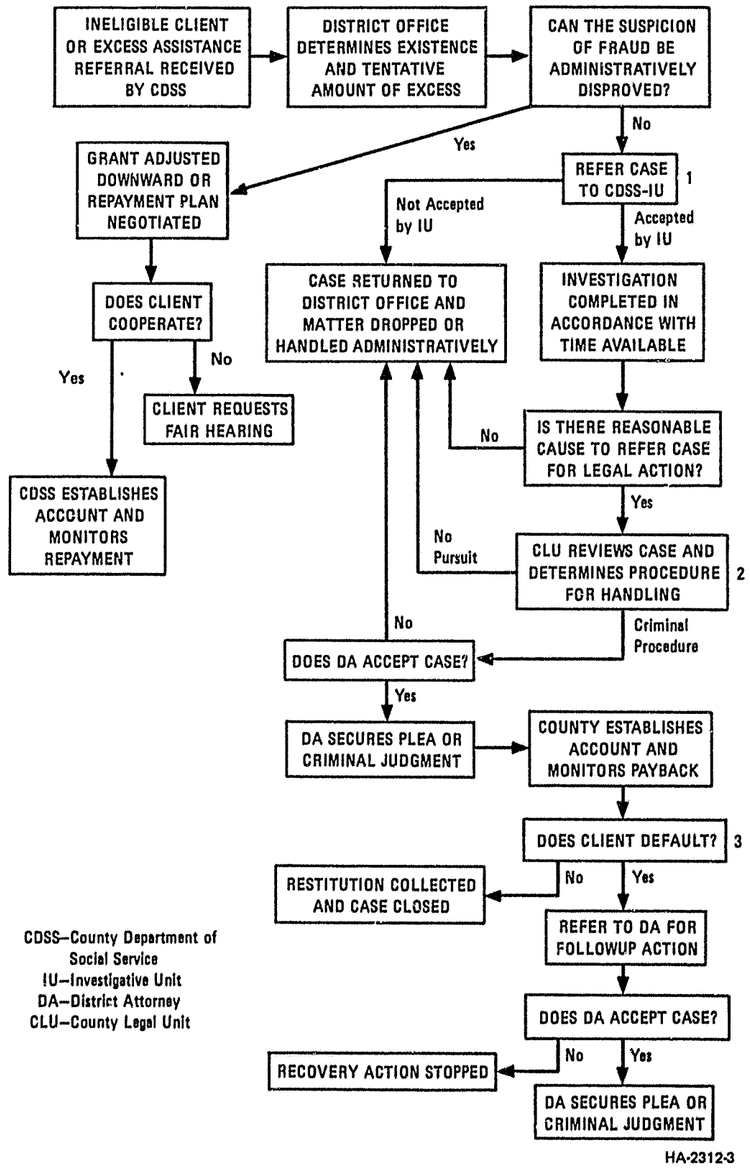
or changes in the family unit should be reported; technicians may overlook certain factors when determining the size of the grant.

There also are, of course, cases involving willful misrepresentation by recipients. But it is difficult to separate the procedures used for handling inadvertent error from those used for handling fraud, because in Colorado, in addition to investigating suspicious cases, county investigation units become involved in many matters having to do with determining eligibility. A technician who becomes suspicious of a recipient's eligibility, or of the grant amount, can refer the case to the investigation unit whether it is suspected to involve inadvertent error or willful fraud. Depending on the technician's workload, it is often up to the investigator to examine the case and determine how to proceed. Procedures for handling errors and potential frauds are shown in Figure 5 which depicts the processing of cases referred to county investigation units.

Three points in the typical error/fraud investigation require discussion (see reference numbers in Figure 5 boxes). We again use the Denver County Department of Social Services for illustrative purposes.

(1) Eligibility technicians, social workers or supervisors can, at any time, refer a case to the Investigation Unit (IU). Typically, cases are screened by the supervisor of the IU. The IU has total discretion regarding the case; it can be accepted, rejected, or deferred. If time is available, some form of investigation takes place, even if it is only a telephone interview. If no time is available, the case will be deferred. There are no incentives to investigate. Workload pressures (two of eight investigators were recently cut from the Denver unit) are often powerful forces in deciding not to investigate.

(2) When, on completion of an investigation, there is reasonable cause to believe that legal action is necessary, the case is referred to the County Legal Unit (CLU). Here the merits of the case are



CDSS–County Department of Social Service
IU–Investigative Unit
DA–District Attorney
CLU–County Legal Unit

FIGURE 5 PROCESSING CASES OF AFDC ERROR AND/OR SUSPECTED FRAUD (GENERALIZED FOR 63 COUNTIES)

reviewed and a decision made as to whether the CLU will try criminal prosecution or refer the case back to the technician for administrative followup. (Table 6 indicates how many cases are handled by law enforcement and how many by administrative procedures.) No formal action is taken on a criminal case until approval has been secured from the Director of Social Services, who ascertains whether there is reasonable cause to proceed with the case. If approval is granted, the attorney files a criminal complaint, affidavit, and application for arrest warrant.[3] The typical case moves from arrest to the court in a few weeks and usually results in a guilty plea and court-ordered probation and restitution. Typically, the court orders incarceration only in cases where there is a long criminal history. Program officials remember no more than a few jail sentences during the past ten years.

(3) The terms of probation usually require that excess payments be repaid on a monthly basis. Promissory notes are secured and an accounting system established. Although an attempt is made to collect the full amount of court-ordered restitution, officials acknowledge that complete restitution is seldom made; there is little legal or administrative followup if recipients default on a promissory note.

Fraud and Abuse in the Colorado AFDC Program. The true magnitude of Colorado's AFDC fraud problem is unknown. When asked their subjective sense of how much fraud exists, agency officials typically report "one or two percent." Investigators, on the other hand, more often feel that 50% of the caseload involves some sort of fraud. Given these widely disparate estimates and no other measures, quality control findings are the only means of illuminating the characteristics of the fraud problem.[4]

Table 6

REPORTED RECIPIENT FRAUD IN
THE STATE OF COLORADO,
FOR PERIOD 4/80 THRU 3/81

Total cases referred to law enforcement		8
Total cases dropped or handled administratively		1,054
Action by law enforcement prosecuted (total)		8
Case dismissed	0	
Acquitted	0	
Convicted	1	
Confession of judgment	1	
Other	6	
Action on cases not referred to law enforcement		1,054
Facts insufficient to sustain fraud case	514	
Reimbursement arranged	36	
Special hardship involved	0	
Unable to locate	97	
Small amounts involved	46	
Other	361	

An analysis of quality control data indicates that approximately 75% of all errors in Colorado's AFDC cases are client-caused. This statistical result contrasts sharply with the feeling of AFDC program officials that errors are generally 50% client-caused and 50% agency-caused. Supporting the data gathered from the Denver Income Maintenance Experiment reported in Chapter Two, approximately two-thirds of all client-caused errors are the result of unreported income or an unreported parent in the home. The remaining errors fall into a wide variety of budget categories having to do with receipt of nonwage income. While such statistical findings vary from period to period, client-caused errors in income underreporting, or misreporting of the family structure, consistently rank high among types of errors found. It is believed by investigators that recipients with fraudulent intent typically leave out the highest wage earner from the reported family unit (often the father), thereby removing large amounts of income from the monthly report. Such errors occur approximately five times more often at the time of the 6-month redetermination than at the time eligibility is initially determined. Finally, underpayments are far less frequent than overpayments, lending credence to those in Colorado who believe that there is a significant amount of willful misreporting.

In terms of the magnitude of the problem, only one source of information is available: quality control data. QC activities not only illuminate where errors are occurring but how many errors occur over time. For the period April-September 1980, 468 AFDC cases were subjected to QC scrutiny. The federal findings for Colorado were as follows:

Ineligible cases	4.29%
Overpaid cases	10.66%
Underpaid cases	1.87%
Total cases in error	16.82%

Thus, for Colorado, approximately one AFDC case in six during mid-1980 exhibited some type of error resulting in an incorrect payment.

Administrative Responses to Fraud Problems. Because Colorado is operating a state-supervised, county-administered program, it is difficult for state-level staff to push administrative improvements down to the largely autonomous counties. Nevertheless, the past six or seven years have seen a concentrated effort by DSS to implement its philosophy that a better managed AFDC program will, by itself, control opportunities for fraud and abuse. With this in mind, DSS has striven to provide county social service directors with management support. Two activities, in particular, are being focused on: (1) training and (2) computerized, centralized, management information systems.

Client-Oriented Information Network. Since 1969, when the state began implementing what was to become a series of discrete computerized information systems, a major thrust of DSS has been to update and integrate the computer capability necessary to deal with family assistance programs. Following guidelines established by the DHHS Office of Family Assistance, the state embarked in 1979 on an extensive project to implement a Client-Oriented Information Network (COIN). Basically, the project is aimed at integrating the Monthly Reporting System currently operational in Boulder and Denver counties, with the prospective assistance payment system existing in all other counties, the various financial accounting systems, and the entry/verification/ certification system. The objective is to create a single, client-oriented data base accessible through fourteen regional data processing centers. As of mid-1981, the system was approximately 60% complete, with full implementation expected by late 1983. At that time, Colorado's AFDC program officials will have one of the most comprehensive management information systems in the country. However, until then, there remains a substantial void in computerized support to county agencies.

Training. The Division of Field Operations within DSS is moving to provide additional training and technical assistance to the counties. Training specialists have been added to augment an existing staff which is currently responsible for monitoring county compliance with federal and

state rules. Recently, this expanded staff also took over responsibility for following up on quality control findings and implementing corrective actions.[5] Plans are underway for each county's operations to be reviewed and for training programs to address identified shortcomings. Division staff are working toward a process whereby quality control findings are linked with audit findings, leading to the preparation of corrective action plans. These plans would then be reviewed and special county-by-county training programs established. While proud about their successes to date, Division staff are not sanguine about the expected negative impact of budget cuts on the Department.

The stated goal for both COIN and the training programs is to reduce error rates by means of improved local management and administration. While the control of fraud and abuse is an issue, however, it seldom receives explicit attention when such assistance activities are planned.

In addition to special purpose administrative efforts at the state level, a variety of reforms are being implemented at the county level. Here, the control of fraud and abuse is more often a stated objective. Denver and Boulder counties currently have their entire caseloads on retrospective monthly reporting. This requires recipients to complete a status report form for each monthly period. Recipients are asked to answer approximately 40 questions regarding the past month for which they received AFDC. On receipt of each month's reports, eligibility technicians determine if payments for the past month were accurate and, if they were not, additions or deletions are made in the next month's payment.

The monthly reporting concept has a number of objectives, one of the most important being the elimination of the need for face-to-face redetermination interviews. Cost factors were expected to be offsetting (expenses for a larger administrative workload are offset by personnel savings due to no redetermination interviews). Denver officials (and others) are not entirely satisfied that monthly reporting does much more than provide a system for recipients inclined to misstate circumstances to do so every month in safety. Furthermore, county officials say that when

changes are reported, monthly checks are delayed, setting up a disincentive to report any changes. County legal aid officials, who are skeptical about any alterations in procedures that tend to place a burden on recipients, say "being on AFDC is now a full time job." Denver's DDSS Director, acting on these concerns, has recently announced that all recipients will be required to appear at a district office for a redetermination interview every six months. The Director's rationale was that facts regarding income and family structure are easier to establish face-to-face than by mail. It is also felt that interviews reduce the number of fraudulent statements made by applicants. The value to the county of obtaining accurate information is evident from the high costs it is willing to accept to handle both monthly forms and redetermination interviews. The state is challenging Denver County over the additional expense, maintaining that face-to-face interviews are not warranted. However, county officials are quick to point out that the state is really of two minds, pressuring the county to reduce its error rate but complaining about the means the county chooses. Officials from both agencies feel that this dispute will not be quickly resolved.

Monthly reporting has been controversial since its experimental inception in 1978. Originally proposed by OFA and the state, it is still controversial at the county level. The Denver Legal Aid Advocacy Group filed suit in 1979 (Iris v. Colorado Department of Social Services, Colorado '79 N.296, 1979), arguing that the monthly reporting system is unreasonably burdensome to recipients. It was claimed that reported cost savings (4.3% of total costs) were due in large part to otherwise eligible people either not participating in the program due to difficulties in filing reports or filing reports inaccurately and being removed from the system. A study made in 1980 by Mathematica Policy Research, Inc., of reporting problems concluded that "between 11 and 39 percent of all cases discontinued under the Monthly Reporting System may have been discontinued for failure to comply with filing requirements even though they were otherwise eligible for assistance." The court ruled that MRS was not an unreasonable burden but that the county should clarify instructions to recipients.

Denver County has also recently addressed the problem of stolen AFDC checks. Photo identification cards are now being issued to all AFDC recipients. Originally requested by the business community and viewed as a service by the county's legal unit, photo identification cards, DDSS feels, are also useful to investigators who report they are stymied in many recipient investigations by identification problems.

Computer-matching of wage records is another administrative approach being used in Denver. In the past, an occasional match was made against the county payroll records or state wage records but this is now a routine practice that has grown out of recommendations contained in state-approved corrective action plans. County officials feel, however, that matching is largely a waste of time and money. Very few hits are made because, they say, the fraud problem in Colorado is not one of misreported wage income. Rather, the problem centers around nonwage income (e.g., tips, gifts) and wage-earning members of the family who are not being reported. Their suspicions are confirmed by the DIME data presented in Chapter Two.

A final local administrative response in Denver is specifically geared to reducing the county's own error rate, as established by QC reviewers.[6] Using "supercheckers" (eligibility technicians who perform a quality control function) to scrutinize each case that is pulled for state QC review, the county ensures that easily spotted agency errors are cleansed from the sample. State officials wonder aloud about the ethics of "superchecking" only those cases being reviewed for quality control, but are acutely aware that Colorado's error rate difficulties are centered in one county--Denver. Apparently, any means of reducing Denver's error rate will be acceptable to state officials who are anxious to avoid fiscal sanctions.

Enforcement Responses to Identified Fraud Cases. Most enforcement responses to fraud in Colorado are reactive. In some counties (e.g., Jefferson and El Paso), the child support enforcement staff provides information to AFDC investigators that can cause an investigator to initiate an AFDC investigation, but more typical is the case that is referred by a

technician who becomes suspicious about an application, a monthly report, or a redetermination interview. The county investigative unit is typically required to review the case but can reject it either because it lacks merit or there is too little time to follow up. Typically, the investigators will perform a 48-hour "mini-investigation" to assist a technician in determining eligibility. If a willful misrepresentation of facts is suggested by the eligibility investigation or by findings after a recipient is admitted to the program, the investigation unit embarks on a more complete examination. Many investigations are limited to a single telephone call or to a single home visit. The applicant or recipient is asked about information on the original application or on a monthly report. If an admission of guilt is offered (said to occur in approximately 50% of the cases), a statement is taken and becomes part of the case package that eventually goes to the legal unit. If no admission is secured and time is available, the investigator may check with neighbors regarding the makeup of the family, check wage records with the Colorado Department of Employment, or check with the Department of Motor Vehicles, etc. However, such follow-up activity is not typical, due to the investigator's time pressures and the low probability that unreported wage income is the problem. More common is the investigation that ends with a single interview and either an admission of guilt or a dropping of the case in favor of the next one in line.

The Denver County IU now has six investigators, four of whom assist technicans in determining eligibility. In 1980, eight investigators completed 1,885 "investigations," some amounting to a single interview or home visit. These investigations concerned a variety of benefit programs, with AFDC and Food Stamp cases in the majority.

There are, of course, cases where substantial fraud is apparent and a relatively complete investigation is made. Of 1,885 investigations, approximately 40 cases were added to the legal unit's small backlog. The others were handled administratively or dropped. The legal unit consists of one county civil attorney (who is also a deputy district attorney) and a paralegal who together are responsible for the 40 or so cases in process at any given time. As with the investigative unit, the legal unit handles

cases from AFDC, Food Stamps, foster care, estates, and other county programs. AFDC cases, however, are in the majority.

When an AFDC case is accepted by the legal unit, a criminal complaint, affidavit, and application for arrest warrant are completed. Upon arrest and arraignment, the accused typically pleads guilty, but at the suggestion of the court the plea is usually on a deferred basis so that after the typical two-year probation period, charges and the conviction can be dropped. In addition, sentences almost always include restitution.

When restitution is ordered, a schedule of payments and a promissory note are secured. A recoupment account is established within DDSS and monitoring of repayments initiated. Default on restitution is a serious problem in Denver, at least to enforcement officials who feel that claims by recipients of "extenuating circumstances" are too often upheld by the court. County staff members feel that only 10% of court-ordered restitution is ever collected.

The legal unit feels that a major barrier to more successful prosecutions lies in a court judgment in 1977 in favor of a client of the County Public Defender (People v. Williams, 197 Colorado 559, 1979). The court ruled that the Executive Branch was technically out of compliance with state law, since DDSS's AFDC rules were not filed correctly with either the Secretary of State or the Supreme Court Librarian. This now, say one county's prosecutors, threatens any successful prosecutions in the state under the welfare fraud statute. However, in another county a prosecutor said that the problem is more one of attitude, because theft, perjury, or false statement charges are potentially successful prosecutorial tools which would bypass technical problems in using the welfare fraud statute.

While there may be technical difficulties in Denver County, there are no significant organizational conflicts among the investigators, the attorneys, and the administrators of Denver's Department of Social Services, because they are all a part of the same agency. Other counties in the

state are not so organized. In suburban Jefferson county (adjacent to Denver, with one-fifth of Denver's AFDC caseload) the investigative unit is a contractually provided service to the Department of Social Services by the District Attorney's Office. In mid-1981 there was only one person in the "unit," but it was not always so small. In 1978, there was a more fully staffed Welfare Fraud Investigation Unit, established with some fanfare by the District Attorney's Office and the Department of Social Services. Staffed by an attorney, four investigators, and an auditor, the unit then was able to investigate welfare fraud cases in an ambitious and systematic way. However, budget cuts, poor personnel choices, organizational conflict, and poor planning eroded the unit to the point that its abandonment is being discussed.

In El Paso County (largely rural except for Colorado Springs), a specialized unit in the District Attorney's Office has been successfully investigating and prosecuting welfare fraud cases since 1974. Three attorneys and three investigators have been organized into a Fraud and Support Division of the DA's Office. Originally, the unit focused mainly on AFDC cases; investigation of family support cases became a secondary responsibility. However, because fiscal incentives in the family support program have changed over the years, making the investigation of family support cases financially rewarding to the county, the unit has slowly shifted nearly all of its attention to investigation of "missing father" cases. There are no fiscal incentives to investigate AFDC fraud; where an AFDC recovery is obtained through the efforts of any county in the state, the amount of the recovery is split 50% federal, 30% state, and 20% to the county, even though 100% of the cost of the investigation and proscecution is incurred by the county.

It is difficult to generalize from these experiences with different structures for fraud control as to what form of organization is best suited to combat welfare fraud. In Denver County, a good working relationship exists between investigators, attorneys, and program officials because all are part of one organization. However, the caseload is very low. This may be due to the involvement of top program officials in decisions to file

charges. In Jefferson County, a separate unit was formed and a contract established between the welfare office and the District Attorney's Office. Investigations have dropped precipitiously as staff have left the unit. In El Paso County, the Department refers all cases to the District Attorney, who has a special welfare fraud unit. However, the unit's attention has been drawn away from AFDC fraud due to the fiscal incentives provided by the child support program, so in this county too, AFDC is receiving little attention.

County enforcement officials generally feel that without state guidance concerning how to attack the fraud problem, and with limited resources, they are doing the best job they can in the best way they can. Certainly no enforcement official could say that much more than the tip of the AFDC fraud iceberg was being controlled. This is contrary to statements from high state and county AFDC officials that fraud is not a serious problem.

Assessment of Colorado's Responses to AFDC Fraud Problems. The picture seems clear--AFDC rolls are shrinking and this rests well with Colorado's largely conservative population. Fraud enforcement officials feel overwhelmed by the assumed magnitude of the problem. Because of budget cuts and other pressures, however, the true magnitude of fraud and abuse remains unknown. AFDC program officials, anxious to cope with the momentum of changing program rules and budget cuts, struggle to keep the program operating. The result is an information gap between enforcement and program staff. With no clear incentives to attack fraud in specific cases, and no priority given from the top, investigators and legal staff charged with fraud control do what they can. It is not difficult to understand, then, the seemingly incongruent sentiments expressed at the beginning of the chapter. To those close to the problem, it is an overwhelming one; to those more removed, fraud control takes its place far down on management's list of concerns.

In terms of incentives, only a reduction of quality control error rates is important. Threatened fiscal sanctions cause program officials to do what they can to reduce errors. However, they can do little more than reduce agency errors. Little can be done to reduce client errors in a situation where too few staff are available to validate each piece of information provided by the client.

Reducing the error rate in state-supervised AFDC programs is not easy. The state has no direct control over county program administration. Table 7 shows the results of three years of efforts to implement corrective actions at the county level--the error rate is creeping up. The federal first quarter 1980 QC report for the state says:

> Colorado continued its retrogressive trend by increasing its error rate instead of decreasing as mandated by the so-called "Michel Amendment." Continuance of this trend will not only prevent the State from meeting its assigned goals, but (Colorado) could incur approximately $2,411,338 in Federal fiscal sanctions based on its present known error rate.

Compounding the problem and increasing the likelihood of fiscal sanctions are the problems of monthly reporting. The same report states:

> The monthly reporting system continues to have a negative impact on the State's error rate with a 85.2% increase in MR payment errors in Denver and Boulder Counties. In addition, a serious increase in client misrepresentation supported the higher error rate.

The frustration mounts as program officials attack the causes of error but error rates go up. Client misrepresentation also climbs. And, most interestingly, the State Legislature remains silent through all of this, except to cut funds for county staff. The last legislative action on fraud control was in 1979 when training, mandatory verification of recipient information, and reporting systems were required; county program staff are still struggling with these mandates, with little success. Since that time, there has been little legislative activity on fraud control. When asked, legislators respond much as do program officials: it is not a serious problem and it ranks below others on a list of priorities. Thus, it seems

Table 7

STATE OF COLORADO
AFDC PAYMENT ERROR RATES (Adjusted Federal Figures)

	Jan/June 1974	July/Dec 1974	Jan/June 1975	July/Dec 1975	Jan/June 1976	July/Dec 1976	Jan/July 1977
Ineligible	4.3	6.1	6.3	5.8	4.4	4.1	1.5
Eligible, overpaid	5.8	4.4	3.7	4.5	5.6	3.3	3.3
Underpaid	0.6	4.6	0.5	0.7	0.8	0.4	0.9

	July/Dec 1977*	Jan/June 1978**	April/Sept 1978	Oct/March 78-79	April/Sept 1979	Oct/March 79-80
Ineligible	4.8	6.5	4.3	6.5	6.3	9.8
Underpaid	0.6	0.8	0.6	0.6	0.7	0.1

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* "Ineligible" and "eligible, overpaid" collapsed into "ineligible" figure July 1977 through March 1980.

** Includes errors for state failure to properly apply child support requirement and failure to obtain Social Security Numbers.

Source: Social Security Administration; Division of Quality Control; Office of Assessment; Office of Payment, Eligibility, and Quality.

clear that the Legislature must await a call to action from program officials, who currently are not overly concerned about the fraud problem.

With the AFDC rolls shrinking and no clamor for fraud control, little attention is likely to be paid to the problem. Because the program is state supervised, "fraud is," as one DSS official stated, "a County problem." As one county attorney stated, "It is an overwhelming problem but we have no incentives; why should we do more than our current resources allow us to do?" Simply put, as in Illinois, no anti-fraud lobby exists in Colorado.

NOTES

1. Colorado has always operated AFDC as a state-supervised program. However, in the mid-1970s an organized move to change to a state-administered program was proposed but quickly dropped by the legislature. Opposition came from county officials in the form of debate over which county commissioners would serve as Regional AFDC Commissioners. In the end, local political pressure succeeded in defeating the move.

2. Over the past 10-15 years, fiscal constraints have resulted in a significant change in AFDC staffing. Less-trained Eligibility Technicans have replaced social workers with MSW degrees in nearly all but supervisory positions. It is reported that conflict between the groups holding these titles is not uncommon. Technicians are often drawn from the WIN program for which all AFDC applicants must register; thus, they are probably more "like" AFDC recipients than are social workers, who are trained to provide services to people usually very different from themselves.

3. If the amount is in excess of $200, the charge is usually based on the state's felony theft statute. An alternative filing charge is a welfare statute (for $500 plus), but it is felt to be a more difficult charge to prove or on which to secure a plea.

4. Unlike Illinois or Washington, Colorado has no well-established welfare abuse hotline on which to base estimates of recipient fraud. Also, Colorado does not yet systematically employ computer crossmatches with Department of Employment wage records.

5. Corrective action plans, prepared by each county in the state, are an attempt to change systems and/or procedures after an analysis is made of local quality control findings. These plans are reviewed by DSS staff; changes are negotiated if suggested by the state, and a composite state corrective action plan is filed with federal Region VII officials.

6. Although the state has been threatened with fiscal sanctions from time to time, and is currently facing sanctions, the federal government has never invoked the law. However, the state has invoked fiscal sanctions on Denver County, where funds have been withheld from the program as the county's error rate has continued to increase.

CHAPTER FIVE

CONTROLLING RECIPIENT FRAUD IN WASHINGTON

"In the last seven years, fraud and abuse has not been a big issue in Washington."

Washington Legislator

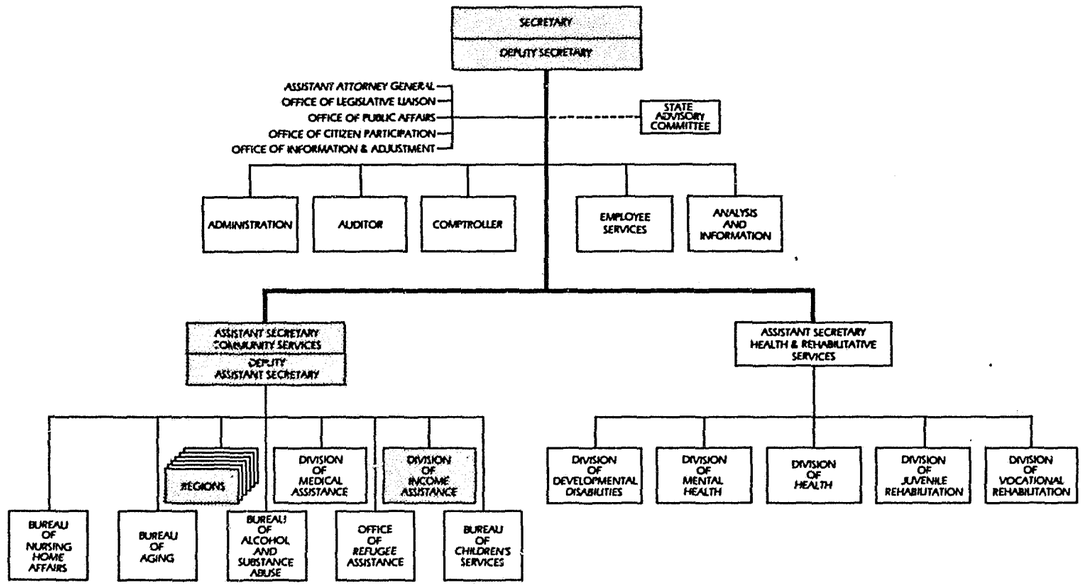
"The way to control fraud is to prevent it from happening in the first place. This means that the skills of frontline workers need to be upgraded...Would it matter to me that if this strategy worked, I might lose my job? Absolutely not."

Welfare Fraud Investigator,
Department of Social and Health Services

"Federal regulations regarding quality control and error rates have probably weakened fraud prevention efforts by shifting resources from frontline workers to overhead."

Division of Income Assistance
Official, Department of Social
and Health Services

The Department of Social and Health Services (DSHS) is Washington's "single state" agency responsible for administering the AFDC program. DSHS was created in 1970 as an umbrella agency to coordinate the delivery of social services in the state. Five agencies--the Departments of Institutions, Public Assistance, Health and Vocational Rehabilitation, and the Veteran's Council--became divisions in the new department. The development of the department into its present organization of five administrative areas (administration, auditor, comptroller, employee services, and analysis and information), two broad program areas (community services and health and rehabilitative services), and six regional offices "has been marked by internal 'turf fighting' and external political criticism." (Bateman, 1980: II-7) (See Figure 6 for an organization chart of DSHS.) Because the AFDC program accounts for roughly 19.4% of the



HA-2312-4

FIGURE 6 WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES ORGANIZATION, Effective May 18, 1981.

DSHS budget, and because AFDC provides benefits to approximately 45,000 families each year, the character of program administration is constantly scrutinized by many individuals, each having different interests (e.g., state and federal executive and legislative bodies, welfare rights organizations, the welfare fraud association, and the Legal Aid Society).

Administration of the AFDC Program. Like Illinois, Washington's AFDC program is state-administered rather than state-supervised. In the central offices of DSHS, the Division of Income Assistance

> develops and monitors all of the financial assistance policies and procedures. The division has responsibility for translating federal laws and regulations and state laws into the policies and procedures used daily by the local offices. Policy statements are contained in the Washington Administrative Code, while forms and procedures are laid out in Manual F. The division has three other important responsibilities: the division works with the financial trainers in the regional offices to train local office workers; it interprets all policy questions and manuals in an effort to reduce error; and it monitors federal Quality Control and program audit findings to improve CSO [Community Service Office] procedures. Division staff also analyze proposed and recently enacted federal and state legislation to evaluate the effect on agency programs and to recommend appropriate actions to management. (Bateman, 1980: II-11)

For individual applicants and recipients, the most important parts of DSHS are the six regional offices and the 54 CSOs. The regional offices interpret and implement central office policy and monitor local CSO performance. There is a degree of autonomy for the regional offices, however, and each develops, implements, and monitors its own regionwide policies on various issues. At the CSO level, where clients apply and go through redetermination for benefits, there is also a range of discretion as to how the office operates.

In the community service offices, AFDC cases are handled by three types of Financial Service Technicians. Reception and Financial Intake System (RFIS) workers process AFDC and other applications. Financial Maintenance Services (FMS) workers handle cases while benefits are being received. The central local office role relating to fraud and nonfraudulent error is

played by Verification, Overpayments, and Control System (VOCS) workers. VOCS workers receive case referrals from a variety of sources. The first is the RFIS worker who notices an inconsistency in an application and decides that further verification of the data is required. The second source of referrals is a FMS worker "whose suspicion is aroused by an inadvertent client comment, an anonymous phone call from an irate relative or neighbor, or by inconsistencies in the information reported by the client during the eligibility review process." (Bateman, 1980: VII-44) A third source of referrals comes from the comparison of the quarterly Employment Security wage lists with client-reported income. This comparison is performed initially in the DSHS central office in Olympia. Matches or "hits" that appear suspicious are sent to the appropriate CSO for further verification.[1] A fourth source of referrals is the toll-free fraud hotline number; again, all calls go to Olympia and are forwarded from there to the appropriate CSO.

When a referral has been received, a VOCS worker tentatively calculates the amount of overpayment and then attempts to disprove the statutory[2] presumption of fraud. This may involve visiting the home of the client, calling collateral sources to verify income, checking with neighbors or similar tactics. On the basis of the VOCS investigation, the CSO can decide to drop the matter, ask the recipient to sign a voluntary repayment agreement, recoup the overpayment through a mandatory 10% deduction from future AFDC checks, or ask the Office of Special Investigations in the regional DHHS office to consider criminal fraud prosecutions.

According to some sources, the 10% deduction is only applied after the existence of fraud has been determined by an OSI investigator. Other sources, however, reported that the 10% deduction can be applied in cases that are not reviewed by the regional OSI. If the 10% mandatory deduction is applied, the client has a right to contest the decision in a fair hearing.

The DSHS Office of Financial Recovery establishes and monitors all repayment activity. If a client stops receiving a grant (for whatever reasons) before the amount of the overpayment has been fully recovered, the

DSHS can file a civil suit against the client and/or attempt to garnishee a percentage of the client's wages--assuming that the client has a "traceable" job.

Following a referral to OSI (close to 95% of all of the AFDC referrals received by the regional offices of the OSI come from a VOCS unit), preliminary or initial review of each case is performed, facts are collected, and the amount of the overpayment is documented. If this review leads to a conclusion that the case does not warrant a full investigation, it is sent back to the referring CSO for disposition. If the initial review shows that the case is fairly solid, a full investigation ensues; when completed, the case is either returned to the referring CSO for administrative disposition or passed on to the appropriate prosecuting attorney's office.

A 1980 study of Washington's AFDC program provided the following description of the handling of recipient fraud cases by the criminal justice system:

> There are 39 county prosecutors in Washington, and each has his/her own guidelines both as to what type of case will or will not be prosecuted, as well as what procedures the special investigator is to employ. In many counties, for example, there exists an unwritten dollar limit of overpayment below which the county prosecutor will not pursue the case in the courts. (For example, the Pierce County prosecutor will not prosecute a case involving less than $1,000 in overpayment.) Also, some county prosecutors will only pursue income-related fraud, while others will pursue "living with" and relationship fraud as well. On the procedural side, some county prosecutors do not object to the special investigator requesting a repayment agreement from the client, while others require that such procedures be postponed until after the prosecutor has disposed of the case.
>
> This lack of consistency in the application of fraud prosecution procedures requires that the special investigator be aware of these variations and plan his referrals to the county prosecutor to accommodate them. This in turn leads to a certain nonstandardization of state-wide procedures which affects not only the Office of Special Investigations, but also the client. It should be noted that a number of counties have alternatives to court prosecution for clients whose case represents a first offense and who agree to cooperate and participate. Thurston County, for example, has what is called the "Friendship Project," which counsels clients weekly and monitors their

repayments. However, if the client fails to follow through with his/her commitment to the Friendship Project, the case reverts back to the county prosecutor.

In prosecuted cases, the client has a choice of either a jury or nonjury trial. If the court finds against the client, it issues a court order requiring repayment. The court order goes back to the VOCS unit which then sends an overpayment letter to the client and to the Reimbursements Section in Olympia, which has the responsibility for taking collection action. OSI then receives a monthly printout from Reimbursement which indicates the name of client, amount to be repaid and the amount repaid to date. In court-order cases, OSI refers any client who has become delinquent in repayment to the county prosecutor who then contacts the client. In repayments which are not court-ordered, the Reimbursements Section has the responsibility of monitoring cases involving delinquent repayments. (Bateman, 1980: VII-47-8)

Fraud Problems in the Washington AFDC Program. As was discussed in Chapter Two, estimates of the extent of recipient fraud are unreliable. Estimates of the incidence of errors in the AFDC program are, however, calculated twice a year in the quality control (QC) program. In general, program personnel speculate that 50% of the state error rate is due to agency error and 50% is due to errors committed by clients. Of the client errors, roughly one-half or 25% of the total error rate is believed to be the result of "willful client misrepresentation."

While most individuals interviewed believe that fraud is not a serious problem in the Washington AFDC program,[3] administrative attention is focused intently on efforts to reduce the error rate in order to avoid the potential imposition of federal sanctions.[4] Tables 8 and 9 provide a detailed picture of the types of errors uncovered in the QC reviews for the periods 10/79-3/80 and 4/80-9/80. (These tables show state QC data, and should not be confused with the final federal error "profile" for Washington for these two periods. The final error rate and profile is negotiated between the federal QC staff and DSHS.) The figures show that the agency is just as responsible for producing errors as are the clients.[5] To a large degree, the corrective action plans--which are intended to address the state's error profile--are designed to reduce the incidence of agency error

Table 8

AGENCY ERRORS IN WASHINGTON AFDC QUALITY CONTROL SAMPLES

Program Area	Number of Errors in Reporting Period 10/79 - 3/80	4/80 - 9/80
Basic Requirements		
School attendance	1	
Living with specified relative	3	1
Deprivation of parental support		
Continued absence	3	
Unemployed father		1
WIN Program-Talmadge Amendment	13	14
Residence	1	
Child support program:		
Social security number	2	5
Assignment of support	6	1
Cooperation in support act		1
Resources available to AFDC family		
Life insurance	1	
Liquid assets and personal property:		
Bank deposits or cash on hand	1	1
Motor vehicle		1
Income available to AFDC family		
Earned income	14	13
Earned income disregards:		
Work incentive exemptions	1	
Work related expenses	1	
Child care expenses	3	1
RSDI benefits	2	
Other pensions or benefits:		
Veterans' benefits	2	
Unemployment compensation		1
Other cash income:		
Contributions		1
Other	1	2

Table 8 (concluded)

	Number of Errors in Reporting Period	
	10/79 - 3/80	4/80 - 9/80
Requirements for AFDC family		
Basic budgetary allowance:		
Shelter only	2	1
Other than shelter, fuel and utilities	1	
Shelter combined with fuel and/or utilities	1	
All basic budgetary allowance	5	3
Special Circumstance Allowance		
Child care	1	2
Other		
Arithmetic computation error	1	
Proper persons in budget	—	3
TOTAL	66	52

Source: DSHS reports to DHHS, Form SSA-4341-BK

Table 9

CLIENT ERRORS IN WASHINGTON AFDC QUALITY CONTROL SAMPLES

Program Area	Number of Errors in Reporting Period	
	10/79 - 3/80	4/80 - 9/80
Basic Requirements		
Living with specified relative	10	9
Deprivation:		
Incapacity		1
Continued absence	10	7
Unemployed father		3
WIN Program-Talmadge Amendment	2	
Child support program:		
Social security number		4
Resources		
Real property--home and other	3	
Bank deposits or cash on hand		6
Need Income		
Earned income	21	15
Earned income disregards:		
Work-related expenses	1	
Child care expenses	1	
RSDI benefits	1	1
Other pensions or benefits:		
Veterans' benefits		2
Unemployment compensation	1	2
Workmens' compensation		1
Other		2
Other cash income:		
Contributions	1	1
Other	3	2
Need-Requirements		
Basic budgetary allowance:		
All basic budgetary allowance	2	1

Table 9 (concluded)

	Number of Errors in Reporting Period	
	10/79 - 3/80	4/80 - 9/80
Special Circumstance Allowance		
Child care	1	
Other		
Proper persons in budget	1	4
TOTAL	58	61

Source: DSHS reports to DHHS, Form 55A-4341-BK.

with the hope that by so doing, client-created error--whether fraudulent or not--will be reduced as a by-product of the process.

Problems Associated with Reducing the Error Rate.[6] Reducing agency-generated errors is complicated by many factors, many of which relate to the context within which all Financial Service Technicians (FSTs) operate. It is difficult to overstate the pressures on the FSTs. To start with, Washington has utilized a Workload Planning and Control Program (WLPC) designed to monitor the efficiency and productivity of FSTs.[7] The program includes specific time allotments for completing specified tasks and, as a result, tends to put a premium on speed rather than on accuracy. On the other hand, FSTs also have standards (which vary in their application from CSO to CSO) regarding how many errors they can commit. Combined with these pressures are the difficulties associated with administering a variety of programs, each with different, sometimes conflicting, and constantly changing requirements.[8] In addition, the clientele has changed in recent years. More applicants than before have income or other resources that require extensive documentation; and with the increasing number of unmarried adults living together, there are more situations where there are no rules for dealing with an applicant's particular situation. And finally, many FSTs have felt some fear and uncertainty when dealing with the clients who may direct their bitterness and anger at them.

Given the nature of this working environment, combined with a low salary, it is no surprise that in many CSOs there is a high rate of turnover among FSTs. In one CSO in Seattle, there was 105% turnover in a recent year; for Region 4 (the Seattle area) as a whole, there was a 74% turnover rate. In addition, there are many unfilled FST jobs. (The reasons for this are not clear, though the long time it takes to process a job applicant was a refrain mentioned by a few individuals.) In summary, then, the lack of a skilled and experienced staff to administer a battery of complex programs means that reducing the error rate will continue to be a vexing and perhaps intractable problem.

Administrative Responses to Fraud and Abuse Problems. Most individuals interviewed in Washington felt that the state is more strict regarding how cases involving alleged overpayments are handled than is required by federal law. For example, Washington has been deducting 10% of the monthly grant in overpayment cases; this was not federally required until October 1981. Even more illustrative is the 25% penalty that Washington has used since 1969. This law--which was contested from its inception by the federal representatives in Region X as well as by the local legal aid society--allows the state to add 25% of the amount of the overpayment to the total amount which would eventually be deducted from the grant.[9]

In general, as is the case in Illinois, the basic philosophy of DSHS is that a soundly managed system has the greatest potential for reducing fraud and abuse. Within DSHS, the Division of Audit has the primary responsibility for ensuring the integrity of all of the programs administered by DSHS. The overall mission of the Audit Division is:

> To conduct both internal and external examinations of financial and other kinds of data, management systems and programs for purposes of making verifications and assessments and suggesting improvements in procedures; to conduct investigations for the prevention, detection and prosecution of welfare and Medicaid fraud; and to administer the state quality control system as mandated by federal regulations.

The most striking change in terms of strategies designed to improve AFDC program management relates to the utilization of QC information. DSHS decided that QC data has the potential to help target corrective action in the administration of the AFDC program.[10] As a result, the QC program was organizationally shifted into the Audit Division where it is hoped that QC data will be utilized as part of a planned comprehensive audit of the DSHS and its component organizations, including the Division of Income Assistance, the Regional Offices, and the local Community Service Offices. Specifically, the Division of Audit hopes to:

- Develop a comprehensive audit program that will provide management with information necessary to improve department operations, assist in controlling costs and fixing accountability.

- Integrate information gained from quality control reviews with the audit and investigation functions to assist management in improving management systems.
- Investigate ways to improve the productivity of auditors, investigators and quality control reviewers and implement improvements as appropriate.
- Revise and update the corrective action policy.
- Develop a comprehensive audit schedule.

The acting director of the Division of Audit is aware that the thrust of these initiatives will demand that auditors behave more like management consultants than like detectives. Accordingly, there is a six-part form for corrective action that begins with a recommendation for correction rather than adopting an accusatory tone. The six parts of the form include the:

- Recommendation as stated in a final audit report.
- Steps to be taken to implement the recommendation.
- Person(s) responsible for each step.
- Time planned to accomplish each step.
- Progress to date.
- Plans for monitoring each step as well as the implementation of the overall recommendation.

As is often the case in Washington, many state-level activities are adaptations of regional-level activities. For example, a corrective action plan for Region 4--which includes Seattle and roughly 25% of the AFDC clients--for April to September, 1980, included the following objectives:

- Discussions of error rates at individual CSOs.
- Corrective action plans tailored by and to specific CSOs.
- A request for all CSOs to develop an auditing plan.

- A brief discussion concerning the use of "screens." (Screens are essentially filters that are used by FSTs to focus their attention on error-prone elements in the application and redetermination process. Screens can be prescribed by the Central Office, Regional Office, or CSO administrator.)

- A list and discussion of three eligibility elements requiring specific corrective action (WIN, unemployment compensation, Absent Parent in the Home).

In addition to these recent general management improvement initiatives, an older inititative targeted specifically at preventing and detecting fraud and abuse was the decision to create the VOCS position in the early 1970s. During the mid-1970s, VOCS personnel were downgraded and, at times, used for jobs other than verification of eligibility. Recently, an effort has begun to upgrade the VOCS function and to ensure that CSO administrators use VOCS personnel "appropriately."

Specific efforts to detect potential fraud cases involve the use of crossmatches of Employment Security tapes with the amount of income reported by a client to an FST, and error-prone profiles.[11] A study conducted in 1981 by the Federal Region X Quality Control Supervisor identified elements of the AFDC application that were particularly error prone. For each element, there is a discussion of the best, secondary, and other sources of evidence for verifying the information given by applicants during initial intake and case redetermination. If these sources of evidence (which include birth certificates for children and applicant; school certification for school age children or applicant; statement of absent parent when whereabouts are known; and statement of landlord or neighbor) were acceptable to DSHS, then clients could, before applying at the CSO, be notified of a few items that are necessary in order to receive assistance. What animated the study was federal concern that the state's Manual F did not do a good job of guiding FSTs in their eligibility determination work.

Other DSHS initiatives designed to prevent fraud and abuse include efforts to clarify the procedures in Manual F as well as to subject new procedures to a fraud impact assessment. This approach, which takes place in the Division of Income Assistance, examines new policies and procedures

for their potential to create incentives and opportunities for defrauding the program.

The agency also conducts its own analyses concerning fraud and abuse issues. In a 1981 study by the Everett CSO, for example, an attempt was made to determine if there was any agency-generated corrective action that could be taken to reduce the incidence of QC client errors. The study found that an FST's communicative ability may have more to do with client error than many of the factors noted earlier regarding the pressures on FSTs. The study found that "simple fraud prevention techniques such as explaining the responsibility to report changes made a difference" in reducing client error. (Of course, the pressures on the FSTs may make it more difficult for them to explain the responsibility to report changes.) The DSHS concluded, interestingly, that ..."The idea that client error is unavoidable given present resources should be rejected. The agency can reduce the incidence of client error within the present framework." In another study (still ongoing at the time of our research), home visits to clients' residences are being made at the time of application and redetermination to see if this practice is a cost-effective way of gathering data from clients as well as verifying data supplied by clients.

Finally, applicants and recipients are encouraged to provide accurate information. A brochure describing the AFDC program states, "You have the responsibility for providing information and verification about any new situation immediately. The best way to do this is to send in the change of circumstances form included with your check each month." The brochure then states:

> The Law
>
> If you make a false statement or hide information you are breaking the law. According to the Washington State law RCW 74.08.055, it is a crime to get any kind of assistance under false pretenses. The penalty can be a fine or imprisonment or both upon conviction. Anyone receiving assistance by making false statements will be reported to the appropriate law enforcement agencies for prosecution.

(The last statement may serve deterrence purposes; it does not, as will be shown below, reflect DSHS enforcement practices.)

Enforcement Responses to Fraud and Abuse Problems. The factors that shape the enforcement process include resource allocation issues as well as political, budgetary, historical, and institutional issues. The resource allocation question permeates the entire process. For example, CSO administrators are budgeted for a specific number of FTEs; however, they have discretion as to how many individuals they want to have performing the various FST jobs. If they decide, most likely due to agency pressure, to allocate more positions to VOCS-type personnel who focus mainly on questions of verification and investigation, this decision will certainly influence the quantity and quality of referrals from the CSO to the local OSI.

Unlike Colorado, Washington's Office of Special Investigations does not suffer from lack of work. There is a tremendous backlog of cases, and in a state with a caseload one-fifth to one-sixth the size of Illinois's, there are almost twice as many cases referred to the OSI as to the Illinois Bureau of Collections and Bureau of Special Investigation. From the period of January to June 1981, the OSI received 5,377 referrals and closed 4,923 cases. Of the cases closed, 818 were sent back to the CSO immediately, 2,045 were given desk reviews, 1,826 were fully investigated, and 234 were referred to the appropriate county prosecutor.

The decision to prosecute a case involves many factors. The most common explanation for why AFDC fraud cases are not prosecuted is that they are simply not important enough to take the time of a county prosecutor who is also dealing with homicide, armed robbery, and rape. On the other hand, a fraud case may be accepted because a fair amount of money is involved[12] or, and more infrequently, because handling a particular case appears to a prosecutor to be a good way to gain some electoral support[13]

In addition to these standard explanations, there are other factors that influence the decision to prosecute. The quality of evidence can be an

important factor influencing the decision to prosecute. There have been efforts to familiarize the OSI investigators as well as the VOCS personnel with the methods prosecutors endorse for gathering and presenting evidence. On the other hand, because of rapid turnover in trial deputies, as well as rapid changes in welfare eligibility rules and regulations, the DSHS investigators often find it necessary to take time to familiarize the members of the criminal justice community with what evidence is pertinent and available for a welfare fraud prosecution.

Another issue that can influence a county prosecutor's decision to go forward with a welfare fraud case relates to the history of program operations and to the dollar costs of prosecuting AFDC cases. Before the Washington legislature initiated a state administered AFDC program, the counties handled the administration of the program. The cost of prosecuting welfare fraud was borne by the counties and any money recouped from a prosecution was divided among the counties, the state, and federal authorities. Currently, with a state-administered program, the prosecution of welfare fraud is still 100% funded by the counties. All recovered funds are divided between the State's General Fund and the federal government; none is returned directly to the counties. This is another disincentive to prosecute welfare fraud, which, as the county prosecutors might see it, ought to be prosecuted by the State Attorney General, since the state both runs the AFDC program and may, in part, be responsible for creating some of the programmatic opportunities for defrauding the program.

Assessment of Washington's Responses to AFDC Fraud and Abuse Problems. Whether or not fraud and abuse is considered a problem depends on one's perspective. In general, there is agreement that the incidence and magnitude of fraud in the Washington AFDC program are significant. However, despite this perception, an equally common perspective is that welfare fraud is not a serious problem, nor is it a high priority on anyone's agenda (with the obvious exceptions of the OSI and VOCS personnel). The reasons for this include: (1) the belief that if one is concerned with controlling frauds against the U.S. government, one ought to consider areas where the dollar

volume is much greater (e.g., Medicaid and Medicare, or income tax fraud) than in AFDC; (2) the belief that benefit levels are inadequate and that it's okay to wink at a mother of four who defrauds the program for $100 a month; and (3) the belief that there are more important issues to worry about, including administering the program for those who truly need the benefits, handling violent crimes, trying to avoid fiscal sanctions by keeping the error rate down, and so on.

In terms of the activities described in this chapter, there are a few indicators that show continuing support for the detection and investigation of cases of alleged fraud if not for active prosecution. As stated earlier, the OSI investigates a large number of cases. In addition, in a legislative year (1981) when the DSHS was staggered by a huge budget cut, organizations within the OSHS such as the OSI--whose basic mission is to ensure that public money is used appropriately--received budgets comparable to those in previous years.[14]

Ironically, it is the opinion of most officials that controlling fraud is best done, not by the OSI or enforcement personnel, but rather by the FSTs at case intake and redetermination--to prevent it from happening in the first place. Unfortunately, the only indicator of overall program performance in regards to controlling fraud and abuse is the QC error rate--unfortunate because, as discussed earlier in this chapter and in Chapter Two, the QC error rate may indicate very little about the causes and magnitude of welfare fraud problems. Nonetheless, as is shown in Table 10 , the trend in Washington is for the payment error rate to fluctuate. Administrative efforts to reduce the error rate, however, may have little success. As a 1980 study conducted by the National Academy of Public Administration concluded:

> The Washington Department of Social and Health Services has given priority to quality control and error reduction during the past decade, and has succeeded in reducing errors to a commendably low level. However, because of past and present efforts, cost-effective options for reducing error rates further have been exhausted. While some major procedural changes, such as the resumption of home visits to applicants, might conceivably reduce error slightly, the costs would be

Table 10

STATE OF WASHINGTON
AFDC PAYMENT ERROR RATES (Adjusted Federal Figures)

	Jan/June 1974	July/Dec 1974	Jan/June 1975	July/Dec 1975	Jan/June 1976	July/Dec 1976	Jan/July 1977
Ineligible	3.6	3.9	3.7	3.1	3.4	2.6	5.6
Eligible, overpaid	2.7	2.5	1.8	1.8	1.5	2.8	1.5
Underpaid	0.6	0.6	0.5	0.6	0.2	0.5	0.4

	July/Dec 1977*	Jan/June 1978**	April/Sept 1978	Oct/March 78-79	April/Sept 1979	Oct/March 79-80
Ineligible	4.9	6.6	6.7	9.6	6.5	8.8
Underpaid	0.4	0.1	0.4	0.6	0.7	0.4

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* "Ineligible" and "eligible, overpaid" collapsed into "ineligible" figure for July 1977 through March 1980.

** Includes errors for state failure to properly apply child support requirement and failure to obtain Social Security Numbers.

Source: Social Security Administration; Division of Quality Control; Office of Assessment; Office of Payment, Eligibility, and Quality.

prohibitive and would exacerbate already severe staffing problems. The practice would also raise concerns about client privacy.

The combined impact of an increasing caseload plus agency benefit and staff reductions necessitated by a projected shortfall...in the agency budget is likely to push the error rate upward despite anything the agency administration might attempt. The persistence of error is rooted in the complexity of the programs and the insufficiency of public support for the adequate staffing. The threat of federal sanctions under such circumstances only serves to impel the agency toward more desperate measures having limited or no utility and negative consequences for clients and staff. (Weatherly, 1980)

NOTES

1. In the Seattle area (i. e., Region 4 of DSHS), most referrals are from the wage matching operation. Close to 90% of all welfare fraud prosecutions in this area are income cases.

2. In Washington there is a presumption--held with varying degrees of intensity by many program personnel--that all client errors may indicate the existence of fraud. This presumption has a legal basis: Subsections 2 and 3 of Section 388-44-020 of the Washington Administrative Code (WAC) state:

   . The failure of any recipient of public assistance to notify the department within twenty days of any change in circumstances affecting eligibility or need, including receipt or possession of all income or resources not previously declared to the department, shall be prima facie evidence of fraud. When a local office finds that an applicant or recipient has misstated or failed to reveal any material fact affecting eligibility or need, it shall presume that such act was done intentionally.

   . It shall be the duty of the department, whenever it finds misstatement or failure to reveal pertinent facts or circumstances, to secure further evidence, whenever possible, which enables it to formulate a firm opinion as to whether or not the act was committed intentionally and fraudulently. In the absence of such further evidence the presumption is not overcome; however, such presumption is rebuttable.

3. Presumably, if it were shown that fraud was a serious problem, then administrative practices would change. For a study that suggests that the incidence and magnitude of AFDC fraud is substantially greater in the Seattle area than is commonly believed, see Chapter Two.

4. For an excellent discussion of Washington's efforts to reduce the error rate, see Weatherley (1980). Weatherley's account corroborates our finding that the concern with avoiding fiscal sanctions preoccupies the minds of many individuals responsible for program administration. Interestingly, the fear of being penalized is based on the fact that the Washington error rate for the base year was relatively low; trying to reduce it at the rate demanded by the Michel Amendment (the fiscal sanction provision) has been exceedingly difficult. Ironically, there is reason to believe that the base year error rate was inaccurately computed and should have been substantially higher; if this were the case, some of the intense pressure on state officials would have been relieved since it is generally agreed that reducing an error rate from, for example, 20% to 12% is easier than reducing it from, for example, 8% to 5%.

5. The fact that the agency is only responsible for one-half of the error rate but is held accountable for all of it by the threat of fiscal sanctions (which are based on the total error rate) provides a source of constant tension between state and federal officials.

6. See, in general, Weatherley (1980).

7. The Workload Planning and Control Program (WLPC), which is viewed as a nuisance by FSTs, may also be responsible, in part, for the existence of some of the FSTs' job positions; a part of the original rationale for instituting the WLPC was the perception in the DSHS that in order to stabilize the number of FTEs in the Community Service Offices, it would be useful to have a measure of the performance of FSTs to present to the state legislature during budget hearings. Since the application of the WLPC, the number of FST positions has increased. That this could have occurred without the WLPC is open to discussion, but it is a common defense given by administrators whenever pressured by disgruntled FSTs. For a description of staff trends, see Bateman (1980: II-41-2); for general discussions of the WLPC, see Bateman and Weatherley (1980).

8. As Weatherley reported, "The complexity of the programs and procedures administered by the Financial Service Technicians truly boggles the mind. The intake workers of the RFIS Unit (Reception and Financial Intake System) take applications for eight different programs.... The rules and procedures governing these programs are replete with inconsistencies and complicating detail.... If the task of the frontline Financial Service Technician were simply to master the intricacies of the programs they administer, this would be taxing enough. However, the programs are in a constant state of flux. There are about twelve to fifteen major policy changes coming down to the local office in a typical week." Weatherley (1980). This kind of environment, combined with the demands of the WLPC system, makes it no surprise that FSTs can literally forget to ask a question of a client that might prevent a fraud from occurring. In one CSO, it was pointed out that a standard question of applicants is, "Do you have a bank account?" If the applicant says "No," an obvious followup question that may not be asked- due to job pressure--which might prevent a fraud, directly or indirectly, would be, "How then do you pay your rent and/or utility bills?" Asking followup questions and in-depth probing, in general, are encouraged by program administrators, but the environment the administrators have shaped for the FSTs discourages them from pursuing such leads in the context of actually interviewing an applicant.

9. For recent cases dealing with the 25% penalty, see Burns v. Social and Health Services 20 Wash. App. 585 (1978) and Bazan v. Dept. of Social and Health Services 26 Wash. App. 16 (1980). For a study examining the deterrent value of Washington's 25% penalty, see Sosin (1981).

10. For a federal perspective on this issue, see General Accounting Office (1980).

11. Specific error-types as identified in the QC reports can provide information to be used in constructing a general profile. However, error-prone profiles are typically tailored specifically to the region or to a particular CSO.

12. The largest sum in a case of recipient fraud in Washington is reputed by some to have been $30,000; according to others, there are innumerable cases in excess of $30,000, the largest having involved $250,000.

13. In fact, many of the 39 county prosecutors do not seek reelection because the demands of the job are extreme and the rewards are relatively slim. From 1965 to 1977, there was a 20% turnover every year in the ranks of the county prosecutors. Of this percentage, two-thirds voluntarily quit the job. Over this period, twenty counties had three or four prosecutors and one county had nine prosecutors during these twelve years.

14. The legislature also voted to terminate the AFDC-E Program which provided assistance to a two-parent unit. A major reason for this decision was the perception that the AFDC-E Program provided a major opportunity for defrauding the entire AFDC Program. The logic was that by eliminating the program in total, a great deal of fraud would be eliminated as well. An unanticipated consequence of this legislation, however, was that 30% of the former AFDC-E clients continued to receive assisstance by enrolling in the AFDC-R Program, the standard single-parent household portion of the AFDC Program. Thus, by passing this legislation, the legislature created an incentive for individuals to either stop living together (whether they remained married or not) or to begin to do so covertly so as to become eligible for AFDC-R benefits. In addition, the average time spent by AFDC-E clients in that program was five months; for AFDC-R clients, the average time is fourteen months. Even if only 30% of the former AFDC-E clients enroll in the AFDC-R Program, it is conceivable that virtually no money will be saved and the incidence of fraud will increase.

REFERENCES

BATEMAN, P. (1980) Administration of AFDC in Washington: A Description of Three Local Offices (Cambridge: Abt Associates).

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

SOSIN, M. (1981) "Washington State's 125% Recoupment Program," unpublished memorandum, Office of Research and Statistics, Division of Family Assistance Studies, Social Security Administration.

WEATHERLY, R. (1980) "The Pursuit of AFDC Error Reduction in Washington State," a report to the National Academy of Public Administration.

CHAPTER SIX

CONTROLLING MEDICAID PROVIDER FRAUD AND ABUSE IN ILLINOIS

It appeared in 1977 that the Medicaid Program might have actually turned around and started on improving itself. However, a review of 1978 indicates that there was no significant change in the Program--only a slight "retrenching" caused by the "Medicaid Exposes" of 1975 and 1976. The same problems exist today that existed in 1974--a relatively few unscrupulous providers managing to acquire vast amounts of Medicaid dollars by actually defrauding the Program or by practicing substandard medicine; while the majority of the providers who are attempting to provide quality medical care have a difficult time receiving adequate payments on a timely basis. (Stein, 1979)

The Illinois Medicaid Program is one of the largest in the United States, offering eight mandatory and twenty-nine optional services[1] to over 1,000,000 recipients in 1981; over $1.4 billion was paid to 25,000 providers of health care. It is also one of the most controversial; the program has been under attack almost since its inception in 1966. Providers have attacked the Illinois Department of Public Aid (IDPA) for low reimbursement levels and long delays in processing claims; recipient and provider fraud and abuse have been attacked by Congress, the General Accounting Office, the legislature, the state auditor, national and local mass media, and citizen groups. Whether or not the Illinois program is in fact less-well run than other Medicaid programs, many people feel that it has suffered from incompetent management and that it has deserved the bad publicity it has received.

Attacks on Fraud, Waste, and Abuse. From 1974 until 1979, a number of investigations documented both fraud and abuse and problems in claims processing in the Illinois Medicaid Program. A series of exposes in 1974 by Chicago Tribune investigative reporter George Bliss began the attack. Bliss

reported that physicians were treating Medicaid recipients in an "assembly-line" manner and focused attention on 1973 HEW audit findings criticizing IDPA handling of the pharmaceutical portion of the Medical Assistance Program. The audit found that pharmacy dispensing fees were excessive and that the state was not exerting controls to ensure that drugs did not exceed patient needs. (Bliss, 1974)

An investigation headed by the Chairman of the Medical Advisory Committee of IDPA then found evidence of assembly-line treatment of Medicaid recipients, sloppy diagnoses, bill padding and careless record-keeping. The report charged that the Illinois Medicaid program lacked adequate controls to insure that medical services billed are actually performed. The report recommended that physicians unable to substantiate their bills with medical records reimburse the state, that physicians engaging in these activities be prosecuted, and that doctors whose records are inadequate be put on six months probation and thoroughly investigated.

The Tribune disclosures prompted Governor Daniel Walker to order an investigation of the Medicaid program's quality of care and the large sums paid to some physicians and pharmacists. After eight months of investigation, a committee composed of members of the legislature and state department heads reported many of the same problems disclosed by the chairman of the Medical Advisory Committee. The report stated that IDPA was not capable of operating the Medical Assistance Program efficiently in the areas of applications, bill processing, or program surveillance. The committee found that the reimbursement system encouraged nursing homes to provide poor care to Medicaid recipients. After checking 19 highly paid welfare physicians, the committee found that at least half were engaging in unsatisfactory practices including "sick call medicine," listening to patients' complaints and prescribing drugs with little or no physical examination.

The Illinois General Assembly's Legislative Advisory Committee on Public Aid (LACPA) conducted an independent investigation and found evidence of needless or nonexistent prescriptions, concluding that much of the fraud

was the work of syndicates of drug store, medical clinic, and laboratory operators created to exploit the Medicaid Program. Coming on the heels of these investigations was a 45-page report to the U.S. Senate Health Subcommittee by the General Accounting Office. The report stated that Illinois was known to be violating fraud control guidelines in 1970 and was still violating many of the same guidelines. IDPA resources allocated to its fraud and abuse unit were characterized as "grossly inadequate" considering the size of the Illinois Medicaid program. The report accused IDPA of hunting fraud in a scattershot manner by investigating individual fraud cases instead of trying to find widespread patterns of fraud and abuse. The report found that since the Medicaid program began in 1966, IDPA had referred only 22 fraud cases to the Illinois Attorney General for prosecution. Not until January, 1975, were the first three fraud cases referred to the U.S. Attorney for prosecution. The report also criticized the way HEW supervised Medicaid programs in various states including Illinois; while HEW could penalize states for violations, it never had.

The LACPA, with a $188,000 investigative budget, then hired 27 police officers to work as part-time investigators to step up investigations of doctors, pharmacies, medical laboratories, and other providers suspected of defrauding the Medicaid program. (Bliss, 1975) The investigators found examples of lax supervision by IDPA of Medicaid providers. One physician barred from the program continued to write prescriptions which were filled and paid for by the Department. LACPA investigators also found that pharmacies suspended from participation in the program merely changed their names and continued to collect Medicaid payments. Before the year had ended, the LACPA agreed to a request by Senator Frank Moss, Chairman of the U.S. Senate Subcommittee on Long Term Care, to conduct a joint investigation into the Illinois Medicaid scandal.

Not to be outdone, Illinois Attorney General William J. Scott established a task force to investigate IDPA, to seek evidence of fraud in social programs, and to recover money collected illegally from the Medicaid program.

permanent review of public aid health care. (Bliss, 1976b) The Department even came under attack by its own medical advisory committee because of initial Department reluctance to take action against doctors whose suspensions were recommended by the committee.

The Internal Revenue Service opened an investigation into Illinois nursing homes that were said to be overcharging IDPA for public aid recipients. In a related investigation, LACPA also assigned committee investigators to concentrate on nursing homes. HEW then formed a special team of 106 investigators, attorneys, auditors, and computer specialists, to begin a massive investigation into Medicaid fraud in several major cities, including Chicago. The team had two objectives: identification of the types of fraud and abuse being perpetrated, and assistance to the State in the development of management systems designed for early detection of illegal operations.

By the summer of 1976, the U.S. Attorney had doubled the number of attorneys assigned to his governmental fraud unit and was coordinating a grand jury investigation, with investigations being conducted by the FBI, the IRS, and the Postal Service. (Merridew, 1976)

The GAO investigation ordered by Senator Moss late in 1975 led to a report in August 1976. The report charged that HEW knew of but was not effective in eliminating medical laboratory overpayments. The GAO found that labs charged substantially more for tests for Medicaid recipients than for other patients, and recommended limiting lab charges to the lowest level in a locality and that Medicaid pay only for services provided by labs certified to do them. (Bliss, 1976c)

In November of 1976, U.S. Attorney Skinner successfully prosecuted the first federal kickback case against Chicago area nursing home owners. They were fined a total of $900,000, and four were given jail sentences of up to three months under a federal misdemeanor kickback statute. The five defendants were found to be connected directly or indirectly with one-third of the nursing homes in Illinois. A week after the trial, Skinner testified

before a subcommittee of the Senate Special Committee on Aging on the necessity to make it a felony to give or receive kickbacks and to impose mandatory jail sentences on those convicted. Congress enacted similar provisions in 1977.

Intensive investigations by federal and state agencies into the Illinois Medicaid program continued in 1977. A wave of federal indictments made headlines, fraud task forces and study groups were formed, and finally new federal and state anti-fraud legislation was passed.

The LACPA remained on the offensive, continuing to attack IDPA's administration of the program. Its chairman concluded that "Illinois is doing a wholly inadequate job of managing Medicaid" shortly after the committee returned from a trip to California to study its privately run Medicaid program, and recommended that Illinois farm out Medicaid to a private firm (Locin, 1977) and that IDPA be stripped of its authority to manage the Medicaid program and its investigative functions.

The LACPA report stated that IDPA "has not been able to operate the business aspects of Medicaid efficiently and in a manner which permits necessary accountability." Among the report's recommendations were a program to certify clinics prior to participation in the Medicaid program and to consider charging recipients a fee for medical services to discourage unnecessary demands for treatment. The report also estimated that fraud and abuse in the Illinois Medicaid program amounted to $200 million annually, or 20% of the $1 billion program. (Elmer, 1977)

The Illinois Fraud Prevention Commission, a 12-member task force formed by Governor Thompson in 1977 and headed by former U.S. Attorney Skinner, released a report early in 1978. Among the commission's findings were that Medicaid providers suspended or terminated from the Medicaid program were able to re-enter by operating under a new name or corporate shell, and that some providers found guilty of fraud had not had their licenses revoked or suspended. The Commission also concluded that the fraud investigations unit of IDPA had been ineffective in prosecuting welfare recipients and Medicaid

providers who defraud the state, and that IDPA's claims processing system emphasized timely payments to doctors and health agencies, relegating control of fraudulent activity to a secondary concern.

The commission recommended that responsibility for criminal investigations of physicians and health-delivery agencies receiving Medicaid payments be transferred from IDPA to a special unit within the Department of Law Enforcement, which would deal solely with criminal fraud cases. The Commission also recommended that IDPA improve computer systems to determine eligibility and to detect fraud, and tighten access to the computer systems by employees administering the programs. The commission conceded that the proposals would add to state costs but stated that they would pay for themselves through detection of fraud. (Petaque, 1978)

The nationwide federal crackdown on Medicaid providers initiated by HEW in 1977 continued into 1978. Project Integrity recovered over $300,000 in ten months from Illinois physicians and pharmacists who defrauded the state's Medicaid Program. (Kotulak, 1978) In April 1978, HEW released an audit report recommending disallowance of $327,380 of federal funds paid the IDPA, due to duplicate payments. HEW's audit agency estimated that during the two-year period ending June 30, 1976, nursing homes received about $1.2 million in duplicate payments. The duplicate payments were attributed to the fact that effective July 1, 1974, IDPA discontinued the use of computer edits to identify potential duplicate payments. At the time of the audit, about $517,000 of the $1.2 million had been identified and recovered. (Illinois Auditor-General, 1979)

Administration of the Illinois Medicaid Program. These attacks on the Illinois Medicaid program have led to a variety of administrative and enforcement responses by state and federal agencies. To understand these responses, we must first describe the structure of the program and the steps involved in admitting recipients to the program and processing claims for payment. The Medicaid program is administered, like the AFDC program, by the Illinois Department of Public Aid (IDPA). (See Figure 7) Half of the program's costs are paid by DHHS's Health Care Financing Administration; the

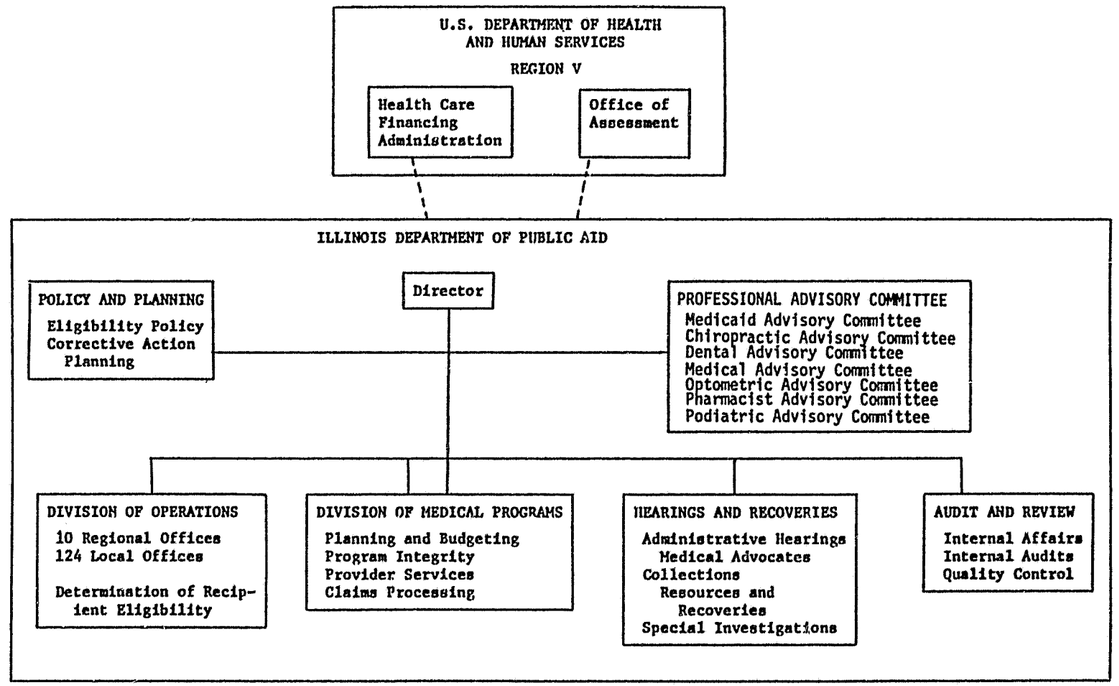

FIGURE 7 ADMINISTRATION OF THE ILLINOIS MEDICAID PROGRAM

remainder comes from state funds. As was indicated in Chapter Three, the county-level offices of IDPA's Division of Operations handle recipient intake and redetermination, assessing eligibility for the Medicaid program and authorizing issuance of the "green cards" which recipients use to secure services from providers. Medicaid recipients fall in four categories:[2]

- Medical Assistance-Grant (MAG), those who receive cash assistance from the state through the AFDC or the Aid to the Aged, Blind, or Disabled (or Supplemental Security Income) Programs.
- Medical Assistance-No Grant (MANG), those who meet all categorical requirements for AFDC or AABD, and whose income is sufficient to meet basic needs, but whose medical expenses exceed their ability to pay.
- General Assistance-Medical (GA-MED), those who receive assistance grants through the General Assistance Program.
- Aid to the Medically Indigent (AMI), those who incomes are not sufficient to meet medical expenses but who are ineligible for MAG, MANG, or GA-MED.

The Division of Medical Programs has major responsibility for central administration of the Medicaid Program. The major activities of this Division are provider enrollment, establishment of coverage and reimbursement policies, monitoring program integrity, and payment of provider claims. Its 661 personnel are organized in six units, four of which deal with issues affecting Medicaid fraud and abuse.

The Office of Planning and Budgeting conducts planning, budgeting, and management analysis activities for the program. The office identifies and evaluates policy alternatives and their potential fiscal impact, and analyzes proposed legislation. Other responsibilities include studying and recommending alternative provider reimbursement rate-setting methods, and monitoring program performance and expenditures.

The Bureau of Program Integrity conducts fiscal audits and investigations of providers who engage in fraudulent behavior or who abuse the Medicaid program. (These activities are described in greater detail later in this chapter.)

The Bureau of Provider Services is responsible for enrolling health care providers, maintaining updated vendor eligibility files, formulating medical policy, and providing medical consultation to other Bureaus as needed.

The Bureau of Claims Processing is responsible for the processing of all provider claims and the operation of the third party liability (TPL) program to identify other sources of health benefits and to recover medical claims already paid for which a third party is responsible.

In addition to these operating units, IDPA has six medical provider advisory committees: the Chiropractic Advisory Committee, the Dental Advisory Committee, the Medical Advisory Committee (physicians), the Optometric Advisory Committee, the Pharmacist Advisory Committee, and the Podiatric Advisory Committee. Each committee is composed of licensed professionals appointed by the Director of IDPA and meets from one to four times per year. In 1980, IDPA formed a twenty-five member Medicaid Advisory Committee composed of the chairpersons of the six medical provider advisory committees and community and recipient members. This committee provides general policy advice to the Department; the provider committees provide technical advice related to their specialties. Meetings are attended by IDPA staff and representatives from state medical professional associations.

While IDPA is responsible for enrolling providers in the Medicaid program, it plays no role in licensing them for delivery of health care services. The Department of Registration and Education licenses, and suspends or revokes the licenses of, medical practitioners (e.g., physicians and dentists), while the Department of Public Health licenses facilities such as nursing homes, hospitals, and clinical laboratories.

Administrative Procedures in the Medicaid Program. Once the local offices have determined that an applicant is eligible for one of the Medicaid programs, a medical eligibility card ("green card") is issued

monthly and mailed to the primary recipient (e.g., the head of the household). The period of eligibility and each covered recipient's name, date of birth, and individual recipient number are listed on the card. If Medicaid services are restricted, the services covered are also listed. Other encoded information includes known resources available for payment of medical expenses. If medical care is anticipated before receipt of the first regular monthly card, an emergency medical form providing a seven-day period of eligibility may be issued. No other personal identifiers such as sex, height, weight, or hair and eye color are listed on the card.

Prior to implementation of IDPA's Medicaid Management Information System (MMIS), provider claims were manually screened for completeness and accuracy by Bureau of Claims Processing (BCP) staff. As various provider groups were added to the MMIS system between 1977 and 1981, the claims processing system was modified. All provider claims now undergo a limited manual examination for errors, are given a unique document control number, microfilmed, batched, and logged by BCP personnel. Unusual or suspicious claims found through manual screening may be sent to the Bureau of Program Integrity for further examination prior to processing and payment. The MMIS subjects claim data to various computer edits including recipient and provider eligibility, pricing information, drug code number and duplicate charges. The computer also groups invoices from the same provider into vouchers, prints the vouchers, and generates the authorization for payment.

Administrative Responses to Attacks on the Medicaid Program. As has been indicated, many groups attacked the Illinois Department of Public Aid throughout the 1970s for failing to control fraud and abuse by recipients and providers, for low reimbursement rates, and for long delays in processing claims. As the nationwide recession hit Illinois particularly hard in 1980, these issues were exacerbated and often eclipsed by serious financial problems, federal cutbacks, and declining tax revenues forcing IDPA to cut its staff and reduce the coverage of the Medicaid program.[3]

For the leaders of IDPA and its Medicaid program, these problems posed a number of dilemmas. The entitlement logic of AFDC, SSI, Food Stamps, and Medicaid, fostered by pro-welfare legislators and welfare rights organizations in Illinois, encouraged efforts to expand eligibility, to reach out to potential recipients, to broaden Medicaid coverage, and to enhance the quality of patient care. But escalating program costs produced demands that the scale of the program be reduced. Making health care accessible to recipients necessitated continuous efforts to enroll providers, but cost factors kept reimbursement levels for noninstitutional providers below market rates, and inadequate administrative systems slowed the processing of claims. Anti-welfare groups in the legislature focused attention on recipient fraud at the same time that pro-welfare forces and the greater expenditures involved were demanding that provider abuses be controlled. Recognizing the validity of both provider complaints and the charges of extensive fraud and abuse, IDPA leaders were forced simultaneously to attack recipient fraud and overutilization, to identify overpayments to providers, to improve claims processing, and to cut costs, trying all the while simply to keep the program running.

Several approaches have been taken to control overutilization of Medicaid services, both to reduce costs and to prevent fraud and abuse. Chapter Three described the steps IDPA[4] has taken to control fraud by recipients, both as to eligibility and the level of AFDC payments; when recipients are declared ineligible for AFDC, they also lose their eligibility for Medicaid benefits unless they remain eligible via the MANG, AABD, GA-MED, or AMI programs.

Other IDPA utilization control programs have targeted specific services, specific recipients, and problem providers. Predelivery controls are used to prevent or minimize the misuse of medical services by requiring preadmittance screening and prior approval before some services are authorized for payment. Services requiring prior authorization generally involve questions of medical necessity, cost, and high potential for overuse. Examples include tinted or plastic lenses, transportation, equipment, and the purchase of private duty nursing services.

Local offices of IDPA approve requests for certain types of care, up to $100.00. Larger requests for prior approval are forwarded to the Bureau of Medical Services in Springfield, which uses medical professionals under contract to review proposed treatment plans submitted by various providers. In 1981, the predelivery control program was expanded to require second opinions when certain surgical procedures are recommended by physicians who have previously been detected abusing the Medicaid program.

Concurrent reviews are monitoring programs to determine if a continuation of long-term care is required. On-site visits are conducted for IDPA by the Illinois Department of Public Health (IDPH) on a contractual basis, although IPDA retains responsibility for monitoring IDPH's performance. Professional medical reviewers evaluate the need for care once every six months in Intermediate Care Facilities (ICFs) and annually in Skilled Nursing Facilities (SNFs). Approximately 46,500 reviews are conducted yearly.[5] One of the semiannual reviews in ICFs is a utilization review to establish each recipient's need for continued treatment in the facility. The other review in ICFs and the annual review in the SNFs include inspections of the quality of care provided by the facility. A point count assessment of each recipient's need for care is completed during the reviews, based on the amount and type of services required by and furnished to the recipient.

The final component of IDPA's attack on recipient overutilization of Medicaid benefits is the Recipient Utilization Review Program (RURP), which uses a computerized review of Medicaid payments to identify recipients who misuse medical services. After a pattern of abuse has been found, the recipient is counseled on the proper use of Medicaid services and then monitored for three months to determine if the pattern has been corrected. If the pattern of misuse is not rectified by the end of that period, the person is assigned to a primary care physician who must approve all nonemergency medical services. From the beginning of RURP in 1976 until 1980, approximately 13,200 recipients had been counseled, 2500 were in the initial monitoring period, 300 previously counseled recipients were being monitored again, 4500 had modified their behavior and were removed from

review, and 3,200 continued to misuse program benefits and were recommended for restriction. IDPA estimates that RURP was responsible for an estimated program savings of $21 million during FY 1980.

Controlling Overpayments to Providers. Identifying from among 26,000,000 claims submitted to IDPA each year those claims that may involve fraud or abuse is a complex process. In part, the complexity arises from the sheer scale of the Illinois Medicaid Program and the constant pressure from providers to process claims quickly. In part, the complexity arises from the dual process of trying to identify both individual claims that may be improper and providers whose patterns of claims suggest that they should be subjected to intensive review. Some claims are invalid on their face (the provider or the patient is not enrolled in the program, or the service provided is not covered by the program.) Some claims have surface validity but raise questions when compared with other claims submitted by the provider. A third set of claims, valid on their face, may conceal services that were never provided or services that are misclassified, e.g., as a $15 "extended examination" rather than as a $10 "limited examination."

The technically simpler process of weeding out claims that are invalid on their face occurs during claims processing, as each claim is checked to determine that both provider and recipient are enrolled in the Medicaid program, that the service is covered by the program, and that the service is related to the stated diagnosis (e.g., that a patient with chest pains is given an EKG rather than an appendectomy). As IDPA's MMIS system was phased into operation between 1974 and 1981,[6] manual screening was replaced by computer edits.

Deciding which of the claims that survive this screening process should be investigated further depends on several factors. In some cases, IDPA already has a basis for suspicion regarding a particular provider. Medicaid calls on the Fraud Hotline, for example, led to reductions or cancellations in 1,177 cases in FY 1979, for a total savings of more than $250,000. Tips come in to IDPA, HCFA, and prosecutors from patients, the media,

legislators, and other audits and investigations (e.g., a DHHS audit of a Medicare provider may trigger an IDPA audit of the provider's Medicaid billings). Peer reviews by Professional Standards Review Organizations (PSROs) can indicate overutilization or poor quality care, which may lead to further investigation to identify fraud or abuse. Past problems with a provider can lead to both prepayment utilization reviews, in which all claims from the provider are individually reviewed, and postpayment audits and investigations. In addition to these leads, providers are selected for analysis based upon statistical profiles that identify aberrant billing patterns, high levels of referrals to other providers, unusual drug prescriptions, and similar irregular behaviors.[7]

Decisions to check out a specific provider can lead to actions by many different agencies. As indicated in Table 11 , both federal and state groups participate in Medicaid provider fraud cases, although the state agencies handle many more cases than do the federal agencies. The two most important units are the Bureau of Program Integrity (BPI) in IDPA and the Medicaid Fraud Control Unit (MFCU) in the Department of Law Enforcement.

BPI is a descendant of Governor Walker's Medicaid Task Force created in 1974. Its primary functions include identification and evaluation of provider patterns of overutilization; determination of the consistency of quality and quantity of medical services; identification and recovery of Medicaid overpayments through field and desk audits, third-party recovery and interprogram crossmatches; identification of providers with a high statistical probability of involvement in fraud and abuse; identification and referral of potential fraud cases to the MFCU; identification of recipient abusers of the Medicaid program; verification of the accuracy of cost statements submitted by hospitals, nursing homes, and clinics; and monitoring of the PSROs.

BPI's control activities include both prepayment and postpayment analyses of claims. Prepayment utilization reviews determine, before payment is authorized, if the medical services rendered were appropriate for Medicaid recipients. The appropriateness of services and payments are

Table 11

PROCESSING OF ILLINOIS MEDICAID PROVIDER FRAUD AND ABUSE CASES

Function	State and County Agencies	Federal Agencies
Audit	IDPA Bureau of Program Integrity (BPI) Auditor-General	DHHS Office of Inspector General Audit Agency
Investigation	IDPA/BPI (non criminal) IDLE Medicaid Fraud Control Unit (MFCU) State's Attorneys	DHHS Office of Inspector General Office of Investigations DHHS/HCFA Regional Office of Program Integrity (noncriminal) FBI Postal Inspectors
Prosecution	Attorney-General Welfare Litigation Unit (noncriminal) MFCU (criminal, Cook County only) State's Attorneys (criminal)	United States Attorneys (Chicago, Springfield, East St. Louis)
Recovery of Overpayments	IDPA	--
Provider Suspension or Termination	IDPA	HCFA (Baltimore)
License Revocation	Registration and Education Public Health	--

considered on a claim-by-claim basis. Reviews catch such abuses as excessive use of laboratory or x-ray services. Prepayment review may result from referrals from within BPI (Peer Review or Narrative Review Committees) or other Bureaus, such as Claims Processing, referrals from outside the department, or utilization analyses performed by the Exceptions Analysis Unit within BPI. Prepayment reviews of provider claims in 1980 resulted in a cost savings of $955,000.

Postpayment audits include both field and desk audits to detect both misutilization and potential program abuse by recipients and providers. BPI conducts limited desk reviews on all Medicaid payments. Several computer programs are used in the process, including exact duplicate billings, multivendor duplicate listings, and utilization reports. Desk audits review computer output for billing errors or program abuses. During FY 1980, BPI conducted 2792 audits and reviews, leading to the identification of $11.5 million in overpayments and the cost avoidance of $45 million.

While virtually all institutional providers (hospitals and nursing homes) are reviewed regularly, noninstitutional providers are scrutinized only in response to indications of problems; BPI does not attempt to review a random sample of their billings. When audits or other sources indicate a potential for fraud or abuse, BPI's Medical Investigations Unit conducts a preliminary investigation to determine if services provided were billed correctly, if providers received kickbacks from suppliers or additional payments from recipients, etc. Simple overpayments can lead to the disallowance of a claim or administrative efforts to recover funds; when a provider disputes the finding, IDPA can ask the Welfare Litigation Unit in the Attorney General's Office to file a civil suit against the provider. If suspicions remain but no action is taken on past claims, the provider may nonetheless be placed on "exception review," leading to prepayment screening of subsequent claims by the provider; 490 providers were on exception review in 1981. If BPI's preliminary investigation of a provider leads to the conclusion that criminal fraud may have occurred, however, a report prepared by BPI is submitted to a Narrative Committee composed of representatives of

BPI and the Medicaid Fraud Control Unit; the Committee can recommend that the case be handled by administrative recovery or civil litigation efforts, termination or suspension from the Medicaid Program,[8] or criminal investigation and prosecution by the MFCU.

The Illinois Medicaid Fraud Control Unit is organizationally somewhat different from the MFCUs in other states. The MFCU is based upon agreements between the Bureau of Financial Fraud and Forgery in the Department of Law Enforcement, the Attorney General, who assigns assistant attorneys-general to the Unit, and county level state's attorneys; MFCU attorneys prosecute their own cases in Cook and surrounding counties, and state's attorneys prosecute Unit cases downstate (with technical assistance, if requested, from the MFCU). Formed in 1978 on the recommendation of the Governor's Fraud Prevention Commission, which concluded that IDPA "has neither the personnel nor the institutional mission to conduct complex financial investigations," and "currently is frustrated in finding sympathetic state's attorneys and courts to hear cases prepared by a 'non-professional' unit," the Unit was initially hindered by opposition from both IDPA, which resented losing its investigative functions, and state's attorneys, who felt that the state was moving into their territory. "The absence of a working relationship with state and local prosecutors" delayed DHHS certification of the Unit until 1979; since that time, interagency conflicts have declined, although DHHS has pushed to have more prosecutors assigned to the Unit and to have the Unit take more cases to court.

Once the Fraud Control Unit receives a referral from IDPA, or a lead from another source (about one-third of the MFCU cases are based on IDPA referrals), several levels of effort may follow. "Integrity reviews" involve a desk analysis of IDPA records on patients and providers; "field investigations" involve reviews of files in the provider's office and interviews with the provider and patients. Cases can then be prosecuted criminally by the MFCU attorney or state's attorneys or civilly by the Illinois Attorney General, or referred back to IDPA for administrative action; some criminal cases are prosecuted in the federal courts in cooperation with the United States Attorney. Table 12 summarizes MFCU activities during 1979-81.

Table 12

ACTIVITIES OF THE ILLINOIS MEDICAID FRAUD CONTROL UNIT

Activity	4/79-3/80	4/80-3/81
Integrity Reviews Initiated	152	89
Integrity Reviews Closed	253	164
Field Investigations Initiated	67	64
Field Investigations Closed	47	65
Cases Referred for Prosecution	28	18
Indictments	12	19
Convictions	5	10

While BPI and the MFCU handle the vast majority of provider fraud and abuse cases from the Illinois Medicaid program, the activities of several other agencies should be noted. Cook County, with over one-half of the state's welfare population, is the only county whose prosecutor has established a special fraud unit. As was noted in Chapter Three, Republican State's Attorney Bernard Carey was very active in prosecuting recipient fraud cases in the late 1970s; his successor, Democrat Richard M. Daley, announced following his election in 1980 that he would decrease his office's role in recipient cases and increase the attention paid to provider cases. In 1982, Daley, the Illinois Attorney General, and the U.S. Attorney for the Northern District of Illinois announced the formation of a task force of fifty investigators and ten prosecutors from their three offices to focus on Medicaid and Medicare provider fraud and abuse (Frantz, 1982). The task force was viewed as a means of resolving both personnel shortages and past rivalries because of which the three offices had been reluctant to cooperate.

The Welfare Litigation Unit of the Illinois Attorney General's Office handles all noncriminal litigation affecting IDPA, including civil recovery suits against vendors, vendor appeals of administrative hearing decisions,

and suits by provider organizations and the Legal Assistance Foundation challenging IDPA policies. If the MFCU or other prosecutors decide not to file criminal charges, or if criminal prosecutions are unsuccessful, the Welfare Litigation Unit may be asked to proceed civilly against a provider or recipient. As with recipient cases, the Unit prefers that smaller and ambiguous cases be handled administratively by IDPA; since litigation can drag on for several years, both agencies tend to share a desire to handle as many cases as possible through the simpler and faster medium of administrative hearings.

The fraud and abuse activities of the federal agencies listed in Table 6.1 tend to be more frequently focused on Medicare problems than on Medicaid, although they share information with the state Medicaid-oriented agencies, monitor their performance, and at times handle Medicaid cases directly, either on their own or in cooperation with the State. The Office of Program Integrity in HCFA's Region V both reviews IDPA program integrity efforts, preparing the fraud and abuse component of the annual State Management Report, and conducts its own preliminary investigations ("integrity reviews"). The DHHS Inspector General's Region V Audit Agency and Office of Investigations share information with IDPA's Bureau of Program Integrity on their activities; while major fraud findings are submitted to the FBI and U.S. Attorney for prosecution, the State is encouraged to handle other leads itself. Spread over a six-state region and focusing primarily on Medicare problems, the HCFA and OIG auditors and investigators seldom go looking specifically for Illinois Medicaid fraud and abuse, but often encounter leads that are useful to the other agencies.

The Chicago Office of the Federal Bureau of Investigation and the United States Attorney for the Northern District of Illinois have taken a great interest in provider fraud cases since the mid-1970s. Working primarily on leads from the media, postal inspectors, and other federal investigators (referrals from IDPA have decreased substantially since the MFCU became operational), they tend to focus on large cases, particularly those involving multiple defendants and institutional providers. While there is no official minimum amount for accepting a case, one federal

investigator stated that the U.S. Attorney was unlikely to be interested in a case involving less than $75,000. Federal, state, and county prosecutors spoke highly of each others' abilities in handling complex fraud cases, attributing limited productivity to staffing shortages rather than to incompetence or lack of interest. In view of these personnel problems and other priorities in the federal courts, and the availability of both judicial and administrative options at the state level, the common assumption was that all but the most serious Medicaid provider cases should be handled by IDPA and the MFCU; if they want to handle cases known to the federal agencies, they are usually welcome to them.[9] The U.S. Attorney clears his potential indictments with the MFCU and, in 1981, appointed three assistant attorneys-general, one from the MFCU, as Special Assistant U.S. Attorneys so they could handle cases in the federal courts.

Assessments of Illinois Medicaid Control Efforts. A 1974 book on the early years of Medicaid offered an observation on Illinois that is as applicable in 1982 as it was in the early 1970s:

> Illinois provides an almost perfect example of the tragic institutional battles that swirl around Medicaid programs in the states. An efficiency-minded governor, hoping to cut costs, found himself faced with entrenched bureaucrats and political machines, with a hostile legislature, judges, and welfare rights organizations, as well as dissatisfied providers. (Stevens and Stevens, 1974: 282)

By 1981, the attacks on Medicaid fraud and abuse in Illinois had been displaced by a pervasive legislative and administrative concern over finances, as the state was forced to cut back in many areas. As the Governor called for Medicaid budget cuts of $170 million and IDPA laid off 400 employees in 1982, the earlier obsession with fraud and abuse problems seemed to disappear. The Legislative Advisory Committee on Public Aid, which had led the attack on IDPA in the 1970s, acquired a new chairman and executive director in 1978, and attention was turned to quality of care and the growing problems of Illinois welfare recipients.

It is difficult to predict how the Illinois fiscal crisis will affect efforts to control Medicaid fraud and abuse. The recession and high

unemployment, coupled with IDPA's staff reductions, guarantee increased recipient eligibility errors; inflation, coupled with reimbursement schedules for providers, which have not changed since 1978, invite providers to overcharge IDPA. From the state's perspective, however, fiscal pressures increase the need to control costs by reducing both outright fraud and more innocent overutilization and provider abuse.

Developments since 1975 have greatly increased both IDPA's and other agencies' ability to prevent and control fraud and abuse. By 1979, HCFA had concluded that "IDPA has developed a vigorous, innovative, and diversified approach to the problems of Medicaid fraud and abuse. Given the limitations of its current data system, the Bureau of Program Integrity has been highly effective in detecting, assessing, and resolving fraudulent and abusive practices." (Health Care Financing Administration, 1979: 30) The long overdue implementation of MMIS in 1981 should improve IDPA's prepayment control efforts, although few took seriously the claim of the LACPA Executive Director that MMIS "would cut fraud and abuse in half overnight." The Recipient Utilization Review Program and the eligibility procedures described in Chapter Three have the capacity to keep recipient fraud under control, although they may be overwhelmed by recession-increased applications and staff reductions.

Improvements in criminal justice efforts have paralleled those in program administration. While federal efforts remain somewhat peripheral to the control process, the operations of the Medicaid Fraud Control Unit, the Welfare Litigation Unit in the Attorney General's Office, the U.S. Attorney's Office, and the new joint federal-state-county task force offer substantial resources for civil and criminal prosecution. A former IDPA director recalled that no prosecutor wanted to touch provider fraud cases until the Chicago Tribune exposes in 1974; prosecutors at all levels seem quite interested in the area now.

But while motivations may be high, expenditures are low. A 1982 study of Medicaid fraud control units by the staff of the U.S. House of Representatives Select Committee on Aging found that Illinois ranked next to

last among the thirty states with MFCUs, in fraud control expenditures as a proportion of Medicaid expenditures. The report attacked Illinois as having very high MFCU costs per conviction, and relatively light sentences (Recktenwald, 1982).

Several conclusions emerge from this description of Illinois' efforts to control Medicaid fraud and abuse. First, policy issues about the administration of the program were inseparable from issues concerning the entire welfare system and its costs. As has been documented elsewhere (Stevens and Stevens, 1974), the Medicaid program in the United States was a hastily contrived effort, which was implemented without adequate planning or the vaguest comprehension of the scale it would attain. Illinois, like other states, had to learn how to run the program and decide what it could afford long after the operation began. Politically skilled recipient and provider organizations and their lawyers were well prepared to protect the initial high payment levels and minimal supervision of payments. The highly visible fraud exposes of the mid-1970s and the fiscal crisis of the early 1980s led to political support for a respectable control system. Despite the widespread recognition of legislators and administrators that provider fraud was a far more costly problem than recipient fraud, public perceptions of welfare queens and the political power of providers meant that recipient control efforts were developed more quickly and with less controversy.

Second, the emphasis in provider control efforts as in recipient efforts has been to get the money back as efficiently as possible, using the judicial system for only the largest and most egregious cases. Providers who are padding their bills are only dunned for overpayments; it is only those with massive overcharges and/or questionable care records who are hauled into court. Administrative recovery mechanisms or suspension from the Medicaid program serve the needs of IDPA more directly than the protracted judicial process.

Finally, the development of control efforts in the Illinois Medicaid program reflects the importance of resource allocation issues. While IDPA is proud of the cost avoidance and recovery record of its Bureau of Program

Integrity, it simply does not have additional funds to devote to fraud control. As the director of the Medicaid Program stated, "Fraud and abuse have an inexhaustible appetite for resources to fight them. The Department is short of staff for cost containment measures, let alone any further buildup of fraud and abuse initiatives. Given the reality that the public does not want the state government to grow, we must focus on areas which have the greatest potential for recovering dollars or for danger to recipients, and try to maintain an appearance of deterrence in other areas." A former director of IDPA added, "You have to remember that we are here to provide a service, not to catch cheaters. Designing our control program therefore requires that we constantly test both public perceptions of our problems and our own guesses as to where the problems are."

Prosecutors must similarly ask where their resources should go, whether they deal only with Medicaid problems or have broader missions. Provider fraud cases are professionally challenging for prosecutors and often promise good media publicity, yet they are time-consuming and expensive; it is often necessary, as a result, for the multipurpose prosecutors to decide how much time can be taken away from street crime or other cases. Even the prosecutors in the Medicaid Fraud Control Unit and the Welfare Litigation Unit also must select those cases that have the highest recovery or deterrence value. The motivational and organizational issues that restricted Illinois control efforts in the mid-1970s have generally disappeared, but the resources issue remain.

NOTES

1. The optional services offered by IDPA in 1981 were: clinic services; prescribed drugs; dental services; prosthetic devices; eyeglasses; dentures; private duty nursing; physical, occupational, speech, hearing, and language therapy; other diagnostic, preventive, and rehabilitative services; emergency hospital services; skilled nursing facility services for those under 21; optometrists' services; podiatrists' services; chiropractors' services; other practitioners' services; care for those under 22 in psychiatric hospitals; care for recipients 65 or older in institutions for mental diseases; institutional services in intermediate care facilities; intermediate care for the mentally retarded; and Christian Science Sanatoria.

2. In 1980, the number of recipients and estimated average annual expenditures per recipient for each of the four programs were: MAG, 726,982 recipients at $791; MANG, 159,323 at $3,754; GA-MED 65,641 at $1,351; and AMI, $14,545 at $1,870.

3. 1982 efforts to reduce Medicaid costs included efforts to restrict the length of hospital stays, limiting hospital reimbursement rate increases to 10% per year, delaying Medicaid coverage until an application is approved (rather than dating from the time of application), delaying nursing home reimbursement rate increases, and eliminating nonessential services for Medicaid recipients who did not receive AFDC benefits.

4. As in the case of AFDC fraud, federal agencies do not play a major role in the control of recipient problems in the Illinois Medicaid program, other than to refer to the state problems encountered in the course of investigations of providers.

5. Unless otherwise noted, statistics presented in this chapter are taken from the Annual Reports of IDPA's Medical Assistance Program.

6. Creation of IDPA's MMIS was a tortuous process extending over seven years, as IDPA changed its specifications, found that it was unable to recruit systems designers to develop the program in-house, and awarded a development contract to a firm which walked out on the job. Pharmacy providers were integrated into the MMIS system during 1977 and hospitals in 1979. The last groups of providers were not phased into MMIS until late 1981.

   These delays in MMIS implementation led to criticism from HCFA, which had to approve each extension and modification of the planning and design contracts, and from legislators who blamed rising Medicaid costs in part on IDPA's incapacity to analyze claims data without the SURS subsystem. In addition, each month's delay cost IDPA $300,000 to $500,000 in federal support, since the federal share of administrative costs rose from 50% to 75% when the MMIS was certified as operational.

   MMIS implementation, when it finally arrived, produced massive short-term headaches. In January of 1982, the Chicago Tribune reported that IDPA was behind in paying almost $100 million owed to providers (Millenson, 1982a); there was a $22 million backlog in payments delayed beyond thirty days, and IDPA was forced to advance payments to ease the cash flow problems of some providers with a high proportion of Medicaid patients. (Millenson, 1982b)

7. With the full implementation of MMIS in 1981, IDPA's capacity to identify unusual billing patterns was greatly expanded through the Surveillance and Utilization Review Subsystem (SURS) of MMIS. SURS contains information from paid claims on the activities and characteristics of both providers and recipients. It groups providers and recipients according to medical, demographic, and utilization characteristics, and develops a statistical profile of each peer group as a baseline for comparison. A statistical profile, compatible with peer group profiles, is developed for each provider or recipient. Comparisons can then be made of individual providers or recipients with the appropriate group profile, and those deviating significantly from preestablished group norms are reported by the system.

   A number of report items are established for each category of provider, including provider treatment patterns and number of drugs prescribed. Recipients may be reported on items such as number of physician visits and number of prescriptions filled during a specific period.

   According to Illinois SURS personnel, this subsystem requires 15 months of trend data from claims to compose meaningful profiles. Since the Illinois SURS subsystem only became operational in 1981, it will be at least a year and a half after that date before SURS data will be useful for analysis and targeting.

8. Between 1976 and 1980, IDPA suspended or terminated 227 providers: 67 physicians, 83 other practitioners, 15 laboratories, 46 pharmacies, and 16 nursing homes.

9. Commenting on the division of labor between MFCU and federal prosecutors, the Director of IDLE noted, "Under the MFCU grant from DHHS, IDPA has no authority to refer cases of suspected provider fraud except to the MFCU. Thus, Unit investigators and attorneys have priority to investigate and prosecute any such cases. If they feel that federal prosecution of a particular matter would be more appropriate than state prosecution, they may refer it to the United States Attorney's office for prosecution. Second, a number of the provider fraud cases being investigated by federal authorities have in fact been referred to them by the MFCU after determination by Unit investigators and prosecutors that prosecution of the allegations in Federal court would be more effective than in State court. All such cases continue to be investigated jointly by Unit investigators and Federal investigators."

REFERENCES

BLISS, G. (1974), "Two Doctors Get Aid Fees Again," Chicago Tribune, March 19.

_____(1975), "War on Aid Cheats Saves $500,000 in Nine Months," Chicago Tribune, September 22.

_____(1976a), "How Physicians Get Lab Kickbacks," Chicago Tribune, February 16.

_____(1976b), "Medical Societies Demand Data for Fraud Probe," Chicago Tribune, February 18.

_____(1976c), "Medical Lab Fraud Out of Hand GAO Charges," Chicago Tribune, August 24.

ELMER, J. (1977), "Move Medicaid From Aid Office: Panel," Chicago Tribune June 22.

FRANTZ, D. (1982), "Task Force to Probe Medicaid in State," Chicago Tribune January 28.

HEALTH CARE FINANCING ADMINISTRATION (1979) Medicaid State Management Report: Illinois (Chicago, HCFA Region V).

ILLINOIS AUDITOR GENERAL (1979), Management Audit: Department of Public Aid Medical Assistance Program (Springfield).

KOTULAK, R. (1978), "$300,000 in Aid Fraud Received from Drs," Chicago Tribune, June 9.

LOCIN, M. (1977), "Private-run State Medicaid Urged," Chicago Tribune, March 8.

MERRIDEW, A. (1976), "Health-Care Frauds Found Bleeding U.S. for Millions," Chicago Tribune, May 20.

MILLENSON, M. (1982a) "State is behind $100 Million in Medicaid Payments," Chicago Tribune, January 3.

_____(1982b) "State will Miss Deadline for Easing Medicaid Jam," Chicago Tribune, February 8.

PETAQUE, A. (1978), "Welfare, Jobs Reforms Outlined," Chicago Sun-Times, February 2.

RECKTENWALD, W. (1982) "Study Rips State Policing of Medicaid," Chicago Tribune, March 29.

STEIN, M. (1979) "Fraud and Abuse in Medicaid During 1978" (Springfield: Legislative Advisory Committee on Public Aid).

STEVENS, R., and R. STEVENS (1974) Welfare Medicine in America: A Case Study of Medicaid (New York: Free Press).

CHAPTER SEVEN

CONTROLLING MEDICAID PROVIDER FRAUD AND ABUSE IN COLORADO

"DEMISE OF MEDICAID FRAUD UNIT CAUSES CONCERN," Denver AP -

"Worried state and federal officials say Colorado may soon be incapable of investigating and prosecuting major violations by Medicaid providers because of a legislative decision to eliminate the state's Medicaid Fraud Unit.

"'There's nobody in the state that's going to pursue Medicaid fraud,' said Colorado Bureau of Investigation Director..., whose agency oversaw the unit. 'These cases take months to put together, and nobody else has a team like we had.'"

Associated Press
Denver Post
June 8, 1981

Although Colorado's Medicaid program has been without serious controversy in its thirteen-year history, the same cannot be said for the state's efforts to control program fraud and abuse. Debate has not centered so much on the amount of Medicaid fraud and abuse but rather on how fraud enforcement activities should be organized, what kind of Medicaid providers should be examined, and whether or not the cost of Medicaid fraud enforcement should be offset by recovery of misused funds.

In Colorado, Medicaid services are provided by statute. During Fiscal 1980, fifteen services were provided by 91 hospitals, 193 nursing homes, more than 700 pharmacies, more than 5,000 physicians, about 200 laboratories, and more than 40 home health agencies.[1]

About 131,000 Colorado residents were recipients of Medicaid in fiscal 1980. The $185 million cost made Medicaid the most expensive benefit program administered by the Colorado Department of Social Services (DSS).

(Included in program expenditures were payments of $3.3 million in Medicare Part B (noninstitutional care) premiums for Medicaid recipients who were also eligible for Medicare.) The nursing home program is the single largest component (41%) of the Medicaid Program; more than 11,000 Medicaid patients used nursing home facilities in 1980.

Approximately 53% of Medicaid costs are funded by the federal government; the remaining 47% is funded by Colorado's Old Age Pension Health and Medical Funds and the General Fund. As with other states, Colorado's Medicaid expenditures are increasing rapidly; they rose from $122 million in 1977 to $185 million in only three years.

Administration of Medicaid Program. The Medicaid Program has been in operation since 1969. The Colorado Department of Social Services (DSS) is the single state agency responsible for the overall administration of the program. Figure 8 presents the overall structure of DSS. DSS's Division of Medical Assistance (DMA) oversees Medicaid program operations, developing policies and procedures with respect to reimbursement, the scope of program benefits, and administrative directives to the fiscal agent. DMA has responsibility for the overall management and administration of the program including, but not limited to, provider relations, reimbursement, detection, third party liability, and verification of services.

Certification concerning eligibility to participate as a provider in the Medicaid program is controlled by the Licensure and Certification Section of the State's Department of Health in coordination with the Department of Regulatory Agencies. The DMA maintains provider agreements with participating hospitals, nursing facilities, and home health agencies. The Medicaid claim form establishes a claim-by-claim provider agreement for physicians and suppliers that participate in the Medicaid program. Claims processing and payment are contractually delegated to the fiscal agent, Colorado Blue Cross/Blue Shield, under the supervision of DMA.

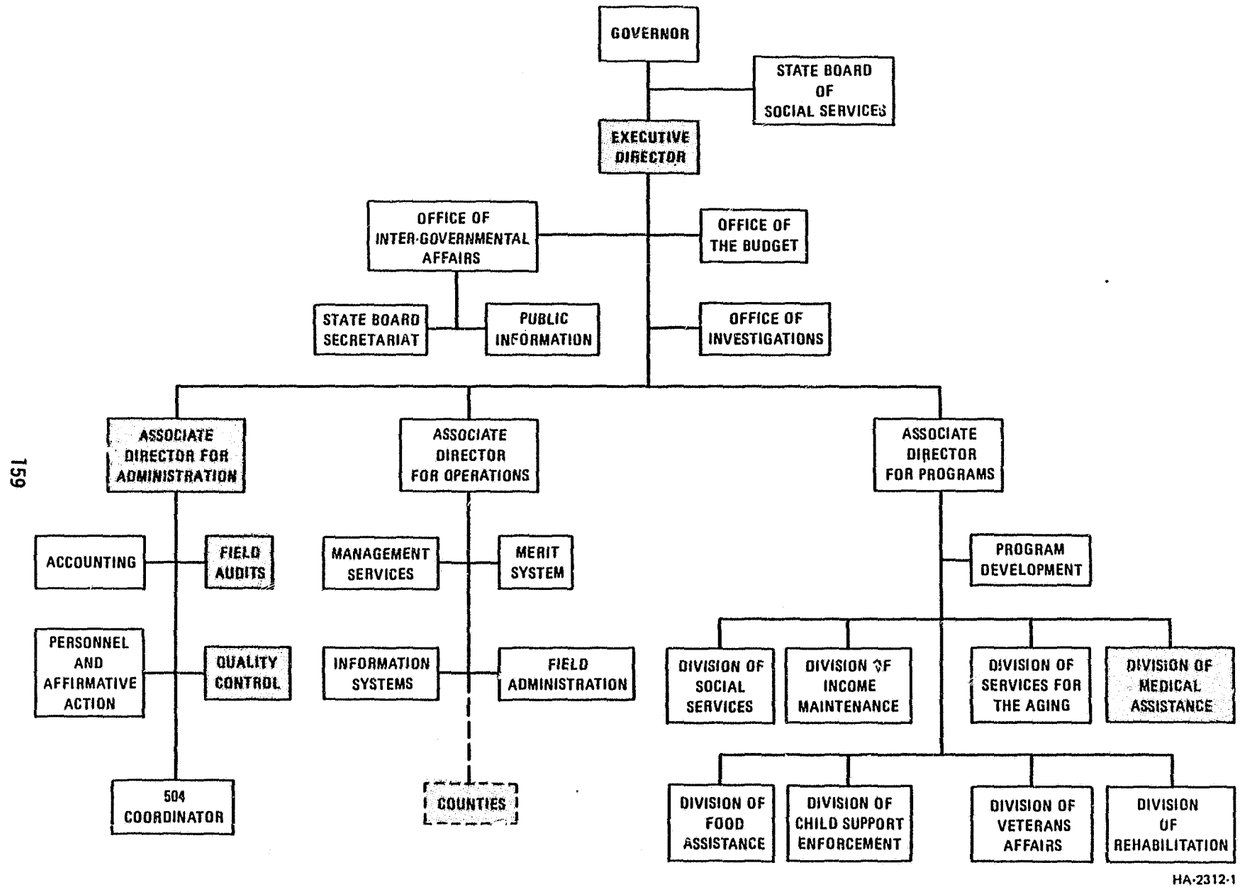

FIGURE 8 COLORADO DEPARTMENT OF SOCIAL SERVICES ORGANIZATION
(as of April 1, 1980)

The Division of Income Maintenance (DIM) has responsibility for establishing Medicaid eligibility policy. Policy issues are typically first identified by county staff through reviews of new federal laws and regulations and by reviewing instructions issued by the HCFA Medicaid Bureau. The Division of Field Operations is responsible for assisting county departments of social service in carrying out their responsibilities, evaluating the effectiveness of program operations, and keeping DSS aware of the impact of policy changes on county operations. Finally, the Office of Appeals handles recipient or provider appeals when eligibility or claims are denied.

The responsibility for the detection of Medicaid fraud and abuse is shared by the DMA, the fiscal agent (Blue Cross/Blue Shield), the Office of Investigations, and the Office of Field Audits. Preliminary fraud and abuse investigations are conducted by the Office of Investigations according to a written manual of procedures. When a preliminary investigation by the State Office of Investigations establishes that fraudulent activity may have taken place, the case is referred to the Colorado Medicaid Investigation Unit (MIU) in accordance with a Memorandum of Understanding between the Department of Social Services and the Department of Local Affairs (organizational home of the MIU).

The MIU has primary responsibility for conducting full-scale fraud investigations and prosecutorial action. The State Office of Investigations maintains responsibility for administrative actions and recoveries under the authority of the DMA.

The function of program audits is shared. The Office of Field Audits within DSS performs audits on patient contributions and personal needs funds in institutional facilities, while an accounting firm performs cost audits of nursing facilities under contract with the DMA. Like the AFDC program, Medicaid is supervised by the state but Medicaid recipients are enrolled through the 63 county departments of social service.[2] While the state sets Medicaid policy, promulgates rules, handles all health provider issues including rate setting, billing, and utilization review, recipients are

enrolled in the program at the county level. Determination of Medicaid eligibility is not typically a specialized function in county offices. Eligibility for the program and for SSI beneficiaries is determined by Eligibility Technicians (ETs). The ETs are also responsible for determining eligibility under the AFDC program and Medicaid eligibility of categorically related families with dependent children. In addition, county staff determine eligibility for other departmental programs, including DSS's financial assistance programs and Food Stamps. However, because there is no county participation in Medicaid costs, because program rules are relatively stable, and because eligibility is tied to standards used for determining eligibility for AFDC, SSI, and other benefit programs,[3] counties don't have the same sense of administrative overload as they do with the AFDC program. No grant calculations are made, little paperwork is necessary, and no particular staff expertise is required. Furthermore, except for undertaking program administration in a prudent and effective way, the counties carry no responsibility for policing Medicaid provider fraud. This function is assigned solely to the state. Accordingly, except for policing recipient fraud as an adjunct to investigating AFDC fraud, counties have little sense of ownership in the Medicaid program.

Enrolling Medicaid providers is the responsibility of the fiscal agent (Blue Cross/Blue Shield). Under contract, the fiscal agent assures that all providers have a Medicaid enrollment application completed, approved, and on file in order to receive payment for covered Medicaid services. The application requires submittal of the license number, effective date of license, and name of the issuing license board. DSS requires that hospitals, nursing homes, home health agencies, and pharmacies execute provider contracts in addition to the approved enrollment application.

Fraud and Abuse Problems in the Colorado Medicaid Program. There are few front page stories of "Medicaid mills" in Colorado. Seldom is there a noteworthy prosecution of a doctor. No pharmacy-physician kickback scandals have surfaced. And finally, statistics suggesting the magnitude of the problem are nonexistent. Instead, the general public sees headlines about

the legislature "killing" the Medicaid investigation unit. Lobbyists for health care providers argue in print with enforcement officials saying that the officials sometimes abuse the legal rights of providers. Enforcement officials respond by charging that the "special interests" have forced budget cuts through the Legislature.

State officials in DSS and federal Region VIII officials are also alarmed about the intense arguments and the abolition of the Medicaid Investigation Unit. Said one program official, "Until all this controversy arose, nobody in DSS thought that there was much fraud in the program. Now we're wondering. We don't feel that our flank is protected. The legislature, in effect, has just told the providers that nobody will be looking; go ahead and and rip us off."

The belief among program officials that there may, in fact, be an intolerable amount of fraud in the program has developed only since the mid-1981 budget cuts. In the past, program officials downplayed the fraud problem--not wanting to alienate providers by suggesting any sort of questionable practice. Enforcement officials, however, have predictably felt that the program was being victimized by a sizeable number of unscrupulous health care providers. Said one, "There must be a lot of fraud in the program because we can only look at a small number of situations and every time we look we find a potential fraud case."

But clearly, officials from the Medicaid program see the problem differently than those from the enforcement units. Program officials are more concerned with the "overutilization" problem, where the recipient visits many doctors, clinics, and/or pharmacies for the same health problem, either in order to satisfy a need for medical attention or to acquire excessive medications. Providers too are potential abusers of Medicaid by "overutilization"--too many X-rays, too many lab tests, too many referrals to specialists. Practices such as "ping-ponging" (unreasonable numbers of doctor referrals, back and forth), "splitting" (pharmacists receiving more than one dispensing fee for a single prescription), "sub-ing" (generic substitution of drugs), and "shorting" (dispensing of fewer than the

prescribed number of pills) are typical examples of questionable care. Program officials view many of these problems as well as overutilization as program abuse rather than as willful criminal fraud. Program and enforcement officials usually agree that a potential fraud problem exists in cases where providers manipulate records, so that they receive payment for services not provided, overcharge for services or medication, or acquire funds from patients illegally. Where such activities are detected, enforcement officials typically receive support from program officials. However, most situations felt to be questionable fall into a vast gray area, and decisions as to how these cases are to be handled prove difficult. Is it fundamentally a problem best suited to provider or recipient education? Or is it a problem warranting civil or even criminal sanctions? Tension is high when these decisions must be made. Program officials are typically inclined to suggest administrative remedies, while enforcement officials tend to be eager to prosecute.

How much fraud and abuse actually exist in Colorado's Medicaid program? As with most nonviolent crime, only a small percentage is ever detected. Two enforcement units maintain statistics, but neither cover anything but their own investigative productivity. The Office of Investigation in DSS recently reported the following criminal investigation accomplishments:[4]

Open cases carried over from FY 1978-79	35
Cases added during FY 1979-80	97
Cases closed "no fraud" FY 1979-80	89
Cases closed or referred to other jurisdictions FY 1979-80	25
Cases pending (backlog) as of 6/30/81	18

Because its mission is broad but its staff small, the Office of Investigation handles only a small percent of all Medicaid investigations. Instead, most provider fraud since 1978 has been handled by the Medicaid Investigation Unit (MIU). Table 13 presents the case activity of the MIU for a 15-month period.

Table 13

CASE ACTIVITIES OF THE COLORADO MEDICAID INVESTIGATION UNIT

REPORTING PERIOD JULY 1, 1979 TO SEPTEMBER 30, 1980

	Complaints	Investigations	Cases	Prosecution Declined	Arrest	Conviction	Civil	Cases Pending
Provider Fraud:								
M.D.	26	8	7	2			2	5
D.O.	5	2	1	1				
D.D.S.	3	3	2	1				1
Pharmacy	5	4	3	2				1
Laboratory	2	1	1					1
Clinic	8	5	5		1		1	3
Hospital	3	1	1					1
Nursing Home	28	13	7		8	1	4	3
Transportation	1							
Assist Outside Agency	16							
	97	37	27	6	9	1	7	15
Recipient Fraud:	6	3						
Fraud Total	103	40						
Patient Abuse:	34	14	7	4	2	2		
Fraud and Abuse Totals	137	54	34	10	11	3	7	15

In combination, the two agencies investigating Medicaid fraud handled approximately 200 cases during a recent 12-15 month period. Approximately two-thirds of these cases are closed after preliminary investigation.

This relatively low level of activity is not considered by Colorado officials to be an accurate reflection of the fraud problem. While the Office of Investigation has been satisfied with the caseload carried by its investigators, the MIU director has been unhappy that his unit's case backlog has been so small. Both units report difficulty in getting referrals from units such as the Surveillance Utilization Review section and the Field Audit unit. The investigators maintain that their task is not so much to detect fraud as it is to investigate allegations of fraud. Allegations, the investigators claim, must be generated by others and the fact that so few cases are surfaced is attributable to flaws in administrative mechanisms designed to highlight questionable claims.

Administrative Responses to Fraud and Abuse Problems. Like most other states, Colorado has implemented computer systems (the Medicaid Management Information System), claims review processes, training and education programs, and a variety of other approaches to manage and control its Medicaid program. However, controlling fraud and abuse is seldom the primary objective. Instead, the legislature and program officials alike have been revamping Medicaid operations for the past few years with an eye toward cost containment. Fraud control is, of course, a likely result of improved management, but only a few administrative reforms are implemented explicitly to control willful wrongdoing.

In this era of exploding costs, controlling the overutilization of Medicaid consumes most of the time of DMA officials. Their attack on cost growth brings together the resources of the fiscal agent, the contract auditor, the Division of Field Operations, the SURS unit, the MMIS contractor, and the counties. Computer-assisted post-payment claims review is a primary weapon. For three years, work has been under way to create a Surveillance and Utilization Review Subsystem (SURS) as a part of the MMIS.

The capability has been partially available since 1980, when a SURS staff of analysts, auditors, and medical specialists was hired. Reviewing exception reports generated by the SURS component of the MMIS, these specialists identify providers or recipients who use the program in excess of the norm. To identify "outliers," the system is programmed to "kick out" quarterly all claims demonstrating program use four standard deviations beyond the mean.[5] Although heavy users of Medicaid are not necessarily abusers of the program, it is felt that these cases represent a higher probability of abuse. SURS medical specialists and a Utilization Review Board then examine each case and recommend to the SURS unit director a course of action. Options include dropping the matter, recommending patient lock-in (described below), recommending recipient or provider education, forwarding provider cases to medical or health care licensing boards, or referring the case to an investigation unit (either the Office of Investigation or, if a full scale fraud investigation seems warranted, the Medicaid Investigation Unit). Patient lock-in and program utilization education are increasingly the most often exercised option. The Utilization Board, after reviewing the case, is responsible for deciding whether or not lock-in and/or education is warranted.

Lock-in, as described in a recent DSS instruction, is a program that identifies Medicaid recipients who overuse medical services and restricts them to services provided by a limited number of providers, which the recipient (or in certain situations the State) chooses. The purpose of lock-in is to educate recipients about appropriate uses of health care services. Its goals are twofold: to improve the continuity and the quality of care for involved recipients, and to improve service utilization patterns in order to control Title XIX expenditures.

Those recipients whose usage of medical services falls outside certain defined parameters as identified through post-payment review of claims are reviewed to determine whether an educational effort through counseling and/or a limitation on the number of providers they can use for a given period of time is warranted. When the State, through the Utilization Review Board, determines that a recipient may benefit from counseling and/or

lock-in, the county workers and providers with whom the recipient has had contact will be asked for additional information and concurrence with the lock-in recommendation. If the providers and county workers agree that the recipient would benefit from such an action, the State will have the county worker explain to the recipient the findings and the options available. The recipient can agree to change his/her usage patterns or participate in lock-in and/or counseling. If the recipient fails to cooperate, the state may lock him/her into specified providers selected by the State. The recipient has a right to appeal such lock-in decisions.

Under lock-in, the recipient and all other eligible family members are required to choose one physician and one pharmacy to be used during the lock-in period. Claims from any other physician or pharmacy not designated by the recipient will be denied. The attending physician may use referrals to provide additional services and the recipient may change providers within certain guidelines. Usage is periodically evaluated to determine if the recipient should continue to be tied to a limited number of providers. Lock-in is for a 12-month period unless the Utilization Review Board determines that the time should be shorter or longer.

Prepayment review of claims is a second administrative approach to controlling fraud and abuse by controlling program costs. Federal regulations require each state to have procedures in place to systematically review provider claims to detect problems prior to payment of the claim. Colorado's fiscal agent has a "Resolutions Unit" that performs this claims quality control function, but seldom does this review result in referrals to the investigative unit. Instead, obvious errors in claims are typically resolved before payment is made. Colorado's MMIS also has a program module for prepayment review, but again, this is more a quality control function than an administrative response to fraud and abuse. In a federal review of Colorado's prepayment review procedures, criticism was directed at the fiscal agent who, it was felt, was not performing the level of review required by the federal government.

Yet another administrative response to the cost growth problem, one more directly tied to controlling fraud and abuse, is the Explanation of Medical Benefits (EOMB) procedure. Now computerized, but handled manually for years, EOMBs are randomly sent out to 5% of the recipients in the form of a letter stating what services were claimed to have been rendered by which provider. The letter encourages recipients to report to the SURS unit providers who submitted claims for services or goods not received by the Medicaid card holder. Program officials report that many recipients call the SURS unit with questions, but only a few referrals are generated. If the disputed claim relates to billing or is otherwise an administrative matter, follow up is made by Blue Shield/Blue Cross. If there is potential fraud, the case is referred to OI or the MIU.

The Office of Field Audits and the private audit contractor systematically review the service and financial records of providers, but Colorado does not rate well in federal assessments of the extent to which this typical administrative control serves to detect fraud and abuse. Federal reviewers felt that too many audit findings were not being forwarded to DSS or the MIU. The accounting firm, whose contract was not renewed, was felt to be contributing to these problems. Another contractor is now performing field audits.

Because Medicaid is a provider of health care of last resort, attention is paid to determining if there is a third party, such as a private insurance company, who should be billed for service provided but has not been. Local county offices are responsible for collecting this information at the time eligibility is determined. Computer matches are made by the fiscal agent of claims received against notations provided by the counties that a third party is liable. Calls from county attorneys, technicians, and investigators begin to apprise DMA as to potential third party liability, but this is difficult information to keep up to date. DMA is continually examining the problem of third party liability, but no easy solutions are apparent.

To reiterate, until the recent legislative attack on the MIU, fraud control was less a concern to DMA officials than cost containment. Costs have been escalating rapidly, and with no budget ceiling in place, program officials have been concentrating on maintaining controls over reimbursement rates and on limiting abuse in program utilization. What administrative practices have been implemented (SURS, prepayment review, audits, EOMB, lock-in, education) are largely responses to program cost growth and not necessarily to a perceived fraud problem. This may be because program officials are concerned with the program's image, especially with respect to the image of providers. Overutilization, for example, is usually viewed as a problem that can be solved by the provision of more education. Problems with provider billing are also usually viewed as resolvable by education. When pressed, program officals concede that providers sometimes overbill or bill for services not rendered but rationalize that this is so because reimbursement rates are set so low. If questioned on their perception of provider fraud, they typically concede that there probably are "a few" providers who are willfully defrauding the program, but that enforcement officials are keeping that problem to an acceptable level. But the enforcement units, say DMA officials, can be a problem. "Those guys in the MIU," states one DMA staffer, "have been too heavy-handed. Having the media along with them on that nursing home raid was excessive". (The nursing home raid is described below.) Program officials view the enforcement units as necessary but as potential harrassers of the providers. Generally, DMA officials are worried that the MIU, in particular, uses inappropriate police-like tactics where less severe approaches would do just as well.

Enforcement Responses to Fraud and Abuse Problems. Enforcement officials' responses to the issue of fraud are predictably quite different from those articulated by administrators. Enforcement officials are likely to charge that Medicaid is riddled with fraud. However, when pressed on whether willful fraud is at the core of the problem or whether the problem is one of "allowable" abuse, they concede that program regulations do seem to let certain kinds of providers "get away with things." But deeply rooted in their minds is the sense that Medicaid providers, in general, and

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2 OF 4

institutions such as nursing homes, in particular, are systematically defrauding the program. "DMA officials," says one enforcer, "bend over backward to protect the providers. They are convinced that the bad publicity an investigation might generate will scare providers right out of the program. We view that kind of publicity as the only deterrent we've got. Nobody ever goes to jail around here."

In August 1981, the Medicaid Investigation Unit was eliminated from the state budget after nearly three years in operation. Its high cost and low productivity was said by budget-cutting legislators to be the problem, but knowledgeable people from throughout state government felt that elimination of the unit was the final chapter of a stormy, long-running story. When the Medicaid program was created in 1969, fraud control was not a major concern. That function, if necessitated by blatant cases, was performed by local district attorneys, the Attorney General, or the Colorado Bureau of Investigation.

When Congress offered to pay 90% of the costs of independent Medicaid Fraud Control units, Colorado's governor in 1978 issued an executive order placing the unit within his own office. Locating the unit in the Governor's office was a compromise designed to minimize friction that had existed for years between the Attorney General and the District Attorneys. The DAs had argued that the Attorney General should not be given authority to prosecute criminal matters--that was their domain. The Attorney General argued that many Medicaid cases would be civil matters and that the units in most other states had been set up in the Attorney General's office. The compromise that evolved resulted in the appointment of a unit director who represented the District Attorney constituency and a deputy director who represented the Attorney General. The two proceeded to engage in a headline-grabbing feud over the operation of the unit. In the midst of the fighting, the director was accused of leaking Grand Jury information regarding an active investigation to the press, and he resigned shortly thereafter.

These and other political pressures soon became too great for the Governor. Within the year, the unit found itself legislatively approved (as

opposed to its earlier establishment by executive order) and transferred to the Colorado Bureau of Investigation (CBI)--a state police department. This too was a move to keep the unit away from the still feuding District Attorneys and the Attorney General. A new director was found to operate the unit under CBI. Auditors were hired to augment the unit's prosecutors and investigators. The unit's second director then resigned within a few months amid a second major controversy when it was alleged that he allowed candidates for the unit's auditor positions to prepare questions for their own state personnel test. Furthering the controversy, early investigations by the unit concentrated on the nursing home industry. The MIU strategy seemed to be to create a deterrent effect by generating a large amount of media interest in their investigations. The nursing home industry, organized into a highly effective lobby, reacted strongly to a raid on one of their member's homes that was covered live by local television news. It was alleged that the investigators alerted the press in advance and, further, that the nursing home industry was being singled out while other Medicaid providers were being ignored.

By mid-1980 the Legislature had changed the unit's name from the Medicaid Fraud Control Unit to the Medicaid Investigation Unit. This was to appease the health care industry, which was bothered by the linkage created between the Medicaid program and the notion of fraud. By this time staffing and operational problems had been largely overcome, and a memorandum of understanding had been signed clarifying procedures for referring potential fraud cases through OI to the MIU. Investigations were more evenly distributed across providers (e.g., doctors, pharmacies, and hospitals, as well as nursing homes). The case backlog was growing as were successes in both criminal and civil judgments. But by mid-1981 the unit learned that the Colorado Senate had voted to reject its request for FY 1981-82 funding.

A variety of reasons other than its costs for discontinuing the unit have emerged. Representatives of Colorado's House, which voted 37-1 to continue the unit, say that general political infighting was behind the move. Another factor may have been that the MIU's 1979 enabling legislation suggested that the unit's continuance would be based, in part, on continued

federal funding at the 90% level. Word had recently been received from HHS that funding of the fraud units was to drop to 75% on October 1, 1981. A third and more prominently discussed reason behind the unit being killed, say MIU officials, was the intense lobbying against the unit by the nursing home industry. The Colorado Health Care Association (CHCA), representing nursing homes, acknowledges heavy lobbying but maintains that its efforts were no more intense than those of the CBI and MIU officials.

At the height of the legislative lobbying, CHCA prepared a briefing packet setting forth the industry's concerns. The comments, summarized below, make clear the reasons why the industry put a major effort into killing the unit.

(1) The MIU report to the Joint Budget Committee (JBC) seems to indicate that there is a pattern of treating physician cases as civil cases, while nursing home cases are more often prosecuted as criminal cases. What is the explanation for this apparent pattern?

(2) The MIU report to the JBC indicates a judgment of $138,000 in one case in which it is our understanding that the judge has vacated the order. In another civil case in which the MIU claims a potential recovery of $32 million, the case is yet to be heard. The MIU has blatantly misled the Legislature as to potential recovery in these cases.

(3) Given some misunderstanding between the potential recovery reported to the Legislature and the $1.6 million reported to HHS, what does the unit see as its actual potential recovery of funds? Why was there a difference in the amount of potential recovery reported to the Legislature from that reported to the federal government (HHS)?

(4) There appears to be a strong relationship between the filing of indictments or other publicized activity by the MIU and Legislative consideration of funding for the MIU. For example, the MIU has filed charges against one osteopath, seeking the recovery of $13,000, which they allege was frauduently obtained from the Medicaid Program, just as the MIU is experiencing some difficulty in obtaining the necessary statutory authority and funding to continue its operations. A couple of years ago, the MIU "raided" several nursing homes to confiscate records despite the fact the MIU had been granted access to the records and, in fact, has been provided office space in the facilities for weeks to review those facilities' records.

(5) The MIU is seeking access to provider records "upon request," instead of by subpoena or search warrant. Is this not in violation of the constitutionally guaranteed protection against unlawful search and seizure (4th Amendment)? Does the MIU have a cavalier attitude regarding the denial of due process for those under its investigation?

By the close of the legislative session, the only fact that seemed clear was that the unit had been scrapped because it was involved in its third major controversy in as many years. Industry lobbyists had succeeded in persuading enough elected officials that the MIU was not worth the trouble and expense. Investigators had failed in their arguments that they were just starting to get close to the fraud problem--that they were in fact making a dent in Medicaid fraud--and that the health care industry was feeling the pressure. "Raw politics," said one investigator, "has seriously damaged our ability to fight Medicaid fraud. We got close, and got hurt."

Even with the clear legislative intent to end the unit, enough concern was expressed by DSS and federal officials that the MIU did not completely disappear in late 1981. Because the unit had cases under current investigation and no other investigative agency had the resources to take on the caseload, the Attorney General agreed at the last moment to absorb small number of MIU staff. Four of the investigators, attorneys, and auditors, were transferred to the Attorney General where they have been assigned to complete work on existing investigations.

The Attorney General, aware that he could come under attack from both the Legislature for thwarting its intent and the powerful District Attorneys for once again stepping into what they regarded as their turf, maintained that he was not concerned. At the time he moved to take over the MIU caseload, he had decided not to run for a third term, thus minimizing his worries about the Legislature. To limit fears of the District Attorneys, he decided to develop remaining cases for civil rather than criminal adjudication. His office has the resources in its current budget for the four additional staff; in fact, there is speculation within the office that the vastly pared-down MIU staff will soon be expanded and coupled to the organized crime unit. Should this occur, Medicaid fraud would be looked at

from a different perspective. The Attorney General has felt that there may be an organized crime potential in Medicaid fraud and that the criminal technique is similar in the two types of crime.

Even during the MIU's relatively smooth period (1980 to mid-1981), the unit experienced operational problems with the DSS. The unit director continually complained that he was not receiving referrals from either DMA or the SURS unit. In frustration, he finally raised this problem with the director of the Department of Local Affairs and the director of Social Services, so as to initiate a high level resolution of the dispute. As a result, lines of responsibility as set out in federal regulations were formally outlined for the first time: the Department of Social Service was to be responsible for identifying and referring potential fraud cases to the MIU and the MIU was to investigate and prosecute. Yet the problem of referrals persisted. Seldom did DSS pass along to the MIU audit findings or results of computer-assisted claims reviews. Audit findings where fraud was suspected were routed through DSS's own Office of Investigations where two-thirds of the referrals were abandoned, a few sent to the MIU, and the remainder investigated and closed by the OI. Computer-assisted claims reviews were promised for months, but with the SURS unit slow to develop, claims reviews were not routinely made until mid-1981, when the unit was finally staffed and its early operational problems worked out.

During the period up to late 1980, DSS, the best source of referrals for the MIU, forwarded a total of 10 cases for investigation. The exasperated MIU director reported "of these 10 cases, three were allegations of Medicaid recipient fraud not within the purview of the unit, two cases could not be prosecuted because of legal deficiencies with DSS's regulations, and another case was referred to the District Attorney for prosecution since the investigation had already been completed by DSS and the theft involved was only $86.00."

Another serious interface problem limiting the effectiveness of the MIU is alleged to be DSS's delay in implementing federal regulations mandating that providers make their records available to the MIU. Lacking direct and

immediate access, the MIU is forced either to obtain a search warrant for the records or secure records by subpoena. Obtaining a search warrant is usually uncertain, because prior to a preliminary investigation by the unit there is often no probable cause on which to base a warrant. Securing a subpoena is both time consuming and problematic.

Although there have been difficulties in establishing a good working relationship, DSS has taken a number of positive steps to resolve differences with the MIU. The Department acknowledges problems with its regulations and is soon to revise the rules, thereby eliminating technical problems that have made it impossible for prosecutors to successfully use laws designed for welfare and Medicaid fraud. However, DSS is still having difficulties with rules regarding assess to records. When officials tried to promulgate a state regulation in early 1980 to meet the federal requirement for immediate access by investigators to provider records, they came up against the intensive lobbying by the nursing home lobby that the MIU met months later. The Colorado Health Care Association was able to slow action on the rule and initiate consideration of a watered-down "30 day notice" rule. MIU officials were outraged, sure that 30 days was more than enough time for unscrupulous providers to completely alter their records so that any trace of wrongdoing would be eliminated.

Assessment of Colorado's Responses to Medicaid Fraud Problems. Intense debate over access to records and lobbying directed against the MIU are indicative of an extremely poor relationship among the health care industry, the Division of Medical Assistance, and the Medicaid Investigation Unit. However, significant improvements have been made in administrative controls over the program. Sophisticated computer programs review claims, highlight questionable practices, send out explanations of medical benefits, and generally oversee the program. Although the Legislature and DSS have attempted to implement enforcement controls, there has been little success. In light of these difficulties, Colorado officials may conclude that Medicaid law enforcement is not worth the effort.

Why has there been so much controversy over the use of criminal investigators and prosecutors to fight fraud? The answer is complex. Certainly, poor judgment was used during the early days of the MIU. Staffing decisions were questionable as were decisions regarding investigation strategy and tactics. But more interesting are the politics of fraud control. The health care industry, particularly the nursing home segment, is extremely powerful. Far more people are in nursing homes, per capita, in Colorado than in other states. Nursing home chains are expanding. Geriatrics, Inc., a subsidiary of the giant institutional service provider, ARA Services, Inc., has moved into Colorado in the past few years, opening homes all over the state, and has been behind the creation of the Colorado Health Care Association. Geriatrics Inc., has also been the source of much of the pressure to limit the MIU's authority and discontinue its funding. Furthermore, the Association's director stated that CHCA actively contributed to the campaigns of top elected officials who were eventually instrumental in eliminating the MIU.

To be successful, enforcement officials need the support of program officials. In Colorado, the support has been lukewarm at best. DMA no doubt was concerned with the high level of controversy that erupted during the first two years of the MIU, and this probably caused it to pull back Without referrals and without a program that wants to be policed, an enforcement agency is crippled.

From DSS's point of view, health care providers are the most important factor in the program. Because reimbursement rates are low and Medicaid recipients can sometimes be less than desirable patients, DSS officials are always concerned that providers will drop out of the program. Incentives to participate are few enough, and when fraud and abuse are surfaced as problems, when investigation units are organized, and when relatively heavy-handed police tactics are used with doctors, pharmacists, and businessmen, DSS officials get concerned that providers will abandon the program. DSS ends up traversing a very narrow line, on one side of which are the enforcement agencies that federal regulations require to be supported by the program and on the other side the providers who are the

operational side of the program. It is not an enviable position. DSS, like similar agencies in other states, is able to maintain balance by compromise. The most fundamental compromise is that questionable provider practice is rationalized to be abuse, not fraud. Program officials are thereby at ease with their decisions to rely heavily on administrative controls such as SURS reviews, EOMBs, and field audits, and to minimize use of criminal investigation and prosecution.

The policies on how many administrative controls or how much effort are to be applied are largely controllable by DSS. For example, the SURS unit has set parameters of four standard deviations as the bounds beyond which exceptions are kicked out. By expanding these bounds to, say, six standard deviations, department officials can by definition reduce the size of the abuse problem. By sending out EOMBs to a smaller sample of recipients, DSS could again curtail the magnitude of the problem. This means that DSS's budget is eventually the sole determinant of how much program abuse is found to exist.

Where abuse is found, the remedy is often education. Another set of instructions on billing are sent out or another visit is made to a provider regarding record-keeping practices. The deterrent value of such "sanctions" probably is minimal. Yet these administrative approaches serve to keep providers enrolled in the program, while the occasional referral of a blatant case to an enforcement agency serves to keep detractors from charging that no efforts are being made to control fraud.

Since the closing of MIU, the health care lobby has effectively kept Medicaid officials from exercising tight control over the program. Where no antifraud constituency was found in the AFDC studies, in Colorado's Medicaid program enforcement agencies form an antifraud lobby, but one crippled by years of controversy. And when confronted by the industry lobby, enforcement officials are no match. What would have happened if the MIU had been charged with detecting and preventing both fraud and abuse with a nonpunitive, nonpolice type of investigation and reporting to program officials on methods, patterns, and trends may never be known.

NOTES

1. Services covered by the Colorado Medicaid program include inpatient and outpatient hospital care, laboratory and X-ray services, physicians' services, family planning, nursing home care, durable medical equipment, home health care, early and periodic screening, diagnosis, and treatment for children (EPSDT), transportation, prescription drugs, mental health, prosthetics, rural health clinics, and community mental health centers.

2. Discussions have recently been initiated about a possible state takeover of all Medicaid eligibility from the counties. If this occurs, the Division of Medical Assistance would have very few ties to county government.

3. 26% of Medicaid recipients are AFDC recipients, 30% are SSI recipients, 39% are old age pensioners, and the remainder qualify for other state programs.

4. Most but not all of these are Medicaid cases. OI also investigates cases in other DSS benefit programs and allegations of DSS employee fraud.

5. Parameters are established by the State Social Services Board in conjunction with the SURS unit director and the Utilization Review Board of doctors, pharmacists, consumers, and Medicaid Program officials.

CHAPTER EIGHT

CONTROLLING MEDICAID PROVIDER FRAUD AND ABUSE IN WASHINGTON

Sure there is a lot of fraudulent intent. But the intent is not really to get big bucks, but rather an attempt to charge their usual and customary fees.

--Audit Official, Department of Social and Health Services

Medicaid program administrators don't know "criminal" from "non-criminal." Many cases are handled administratively which have criminal potential.

--HCFA Regional Office Official

The Washington Medicaid program is administered so well that it may be possible to begin to perform the annual state assessment only every other year.

--HCFA Regional Office Official

Administration of the Washington Medicaid Program. In Fiscal Year 1979, the Washington Medicaid program served a monthly average of 115,947 recipients. Total expenditures for the year were $321 million, of which the state paid 50%.[1] (Medicaid Management Bureau, 1980: 3). The Division of Medical Assistance (DMA) in the state's Department of Social and Health Services (DSHS) is the "single state agency" designated to administer the Medicaid program.[2] Individual recipients of Medicaid benefits are enrolled through the DSHS Community Service Offices described in Chapter Five. All other aspects of Medicaid program administration are handled by DMA.

DMA has four offices (see Figure 9). The Office of Medical Policy and Procedure is responsible for statewide administration of medical program policy. This includes review of questionable billings and medical decisions on the authorization of payment by medical consultants located throughout the state. A pharmacist consultant in this office is responsible for the

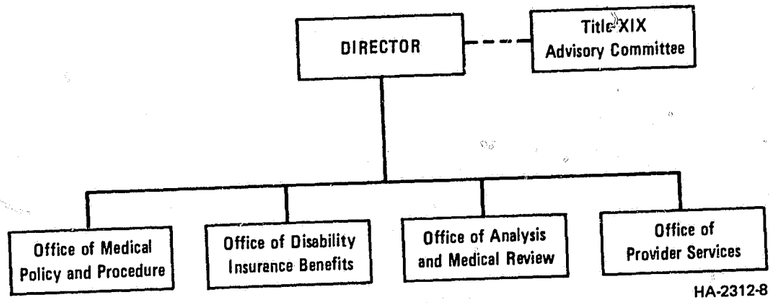

FIGURE 9 DIVISION OF MEDICAL ASSISTANCE, DEPARTMENT OF SOCIAL AND HEALTH SERVICES, WASHINGTON

Drug Formulary and Therapeutic Index and provides consultation regarding drug prescriptions. The Program Administration Section is responsible for providing field representation and training to the DSHS Community Services Offices on procedures related to medical assistance.

The Office of Disability Insurance Benefits has contractual responsibility, delegated by the Social Security Administration, to make disability determinations on Social Security and Supplemental Security Income (SSI) disability applications for the State of Washington. The office prepares medical, vocational, and other evidence to support disability applications and makes the decision as to whether or not disability exists as defined by federal regulations.

The Office of Analysis and Medical Review carries out reviews of Medicaid issues and operations, making and implementing recommendations for improved management. This office is also responsible for developing reimbursement methods and rates for medical services, providing ongoing review and analysis of the division's fiscal status, and acting as the primary point of contact between the MMIS and outside users. In addition, the office is responsible for conducting prepayment and postpayment utilization reviews on Medicaid providers and recipients to ensure that services are medically necessary and appropriate.

The Office of Provider Services is responsible for the adjudication and control of claims under the Medicaid program. An integral part of this function is the translation of medical policy established by federal and state regulations into claims processing criteria in the Medicaid Management Information System. The office is also responsible for the identification, investigation, and recovery of all third party benefits available to medical assistance recipients, and for conducting provider education workshops and personal assistance visits.

Responses to Fraud and Abuse Problems. Not surprisingly, Washington officials have diverse perspectives on the nature and extent of their

Medicaid fraud and abuse problems. Program administrators believe that recipients and providers "overutilize" the program; auditors and investigators think that "overutilization" is merely a euphemism for abuse and fraud.[3] Since the only data on the program lies in the Medicaid Management Information System, which has been operative since 1976, and since DMA controls the reports taken from MMIS, it is impossible to judge which perspective is more accurate.

Paralleling our findings in Chapter Five, Washington officials regard Medicaid provider fraud and abuse as a problem less significant than controlling costs, ensuring that providers remain satisfied and active, or making certain that recipients obtain the medical assistance they require. Except for the few providers who serve primraily Medicaid clienteles, officials fear that an agressive enforcement program would discourage participation by honest providers because of a fear of inadvertantly getting caught up in erroneous billing practices. This fear is compounded by DMA reimbursement practices: individual Medicaid providers are reimbursed at between 65% and 70% of "usual and customary" charges (Medicare reimburses @ 80%).[4] DMA has even greater need of institutional providers;[5] a strong enforcement program, it feels, might reduce the availability of hospitals and nursing homes for Medicaid patients, or the quality of care offered in participating institutions. To the extent that controlling fraud and abuse is consistent with its cost-containment and service goals, however, DSHS has been quite active.

The three offices within DSHS that monitor the integrity of most Medicaid program operations are the Office of Analysis and Medical Review (OAMR is part of the DMA), and the Office of Operations Review (OOR), and the Office of Special Investigations (OSI), organizationally lodged within the Auditor's Division.[6] The center of activities pertaining to the control of fraud and abuse is OAMR's Medical Services Review Section (MSR), which operates the Medicaid Management Information System (see Figure 10.). The Surveillance and Utilization Review subsystem (SURS) of MMIS is the major source of information regarding the utilization patterns of both Medicaid providers and recipients. The system is programmed to provide

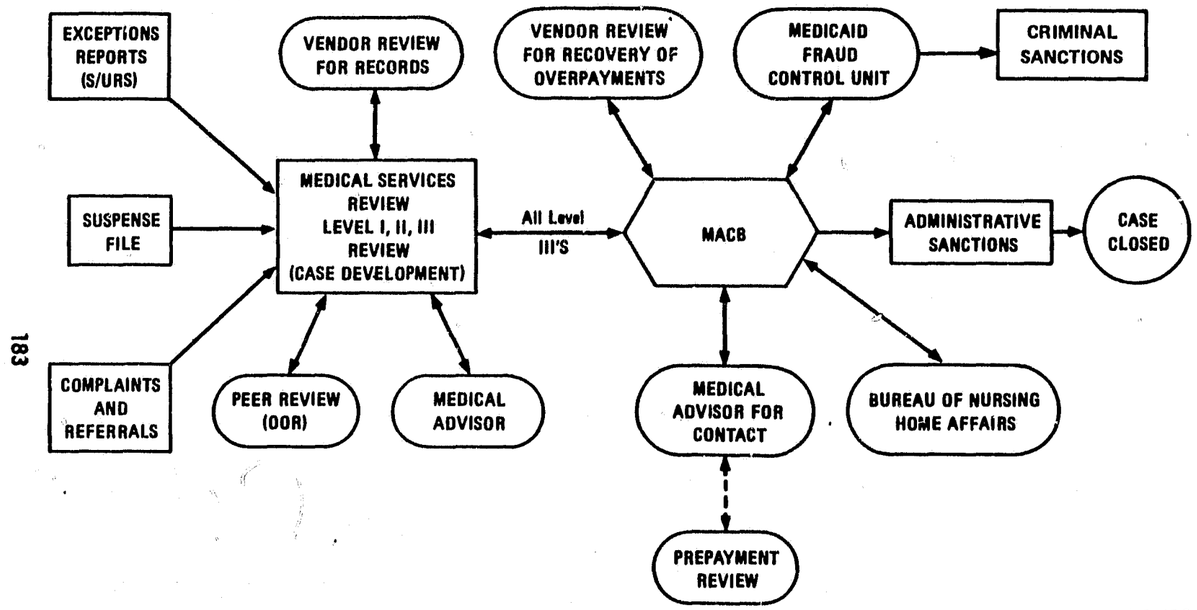

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FIGURE 10 CASE PROCESSING IN THE DIVISION OF MEDICAL ASSISTANCE

exceptions reports, which identify individual providers and recipients whose utilization patterns appear excessive or aberrant.[7] SURS is thus the main source of cases that involve potential fraud and abuse. Other sources of potential cases are the suspense file, a list of previously reviewed providers who have been scheduled for reanalysis, and complaints from providers (most often regarding specific patients) and from patients (most often regarding specific providers).[8] A final and infrequent source of referrals is the Region X Health Care and Financing Administration Office.

Once a referral is received, the appropriate unit within the MSR examines the case for its fraud and abuse potential. This type of examination is called a Level I or Initial Review, and usually relies on the SURS data. In order to lead to a Level II or Integrity Review, the case must show significantly deviant practice when compared with peer group norms. Level II reviews examine the specific areas of exception or deviance as well as the provider's history and paid claims. Records from the Vendor Review Section in the OOR may be required in a Level II review. A medical advisor may also be used to examine the questionable case(s) to determine if there was a defensible medical reason for a particular treatment or pattern of utilization. In addition, many Level II cases are discussed informally with Medicaid Fraud Control Unit staff. When sufficient evidence of fraud or abuse is not found, the cases are normally closed. If a case continues beyond this point, it becomes a Level III or Full Scale Review. This review may include documentation of examples of fraud or abuse, contact with the providers or recipients involved, and an on-site review of provider records. Generally, Level III reviews result in a referral for further action or the imposition of an administrative sanction. Possible administrative sanctions include provider/recipient education, placing the provider on prepayment review, recovery of overpayments, referral to peer review, audit, or the Medicaid Fraud Control Unit (MFCU), suspension or termination from the program, or referral to the professional licensing agency.

Regardless of the sanctions involved, all Level III reviews are referred to the Medicaid Abuse Control Board (MACB).[9] The MACB was formed in 1978 and includes representatives of DMA, the Office of Special Investigation's Medicaid Fraud Control Unit, the Office of Operations Review, and the Bureau of Nursing Home Affairs of DSHS's Community Services Division. The DMA representative serves as the control point within the Board. The Board meets twice each month to discuss cases and allocate responsibilities among the members for further action.

Outside of DMA, all other DSHS activities which monitor the integrity of the Medicaid program are conducted in the Division of Audit, specifically its Office of Operations Review (OOR), Office of Special Investigations (OSI), and the Medicaid Fraud Control Unit in OSI. The OOR has three audit sections: Performance Audit conducts internal audits of DSHS and contract audits of social service vendors; Fiscal Audit conducts cost reports and trust fund audits of approximately 285 nursing homes; and Vendor Review audits medical service vendors, including hospitals, physicians, pharmacies, and dentists. Fiscal Audit and Vendor Review can be asked by OAMR or by the MACB to provide or collect information regarding a provider whose practices appear questionable; however, these two sections also have their own audit plans, which include random as well as targetted audits.

Vendor Review, for example, has recently started to audit hospitals and has plans to pursue hospital audits in conjunction with Federal Region X personnel.[10] Audits of Medicaid providers received considerable legislative support in 1979 with the passage of Senate Bill 2337, which authorized the inspection and audit of vendor records. (The legislation was contested by the provider community but was upheld in court in Latta vs. State Department of Social Services, 92 Wash. 2nd 812,601 P2nd 520 (1970)). During the first year (1979) of the expanded program, sixty audits were completed, with forty revealing enough defects to present problems. The most commonly reported findings included billing in excess of usual and customary charges; billing more than once for the same service; billing individual services when covered by "flat fee," e.g., surgical procedure or obstetrical care; billing total care when only partial care was provided,

for example, billing for total pregnancy care when care did not begin until the third trimester; no documentation of services in records, or inadequate records; billing for a higher level of service than was provided; billing for well-patient exams; upcharge for referral laboratory charges; billing and receiving payment from more than one source, i.e., DSHS and third party insurance (failure to return DSHS payment); and overutilization, i.e., billing for a standard office call to all patients, regardless of complaint or condition.

The most severe measures available to MACB, of course, are to recommend license revocation or criminal prosecution. But because of the difficulties associated with criminally prosecuting Medicaid providers, recent legislation provided the Secretary of the DSHS the authority to levy civil fines for provider fraud up to three times the amount of the identified overpayment plus one percent per month interest.

The third Audit unit which deals with fraud and abuse issues is the Medicaid Fraud Control Unit. A memorandum of understanding between DMA and the MFCU provides that DMA has primary responsibility for the prevention and detection of fraud, abuse, and improper practices, and the MFCU has primary responsibility for the investigation and prosecution of provider fraud. The Civil Recovery Unit has the responsibility to prepare vendor audits and/or case reports and, where appropriate, assess civil penalties, and review and coordinate collection of overpayments. The CRU consists of an Assistant Attorney General, an investigator, and an auditor.

In 1980, the MFCU received 233 complaints; of these, 43 came from within DSHS. Most referrals to the MFCU come from OOR field audits, the SURS system, and returned Medical Services Verification (MSV) forms. Some referrals come from the Welfare Fraud Hotline and a few come from various proactive tactics undertaken by the MFCU. (The proactive efforts can be troublesome to the DMA, which is constantly worried about keeping providers satisfied and not harassed; as a result, the authority to use proactive methods is an irritant to the DMA.)

Regardless of the source of a referral, the MFCU has developed a case development procedure for investigating and prosecuting cases of alleged provider fraud. Figure 11 outlines this process. An initial review of all new cases is made by a supervising investigator. This may involve contact with other offices and agencies as well as an analysis of documentation and records. If the case appears to have merit, a meeting, called a case development conference, is called.

The purpose of this meeting is to determine the initial disposition of the case. In addition to the supervising investigator and the investigator/auditor, the Civil Recovery Unit/Assistant Attorney General (CRU/AAG) and the Special Medicaid Prosecutor[10] (who is based in Seattle rather than Olympia) attend this meeting. If it is decided that the case should not be pursued, it is closed and the supervising investigator, the CRU/AAG, and the Special Prosecutor write briefs explaining the decision. If it is determined that further investigation is needed, an investigative plan is developed and the case is assigned to an investigator or auditor. In addition, a decision can be made at this time to pursue the case on a civil rather than criminal basis.

During the course of the investigation, the Special Prosecutor is kept informed of its development. If subpoenas, search warrants, and legal advice are required, the Special Prosecutor is consulted. At the conclusion of an investigation, the case is reviewed. If the case has prosecutorial merit, a formal report is submitted to the Special Prosecutor and a court date is set. If all parties agree that the case lacks prosecutorial merit, the Special Prosecutor writes a formal opinion and the case is assigned to the CRU/AAG for review.

If civil recovery is appropriate, the CRU/AAG proceeds as necessary. If civil recovery is not to be pursued, the case is returned to the supervising investigator with a formal statement written by the CRU/AAG. The supervising investigator then writes a final report, which is forwarded to the appropriate agencies. Any recommendations or problems identified during any phase of the investigation are included in the final report.

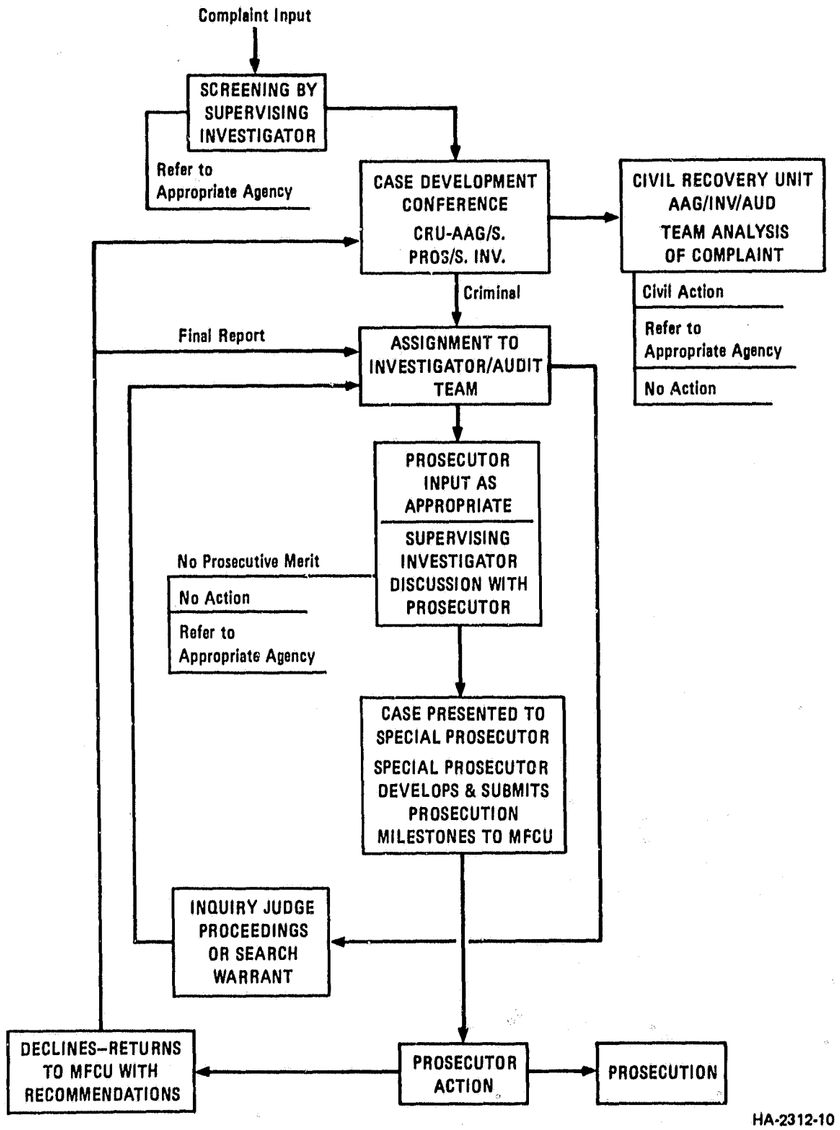


FIGURE 11 MEDICAID FRAUD CONTROL UNIT CASE PROCESSING

Assessment of the Efforts to Control Fraud and Abuse in the Washington Medicaid Program. In 1979, overpayments to providers totalling $121,792 were identified; in 1980, overpayments to providers totalling $484,768 were identified by DMA. Of this sum, $207,495 was identified during Level II reviews and $277,273 during Level III reviews. In 1981, Integrity Reviews identified $934,080 in overpayments and Full Scale Reviews identified $1,893,627, a total of $2,827,707. In 1979 and 1980, the MFCU identified overpayments totaling $384,845 and $247,000, respectively. In addition to this sum, $1,729,963 was identified by the Office of Operations Review to have been paid to hospitals for Medicaid services covered by Medicare or other third parties. The size of this figure, which is three to four times the magnitude of the dollars identified during the OAMR reviews of provider utilization patterns, may explain, in part, why controlling fraud and abuse is not the main concern of the DMA. Cost containment is the main concern; if the costs required to locate and subsequently recoup dollars from third parties (e.g., absent parents, workmen's compensation), for example, are commensurate with the costs of recouping dollars lost through fraud and abuse, the departmental resources available for recoupment work may well be allocated to recover dollars from third parties. On the other hand, a major cause of third party liability (TPL) problems is the inability of financial service technicians to elicit--at the time an applicant applies for benefits--information concerning any TPL sources. In order to effectively confront the TPL issue, the DMA would, most likely, need to work in tandem with the Division of Income Assistance and the various Regional Offices of the DSHS. This could result in a corrective action program too expensive to justify.

As for prosecutorial activity, 27 cases were referred to the Special Prosecutor's Office and/or county prosecutors in the period 1979 through 1980. Of the cases handled by the Special Prosecutor, nine were referred with a request that charges be filed; two of these were declined by the Special Prosecutor's Office, and seven were charged resulting in six convictions and one acquittal. The remaining 17 cases were submitted to the Special Prosecutor's Office either to affirm a Medicaid Fraud Control Unit staff conclusion that the case did not warrant additional investigation, and

should therefore be administratively closed, or to request further legal advice.

A striking contrast to these figures is provided by the Fiscal Audit and Vendor Review Sections in the Division of Audit. Unsubstantiated data show that $6.3 million was saved as a result of nursing home audits in 1980, and during the first 4 1/2 months of 1981, Vendor Review identified approximately $5.3 million in overpayments.[12]

As far as specific sanctions are concerned, three providers were suspended from the Medicaid program in 1979 and one in 1980; one was removed from the program in 1979 and four in 1980; four were fined in 1979 and three in 1980; and two were given jail terms in both years. (Engquist-Seidenberg, 1981: 110) According to the DSHS, nine providers were terminated from the program in 1979, eight in 1980, and twelve in 1981. On the recipient side, fourteen patients had been "locked in" to seeing a specific physician and/or pharmacist at the time of the field work. Estimates of the cost savings resulting from the practice of controlling patient utilization are $2,724 per year per recipient.

The interpretation of the preceding data depends entirely on the perspective of the individual making the assessment. To HCFA's Medicaid Management Bureau, which prepares the annual state assessment, and the former Office of Program Integrity, which prepares the fraud and abuse section of HCFA's state assessment, the Washington Medicaid program is administered in exemplary fashion.[12] The DMA, of course, feels likewise and is pleased that Region X personnel interpret the data supplied to them by the DMA in the way they do. What the data mean to the different members of the state legislature is not obvious, although when the federal share of the financing for the MFCU fell from 90% to 75%, the state increased its share of the funding from 10% to 25%.[13]

The MFCU and perhaps the Region X Office of Investigations in DHHS's Office of Inspector General, however, believe that a great deal needs to be done in order to better control fraud and abuse. Law enforcement personnel

find it inconceivable that there could be so little fraud and abuse in a program of this magnitude. Rather than seeing the data as indicating a job well done, they believe that only a fraction of the fraud and abuse has been detected and reported.

The Special Prosecutors and the Washington Association of Prosecuting Attorneys (WAPA) feel that law enforcement is not a high priority for the administrators of the Medicaid program, pointing to the the low number of referrals and their belief that the Secretary of the DSHS examines all criminal cases at a relatively early point in case development (which is categorically denied by the Secretary). This perception pervades the WAPA's (if not the Special Prosecutor's) assessment of the DSHS's commitment to fraud and abuse control in the Medicaid program.

The different capabilities and perspectives of the various agencies involved in controlling provider fraud and abuse suggest that which individual(s) or agency receives a referral or detects a case is one of the most important factors in determining the outcome of the case. In this regard, Washington has a situation of concurrent jurisdiction. What this means in practice is that there is no clear allocation of cases to participants on the basis of type of case. Rather, the agency that detects the case often determines what type of case it is as well as how it should be handled. If the detecting agency determines that it is a case better suited to another office, then it refers the case to the appropriate party. How and when this determination is made has to do with individual personalities, the history of relationships among individuals and agencies, politics, bureaucratic survival, and so on. The pressures on and capabilities of each participant in the control process determine the quality of control efforts as well as potential opportunities for policy intervention.

NOTES

1. The number of optional Medicaid services provided by Washington may be cut from twenty-two to fourteen due to budgetary constraints. The optional services available in 1981 include prescribed drugs; podiatrists', optometrists', chiropractors', and other practitioners' services; private duty nursing; clinical services; dental services; physical therapy, occupational therapy, speech therapy; dentures, prosthetic devices, eyeglasses; diagnostic, preventive, and rehabilitative services; services for individuals 65 or older in institutions for tuberculosis or mental disease; intermediate care facility services; inpatient psychiatric facility services for individuals under 22 - categorically needy only; transportation; skilled nursing facility services for patients under 21 years of age; and emergency hospital services.

2. From 1966 until 1978, DSHS was designated as the single state agency. The designation was transferred to DMA in 1978 to permit Washington to take advantage of the 90% federal funding authorized in 1977 for Medicaid Fraud Control Units. Since federal law required that the MFCU be independent of the single state agency, DMA became the single state agency and the MFCU was placed in the DSHS Office of Special Investigations. While the MFCU is thus independent of DMA, it still falls under the umbrella of the Secretary of DSHS. (Medicaid Management Bureau, 1980: 164)

3. Title 74 of the Revised Code of Washington describes provider activities that legally constitute fraud, outlines the sanctions that can be applied to those who defraud the program, and mentions certain procedural requirements. (The comparable statutory provisions for Medicaid recipients are presented in Chapter Five.)

   74.09.210 Fraudulent practices--penalties.

   (1) No person, firm, corporation, partnership, association, agency, institution, or other legal entity, but not including an individual public assistance recipient of health care, shall, on behalf of himself or others, obtain or attempt to obtain benefits or payments under this chapter in a greater amount than that to which entitled by means of:

   a. A willful false statement;

   b. By willful misrepresentation, or by concealment of any material facts; or

   c. By other fraudulent scheme or device, including but not limited to;

      i. Billing for services, drugs, supplies, or equipment that were unfurnished, of lower quality, or a substitution or misrepresentation of items billed; or

      ii. Repeated billing for purportedly covered items, which were not in fact so covered.

   (2) Any person or entity knowingly violating any of the provisions of subsection (1) of this section shall be liable for repayment of any excess benefits or payments received, plus interest on the amount of the excess benefits or payments at the rate of one percent each month for the period from the date upon which payment was made to the date upon which repayment is made to the state. Such person or other entity shall further, in addition to any other penalties provided by law, be subject to civil penalities. The secretary of social and health services may assess civil penalties in an amount not to exceed three times the amount of such excess benefits or payments: Provided, That these civil penalties shall not apply to any acts or omissions occurring prior to the effective date of this act.

4. The DMA, for its part, perceives the budget allotments in a zero-sum fashion: to increase the Medicaid reimbursement rate could mean that the reimbursement rate for Medicare or Workmen's Compensation might require a decrease.

   The fee schedule can also lead to a situation where the character of care provided to Medicaid recipients is changed--perhaps for the worse. For example, if a particular medical procedure usually takes 30 minutes to perform, it's possible that a physician will perform it in 20 minutes for a Medicaid patient. The justification for this is that the reimbursement rate is only 60% of "usual and customary" so why not provide care that is roughly 60% of "usual and customary." In general, the reimbursement rates create incentives for handling Medicaid patients more quickly than is "usual and customary" in order to ensure that a provider's aggregate income is either at its "usual and customary" level or increasing at its "usual and customary" rate.

5. In fact, according to the Washington State Medical Association, 75% of all Medicaid dollars go to hospitals and nursing homes, 15% to rural health clinics, pharmacists, and dental, and 10% to physicians. Of the 10% that goes to physicians, there are 400 to 500 physicians out of a population of 8,000 to 9,000 licensed physicians who receive most of the Medicaid business.

6. Although defrauding the Medicaid program violates federal as well as state law, the Region X representatives of the Health Care Financing Administration and of the DHHS Office of the Inspector General have relatively little to do with the routine control of fraud and abuse. They monitor the state's efforts in this regard but focus their fraud and abuse control efforts on the Medicare program, which is 100% funded by the federal government.

7. For inpatient hospital care and long-term care, the S/UR system provides a secondary review mechanism. The Washington State Professional Review Organization has authority for primary review of inpatient care.

8. Washington mails a form called a MSV (Medical Services Verification) to a sample of recipients similar to Colorado's EOMBs. The recipients are asked to respond as to whether they received the services for which the department paid. Returned MSVs provide leads to fraudulent and abusive practices. Recently, the MSV procedure has been modified to include both a targeted and a random selection of providers. The recipients are provided a postage-paid envelope in which they can return the verification form. All targeted MSVs must be returned; those who do not respond to follow-up efforts are reported to the MFCU. When the DSHS used them on a 100 percent basis, MSV forms returned to DSHS by recipients led to several major prosecutions and, according to the Special Prosecutor, remain one of the best tools for identifying fraud.

9. Since the MSR handles all analysis of SURS data, no case which has not been processed by MSR through a Level III review will come before the MACB. Some law enforcement personnel allege that potential fraud cases do not reach MACB, and thus that they must generate their own cases.

10. Since 1978, Washington has had a Special Prosecutor's Office for Medicaid provider fraud prosecution. The reason for the establishment of the office was that in order to qualify for the 90% federal financing of the MFCU, the state had to have a criminal prosecutorial authority either in the MFCU or affiliated with it. Since in 1978 the Attorney General's Office did not have authority to prosecute criminal cases (it has recently received limited authority for criminal prosecutions), an alternative arrangement was required. Under a contract negotiated between the DSHS and the Washington Association of Prosecuting Attorneys, the Association agreed to provide the required prosecutorial authority and expertise. There are two special prosecutors based in Seattle. In effect, they are deputized as prosecuting attorneys by the County Prosecutor in whose jurisdiction a case exists. Currently, the special prosecutors are deputized in eleven of Washington's thirty-nine counties. The eleven counties include close to 75% of Washington's population.

11. The latter figure is projected from the results of an annual audit sample that includes from 2% to 2.5% of all Medicaid providers.

12. The program is held in such high esteem that there was talk in Region X offices of performing the state assessment for Washington only every other year.

13. By providing continued funding for the MFCU, the legislature also changed the unit from "project" status to "permanent" status. Insofar as a stable and experienced staff is valuable for performing its work, this change in status may assist the unit's effectiveness (by any measure or criteria) because there will be less of an incentive for unit personnel to leave the job for fear the "project" will be terminated.

REFERENCES

ENGQUIST-SEIDENBERG, G. et al. (1981) State Initiatives in Medicaid Cost Containment (Washington: National Governors Association)

MEDICAID MANAGEMENT BUREAU (1980) Review of Medicaid Operations, Department of Social and Health Services, State of Washington (Seattle: HCFA Region X)

PART III
PERSPECTIVES ON FRAUD CONTROL

CHAPTER NINE
FRAUD CONTROL AS AN ECOLOGY OF GAMES

Why have state fraud control policies evolved as they have? While some of the practices found in our case studies reflect idiosyncratic factors, such as individual personalities and abilities, state laws, bureaucratic structures, media scandals, and so forth, there are many similarities among the states, both in the limited emphasis placed on fraud control and in the techniques used for prevention and enforcement. We will argue in the following chapters that these policies are not simply products of decisions regarding what to do about fraud and abuse problems, but also are the by-products of decisions about other issues. Many groups participate in these decision-making processes, and each group has its own interests and priorities. For most, issues of fraud and abuse are subordinate to other matters, leading to fraud control policies and practices which are both less active than might be desired and at times counter-productive to the goal of fraud control. In Chapter Fifteen, we will argue that, unless the incentive systems which currently structure these decision processes are changed, it is unlikely that more effective fraud control policies will be developed.

Most discussions of fraud and abuse problems and of techniques to reduce them involve a relatively small number of specialists--investigators, prosecutors, journalists, and a handful of legislators and administrators who concentrate on the problem. Intermittently, the activities of these specialists capture the headlines with dramatic statements that fraud is rampant in a government program, and new legislation or bureaucratic procedures are proposed. Most of the day-to-day character of benefit program administration, and of the fraud control activities which accompany it, however, is shaped by decisions about much broader issues, such as how society should handle health and welfare problems, how government functions

should be allocated among federal, state, and local governments, how government budgets should be distributed, and how the criminal justice system should function. An understanding of fraud control policies, and recommendations to improve them, must therefore be based on an understanding of these related issue areas and the ways in which they structure opportunities to act against fraud and abuse problems.

The relationship among fraud control and these other issue areas might be described as an ecology of games (cf. Long, 1958). Each game has its own primary issues and players, but also interacts with other games; some issues are settled by the players operating in one game, while others cut across a number of games. The outcome of multigame issues will depend on the activities of all players. Some players will specialize in fraud control issues, but most will identify primarily with other games, regarding fraud control as only an incidental aspect of what to them are more salient problems. Some players may not think of themselves as being involved in fraud issues at all, even though their actions have the effect of shaping responses to fraud problems.

Our use of the terms "games" and "playing" should not be taken to imply frivolity or light-heartedness; for most players, the games we will discuss involve very important issues, and their outcomes affect their and others' well-being. In using the term, we hope to draw attention to the specific issues around which controversies center, and the roles which various persons and organizations play in those controversies. (Cf. Allison, 1969: 708) Furthermore, we do not wish the reader to overestimate the precision or rigidity of the games model. Some games involve many players and high public visibility; other games concern smaller issues and fewer players, and are virtually unknown to the public. The boundaries of each game are often very fuzzy, and it may be difficult to predict whether an issue will be played out in one game rather than another. Similarly, it may be difficult to determine whether an individual is playing in one game or another. Games also vary in their duration. Some endure for many years with stable issues and players, while others emerge suddenly and soon disappear. (In this regard, we might contrast the enduring National Defense, Welfare, and

Taxation games with the more ephemeral Student Unrest, Crime in the Streets, and Violence games which were so visible in the late 1960s.) In games which are likely to extend over time, players may tend to conserve their resources for future plays and to avoid direct confrontation with the other players who will continue to play. In "one play" games, or when a player expects to play only once in a long term game, however, players may be willing to expend all their resources at once.

Our games image is further complicated by the fact that fraud control policy is shaped by decisions made at federal, state, and local levels. At each level, the issues may be defined differently, the players may be different and/or have different status vis-a-vis other players, and games may intersect differently. In a single year, for example, federal-level discussions might focus on welfare policy issues, with liberal Congressmen winning higher AFDC budgets, while state-level debate emphasized cost issues, with conservatives blocking a tax increase; at the county level, the prosecutor might be deciding whether to stress recipient or provider fraud cases.

Similar complexity and fluidity in the games model is produced by changes over time. High unemployment may increase both recipients' demands for benefits and taxpayers' demands for cost-containment, while prosperity may decrease interest in both issues. Scandals may suddenly (if temporarily) attract attention to fraud and abuse problems which few people knew or cared about before. Scandals may also change the informal rules of a game. While it may normally be understood that no player should rock the boat or publicly criticize other players, a scandal may lead to a policy of total warfare ("I know that we overlooked this in the past, but if we don't get error rates down fast, we'll all be out of a job."). Changes in key personnel--a new chairman of the legislature's welfare committee, a new welfare director, a new prosecutor--may reverse old priorities, change power relationships or friendships, or produce uncertainties while everyone waits to see who will do what.

Even accepting these ambiguities and uncertainties in the games model, it has a number of implications for our analysis of fraud control policies. As fraud and abuse became major public issues in the mid-1970s, they were thrust into a policy formulation and implementation system which was structured along other lines. At federal, state, and local levels, other issues and priorities had already determined the committee system of legislatures, the organization chart of the executive branch, the routines of the criminal justice system, and the priorities of major professional associations and interest groups. Except for those relatively narrow issues which affected only those persons who were already active in the Fraud Control Game, fraud and abuse had to stand in line to compete for the attention of players in other games.

A Taxonomy of Related Games. Recognizing that there may be different ecologies of games at federal, state, and local levels, and in each state and community, and that the boundaries of each game are somewhat vague, it appears that at least six basic games affect the character of fraud control policies. The issues or stakes which define these games (cf. Bardach, 1977) and the most frequent actors in them are:

1) The Welfare Policy Game. What welfare benefits will be distributed to which recipients? What standards and procedures will be used in distributing benefits? What trade-offs should be made between rapid processing of applications and careful scrutiny to verify eligibility? In some areas at some times, "welfare" issues become intermingled with "race" issues. Frances Fox Piven and Richard A. Cloward argue that welfare policies have also been used at various times to "mute civil disorder" or to "reinforce work norms" (1971:xiii). Whether one stresses the manifest or latent functions of welfare policies, the regular players in this game are welfare recipients, the welfare agencies, the legislature, and the governor. The interests of the recipients are often represented by welfare rights organizations, legal assistance foundations, university schools of social work, and private charities.

2) The Health Policy Game. What health care services should be provided at public expense? By which providers? Should reimbursement equal costs or current market rates, or be set at some lower level? Should patients have complete freedom to choose their own providers ("mainstream medicine") or should they be steered toward county hospitals, health maintenance organizations, or other specific providers? Should recipients be eligible for unlimited services or restricted to "necessities"? Should providers' treatment decisions be reviewable, and if so, by whom? The major players in this game are providers and their professional associations, the welfare agency, the legislature, and the governor. Since decisions about publicly funded health care also affect the structure and finances of private care (especially with regard to nursing homes and hospitals in areas with large welfare populations), public health policy issues are of great concern to other health-related organizations, such as insurance companies and health departments. (Insurance companies also become involved as carriers or intermediaries in Medicaid and Medicare programs.) Recipient organizations, particularly those representing the elderly, can become players in games dealing with health care services, but are less interested in reimbursement issues.

3) The Criminal Justice Game. How should violations of program regulations be defined for civil, criminal, and administrative adjudication purposes? What penalties should be imposed for each type of violation? What types of cases should be given priority, either among program fraud cases or between fraud and other crimes? What resources should be allocated to fraud enforcement programs? Should fraud cases be processed through existing agencies or specialized bodies? Should fraud enforcement efforts be separately organized and budgeted, or should they utilize existing agencies (state and local police departments, prosecutors, and courts) and their resources? The major players in this game are the control units in welfare agencies, specialized Medicaid Fraud Control Units, and nonspecialized investigations,

prosecution, and court agencies. The interests of potential violators are represented by both their professional associations and their attorneys (primarily poverty lawyers for recipients and the private bar for providers). Statutory changes being considered by the legislature will also attract the attention of the state and local bar associations, police groups, and conferences of judges and prosecutors.

4) The Fiscal Policy Game. Two sets of issues are involved -- how much should be allocated to different public programs, and where should the money come from? The first issue involves questions of the total scale of government expenditures and their distribution among social and other programs. At the national level, for example, there will be simultaneous debates over the size of the national budget, the allocation of funds between defense and domestic programs, and the allocation of funds among domestic programs (health, education, welfare, roads, agriculture, and so forth.) The second issue involves cost allocations among levels of government and revenue sources (e.g., income, sales, or property taxes). When higher expenditures for welfare programs or fraud control are sought, therefore, they will compete with claims for such programs as defense or education, and arguments will be made that government is already too big, or that some other level of government should fund the effort. Every group seeking public funds becomes involved in trying to influence the governor and the state legislature, or the president and Congress; each level of government will try to minimize the share of a program's costs which it will have to pay.

5) The Intergovernmental Relations Game. Closely tied to the question of who will pay for programs are the questions of who will operate them, specify the details of implementation, recruit and supervise personnel, etc. This game involves issues of relationships among federal, state, and local governments, among headquarters and field offices (federal regional offices, county welfare offices), among

legislatures and executive branch agencies, among welfare agencies and control agencies, ad infinitum. Using the rhetoric of "states' rights," "the independence of the judiciary," "legislative oversight," the "expertise" of program specialists, etc., each agency will try to maximize its authority and minimize "interference" by other agencies.[1]

6) The Public Administration Game. While the Intergovernmental Relations Game involves conflict among organizations, the Public Administration Game involves issues within organizations. Eugene Bardach offers the image of a Management Game in which managers try to combat incompetence, variations in policy implementation, lack of coordination, etc. (1977: 139-141). "Headquarters" is always trying to force the field to follow agency policies, while the field is always trying to expand its freedom to make discretionary judgments. Fieldworkers always feel that they understand the real world (e.g., the needs of the poor, the application process) better than the bureaucrats in headquarters, while managers always assume that their employees will, if left unsupervised, ignore agency policies or sleep on the job. The issues in the Public Administration Game are further multiplied when authority is legally divided, as between DHHS and the state welfare agencies, or between the state and counties in a state-supervised welfare system. Over such issues as forms, reporting requirements, quality control systems, and approvals, managers play for control and subordinates play for independence.

It is unlikely that these six games are the only games whose interaction shapes fraud control policy in a specific state or benefit program. In an election year, fraud and welfare issues may provide opportunities for aspiring politicians to play in the game of public name recognition or political party status, or for the "outs" to blame the "ins" for "rampant" fraud, waste, and mismanagement. Newspapers and citizen groups may find the same issues useful opportunities to build circulation or membership. Rural and suburban groups may use them to prove the inherent

iniquity of city-dwellers. Regardless of the games which can be identified, our point, depicted in Figure 12, is that fraud control policies have many sources. The narrower, technical issues of <u>how</u> to implement fraud control policy are decided by small groups of specialists, but the broader issues of whether to make control a high priority, <u>which forms</u> of fraud and abuse should be emphasized, and <u>how much</u> should be spent in the process are parts of much broader games played by many officials, groups, and organizations.

<u>Players and Playing</u>. Fraud Control and the games related to it are played in a variety of settings--before the chief executive (governor or president) and legislature as the players fight over budgets and substantive legislation; before welfare agency leaders as budget requests, regulations, and policies are shaped and implemented; before the courts as the legality of agency policies is challenged; and in the media, election campaigns, and other public settings as players seek public support for their positions. In these different settings, decision-makers may be influenced by different resources possessed or expended by players: elected officials may consider the number of votes or potential campaign contributions[2] of players, prosecutors and judges may react to the legal arguments and legal skills of players, administrators may look for technical expertise or detailed knowledge of program operations,[3] and so forth. Since players have varying amounts of these resources at their command, they will have different abilities to persuade decision-makers. (While players may act on the assumption that another player will expend his resources, many players do not utilize available resources or do not use them in them in a particular game; thus a "poor" player who uses his resources may be more influential than a "rich" player who is inactive. For some period of time, of course, the rich player's <u>threat</u> to act could be as effective as a completed act; presumably, the credibility of such threats would erode over time.) Players also differ in other ways. They play for different stakes--some seek material stakes (higher AFDC grants or Medicaid payments, jobs, etc.), while others want prestige or publicity (to become known as a leader in the medical society, a tough prosecutor, an up-and-coming politician), symbolic ends (the rights of the poor, law and order, the

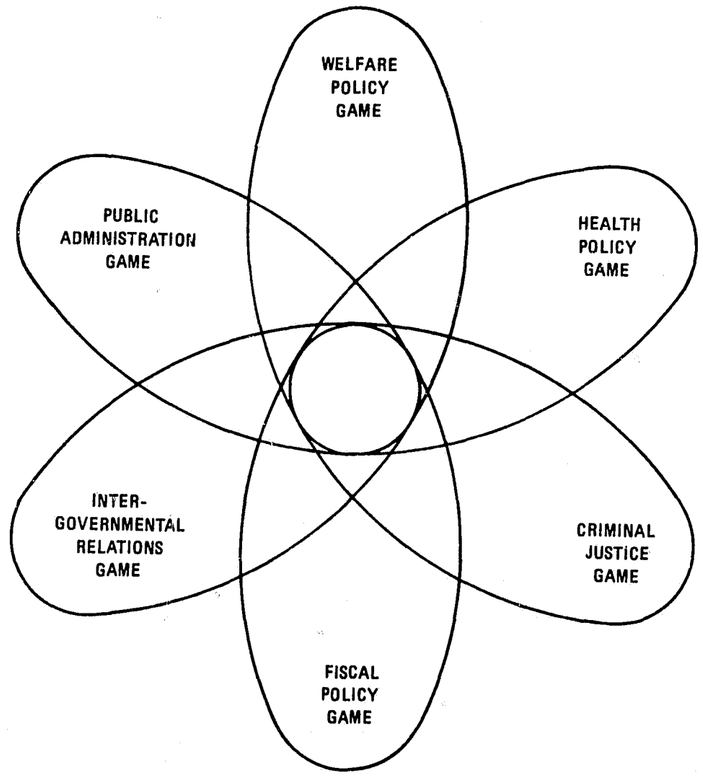


FIGURE 12 FRAUD CONTROL POLICY AS AN ECOLOGY OF GAMES

doctor-patient privilege, states' rights), or simply the fun of playing. Some players may enter a game only when a specific issue arises, while others try to maintain a permanent position in a game. In Congress, for example, Senator Edward Kennedy has long been active in health care issues, Senator Frank Moss long maintained an interest in the problems of nursing homes (see Mendelson, 1974: 230), and Rep. Claude Pepper has held many hearings on the problems of the elderly.[4]

Players will have different definitions of the "issues" involved in each game. Some will see fraud and abuse as crimes, a waste of public funds, or indications of incompetence or mismanagement in the welfare agency. Other players, however, will argue that the "real" issues are the delivery of services to the poor, the quality of health care, adequate grant levels, and bureaucratic "harassment." Plays are based on very different perceptions and levels of information about agency programs and policies, about fraud and abuse problems, and about what is or will be going on in a game; some players have very detailed and current information, while others know little more than or even as much as what is reported in today's newspapers. Each play and each game will thus be conducted in an atmosphere of uncertainty, since few players will know what resources are held by other players or whether they will be expended in this game.[5] Will the welfare lobby bus 10,000 AFDC mothers to the capital when the legislature debates the AFDC budget? Will the medical society call in its debts to get higher reimbursement rates? Will the local hospital carry out its threat not to accept Medicaid patients if the welfare agency tries to collect on the overpayments documented in an audit? Because of the strategic value of information, all players will try to overstate their position to conceal information about their true resources and their plans and to gain information about other players.

Finally, we should note that most players participate in more than one game at any time and may vary their level of involvement from time to time. Players must allocate their resources among all games, trying to expend as few as possible to win a particular victory, and of course, trying to gather new resources along the way. Persons who do not normally participate in a

game may enter when they perceive their interests to be affected. A game normally involving only a few players might suddenly expand when a crisis (e.g., a welfare fraud scandal or a tax revolt) mobilizes normally quiescent players. (Coleman, 1956; Edelman, 1964).

The Players and Fraud Control Games. We can now describe the players in the various games which affect fraud control policy, and the perspectives they will bring to fraud control issues.[6] Our basic assumption is that players will perceive various incentives and disincentives to support policies to control fraud and abuse. While their perceptions may not always correspond with reality, those who perceive net incentives (more incentives than disincentives) will support fraud control, while those with net disincentives will oppose it. The extent to which players will actually expend resources in support of their position will depend on what resources they have available and their willingness to expend them in this game at this time for this purpose (i.e., there may be many more persons who support or oppose fraud control than who actually play to bring it about or to prevent it). Whether fraud control policies will be adopted and implemented depends on whether more resources are expended for or against it, not only in the Fraud Control Game but also in related games.

Players can be classified according to the scope to their interests and the frequency with which they become involved in relevant games. Some players are interested only in welfare and/or fraud issues, while others are interested in the full range of public policies; some players are continually involved while others are involved only intermittently or even on a one-shot basis. Table 14 suggests the players who fit into these categories. The players who are interested in welfare and fraud issues on a continuing basis are recipients, providers, the federal, state, and local agencies which fund or administer welfare programs, and the agencies which implement antifraud and abuse control efforts. Also continually involved but dealing with broader issues are chief executives and their budget offices, legislatures, and the interest groups which concern themselves with

Table 14

PLAYERS IN FRAUD CONTROL AND RELATED GAMES

FREQUENCY OF INVOLVEMENT	SCOPE OF INTERESTS: Narrow (Welfare and/or Fraud)	SCOPE OF INTERESTS: Broad
Continuing	Recipients Welfare rights organizations Legal assistance foundations Schools of social work Private charities Providers Professional associations Insurance companies Program agencies U.S. Dept. of Health and Human Services U.S. Dept. of Agriculture State welfare agencies County welfare agencies Control agencies Quality control Investigators Prosecutors Medicaid Fraud Control Units	Chief executive President Governors Budget offices Office of Management and Budget State bureaus of the budget Legislatures Congress State legislatures County boards Intergovernmental lobbies National Governors' Association National Conference of State Legislators Associations of counties Good government lobbies
Intermittent	Special investigative commissions	Taxpayers associations Investigative journalists Auditors General Accounting Office State auditor

Source: This typology is adapted from Sayre and Kaufman (1960:79).

general issues such as "good government" or the allocation of programs and their costs among federal, state, and local governments.

While most games are decided by the interactions of these "repeat players," their hegemony is occasionally broken by the intervention of normally inactive players. Audit agencies or investigative journalists may decide to scrutinize the operations of the welfare system, creating a "welfare fraud scandal," or a taypayers' association may arise to condemn the costs of government. In response to such crises, special "blue ribbon" commissions may be appointed to investigate problems and recommend solutions;[7] the Illinois Fraud Prevention Commission described in Chapter Three was such a "one shot" player, appointed by a new governor and disbanded six months later after issuing recommendations for reorganization and new legislation.

In the following chapters, we will analyze in detail the perspectives of the program administrators and control specialists who are continually involved in fraud control games. First, however, we can sketch the general characteristics of those with whom, regularly or intermittently, the specialists must deal.

1) Outsiders: Voters, Taxpayers, and the Mass Media. Attempting to characterize such diverse groups as voters, taxpayers, and the mass media is a risky venture, both because of their diversity and because of their peripheral roles in public policymaking. The media intermittently provide coverage of public issues and express editorial positons on them, and surveys give responses to the questions asked. Yet this information by itself says little about the intensity of their feelings, the probability that voters or the media will act on these beliefs, or the impact they will have on other players.

The role of these outsiders in fraud-related games is often weakened by internal contradictions in their attitudes. On the one hand, most people accept the necessity of public support of the poor. A 1976 Harris Survey, for example, found that 94% of 1500 respondents agreed with the statement,

"It is not right to let people who need welfare go hungry." On the other hand, 89% of the respondents in the same poll felt that "Too many people on welfare could be working," and 85% agreed that "Too many people on welfare cheat by getting money they are not entitled to." (Harris, 1976) Adding to this ambivalence about welfare recipients is concern about the welfare system's costs; since 1976, surveys conducted by the National Opinion Research Center have repeatedly found 45-50% of respondents expressing the belief that "too much" is being spent on welfare. A 1978 survey of 800 Illinois voters found "controlling costs" to be a paramount concern of 78%, and 84% rated "prosecution of welfare and Medicaid fraud" as their highest single issue of concern (Skinner, 1979: 75-76). Regardless of how one interprets recent elections and taxpayer revolts (see Lowery and Sigelman, 1981), it is fairly clear that the 1960s' enthusiasm for social programs has subsided.

These surveys suggest three simultaneous aspects of public attitudes about the welfare system -- sympathy for the poor, concern for the costs of government, and a feeling that defrauders should be prosecuted. Feelings about Medicaid providers, however, are likely to be quite different. Medicine is one of the most highly esteemed of professions, and health care institutions are valued and respected in most communities. Unlike welfare recipients, providers are likely to have middle class or above status. "The importance of ideological legitimacy," Bruce Vladeck argues, "should not be underemphasized, for public imagery plays a crucial role in nursing home politics. While their for-profit status marks proprietary nursing homes as suspect in some public-health, academic, and left-wing political circles, it has quite the opposite effect among many conservative, rural, and/or Republican legislators. The god-given right of every American citizen to make a buck occupies a hallowed place in much of the American political system." (1980:196).

Somewhat different conflicts confront the mass media. Editorially, they may endorse the current administration and be reluctant to criticize its management record, or may support welfare programs and be reluctant to publicize any fraud and abuse problems. As a journalistic matter, the media

may feel that welfare administration is too complex to be comprehensible or interesting to readers or viewers, or too conflictual, alienating either the poor or the affluent segment of their audiences. As a matter of resource allocation, a newspaper or station may have to choose between passive acceptance of whatever information is "fed" to it by the welfare agency or investing heavily in investigative journalists to develop in-depth stories. Coverage of a juicy scandal may make good copy or help in a circulation or ratings war, and a successful investigation may win a Pulitzer prize, but less dramatic issues involving the welfare system and "garden variety" fraud and abuse must compete with all other topics which might be used in today's paper or the ten o'clock news.

What should the regular players expect about the participation of these outsiders in fraud-related games? For the most part, the outsiders probably have a very large "zone of indifference" (cf. Barnard, 1938:167) about welfare and fraud issues; unless fraud or the costs of welfare become <u>too</u> great, or unless recipients and providers are screaming <u>too</u> loudly about cutbacks or harassment, the public and the media are unlikely to care greatly about what the regulars decide. A major and continuing fraud scandal or tax revolt, however, may translate amorphous issues into comprehensible outrages--a welfare queen, a Medicaid mill, a tangible chunk of <u>my</u> tax bill--but there otherwise will be little incentive to become involved.

2) Insiders: Executives, Legislators, and Budgeters. Under some circumstances, official decision-makers simply ratify the outcomes of conflicts among other players, approving budgets or laws based upon completed negotiations between, for example, welfare agencies and their recipients and providers. At other times, however, they make decisions on their own, hearing the arguments of all players and refereeing their claims. To some extent, like the outsiders, they too may have a zone of indifference, allowing agencies and their clients to work out budget priorities and implementation policies. Yet, since they are called on from time to time to hear appeals from dissatisfied players and routinely must

deal with related issues during budget and legislative processes, their perspectives are constantly relevant to the specialists.

The insiders vary in their constituencies and in their roles in policymaking. Their constituencies can range in size from a city ward to a state legislative district, a state (governors, U.S. senators), or the nation (the President). Their constituencies also vary in composition; some have large welfare populations while some are quite affluent. The insiders will face differing demands from their constituents; those with large voting blocks of welfare recipients or financial support from providers will be expected to support expanded programs and benefit levels or to oppose agency harassment, while those with affluent constituents and supporters would face pressures to keep taxes down or support other programs. Elected officials with more balanced constituencies, however, would usually be able to offer, without offending anybody, vague platforms about the needs of the poor, the necessity to keep taxes down, and the importance of punishing "welfare chiselers."

While many elected officials are often free to take unidirectional positions for or against welfare issues insofar as their constituents are concerned,[8] they are also repeatedly thrust into conflicts which force them to reconcile competing interests. Playing in the Fiscal Policy Game, legislators, budget offices, and executives must allocate funds among programs; substantive legislation may generate conflicts among, for example, the Health Policy, Welfare Policy, and Criminal Justice games. The insiders are therefore forced to play different roles in these situations. In substantive legislation, elected officials can emphasize constituent or partisan interests. Andrea Lange and Robert Bowers, for example, conclude that "As legislation is marked-up, legislators are inclined 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." (Lange and Bowers, 1979: 92-93).

While individual legislators and the legislative committees which deal with single issues such as health or welfare are free to take simple positions, budget committees, budget offices, and chief executives must deal with broader problems. Individual agencies can easily advocate legislation and budgets which aid their clients but, as John Wanat notes, "the chief executive must assume both a programmatic and a fiscal posture. Support for specific programs is the means whereby supporters are rewarded. . . . but the executive must also keep an eye on the treasury. To support too many programs at too high a level of funding usually means that taxes must be raised, an expedient that is sure to lose supporters at the next election." (Wanat, 1978: 60)

While constituency pressures may lead some insiders to take active positions in welfare and fraud-related games, and their roles may force them to participate in some decisons, particularly those related to budgets and intergame conflicts, the insiders face a number of incentives to avoid involvement as much as possible. Conflicting public attitudes about welfare mean that <u>any</u> public posture could be a no-win situation, antagonizing either recipients and providers or taxpayers. In addition, the sheer complexity of welfare regulations makes it very difficult for any legislator to understand how the system works. As a general rule, we would expect that every legislature will have a few active players (both pro- and antiwelfare) in welfare games and many generalists who wish that welfare issues would go away.

Chief executives may similarly wish to avoid any strong public identification with welfare issues. As the head of the executive branch, they are responsible (at least in the public's eyes) for the actions of all agencies, and the costs and performance of the welfare system become part of their record. While it is easy for an executive to take strong positions in the Intergovernmental Relations Game (e.g., for a governor to seek to maximize federal funding and state autonomy), he or she will have a strong incentive to try to keep out of other games, since recipients and providers will never feel that they are getting enough, taxpayers will always believe they are paying too much, and civil servants, prosecutors, and judges will

resent executive interference in their activities. While executives cannot escape playing in these games, particularly when they involve fiscal issues, the best they can usually hope for is to minimize potential losses.

For a variety of reasons, therefore, we would expect that legislators and executives will be important, but often reluctant players in the games which determine fraud control policy. Some will find it productive to take strong pro-welfare or anti-fraud positions, but none will wish to become associated with higher taxes. Under normal circumstances, it will be politically advantageous to adopt a "Not our Problem" (Bardach, 1977: 159) posture, letting the welfare agency and the criminal justice system take the heat for low benefits, high costs, and any fraud and abuse which become known. A scandal may make it necessary (more for the chief executive than for the legislature) to "do something", but otherwise fraud control policies will be shaped by the interaction of the specialists. We turn now to recipients, providers, and program and control agencies.

NOTES

1. The involvement of so many agencies, Eugene Bardach notes, makes it possible for an agency to avoid unwanted responsibilities ("Not our Problem") and deflect criticism ("Their Fault") (Bardach, 1977:162). As an example, Bruce C. Vladeck argues that "The recent stalemate between state and and federal governments on nursing home policy illustrates the extent to which the federal system focuses on questions of money--or more precisely, around the struggle to let someone else's constituents pay the taxes--far more than on questions of programmatic content. The sharing of powers between federal and state governments permits politicians at all levels to pass the buck on difficult problems such as 'levels-of-care' policy, the creation of reimbursement methods, or quality-cost tradeoffs." (1980:207)

2. From time to time, charges are made that, in addition to legitimate campaign contributions, players resort to outright bribery to influence legislation and its implementation. Nursing home critic Mary Adelaide Mendelson, for example, reports, "A friendly Ohio state senator told me that money openly passed from the industry to legislators to influence their votes on the nursing home regulatory bill. . . . The comment on money passing from the industry to the proper people is beyond my ability to prove. Yet a system of payoffs is the repeated explanation I am given of why government fails to respond to pressures to enforce its minimal regulations, to strengthen existing legislation, or even to understand the industry." (1974:219-220)

3. Cf. Vladeck (1980: 195): "Like most lobbyists for most industries, those who represent nursing homes spend most of their time collecting and dispensing information and arguing their constituents' cases. The national associations finance major studies of reimbursement and other issues; employ experts who can explain the most detailed arcana of accounting or regulatory practice to a congressman--or, more likely, a congressional aide--better than anyone HEW is likely to send over; appear at all the congressional hearings; and meet periodically with HEW officials. Information, which can be a scarce and valuable commodity in Washington and most state capitals, is the primary stock in trade for nursing home associations and their state affiliates."

4. Eugene Bardach (1977) describes the long-term efforts of California state assemblyman Frank Lanterman to control all legislation (and its implementation) dealing with mental health; his interest, knowledge, and political influence were so great that it was widely believed that no mental health proposals could survive in California without Lanterman's approval or acquiescence.

5. Bardach notes a number of uncertainties about the future in any policy implementation process. "How skillfully, vigorously, or cunningly will the relevant actors play their games? Will they recognize all their opportunities? Will they seize them if they are recognized? Will they play cooperatively or exploitatively? What games will merge into larger ones--and what larger games will decompose into smaller ones?

   "The scenario-writer cannot readily predict who will be playing in the implementation games. Although most of the probable players are identifiable by reason of their having played in previous policy and implementation games in the program area, there may be some new ones. In addition, not all the old ones will actually play." (1977: 268, 279).

6. For a comparable analysis, using the vocabulary of cost-benefit analysis, of issues of corruption in zoning and building regulation, see Gardiner and Lyman (1978: Part Three).

7. For an analysis of the role of similar investigative commissions concerned with racial violence, see Lipsky and Olson (1977).

8. Political scientist John Wanat observes that "A triangle of mutual interests often develops among agencies, their clients, and the appropriations decisional unit in the legislature. Clients want to receive services from agencies. But agencies need money which only legislatures can bestow. Consequently, clients will urge legislators to appropriate for 'their agencies.' Legislatures, on the other hand, want votes, which will be forthcoming if clients are happy. And agencies are willing to make clients happy if they have the resources to do so. This mutuality of interests guarantees that information about needs, programs, and financing is exchanged in the triangle." (Wanat: 1978:72)

REFERENCES

ALLISON, G. (1969) "Conceptual Models and the Cuban Missile Crisis," American Political Science Review, 63 (September): 689-718.

BARDACH, D. (1977) The Implementation Game: What Happens after a Bill Becomes a Law (Cambridge: MIT Press)

BARNARD, C. (1938) The Functions of the Executive (Cambridge: Harvard University Press)

COLEMAN, J. (1956) Community Conflict (Glencoe: Free Press)

EDELMAN, M. (1964) The Symbolic Uses of Politics (Urbana: University of Illinois Press)

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

HARRIS, L. (1976) "Majority ambivalent on welfare", Chicago Tribune, June 10.

LANGE, A., and R. BOWERS (1979) Fraud and Abuse in Government Benefit Programs (Washington: Government Printing Office)

LIPSKY, M., and D. OLSON (1977) Commission Politics: The Processing of Racial Crisis in America (New Brunswick: Transaction Books)

LONG, N. (1958) "The Local Community as an Ecology of Games," American Journal of Sociology, 64 (November): 251-261

LOWERY, D., and L. SIGELMAN, "Understanding the Tax Revolt: Eight Explanations," American Political Science Review 75 (December): 963-974

MENDELSON, M. (1974) Tender Loving Greed: How the Incredibly Lucrative Nursing Home "Industry" is Exploiting America's Old People and Defrauding Us All (New York: Random House)

PIVEN, F., and R. CLOWARD, (1971) Regulating the Poor: The Functions of Public Welfare (New York: Random House)

SAYRE, W., and H. KAUFMAN (1960) Governing New York City: Politics in the Metropolis (New York: Russell Sage Foundation)

SKINNER, S. (1979) "Remarks" in DHEW Secretary's National Conference on Fraud, Abuse, and Error: Conference Proceedings (Washington: Government Printing Office)

VLADECK, B. (1980) Unloving Care: The Nursing Home Tragedy (New York: Basic Books)

WANAT, J. (1978) Introduction to Budgeting (North Scituate, MA: Duxbury).

CHAPTER TEN

RECIPIENTS' AND PROVIDERS' PERSPECTIVES ON FRAUD CONTROL

> Freeze, freeze thou bitter sky,
> Thou dost not bite so nigh
> As benefits forgot.
> Though thou the waters warp,
> Thy sting is not so sharp
> As friend remembered not.
>
> William Shakespeare
> As You Like It, Act II

Smart crooks should get out of violence and street crime and get into fraud--there is more money and less risk. Cops and prosecutors don't get as mad at you it you're into fraud as if you're into violence.

Donald R. Cressey

> We deplore any activity which is fraudulent, and we support efforts directed toward identifying the fraudulent, prosecuting the fraudulent to the full extent of the law, and jailing those convicted. ...
>
> The imposition of onerous and unnecessary requirements would, however, create further disincentives for provider and practitioner participation in the Medicare and Medicaid programs. This will further diminish care available to program beneficiaries. (American Medical Association, 1977: 264)

Government benefit programs distribute funds to accomplish their programmatic goals, either paying recipients directly in the form of welfare checks or Food Stamps, or making indirect payments to those who provide services to recipients. Both recipients and providers naturally seek to increase the size of welfare checks, the coverage and reimbursement levels of the Medicaid program, and simplicity in dealing with officialdom. In seeking maximum benefits and minimum "harassment," they are of course acting like any other claimants on government resources or policies. But what are their perspectives on fraud and abuse in these programs? While they

obviously want more benefits for themselves, are they prepared to violate program rules to get them? If they don't themselves cheat, are they willing to assist program and enforcement personnel in their control efforts? Do they support active control programs? From a number of perspectives, neither recipients nor providers have significant incentives to support fraud control, and often face major disincentives.

Material Incentives and Disincentives. What incentives might recipients and providers perceive to support or cooperate with measures to reduce fraud and abuse in benefit programs? At the individual level, they may want to maintain the goodwill of program officials so as to continue the flow of benefits. "Don't get your caseworker or claims processor mad at you," the argument might run, "or they will cut your benefits or hassle you to death." While benefit programs provide innumerable opportunities for hassling and delay, most decisions are basically nondiscretionary and routinized; you may have to call on legal assistance in some cases, but eligible welfare applicants are entitled to stated benefits and enrolled providers are entitled to scheduled fees.[1] Furthermore, there is substantial turnover among agency personnel--the welfare recipient's file may be assigned to a number of caseworkers in the course of a year, and a provider's claims may be handled by any one of a group of claims processors--so there may be little incentive to curry favor with a particular bureaucrat. Individuals may well believe that their contact in the bureaucracy has the ability to increase or decrease the amounts which they receive. They may also place a substantial premium on speedy payment or tranquility, accepting what they are given to avoid confrontation. If so, they may feel that it is valuable to avoid getting a reputation as a troublemaker or chiseler. If, on the other hand, they feel that they can easily and inexpensively "get what's coming to them" (or more), this incentive will be of little importance.

A second, more abstract, incentive to support fraud control might be to avoid killing the goose that is laying the golden egg. "If scandals about fraud and abuse keep hitting the newspapers," this argument will run,

"Congress or the state will cut benefits even further or kill the program entirely." While some institutional advocates of benefit programs, such as health and welfare lobbies, and legal assistance foundations, may think at this macroscopic level, it is less likely that an individual recipient or provider will see this threat as an imminent possibility or see his or her actions as making cutbacks more or less likely to happen. In some government programs, benefits are received by so small and so cohesive a group that we might imagine them getting together to say, "Let's cool it or we'll all be in trouble"; but since there are millions of welfare recipients and hundreds of thousands of Medicaid providers, it is unlikely that such concerted planning could take place.

Against these remote and abstract incentives are many material disincentives to support fraud control. Most obvious are the direct benefits to be received from overstating your welfare eligibility or the Medicaid services you have provided. Less obvious is the fact that providing information to the welfare agency, either to avoid committing fraud oneself or to turn in someone else, is time-consuming and possibly risky. The processes of the welfare system may make it easier, simpler, or quicker to give incorrect or less-than-complete information or to leave unchanged information which is no longer correct. Even a recipient who understands her legal obligation to report changes to the welfare office may find it difficult to contact her caseworker or, even worse, to stand in line to give information which will work to her detriment. Similarly, the provider may feel that it is not worth his time and effort to verify a patient's Medicaid eligibility, third party liability, or even that the person in his office is Jane Smith; to seek out information as to whether a service rendered should be marked Code X or Code Y is probably more time-consuming than to fill out the claim form for whichever service pays more. An even greater disincentive comes from the risk of becoming an object of closer scrutiny: if a recipient is repeatedly changing her eligibility situation or the provider is repeatedly asking suspicious questions, the caseworker or claims processor may be put on guard: "Oh oh, here's something from Smith again." Since there are no rewards for turning

yourself or others in, and it is very likely that penalties will be imposed, it is surprising that some people actually do so.

Many aspects of the structure of the Medicaid program create more specific disincentives for providers. As Boston's Commissioner of Health and Hospitals stated the issue, "As long as the basic structure of the program is to pay individual providers for whatever they do to individual patients, when they do it, we shall have a Medicaid and Medicare System that is prone to abuse and too expensive. No amount of regulatory threat will be able to overcome the incentives contained in the reality that more work on a patient means more money for the provider." (Rosenbloom, 1977:163). Medical sociologist David Mechanic adds, "The major disadvantage of fee for service is that it creates an incentive for unnecessary and sometimes dangerous procedures, particularly discretionary surgical interventions." (Mechanic, 1978:388). Whether or not we accept Mechanic's observation that "the income earned by a physician tends to become an important symbol of his success" (Mechanic, 1978:386), it is obvious that the fee for service system (as opposed to reliance on prepaid health maintenance organizations or salaried VA or county hospital doctors) invites the individual provider to submit claims for as many billable services as possible, to mass produce ("ganging" all members of a family, "pingponging" to other specialists in the clinic, etc.), or to overclassify each service provided.

Similar disincentives face other Medicaid providers: pharmacists are paid for each prescription filled, inviting "splitting," in which large orders are disaggregated so that each smaller order gets a processing fee, and discouraging questioning of the appropriateness of a prescription. Hospitals, on the other hand, being reimbursed on a "reasonable cost" basis, have no incentive to keep costs down or to discharge patients to nursing homes or ambulatory care. No provider, in short, is rewarded for economizing or for monitoring either the excesses of other providers or possible recipient fraud. Fiscal intermediaries such as Blue Cross/Blue Shield are in fact discouraged from such monitoring activities, since their contracts from Medicaid agencies reward speed in processing claims and do not reimburse them for the extra expenses involved in verifying claims.

(Hospital Audit Project, 1981:8) Whether we attribute this rule-bending to greed, to humanitarian desires to help recipients get as much care as possible, to interprovider jealousies ("Why should doctors take a beating when hospitals are making a fortune?"), or to revenge against a system which offers below-market payments with inordinate delay (Stevens and Stevens, 1974:265-6), it is clear that the incentive system works against provider participation in fraud control efforts. Many providers may not need to cheat, either because they have enough private patients or are satisfied with the results of the legitimate reimbursement system, but they are certainly getting no material rewards from the system for their honesty.

Normative Incentives and Disincentives. If there are few material incentives to support fraud control, are there normative or ethical incentives? In the abstract, we might expect that no one would want to violate laws or regulations, or at least that such considerations would detract from material gains from fraud and abuse. In the case of benefit program fraud and abuse, the issue becomes less clear cut. The first factor which must be recognized is one of vagueness or uncertainty, often compounded by ignorance. While officials may believe that they have created programs which unambiguously spell out who is eligible for what, and under what conditions, their intentions may be less clear to recipients and providers. Many recipients may fully comprehend program requirements and deliberately conceal facts which will reduce or terminate benefits, but others, particularly those with limited education or who do not speak English, may never get the message or forget it after they enter the system. To the extent that the vocabulary and logic of officialdom are fundamentally foreign to many recipients, we need not assume fraudulent intent when their responses or nonresponses do not accord with officials' definitions of reality.

A similar problem at times faces providers, although their sophistication is usually much higher than that of recipients. We might expect that every physician will know the difference between an EKG and a tonsillectomy, but the difference between a "routine office visit" and an

"extended examination" is less clear cut, and it may be fully justified from a medical point of view to give a full examination, throat culture, and prescription for pencillin to every member of a family when one child has a sore throat. For institutional providers, the boundaries between reimbursable and nonreimbursable operating expenses may be particularly opaque. Recipients can of course ask their caseworkers for clarification, and providers can call Medicaid to resolve a billing ambiguity, but it is not surprising that many resolve doubts in their own favor and wait to let officials detect and correct any errors.[2]

A second factor which erodes normative incentives not to cheat concerns recipients' and providers' perceptions of the legitimacy of the program. While the caseworker may think of herself as the recipient's friend or advocate vis-a-vis the bureaucracy, the recipient may see the caseworker as a hostile policeman, prying into her private affairs to find ways to kick her off welfare rolls; at best, the caseworker may be viewed as a faceless bureaucrat who cares more about filling out meaningless papers than about the recipient's problems of basic survival.[3] For the Medicaid provider, the employees of the welfare agency may be mere "clerks" who know nothing about health care or its economics. While individual recipients or providers may establish personal relationships with their counterparts in the welfare establishment, most contacts are impersonal and transitory. Taxpayers may assume that recipients and providers should be grateful for the public funds they receive, but images of condescension, snooping, overt or covert hostility, and omnipresent delay and inefficiency are likely to predominate. Even when a recipient is ashamed to be on welfare rather than to be working or self-sufficient, and even when a provider would prefer to be treating rich patients rather than poor ones, they are unlikely to perceive the bureaucracy as doing them a favor; recipients are more likely to see welfare benefits as "rights" rather than "charity," and providers are likely to see themselves as being underpaid and hassled for offering a service at the government's request. Indeed, the fact that participation in the welfare system is essentially involuntary or undesired may intensify feelings of resentment; regardless of the individual's rationalization for why he or she is on welfare or practicing in the ghetto rather than in the

suburbs. "They can't push me around" may be a more common attitude than a feeling of loyalty which would create normative support for fraud control.

These individual-level feelings are often reinforced by group loyalties: within limits, supporting fraud control involves helping "them" against "us." Unless the fraudulent behavior is egregious and/or personally offensive ("Mrs. Smith is a rotten mother." "Those people are giving nursing homes a bad name."), the natural tendency is to empathize with or overlook the marginal misdeeds of people like yourself, people doing something you might well do yourself. Feeling no particular loyalty to the system ("Nobody can live on welfare today." "Medicaid doesn't understand how much it costs to run an office." There is little ethical reason to help "them" out with "their" fraud problems. If you do dislike what defrauders are doing, it is often easier and safer to respond informally, telling them off or encouraging other providers to ostracize the bad guys, than to turn them in and run the risk of being shunned as a whistle-blower. Just as ghetto residents are leery of calling on the outside world to deal with internal problems, so the health care industry has long nurtured a code which declares "medical" issues out-of-bounds for nonprofessionals. Sociologist Gilbert Geis and his colleagues comment:

> It seems likely that the behavior which enables one to engage in fraud is at least partially learned from others in the profession, and that professional values may effectively neutralize conflicts of conscience and less salient formal professional norms. For example, most doctors who engage in fraudulent practices may do so without any change in self-identity. That is, they may rationalize their behavior in terms of professional values, informal norms, and the expectations of their peers. They may neutralize their deviance by "normalizing" the behavior or seeing it as morally justifiable and society's definition as invalid (e.g., the government doesn't have the right to interfere with my professional practice and duties). (Geis, et al, 1981: 9)

Since each medical discipline refuses to accept the opinions of anyone other than "peers," and since peer reviews are limited to medical issues (Is X treatment appropriate for Y problem? Is Dr. Smith prescribing excessive drugs or unnecessary surgery?) rather than financial issues (Is this response wasteful or overpriced?), the net result is that no one is accepted as a legitimate judge of how "I" practice my profession, and each

professional association vigorously fights off bureaucrats' attempts to "interfere." While the associations officially condemn both bad medicine and abusive billing practices, as indicated by the American Medical Association's statement at the beginning of this chapter, individual providers may find this assessment irrelevant unless they are in danger of being denied referrals or hospital privileges, or the association is considering suspending their license.

In the context of programs where definitions of "legal" and "illegal" are fuzzy at the margins, and where relations with officials may be strained or even hostile, recipients and providers have few normative incentives to cooperate with or even support fraud control efforts. In some cases, individual spite or jealousy may lead to a phone call to report the neighbor who has returned to work or the doctor who is padding his bills; self-interest or anger may motivate reprisals against the pharmacy which is supplying drug addicts or the nursing home which is ignoring Aunt Jane's needs. Apart from these individual-level motivations--a desire to "get" a specific recipient or provider--abstract ethical norms provide few incentives to support fraud control.

Deterrence. It has long been argued by criminologists that people will be deterred from criminal behavior if they expect to be punished for it. Deterrence theory centers around two factors, the magnitude of the penalties to be imposed relative to the anticipated gains from illegal behavior, and the probability that these penalties will in fact be imposed. On both counts, it is very unlikely that recipients and providers face significant threats. In part, this arises from the low visibility of the events which are the basis of benefit program decisions. It is very unlikely that any official will know if Mr. Smith is still living at home, if the 17-year-old has moved out, or if Mrs. Smith has a part-time job. Similarly, it is hard to tell if Pat Smith did or did not receive a physical examination or an inoculation, if the pharmacist dispensed 25 pills rather than 50, or if the taxi took the patient to a hospital. In claims for welfare or Medicaid benefits, the assertions of the claimant are only occasionally disputable by

other evidence, and a calculating recipient can ask for payment in cash just as a calculating provider can take steps to be sure that his records are in order.

Our case studies provide extensive support for the conclusion that neither of the elements of deterrence exist in the area of benefit program fraud and abuse: very few penalties are imposed, and most penalties are trival. A high, if unknown, proportion of all fraud is never detected; most of the known cases lead to no action and most of the cases where some action is taken involve reimbursement rather than additional penalties. (If "they" find out about "you," and if they decide to do something about it, the odds are that they will only ask you to pay the money back. Even when they ask you to pay the money back, they are likely to settle for a promise of partial payment, and then take few steps to actually collect.) Welfare recipients rarely have assets which can be seized, and it is unlikely that a provider will be put out of business to pay a fine. Recipients can stay on the welfare rolls if they are still eligible, and few providers will be suspended from the program unless they are actually convicted. (In some cases, Medicaid agencies don't even do that.) A few welfare queens and a few providers are actually sent to jail, but most of the cases which do get to court lead to probation with an order (only sometimes enforced) to repay.

In a setting in which the probability of detection is low, and most penalties are small, should we expect deterrence to occur? Fundamentally, that must depend on how the individual weighs those risks against the benefits of fraud and abuse. For those who subjectively feel themselves to be suffering, the extra dollars may be very attractive. For those who place a high value on personal integrity or public esteem, or for the providers who fear even a small probability of having their license and/or their Medicaid program participation terminated, however, the risks may be too great.

Recipients, Providers, and the Fraud Control Game. The systems created by government benefit programs give recipients and providers few

incentives--material, normative, or deterrence--to support fraud control. When fraud and abuse issues arise, recipients and providers will oppose control measures, even if they voice support for the principle of integrity. They will argue that control will hurt poor people and reduce their access to health care, or will divert tax resources from the program's intended beneficiaries. When specific control efforts are proposed, they may oppose them, try to deflect reporting burdens on to others, or try to ensure that enforcement efforts are controlled by sympathetic forces (e.g., peer review panels of practicing physicians). Without, at least openly, opposing more severe penalty systems for the "rotten apples," they will argue that the basic problem is one of bureaucratic confusion or "education" of program participants. One nursing home association, for example, has asserted that "Fraud and abuse are labels used to publicly paint health care providers as exploiters of their elderly patients and of their public trust. The fact is that Medicaid abuses may result from a variety of causes, including provider misunderstanding of reimbursement requirements, billing errors, and in some cases, deliberate intent." (American Health Care Association, 1979). In some states, welfare lobbies and provider associations are sufficiently powerful to block control programs which might affect them; regardless of their strength, they will downplay the significance of fraud issues.

This conclusion should not, however, obscure two other basic facts. First, for whatever reason, most recipients and providers probably do not significantly abuse their benefit programs; all public and private investigations of fraud and abuse have concluded that the majority of participants do not rip off the system. Second, fraud control is not the central issue of interest to recipients and providers. They and their representatives are most actively involved in the games which determine benefit levels, not control policies. The Welfare Policy Game is critical to recipients, and the Health Policy Game is critical to providers.

As players in these policy games, we must remember that recipients of AFDC, Food Stamps, and Medicaid benefits vary tremendously, from teenage mothers to elderly residents of nursing homes, from the temporarily

unemployed to the long-term "welfare class." Some meekly accept what they are given, while others use welfare lawyers and/or elected officials to challenge policies and procedures; while individual recipients have only their numbers as resources to play, recipient organizations may have the resources of legal and political expertise. For them, playing in the Welfare Policy, and (at times) Criminal Justice Games may provide both cost-effective ways to serve client interests and the satisfaction of changing the system. Recipients occasionally appear en masse at legislative hearings on welfare bills, and their organizations frequently confront the welfare agency, control agencies, and the legislature on both welfare and control issues; their success in these games will depend on both legal factors (Is the welfare agency violating state or federal regulations?) and the political power of the recipients.

Similarly, Medicaid program policies and fraud control policies are of varying importance to health care providers or vendors. Some depend heavily on patients subsidized by Medicaid and Medicare; some have very few public patients. Some have more patients than they can handle, and can afford to tell the welfare system to "get lost" if payment or control policies are objectionable; others need every patient they can get on whatever terms are offered. All vendors have an incentive to emphasize a public image as benevolent "health care providers" rather as businessmen hustling a buck, and to condemn the welfare agency for "unnecessary paperwork" which interferes with the doctor-patient relationship. They will seek to characterize fraud and abuse as either the misdeeds of a few rotten apples or the inevitable consequence of "incomprehensible" or "inadequate" program policies. While most of their resources are expended in the Health Policy Game, they also will have an incentive to play in the Criminal Justice Game, to minimize the scale of control efforts, to tighten evidentiary requirements for fraud convictions, and to minimize potential penalties. While providers are fewer in numbers than recipients, their greater funds, access to officials, public respect, and political skill often make them immune to attempts at control.

NOTES

1. The degree to which benefits or Medicaid payments are discretionary or fixed depends to some extent on the system used by each state. In "flat grant" states, an AFDC check is determined solely by the size of the assistance unit; bureaucratic discretion is basically limited to judgments as to whether a spouse or child is still part of the unit and whether assets should be counted. In states which calculate grants on the basis of such factors as housing, food, and clothing costs, opportunities for discretionary judgments are much more frequent. In Medicaid, there is a difference between individual and institutional providers. For individual providers, there may be differences of opinion as to whether Procedure X or Procedure Y took place, but the fee tied to each is fixed; for institutions, the major "judgment call" is whether certain costs are allowable in calculating reimbursement rates.

2. Susan Shapiro (1980: 26-28) discusses the debate in the research literature over whether white collar offenses should be labeled "criminal." Without attempting to enter that debate, we can simply note that the ambiguity in the issue may contribute to an erosion of offenders' normative incentives to support fraud control.

3. This tension between welfare and control functions is inherent in the role of the caseworker. Michael Lipsky (1980: 11-12) observes, "What to some are the highest reaches of the welfare state are to others the furthest extension of social control. Street-level bureaucrats are partly the focus of controversy because they play this dual role. Welfare reform founders on disagreements over whether to eliminate close scrutiny of welfare applications in order to reduce administrative costs and harassment of recipients, or to increase the scrutiny in the name of controlling abuses and preventing welfare recipients from taking advantage."

   AFDC recipients' attitudes toward their caseworkers are explored in depth in Handler and Hollingsworth (1971: Chapter Five).

REFERENCES

AMERICAN HEALTH CARE ASSOCIATION (1979) Nursing Home Examiner's Guide--Medicaid Abuse Detection (Washington: AHCA).

AMERICAN MEDICAL ASSOCIATION (1977) Statement before the Joint Hearing before the Subcommittee on Health, Committee on Ways and Means, and the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, United States House of Representatives, Medicare-Medicaid Antifraud and Abuse Amendments, Serial 95-7.

GEIS, G., H. PONTELL, and P. JESILOW (1981) "Practioner Fraud and Abuse in Government Medical Benefit Programs," Research proposal to the National Institute of Justice.

HANDLER, J., and E. J. HOLLINGSWORTH (1971) The "Deserving Poor": A Study of Welfare Administration (Chicago: Markham).

HOSPITAL AUDIT PROJECT (1981) United States Department of Health and Human Services, Office of the Inspector General.

LIPSKY, M. (1980) Street-Level Bureaucracy: Dilemmas of the Individual in Public Services (New York: Russell Sage Foundation).

MECHANIC, D. (1978) Medical Sociology, 2nd ed. (New York: Free Press).

ROSENBLOOM, D. (1977) Statement before the Joint Hearing before the Subcommittee on Health, Committee on Ways and Means, and the Subcommittee on Health and the Environment, Committee on Interstate and Foreign Commerce, United States House of Representatives, Medicare-Medicaid Antifraud and Abuse Amendments, Serial 95-7.

SHAPIRO, S. (1980) Thinking About White Collar Crime: Matters of Conceptualization and Research (Washington: National Institute of Justice).

STEVENS, R., and R. STEVENS (1974) Welfare Medicine in America: A Case Study of Medicaid (New York: Free Press).

CHAPTER ELEVEN

PROGRAM ADMINISTRATORS' PERSPECTIVES ON RECIPIENT FRAUD CONTROL

We have indicated that few outsiders have a continuing interest in fraud control issues, and that recipients and providers have many reasons to oppose, or at least not to cooperate with, fraud control efforts. As a result, the nature and extent of fraud control activities are shaped primarily by the policies, procedures, and priorities of welfare agencies and the agencies which process suspected fraud cases. In our analysis of the perspectives of these agencies, we will consider separately control efforts focusing on recipient fraud and those aimed at fraud and abuse by Medicaid providers. Although there are some differences among the regulations governing the AFDC, Food Stamps, and Medicaid Programs, the forms of recipient fraud and official responses to them are essentially identical in the three programs. Provider fraud and abuse involve different people, behavior, and control responses.[1] We will also consider separately those officials whose primary function is to distribute benefits to recipients and providers ("program administrators") and those whose primary function is to identify and respond to suspected cases of fraud and abuse ("control agencies").[2] In this and the following chapter, we will focus on the perspectives of program administrators; in Chapters Thirteen and Fourteen, we will discuss control agencies.

The Ambiguity of Goals in Benefit Program Administration. When analyzing an administrative agency's implementation of the policies set for it by a legislature, it would be convenient to assume that the agency has a clear and consistent set of goals, that it has control over the activities of its personnel, and that it knows how to accomplish its goals. When considering the goal of controlling fraud in benefit programs, however, the

more accurate administrative image is one of "organized anarchy." In Leadership and Ambiguity, Michael D. Cohen and James G. March use the term "organized anarchies" to describe organizations with problematic goals, unclear technologies, and fluid participation (1974: 2-3). In such settings, they argue, "most issues most of the time have low salience for most people, . . . the total system has high inertia, . . . any decision can become a garbage can for almost any problem, . . . the processes of choice are easily subject to overload, . . . and the organization has a weak information base." (1974: 206-7, emphasis in original). With regard to fraud issues, all of these factors confront the administrators of benefit programs: organizational goals are ambiguous or conflicting, techniques for reducing fraud are of unknown effectiveness and/or have negative side effects, and participation in decisionmaking is highly unpredictable. Fraud issues are usually of lesser importance to administrators than are other issues, administrative routines are difficult to change, other issues are brought into any discussion of fraud problems, most administrators are given more instructions than they can possibly handle, and they know little about how problems have been or are being handled.

The problem of goal ambiguity is illustrated by a set of administrative goals for the AFDC program stated in a 1977 study conducted for the Social Security Administration:

- Quality Service Delivery--AFDC services should be available and accessible to those who are potentially eligible, and they should be provided in a manner that protects client dignity and rights.
- Accurate Program Implementation--Benefits should be provided only to persons who meet specified Federal and State eligibility requirements, and in the amount specified in the State plan.
- Efficient Program Administration--Services should be provided at "reasonable" administrative costs.

Subgoals included prompt eligibility determination and check issuance, office accessibility, a responsive fair hearings system, courteous and humane treatment of clients, protection of privacy, accurate determination of eligibility and payment levels, and timely conduct of redeterminations. (Booz, Allen, and Hamilton, 1977: 3-4).

While all administrators would agree that they should deliver quality services accurately and efficiently, these abstract goals do not really tell them what to do with any precision:

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

> ". Pressure on eligibility workers to rule conservatively on discretionary matters and thereby reduce ineligibility and overpayment errors may generate an increase in underpayment errors and incorrect denials of eligibility.
>
> ". Increase in the frequency of reporting or the extent of documentary verification required of clients increases the burdens on clients and the rate of denial of applications for failure to comply with procedures.
>
> ". Requiring more extensive case investigation by eligibility workers, if not accompanied by increase in staff, may result in delays in processing applications." (Bendick, 1978: 36-37)

(2) Maximizing accuracy costs money. The Urban Institute study concluded that "reduction of error rates is associated with rises in administrative costs. In such circumstances, the concern that the incremental rise in administrative cost under a program of further corrective action might be larger than the incremental savings in payment errors avoided is a legitimate concern." (Bendick, 1978: 34). A 1977 study by the House Agriculture Committee estimated that "complete verification of every aspect of a Food Stamp application would take twelve hours and would cost eight times as much in additional salaries as it would save in reductions in fraud and error." (Stover, 1981: 21)

(3) Maximizing one or more of these goals may conflict with other, nonprogrammatic goals, such as maintaining good relations with recipients, legislators, or work associates. Recipients and sympathetic legislators may rebel against increased "harrassment," caseworkers and their unions may object to increased paperwork, etc.

Our point is not that program administrators are unaware of or reject the goal of controlling fraud, but rather that their pursuit of this goal is inevitably constrained by other goals which they must simultaneously pursue, and which may have higher priority.

The Decentralization of Power. An administrator who wants to reduce fraud in his program has only limited opportunities to do so, since power in benefit programs is widely decentralized. Many people are in positions where they can contribute to the reduction of fraud, but no one has control over all of the units which play, or might play, roles in fraud control. With regard to the processing of individual fraud cases, for example, the welfare agency has the power to reduce or terminate benefits (although the recipient can appeal this decision to the courts). The power to impose additional penalties or to order repayment of excess assistance, however, lies in the hands of the civil and criminal courts; in many states, the welfare agency can go to court only with the approval of a prosecutor or independent investigative agency. While the welfare agency has the power to initiate enforcement actions, it is the prosecutors and judges who decide whether these requests will be pursued.

With regard to the day-to-day administration of benefit programs, there is an almost total decentralization of power: virtually all decisions about individual cases are made by the caseworkers, eligibility technicians, and intake officers who process applications and redeterminations, and carry out other case management functions. Regardless of what is said in federal and state policy directives and verification manuals, if these front line workers do not collect relevant information or ignore information they have received, erroneous payments will be made. While incorrect denials and underpayments can be corrected in the appeals process, and a few errors will be caught by quality control reviewers or computerized matching programs, most approvals and overpayments which are not caught in the local offices will continue to go undetected. Supervisors have little control over these decisions, since it is almost impossible to prove that a worker's negligence caused an error; staff unions and civil service rules make it difficult to

discipline employees who do not follow agency procedures. In states in which benefit programs are administered by county agencies, state officials have even less control over local workers.

With regard to basic issues of benefit program policies and administration, power is to some extent shared by state and federal agencies. Annual state plans are submitted to federal funding agencies; unless it is found that the plans are not in compliance with federal guidelines, the federal agencies must fund specified percentages of program and administrative costs. Policymaking power, therefore, lies primarily at the state level, with federal agencies retaining a residual veto over state decisions.

The role of federal agencies in supervising state program administration has varied over the years. From the mid-1930s to the early 1950s, federal agencies closely monitored state plans and rejected noncompliant proposals; since then, however, negotiation and compromise have been more typical patterns (Steiner, 1966: Chapter Four). It is unclear whether the decline in confrontations has come from widespread state compliance, from fear that Congressional unhappiness with program costs poses a greater threat than any state's individual trangressions, or from the political reality that, as Gilbert Y. Steiner puts it, "No administrative agency is so politically insensitive as to take untimely punitive action against a state official who has friends in high places in Congress or the White House." (1966:88)

While formal rejection of state plans is thus unlikely, the federal agencies have a variety of techniques by which they can push the states in desired directions. Special funding is available for states which establish such programs as management information systems, fraud units, or child support enforcement units. Favored states can be granted waivers of federal requirements and given funding for demonstration projects. Less favored states can be harassed with noncompliance audit reports. Fundamentally, though, federal agencies have only a limited capacity to monitor state administration; the 1977 AFDC study by Booz, Allen, and Hamilton concluded

that "Information on many areas of administrative performance is not currently reported to HEW . . . Compliance monitoring is not conducted in a comprehensive manner . . . . In the absence of dynamic Federal leadership, State and local agencies have to function with non-specific statements about Federal administrative priorities and performance standards within the AFDC program." (Booz, Allen, and Hamilton, 1977: 27-28).

While our case studies confirmed this assessment that the states play primary roles in the formulation of welfare policy, we must point out that at the time of our field research (1981), it was unclear whether fiscal sanctions tied to error rates (the Michel Amendment) would signal a return to stronger federal control. A 1977 study of state corrective action programs concluded that HEW's fiscal sanction regulations had "prompted states to redirect management attention to reduction of reported errors." (Touche, Ross, 1977: 116) While the state officials we interviewed were clearly apprehensive about the possibility of sanctions, they also knew that federal agencies have been more interested in "good faith" compliance efforts than in imposing penalties; all will be watching closely to see how federal agencies react in 1983 and 1984 as the Congressional error rate deadlines pass.

The Uncertainties of Technology. If an administrator wants to reduce fraud and has control over relevant people and resources, would he know what to do? Even if he is a competent administrator would he know what specific steps to take? An official of the American Public Welfare Association summed up the frustration felt by many welfare administrators. "Sure, they know they have fraud problems, and they are concerned about them, but they don't know what to do. Most of the time, they feel that the politicians don't care about fraud problems. Legislators don't have any answers either; if they get mad enough, all they know how to do is fire the director!"

Uncertainties about means-ends relationships in fraud control have several sources. The first is a pervasive lack of data about the consequences of corrective action programs. The quality control system

provides information about the types of fraud which exist in the program (unreported income, absent children, etc.) and thus identifies targets for a corrective action program, but it does not tell the administrator who is causing the problem (which offices or workers are more accurate than others) or what response, if any, will solve it. In part, this is a result of the small sample size of the QC process; while sufficient to measure statewide error rates, the samples are not statistically valid for local offices. Even where, as in Illinois, the states draw larger samples to measure office-level error rates, so few fraud cases are found that the administrator can't reach statistically meaningful conclusions about the causes of fraud or the effectiveness of different response options. As a 1980 study of AFDC administration in Wisconsin concluded, "For most local agencies in this state neither the critical information on quality nor appropriate local procedures to monitor quality are presently available." (Witte, 1981: 28)

Second, even if accuracy data were available, the administrator would find it almost impossible to conduct credible cost-benefit analyses. The Wisconsin study offered the following comparison:

> In the private sector, attempts to correlate error levels with sales volumes and customer complaints are possible. Further, in an environment where work standards are common, the costs of production changes introduced to solve quality problems can at least be estimated so that some measure of the marginal cost of lowering the error rate can be made.
>
> In the state of Wisconsin, and I believe in almost all other states, these conditions are not present . . . estimates of an acceptable level of error are mixed. Attempts to rationally calculate the types of errors that are easy to avoid, and should be easy to eliminate, become very controversial once the discussion moves beyond the most obvious technical errors and comes to rest on the issue of client versus agency error. Similarly, with the exception of innovations like a fraud investigator, cost data for initiating new administrative procedures will be very difficult to ascertain . . . . As a beginning it will be necessary to establish work standards and labor reporting networks so that costing can be based on process rather than on line item budget categories . . . . An accurate measure of the cost-benefit tradeoff in reducing errors in AFDC or other social programs is impossible at the present time. The problem would become more difficult if we were also

to attempt to factor in the decline in quality of service as a cost. (Witte, 1981: 29; emphasis in original)

Thus, welfare administrators may well find themselves in situations where the costs of innovation (budget costs, staff resistance to change, recipients' protests, etc.) may be far more predictable than its benefits. As political scientist Gilbert Y. Steiner concluded about the lack of innovation in welfare programs generally, "Without information, and with media of communication available to broadcast blunders widely, policy-makers sensibly find the status quo to be the only possible policy." (1966: 141).

Administrators' Responses: Incentives and Disincentives. Administrators respond to fraud issues, then, in settings in which goals are conflicting, power is decentralized, and the technology of control is uncertain. Their responses in the Fraud Control Game also take place in settings which are influenced by events in the other games described in Chapter Nine. Trying to satisfy recipients' demands in the Welfare Policy Game, for example, may antagonize the governor and legislature in the Fiscal Policy Game, trying to satisfy federal agencies' demands for tight control in the Intergovernmental Relations Game may antagonize agency subordinates in the Public Administration Game, etc. Because of other past, present, and future plays in these games, administrators may have few resources available to spend on plays directly dealing with fraud control issues.

While there will be substantial variations among settings, over time and from place to place, administrators will act to increase fraud control efforts when they see more incentives than disincentives to do so. Their calculations of incentives and disincentives will be affected by the following factors:

(1) Incentives to control fraud are usually less significant to administrators than incentives to maintain the flow of benefits to recipients. Therefore, fraud control strategies which interfere with

routine case intake and case management processes will be adopted less frequently than strategies which do not interfere.

(2) Incentives to control fraud are less significant to administrators than incentives to control costs and errors. Fraud control strategies which will reduce costs and errors will be adopted more frequently than strategies which increase, or leave unaffected, costs and error rates.

(3) Incentives to control fraud will be increased by threats to the autonomy of the agency. Such threats can be caused by scandals, legislative investigations, or fiscal crises.

(4) Disincentives to control fraud will be reduced if the costs of control efforts are absorbed by someone else (e.g., if another level of government will fund control efforts, if another agency will provide the staff to handle investigations and prosecutions, etc.).

(5) The distribution of incentives to control fraud is inversely proportional to opportunities to control fraud. Federal and state administrators face the strongest incentives but the weakest opportunities, while local caseworkers have the most opportunities but the fewest incentives to do anything about fraud.

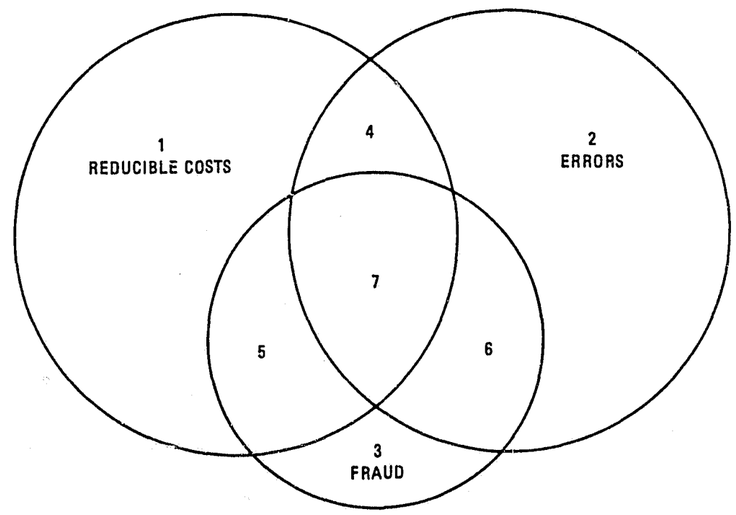
Let us look at each of these propositions in detail.

(1) The Primacy of Service Delivery. The delivery of benefits to AFDC, Food Stamps, and Medicaid recipients is the reason for the existence of the welfare system, and the positions of most federal, state, and local welfare administrators are defined in service-delivery rather than accuracy or efficiency terms. The welfare process is organized to satisfy the imperatives of processing applications and issuing checks. Failing to satisfy these imperatives can lead to court injunctions or penalties, and/or to protests by recipients and legislators. While the administrator may be able to justify some delays and burdens placed on applicants to prove their

eligibility, there are outer limits to the controls which can be installed in the name of accuracy. More fundamentally, administrators (as opposed to control personnel) are likely to feel that accuracy is not their problem: their agency exists to alleviate poverty, not to catch cheats. As a result, they will feel that the delivery of adequate benefits with reasonable speed, courtesy, and efficiency is a sufficient goal; someone else can worry about whatever mistakes are made.

(2) The Primacy of Cost- and Error-Reduction. Most taxpayers do not like to pay for welfare programs, and agencies threaten to impose penalties for agencies with high error rates. Program administrators can thus expect prompt criticism if their records on either criterion look bad. Controlling fraud, as distinct from controlling costs or errors, is less easily measured and less likely to attract attention unless a scandal occurs.

The differences between reducible costs, errors, and fraud can be illustrated by Figure 13. While their relative magnitude and the extent of overlap will vary from state to state, the figure illustrates several facts which administrators must consider. (a) Costs can be reduced in situations where neither fraud nor errors have occurred (subset 1). Eligibility policies and benefit levels, for example, can be reduced with the consent of the legislature, and the application process can be delayed or made so inconvenient that some applicants will go away. An active program to locate missing parents can produce a source of child support which will reduce or terminate AFDC eligibility, or which will provide third-party liability (the father's health insurance) reducing Medicaid costs; it may also (subsets 5 and 6) uncover fraud by proving that the parent is not missing and/or has been providing support which the recipient has concealed. (b) Many errors which are counted in the state's error rate involve neither fraud nor reducible costs (subset 2). Examples would be missing birth certificates or social security numbers, the failure of eligible recipients to register for the WIN Program, etc. These do not involve fraud unless the recipient intended to deceive the agency (subset 6); they do not reduce agency costs since the agency must continue to award benefits once the error is



1 – No fraud or error, but potential cost reduction
2 – Errors involving neither fraud nor reducible costs
3 – Fraud (with intent to deceive) not involving error nor costs
4 – Errors not involving fraud, but affecting costs
5 – Fraud; correction would reduce benefit levels
6 – Errors involving fraud, no cost reduction
7 – Errors involving fraud and affecting reducible costs

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FIGURE 13 ADMINISTRATORS' CONTROL TARGETS: COSTS, ERRORS, AND FRAUD

corrected. (c) Some cases of fraud do not involve errors if the concealed event took place after a correct eligibility decision was made (subset 3, if the concealed item did not affect benefit levels, or subset 5 if benefits would be reduced). (d) Finally, many errors which impose costs do not involve fraud, (subset 4) if the agency incorrectly calculated benefits or the recipient's concealment was unintentional.

Administrators, as a result, might respond to these possibilities differently, depending on priorities, estimates of the extent of overlap among these subsets, and the expected ease of dealing with one target rather than another. If the agency is in danger of an error rate sanction, for example, a crash program targeted on social security numbers or WIN registration will produce faster results with less staff effort than investigations to detect unreported income. Costs, on the other hand, can be reduced more quickly by requiring monthly reporting or burdening the applicant with greater verification tasks; either response will discourage the fainthearted as well as those who have something to hide.[4] Our point is not that administrators will deliberately ignore fraud issues (subsets 3,5,6,7) in setting their control stategies, but rather that subsets 1, 2, and 4 may be easier to address and offer payoffs more immediately valuable to the agency.

The importance of cost factors can also be seen in agency policies regarding responses to specific cases of excess assistance. Once the recipient's grant is revised to provide the correct award, or terminated for ineligibility, efforts to recover overpayments or to seek civil or criminal penalties are of limited value to the administrator. While the work involved is usually small, prosecution is a low benefit/high cost option. Apart from the general deterrence or political merits of prosecution, it does nothing for the welfare agency which cannot be accomplished by simply kicking the recipient off the rolls. Less than one-fourth of the fines ordered by courts are ever paid; in the rare case where the defendant is sent to jail, the welfare agency usually has to pay for foster case for her children. Unlike the Medicaid program in which conviction terminates a provider's eligibility, AFDC or Food Stamps convictions do not by themselves

debar a recipient from future benefits, so prosecution gives the agency no additional protection against a particular recipient. Furthermore, by sending a case outside the agency, the agency loses control over the terms of disposition, becomes subject to the schedules and requirements of the prosecutors, and exposes its failings to public view.[5]

The costs of trying to recapture overpayments are low, but the benefits vary, depending on whether the recipient remains on the rolls and whether she has attachable assets. If she remains on the rolls, the overpayments can be recaptured from future welfare checks (grants can be reduced by up to 10% for repayment purposes); if she is off the rolls and has no assets, the probability that a repayment order will be honored is low.

When contrasted with the certain costs and questionable benefits of prosecution or repayment efforts, the option of revising or terminating the grant becomes quite attractive. Such actions fit in with normal agency routines, since caseworkers are constantly revising or terminating grant awards, either proactively or reactively. They are supposed to review each file at least once a year, and may check to see if old eligibility information is still valid; some recipients will call in to say they now have a job, that their husbands have returned home, etc. These actions are also simpler than prosecution, since they do not require proof of knowledge or intent; more importantly, these responses satisfy all of the bureaucratic interests of the agency, purging the rolls of ineligibles or at least canceling future excess payments.[6]

(3) Maintaining Agency Autonomy. Under normal conditions, therefore, program administrators are likely to have stronger incentives to emphasize benefit delivery than to emphasize accuracy; to the extent that accuracy becomes a priority, costs and errors may be emphasized over fraud. Within limits set by the legislature and by recipient groups and their lawyers, administrators can usually run the welfare system as they wish. From time to time, however, their autonomy is threatened, as the media, legislators, governors, presidents, and others publicly criticize agency policies and

performance. Some criticisms will come from the welfare lobby, challenging benefit levels and barriers to access; others will come from conservatives and taxpayers' groups, challenging welfare costs and fraud problems.

To prevent the occurrence of such threats, or to combat those which do arise, administrators can pursue a variety of strategies. One is to deny responsibility and shift the blame to others. To the welfare lobby, the administrator will say, "We didn't set grant levels, the legislature did. We're so short of staff that we can't get the grants out any faster." To conservatives, "This is an entitlement program; if that many people are poor, our costs have to go up. Besides, have you tried to care for three kids on $300 per month?" To combat the image of Cadillac-driving welfare queens, the agency will issue statistics stressing that recipients are children, aged, infirm, or unemployable.

A counteroffensive more specifically focused on allegations of "rampant fraud" involves the creation of a public image of "running a tight ship." Central to this image-building will be an emphasis on verification procedures, cross-checking, computerized matching program, etc.--"We do everything we can to confirm eligibility; how could we have known that she had a babysitting job/boyfriend/bank account in another name?" Backing up this reputation for "toughness" can be a statistics game--the number of applications rejected (overlooking the fact that the application was approved a week later when the mother brought in the necessary birth certificate), the number of grants cancelled (overlooking subsequent restorations), the number and amount of repayment orders issued (overlooking nonpayment), and so forth. Each time that a recipient fraud case is prosecuted, the agency can publicize the event.

In addition to these public relations-oriented responses to external threats, administrators can make real changes such as tightening verification procedures, allocating more staff resources to control functions, and recommending punitive action against a higher proportion of defrauders. While our case studies provide examples of such strategies (e.g., Illinois' responses to scandals and Washington's responses to fiscal

sanction threats), we should also note that most crises are short-lived. Federal agencies usually retreat from imposing sanctions, and politicians and the media usually find something else to talk about.[7] Unless the threat has escalated to the point where "heads are going to roll" or the threat coincides with something the administrator wants to do anyway (to reallocate staff, to dump incompetent subordinates, to punish enemies), most administrators can ride out a storm with conciliatory press releases.

Even though external threats are usually more ephemeral than lasting, welfare administrators <u>have</u> paid more attention to fraud problems since the mid-1970s. Perhaps the simple fact of public discussion of the issue, stimulated by GAO and Congressional diatribes throughout the 1970s, led administrators to focus on this aspect of their operations. Some administrators may have taken on the problem as a matter of professional pride; professionalism may not by itself dictate a specific fraud policy, but paying attention to applications and case files is likely to uncover a higher proportion of the fraud which occurs.

(4) <u>The Allocation of Fraud Control Costs</u>. Just as the net incentives (the relationship of incentives to disincentives) of an administrator can be increased by additional incentives, they can also be increased by a decrease in disincentives. One of the disincentives to fraud control which can most simply be decreased is costs: if you are rewarded for fraud control, or if someone else pays the costs so that it is free <u>to you</u>, your net incentives will increase. While specific approaches will be examined in greater detail in Chapter Fifteen, several examples can be mentioned here. At the state agency level, federal agencies have paid most of the costs of Child Support Enforcement Units and Medicaid Management Information Systems. At the level of the individual caseworker, the pursuit of fraud is an extra burden and can conflict with other duties. Directly confronting a recipient with verification questions ("You don't really expect me to believe that . . .") can be physically dangerous, emotionally taxing, and an obstacle to gathering the other information the worker needs. If the work of pursuing a specific fraud lead (calling employers, documenting excess assistance,

packaging the file for prosecution) will be handled by someone else (e.g., a centralized investigations unit or collections office), however, the caseworker will have fewer disincentives to report it than if she has to do all follow-up work herself.[8]

(5) The Incongruity of Incentives and Opportunities to Control Fraud. Since the early 1970s, Congress and the General Accounting Office have repeatedly berated federal benefit program administrators for the recipient fraud records of their agencies. While these attacks have created incentives for federal officials to reduce fraud, we have noted that they have almost no opportunities to do anything. Their QC reports can identify the states with high and low error rates, and they can require the states to submit corrective action plans. They can offer a few incentives, such as demonstration grants and waivers of federal regulations, to innovation-minded states. But unless the basic political superiority of the states is altered, however, they can not in fact impose fiscal sanctions on laggards.

State-level welfare officials face pressures from both legislators and federal agencies to reduce fraud, but their opportunities are limited. They can establish centralized fraud enforcement programs (investigative units, computer matching programs, etc.) and can modify program regulations to facilitate control efforts. Central control over basic program administration functions, however, is quite weak. In state-supervised systems, the state has virtually no power over county administrators; in state-administered systems, control is weakened by union, civil service, and political constraints. While administrators may want to use the fraud issue as an excuse to tighten control over subordinates' adherence to agency regulations, efficiency, or productivity, playing in the broader Public Administration Game, they may conclude that fraud per se is not their most important management problem. Lacking the ability to control day-to-day administration, they may also conclude that it is more prudent to stay away from fraud problems; without "guilty knowledge" of uncontrollable problems, they can try to pass the blame on to local workers when a case of fraud is uncovered by someone else.

While centralized enforcement efforts can look for and respond to fraud cases, it is in the local offices and their handling of applications and case files that the most frequent opportunities to prevent recipient fraud and to catch past mistakes occur. For a number of reasons, however, local caseworkers have fewer incentives than their federal or state "superiors" to emphasize fraud control. First, front-line welfare workers are poorly motivated, burnout occurs quickly, and most expect to move on to other jobs as soon as possible. (Street, 1979: 58) Salaries are set by union contracts or civil service pay scales. A study of Illinois AFDC workers noted, "The caseworker has limited incentives to seek out instances of clients' not reporting changes. Wage increases for superior performance can be earned, but performance is evaluated on a variety of activities; there is no direct reward system for superior 'investigative' work. Increasing cancellations by uncovering ineligibility factors may help in keeping the total caseload under control, but it is not clear that this works to the caseworker's advantage, because caseloads are periodically redistributed." (Zeller, 1981: 57) Within the broad range bounded by superior performance ratings and the threat of dismissal, caseworkers have little incentive to be efficient. (Lipsky, 1980: 126)

Second, the work activities of caseworkers are inherently difficult to monitor. While supervisors can review, either online or in periodic file checks, the forms which caseworkers complete, they have no way of knowing whether the caseworkers in fact completed verification procedures, whether the appropriate questions were asked, or whether information which was obtained was entered in the file. Supervisors can check to see that the right forms were filled out, and whether decisions were correct based on the information which is recorded, but antecedent activities are invisible. There is a very remote possibility that a particular file will be selected for an in-depth quality control analysis, but even then the caseworker can argue that computers were down, sources were unreachable, or "there wasn't time" to get everything done.

Third, to the extent that caseworkers are subject to their supervisors' control, uncovering fraud is not a major priority. In a work environment

with a ludicrous overload of instructions (a 1976 study of the Michigan welfare program calculated that caseworkers were expected to use over 2,000 pages of agency information, receiving 22 new pages each week; Bernard, 1979), "agencies must make as a first order of business . . . filling out scores of forms and constructing voluminous case records." (Street, 1979: 35) Assuming, in this environment of minimal supervision and work overload, that workers will only attend to those matters which might invite sanctions if ignored (Lipsky, 1980: 19), workers will emphasize meeting deadlines (e.g., issuing emergency Food Stamp authorizations within 3 days, determining AFDC eligibility within 45 days), filling out the forms which are needed to issue checks, and generally keeping up with whatever matters a recipient or supervisor will notice.

A final factor which affects caseworkers' stance toward fraud concerns their attitudes toward recipients themselves. Until the 1960s, income maintenance functions were combined with social service functions, and caseworkers tended to develop a measure of familiarity and empathy with recipients. With the separation of payment and service functions and a decline in home visits, agency-recipient contacts decreased. Which worker would deal with which recipient became an essentially random process because of high rates of staff turnover and the great deal of mobility that occurs among parts of the recipient population. Caseloads change continuously as recipients leave or rejoin the rolls and change addresses, and as alterations are made in work assignments to cover the caseloads of workers who have left the agency. (Street, 1979: 61) Given this transitory and specialized interaction, it is not surprising that a caseworker's primary reference group becomes fellow workers rather than recipients. (Lipsky, 1980: 47)

If caseworkers are detached from recipients, are they hostile and suspicious? Surveying caseworkers in a Chicago welfare office, Naomi Kroeger concluded that 60% had basically positive attitudes toward their clients (Street, 1979: 51). In a small welfare office in Wisconsin, John Witte asked workers "to classify clients as 'cheats,' who attempt to play the system by whatever means; 'casual clients,' prone to forgetfulness,

etc.; and 'idyllic clients' who are scrupulously honest and administratively efficient . . . . Almost everyone puts the 'cheaters' at a very low level (5 to 15 percent), while the 'casual clients' were in the majority (40 to 60 percent) with the 'idyllic clients' comprising about 25 to 30 percent." (Witte, 1981: 20) Combining these figures with the essential depersonalization of the welfare process, we might predict that workers will develop a personal and warm relationship with a few recipients and a neutral, bureaucratic attitude toward most. Toward those few recipients who are found to be aggressive defrauders ("cheats," in Witte's terminology), however, it is likely that caseworkers will feel antipathy. Finding out that Mrs. Smith failed to report her babysitting income may be mildly irritating; finding out that Mrs. Jones has three AFDC grants and a full-time job will be infuriating.

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

NOTES

1. Parallel to the fraud problems posed by Medicaid providers are those of Food Stamp issuers, retailers, and wholesalers. While state welfare agencies address problems of recipient fraud in the Food Stamp program, virtually all control efforts directed at issuers, retailers, and wholesalers are conducted by federal agencies (the Food and Nutrition Service and Office of Inspector General of the Department of Agriculture) and will not be discussed in this volume. The Food Stamp enforcement activities of USDA OIG are analyzed in depth in Stover (1981).

2. Our distinction between program and control personnel is on a functional rather than organizational basis because, although all benefits are distributed by welfare agencies and all criminal prosecutions are handled by criminal justice agencies, intermediate control functions (e.g., detection, investigation, and noncriminal adjudication) are variously assigned in different states to welfare, criminal justice, and other agencies.

3. "In 1976, New York City introduced administrative controls that were credited with reducing the acceptance rate for new welfare applicants by half and terminating 18,000 cases per month. But this was accomplished because eligibles were being turned away 'by very negative administration of work and parent-support rules,' and because half of those terminated failed to show up for recertification, to respond to mailed questionnaires, or to verify school attendance. Their ineligibility was strictly a matter of difficulty or reluctance to pay the costs of remaining on the rolls until forced to do so. Meanwhile, according to one administrator, welfare centers are 'overcrowded,' 'noisy,' and 'dirty.' 'Some clients wait four to five hours for service and too often are required to make more than one visit to the center to complete their business. In addition, they don't know the names of people who are serving them.' In these and other ways, eligible clients are asked to pay the costs of seeking relief." (Lipsky, 1980: 104; emphasis in original)

4. In times of fiscal stress, administrators may expect to be praised for such cost-cutting endeavors (at least by those who worry about budgets rather than recipients). Under some circumstances, however, reducing the welfare rolls can be costly; like the administrator of a school district with declining enrollments, welfare administrators in systems which allocate staff positions on a capitation basis may find that with fewer welfare cases, they are given fewer positions.

5. Why, then, are any cases prosecuted? While we would need a detailed analysis to determine exactly when more severe responses are employed,

two guesses might be made. First, some cases may fall under the category of "aggravated offenses"--e.g., cases where the recipient systematically deceived the agency by setting up multiple grants with fictitious social security numbers, concealing a full-time job, claiming nonexistent dependents, etc.--and are likely to annoy the agency to the point where they want to retaliate by putting the recipient through the inconvenience of prosecution whether or not a real penalty will be imposed. (Cf. Gardiner's 1969 analysis of traffic officers' perceptions of moving violations.) Second, agencies are likely to feel that they have to push at least a few cases either for purposes of deterrence or as a matter of public relations, convincing legislators or the public that tax funds are being carefully protected. The selection of specific (non-aggravated) cases for prosecution may be based on processing convenience (e.g., it is easier to prove that the recipient has a full-time job than to prove that her spouse in fact lives at home) or may be a virtually random selection from among possible targets.

6. This explanation parallels Robin's (1970) conclusions as to why department stores rarely prosecute employees who steal: firing thieves, possibly with restitution, got rid of the problem and avoided publicity. Unlike ordinary crimes against persons, Robin notes, no particular person in the store was victimized by the theft, so even though "the company" may have suffered a loss, no official had a personal stake in retribution. The obvious parallel would be that welfare fraud does not injure any specific welfare bureaucrat.

7. On the relatively short life of police corruption scandals and the rapid return to "business as usual," see Sherman (1978).

8. On the tendency of paperwork requirements to keep caseworkers from reporting fraud incidents, see Dennis (1981: 59). The impact of a shifting of paperwork requirements to a central collections unit in Illinois was discussed in Chapter Three, supra. Lipsky (1980: 146) and Witte (1981: 23-25) also point out that the designation of specialized investigators relieves the income maintenance worker of concerns about overpayment issues; while this reduces role conflict (allowing the worker to be a good guy, handing out the money), it may also be dysfunctional, leading them to ignore the problem completely.

REFERENCES

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

BERNARD, S., B. BUTLER, and D. EISENBERG (1979) "Policy Overload: The Plight of the Assistance Payments Worker," Administration in Social Work, 3 (Summer): 219-232

BOOZ, ALLEN, and HAMILTON (1977) Comprehensive Study of AFDC Administration and Management: Executive Summary (Washington: Social Security Administration)

COHEN, M., and J. MARCH (1974) Leadership and Ambiguity: The American College President (New York: McGraw-Hill)

DENNIS, C. (1981) The California/Los Angeles County AFDC Quality Control Programs (Los Angeles: Report to the National Academy of Public Administration)

GARDINER, J. (1969) Traffic and the Police: Variations in Law-Enforcement Policy (Cambridge: Harvard University Press)

LIPSKY, M. (1980) Street-Level Bureaucracy: Dilemmas of the Individual in Public Services (New York: Russell Sage Foundation)

ROBIN, G. (1970) "The Corporate and Judicial Disposition of Employee Thieves," in E.O. Smigel and H.L. Ross, eds., Crimes Against Bureaucracy (New York: Van Nostrand)

SHERMAN, L. (1978) Scandal and Reform: Controlling Police Corruption (Berkeley: University of California Press)

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

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

STREET, D., G.T. MARTIN, and L.K. GORDON (1979) The Welfare Industry: Functionaries and Recipients in Public Aid (Beverly Hills: Sage)

TOUCHE ROSS (1977) Evaluation of AFDC-QC Corrective Action Final Report (Washington: U.S. Department of Health, Education, and Welfare)

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

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

CHAPTER TWELVE

PROGRAM ADMINISTRATORS' PERSPECTIVES ON CONTROLLING MEDICAID PROVIDER FRAUD AND ABUSE

Medicare and Medicaid are the greatest measures yet devised to make the world safe for clerks. (Drucker, 1978: 40)

With substantial help from the media and Congress, the issue of Medicaid error has tended to be presented as a morality play; perverse providers and welfare cheats conspire to rip off government; lethargic or incompetent bureaucrats fail to get tough with them; the noble "public" loses. To some extent, of course, cupidity, incompetence, and administrative spinelessness do account for error. But the issue of error looms as vastly more complex than this morality play conveys. Sometimes the definition of error is far from clear; failure to detect error may often be not so much a matter of a will but of a way; what appears on the surface as incompetence may reflect more basic dysfunctions in the personnel game (for example, low salaries and high turnover); a seeming unwillingness by federal and state officials to do the things necessary to combat error may reflect a reasoned judgment that the economic costs of the combat would dwarf any money saved. What often appears as a morality play to the public, then, is a complex unfolding of events involving trade-offs among conflicting objectives, limits to our understanding about the nature and extent of error, and uncertainty over how to design systems to cope with it. (Thompson, 1981: 147-8)

In the euphoria of mid-1960s' concern for the problems of the poor, many forces combined to create a Medicaid program which would expand dramatically. The welfare lobbies which had supported Great Society legislation wanted to maximize the number of persons who would be eligible and the services which would be provided; the various institutional and individual provider groups wanted to ensure that they would be included in each state's plan and that reimbursement rates would be as high as possible. Meanwhile, both federal and state bureaucracies hurried to cash in on the new and open-ended source of funding. (The development of Medicaid from 1965 to 1973 is described in Stevens and Stevens, 1974.) In both the Health Policy and the Intergovernmental Relations games, therefore, recipients, providers, and bureaucrats shared a common interest in an expansive approach to implementation; getting recipients into the system and

payments out to providers overrode concern for designing a program which would facilitate or even permit control of expenditures.

As Medicaid grew in the late 1960s and early 1970s, however, it came under attack from a variety of sources. The attacks took several forms, each assuming a different problem and a different solution.

(1) State Medicaid programs cover more services than taxpayers can afford; coverage should be reduced.

(2) Too large a share of the population is being covered; eligibility should be reduced.

(3) More is being paid than is necessary to secure covered services; less expensive delivery systems should be developed.

(4) Recipients are seeking and/or providers are giving more services than are "medically necessary"; "overutilization" should be reduced.

(5) Medicaid programs are contributing to the health problems of the poor by supporting drug habits, sleazy nursing homes, incompetent physicians, etc.; payments should only be made for "quality" care.

(6) Ineligible recipients are gaining access to Medicaid benefits; ineligibles should be identified and terminated. (Unlike the AFDC and Food Stamps programs, in which benefits are scaled to the degree of need, Medicaid eligibility is a yes-no decison. While the medically indigent must "spend down" their own resources before Medicaid assumes liability, all recipients have equal and unlimited access to services. (An erroneous AFDC or Food Stamp award might cost the state $100 to $300 per month, but an erroneous admission to Medicaid eligibility could cost thousands of dollars in hospital, nursing home, or doctor bills.

(7) Providers are fraudulently billing for services never provided; defrauders should be identified, their claims disallowed, penalties imposed, etc.

(8) Through simple administrative errors, program agencies are paying for uncovered services, for uncovered patients, for duplicate claims, for claims covered by insurance or another program, etc.; administrative systems should be improved to provide more accurate claims processing.

(9) Even when providers submit proper claims, the Medicaid agencies are slow in processing them, demand "unreasonable" documentation or bookkeeping, etc.; claims should be paid with maximum speed and minimum "hassle."

While all of these attacks were directed at the Medicaid program, a number of them concerned problems over which program administrators have little control. Congress and the state legislatures specified the services to be provided (#1) and the classes of recipients who would be eligible (#2). The costs of service delivery (#3) to some extent depend on Congressional decisions to utilize commercial health care providers ("mainstream medicine") and to reimburse hospitals for their full costs, and on state legislative decisions regarding reimbursement rates for nonhospital services.

Medicaid agencies also have little control over recipients and providers. The extent (#4) and quality (#5) of utilization are overwhelmingly based on decisions made by recipients and providers. Recipients choose which provider to patronize; providers choose whether or not to participate in the program, and which services to give each patient. (Overutilizing recipients can be "locked in" to designated providers, and overproviding providers can be forced to secure prior approval before giving service, but all others can do as they wish.) Recipient eligibility (#6) is determined by the Social Security Administration (for SSI recipients) and by the welfare agencies (for AFDC recipients and the medically indigent).

Provider licensing is controlled by state health, hospital, or licensing agencies. Any licensed providers who agree to the terms set by the Medicaid agency (maintaining records, accepting Medicaid as full payment, etc.) can participate in Medicaid, although they can be subsequently suspended or terminated for abusive practives. (Termination by the Medicaid agency does not, however, lead to automatic license revocation, as the licensing agency conducts its own revocation proceedings.)

The first six listed attacks on Medicaid, therefore, centered on problems which were built into the basic design of the program (recipient categories, service coverage, and reliance on commercial providers), or which were controlled by other agencies[1] (eligibility determination and provider licensing), recipients (provider selection), and providers (treatment plans). Program administrators could play marginal roles in recommending alternative coverage or reimbursement policies to the legislature, and could monitor provider and recipient utilization decisions, but ultimately the central components of these issues were out of their hands.

The last three attacks--provider fraud and abuse (#7), claims processing error (#8), and delay (#9)--however, concerned matters which were more amenable to actions by the program agencies, since the agencies controlled the claims processing system and could develop programs to identify fraud and abuse. In establishing control programs, however, Medicaid administrators had to cope with problems arising out of conflicting objectives and incentives, the political power of providers, and primitive technology.

The Problem of Provider Participation. Administrators of welfare programs, such as AFDC or Food Stamps, deal with essentially captive populations; welfare recipients have nowhere else to seek assistance. Medicaid administrators, however, do not have captive providers: unless providers agree to enroll in the program, recipients will not receive health care. As the director of the New Jersey Medicaid program put it, "We exist

in a symbiotic relationship with our providers. We need them and they need us, but in most respects we need them far more than they need us, because this is a very rare and valued technology that the health professionals have a monopoly on." (Problems of Medicaid Fraud and Abuse, 1976: 113)

At the same time that legislators and the media demand that the Medicaid agencies cut costs and increase accuracy in claims processing, provider groups are demanding higher reimbursement rates and faster payments. The "commercial market strategy" (Thompson, 1981: 109) underlying Medicaid therefore confronts administrators with the dilemma of trying to maximize recipients' access to services while trying to minimize costs, payment errors, and provider fraud and abuse. The director of Michigan's Medicaid program stated the dilemma explicitly:

> There are two significant but opposing forces at work in the management of the Medicaid program. On the one hand, it is crucial that we review, adjudicate, and pay claims in a timely and equitable manner. If we don't, we will not be able to obtain the services of health services providers. Without their participation, we deny the indigent, particularly aged and children, access to the mainstream of quality health care. On the other hand, since we are spending in excess of $2 million a day in public funds, it is essential that all claims are carefully scrutinzed to ensure that they are valid and proper and that the possibility of program abuse is minimized. (Allen, 1979: 33).

State Medicaid agencies have responded to this dilemma in different ways. As suggested in Figure 14 , some states have displayed a "provider orientation," with high reimbursement rates, simple enrollment and claims procedures, rapid payment, and minimal pre- or post-payment surveillance of claims; other states have shown a more marked "control orientation," emphasizing cost containment and verification of claims.[2]

For a number of reasons, a provider orientation was the most common state response in the early years of the Medicaid program. The emphasis in the legislation passed by Congress in 1965 was on access of the poor to health services, rather than efficiency and economy (Thompson, 1981: 114), so federal and state agencies were expected to bring providers into the

CONTINUED

3 OF 4

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

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FIGURE 14 A CONTINUUM OF AGENCY POLICIES TOWARD PROVIDERS

program as rapidly as possible. Even if some providers were expensive or of dubious competence, they were at least offering previously unavailable care to the poor.[3]

A second explanation for the early provider orientation was the widely shared assumption that it was necessary in order to persuade providers to participate in the program. In some areas, or for some types of services, it was believed that the supply of providers might not equal recipient demands, and that accommodative provider orientations would be needed to compensate for the below-market rates which the Medicaid program offered. Whether a provider orientation was necessary in order to induce participation, however, varied from provider to provider. Some individual providers and public or charitable institutions accepted Medicaid patients as a matter of professional obligation, but others weighed participation in Medicaid as a matter of economics: would net revenues exceed alternative sources of income? If a provider already had as large a practice as he wanted, billing at full market rates, then accepting different patients at below-market rates would be costly. Conversely, if a provider had a less-than-full practice, or empty beds in a hospital or nursing home, Medicaid revenues would offer a new source of business. (Providers in inner-city areas, of course, had to participate in Medicaid or risk losing their patients to participating competitors.) The distribution of providers among these categories was likely to vary by provider type and by geographic area: while nursing homes and "shared health facilities" (Medicaid mills) were likely to be available or to spring up in response to the availability of funding,[4] some specialties were in short supply and some areas (particularly rural areas) had few medical providers of any sort.

Were accommodative provider orientations necessary to secure provider participation? No one knows, because few states were willing to take the risk of trying to find out, particularly in the early days. As Judith Feder and Bruce Spitz note, "With Medicare and Medicaid programs, the government constantly faces the threat that hospitals will refuse to treat government-financed patients or will provide them 'second-class' care. The importance of Medicare and Medicaid revenues makes it unlikely that many

hospitals will refuse to serve government patients. But for political purposes, an industrywide boycott is unnecessary. Refusal to participate by a few prominent hospitals would probably suffice. This threat is believable and therefore effective." (Feder, 1980: 311)

An additional explanation for Medicaid agencies' provider orientations has been the political power of providers. As was noted in Chapter Nine, health professionals enjoy high public esteem, and their associations are well-prepared to monitor legislative and agency policymaking, mobilizing members to descend on the state capitals and going to court to challenge statutes or regulations. Bruce Vladeck's comment about nursing homes applies to many of the professions participating in Medicaid: "Nursing homes and their associations spend a lot of money on legal fees, employ highly skilled counsel, and are well represented in court. Their hired guns are generally better paid, better educated, more experienced, and more numerous than the government's, and they win more than their share of court contests." (Vladeck, 1980: 197)[5] Given these political and litigative skills, it is not surprising that providers were a more frequent influence on program agencies than legislators, the public, or Medicaid patients.

Even without political threats, Medicaid agencies may have tended toward a provider orientation because, through advisory councils, peer review panels, and other mechanisms, they were in day-to-day contact with the providers and their associations. Lacking the daily contact with recipients of their AFDC and Food Stamp counterparts, the Medicaid administrators most frequently heard the providers' side of the story. Vladeck's observation about the agencies which regulate nursing homes might also apply to Medicaid agencies: "State and local health departments, as well as the Public Health Service in HEW, have defined their constituencies as consisting primarily of their fellow professionals in the private sector. The Bureau of Health Insurance in the Social Security Administration similarly showed more solicitude for the interests of hospitals and other service providers than for its beneficiaries." (Vladeck, 1980: 199)[6]

A final explanation for provider orientations may be the sheer fact of technological and/or administrative incapacity, widespread when Medicaid began and still common today. It is difficult for a government agency to hire and retain health professionals able to second-guess providers' treatment decisions; when the movement to establish peer review systems began in the early 1970s, the agencies were forced to turn the process over to the provider organizations. (This delegation, of course, also reflected the political dominance of the providers, but it is doubtful that the agencies could have hired comparable technical staffs themselves.) Accounting systems established by institutional providers have, perhaps intentionally, made it virtually impossible for government agencies to fathom providers' costs (Feder, 1980: Chapter Six), so they essentially have to rely on provider-supplied data. Even the mechanics of paying claims overwhelmed many state agencies; 31 states have contracted out all or part of their Medicaid claims-processing functions to fiscal agents or health insurers (Health Care Financing Administration, 1979: 101).

The Problem of Incentives for Control. Adopting a provider orientation served a number of purposes for both HCFA and the state Medicaid agencies--it maximized recipient access to health care services, it minimized complaints from providers, and it made everyone look good: the scale of expenditures proved that the agencies were serving an important function. HCFA, vis-a-vis the states, and the states, vis-a-vis providers, had every incentive to play the Easy Money Game (Bardach, 1977: 66), doing whatever was necessary to get the money out. HCFA, the states, the providers, and recipients thus had common interests and supported each other--until concerns about funding and provider fraud and abuse surfaced. When these concerns arose, however, they did so in a setting in which statutory policies, organizational incentives, and administrative routines militated against regaining control.

The earliest efforts to control the costs of Medicaid focused on the scope of the program and on eligibility. State legislatures considered reductions in recipient eligibility,[7] optional services, and reimbursement

policies. The Social Security Administration and the state welfare agencies, as was discussed in Chapter Eleven, sought ways to identify ineligible recipients, to identify sources of third-party liability for health costs,[8] and to pursue child support enforcement actions which might also uncover sources of third-party liability.[9]

When Congress turned its attention to the administration of Medicaid policies, it confronted a decentralized program in which the federal government had done little to circumscribe state activities. Just as the state agencies began with a laissez-faire attitude toward providers, the federal agencies (HCFA and its predecessor agencies, the Medicaid Bureau, and the Medical Services Administration) began with a laissez-faire attitude toward state agencies. Unlike the AFDC program which, from its beginnings in 1935 until at least the early 1950s, had strong central direction, the Medicaid program began with little central leadership; a number of states were off and running with their Medicaid programs in 1966 before the tiny MSA staff was prepared to issue regulations and monitor state plans. (Stevens and Stevens, 1974: Chapter Five)

That Medicaid began in so decentralized a manner was in part an accident of history--federal attention was focused on the simultaneous inauguration of the Medicare program (which was, after all, to be federally administered). Medicaid was expected to be a smaller effort (the "sleeper amendment" to the 1965 Medicare legislation), and, as a "welfare" program, it was seen as fitting in with the states' historic role in providing for the poor. Accordingly, federal interest in the Medicaid program was initially limited to monitoring compliance with federal policies and guidelines. (Cattani, 1976: 47) Federal monitoring focused on the annual state Medicaid plan, specifying eligibility and reimbursement practices. Policies deemed not in compliance with federal regulations could lead to disallowance of federal cost-sharing.

In the 1970s, the opportunities for federal control were expanded through new legislation providing both incentives and fiscal penalties. Special funding was made available for states to establish Medicaid

Management Information Systems (MMIS) and Medicaid Fraud Control Units (to be discussed in Chapter Fourteen). States were also required to estimate through statistical samples the percentage of ineligible persons receiving medical assistance. In 1978, the Medicaid Quality Control system was expanded to cover payment as well as eligibility errors; and failures to identify third-party liability penalties were to be imposed on states which failed to meet error reduction goals. (General Accounting Office, 1981: 4) In 1980, Congress added to the MMIS fiscal incentive a fiscal sanction threat; not later than 1982, each state had to have an operational MMIS or face reductions in federal financial participation in administrative expenses. [This requirement did not apply to smaller states, and the Secretary of DHHS was authorized to waive penalties if he concluded that a state was unable to comply "for good cause...or due to circumstances beyond the control of the state." (Public Law 96-398, Sec 9D1 (8) (A)]

While Congressional pressure on HCFA to "do something" about Medicaid costs has steadily escalated, HCFA's influence over the states has remained limited. HCFA, like the Social Security Administration, has waived requirements for agencies trying to improve administrative systems, provided demonstration grants to support innovations, and attempted to coordinate technical assistance efforts. Like the AFDC agencies, however, the state Medicaid agencies complain that federal regulations are vague, constantly changing, complicated, and often unworkable. A 1977 study of nine states concluded that noncompliance with federal Medicaid regulations was widespread, and "occurs primarily for three reasons: (1) some Federal policies are unworkable, and in the interest of administrative efficiency, States develop procedures that are out of compliance; (2) Federal regulations are difficult to understand, and as a result, States are often unaware that they are out of compliance; and (3) States disagree with various aspects of Federal policy both for philosophical and administrative reasons." (Rymer, 1979: 199)

A 1981 study by the General Accounting Office concluded that HCFA was doing little to support state corrective action efforts, that responsibility for approving state requests was fragmented between regional and central

offices, and that HCFA's regional offices did little either to offer corrective action suggestions to the states or to monitor plans proposed by the states. (General Accounting Office, 1981: 28-30) HCFA has yet to impose quality control or MMIS fiscal sanctions, waiving penalties when states submit corrective action plans or appear to be making "good faith efforts" to remedy problems. GAO commented, "Unfortunately, this emphasis on corrective action plans apparently was an effort not so much to improve Medicaid management as to avoid imposing the fiscal penalties." (General Accounting Office, 1981: 11)[10]

These studies by GAO and DHHS confirm the findings of our case studies that federal agencies have offered some financial and technical assistance for state improvements in Medicaid administration, but that states have fundamentally been free to determine for themselves how much emphasis to place on controlling provider fraud and abuse. Whether the state agencies initially felt any incentive to respond to Congress' concerns depended on the relative importance of their provider lobbies and fiscal conservatives within their state legislatures. So long as providers and recipients were happy and there were no financial problems, program administrators had little incentive to worry about control issues. Getting the providers in and the payments out were difficult enough without worrying about errors. Federal agencies were unlikely to cause trouble and legislators seemed more responsive to the providers' point of view than to control problems. The states received no additional rewards for establishing control programs (Problems of Medicaid Fraud and Abuse, 1976: 56, 106) and it was virtually impossible to recapture improper payments,[12] so control efforts made little sense.

Regaining Control: The Problem of Technology. By the mid-1970s, Medicaid agencies were given incentives to move toward a control orientation when taxpayers and legislators began to complain about the program's costs, and when official and media investigations exposed provider fraud and abuse. As the statement by Frank Thompson at the beginning of this chapter indicated, however, a will to control providers did not provide a way.

Technological problems took many forms. One was conceptually simple but logistically difficult--the problem of processing millions of claims, checking to see that each was for a covered service given to an eligible recipient by an enrolled provider. If State X's Medicaid program covered eyeglasses, for example, and Jane Smith was eligible for Medicaid, and Optometrist Jones had agreed to participate in the program, then a claim for $Y should be paid. The claims processing system, manual or computerized, state-operated or contractor-operated, had to be able to compare each claim form with lists of recipients, providers, services, and fee schedules. (Further complications would exist if a recipient had been locked in to specific providers, if a service required prior approval, or if the provider was required to secure prior approval before giving service.) If the recipient was also known to be covered by some other program (such as insurance, Medicare, VA benefits, etc.), the system was also expected to be capable of rejecting the claim and referring the provider to the source of third-party liability, since Medicaid was to be only the payor of last resort.

That it was difficult to build claims processing systems which can check these items is suggested by the Medicaid quality control reports. During the period of July to December 1978, the quality control studies found error rates of 7% in payments for ineligible recipients, third-party liability, and processing claims; erroneous payments totalled $635 million. (General Accounting Office, 1981: 2)

Building a claims processing system which would function with reasonable speed and accuracy served the providers' needs for prompt reimbursement, legislators' needs for accountability, and administrators' needs for management control. When the issue of control was expanded from claims processing accuracy to identifying provider fraud and abuse--such as services which were never provided or services which were medically unnecessary--the problem became far more complex. Like the AFDC administrator who must basically rely on the statements provided by recipients to determine eligibility and grant levels, the Medicaid

administrator must usually accept at face value the assertions of providers that they delivered claimed services.

Occasionally a recipient will turn a provider in ("I think Dr. Smith is doing something funny") or a provider will trip himself up with patently false claims (e.g., a claim for filling a previously extracted tooth or nursing home charges for a deceased resident) Without such leads, the Medicaid administrator has no idea where his problems lie, or even whether he has problems. While the AFDC quality control system can identify the frequency of each of the types of errors which have been made (unreported income, family composition, etc.), the Medicaid quality control system says nothing about providers, but only reports the percentages of recipient eligibility, third-party liability, and claims processing errors. (Rymer, 1979: 196) The Medicaid administrator knows the results of provider audits and investigations which have been conducted (overpayments identified, recoveries, provider terminations, etc.), but cannot know whether they represent all of his mistakes or the "tip of the iceberg," or whether the distribution of mistakes in the entire program matches the distribution among claims which were audited or investigated.

Lacking such information, several approaches were possible. One was to proceed randomly, auditing every nth claim to see whether the provider's records substantiated claimed services. A second approach was to select targets on the basis of their Medicaid receipts; even if the frequency of fraud and abuse were to be smaller than for less active providers (which was, of course, unknown), the scale of recoveries was likely to be larger. If investigations showed that the providers were also offering bad medicine, this approach had the additional advantage of safeguarding the greatest number of patients.

Since the early 1970s, efforts have been made to develop a more scientific approach to the selection of targets for audit and investigation, one which would be more cost-effective than random selection and more diversified than targeting the larger providers. The underlying assumption of this approach is that providers whose treatment patterns are different

resembled those of peers, this approach allowed the agencies to maintain a rapid payment system and to avoid contact with providers until intensive analysis was called for.

To provide the methodology for this approach, DHEW began in 1970 the development of a model Medicaid Management Information System, whose Surveillance and Utilization Review Subsystem (SURS) was intended to:

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

Twelve years later, the SURS systems have yet to fully meet these objectives. Like the Illinois experience described in Chapter Six, many states had problems in developing operational MMIS systems (see Thompson, 1981: 135-37). Even when states solved their basic programming problems, analytical and staffing difficulties remained. Developing statistical profiles requires both categorization of recipients and providers and accumulation of historic data; determining what constitutes "significant departure from normal medical practice" requires some definition of "normality"; and analysts must be available in sufficient numbers and with sufficient training to review the profiles generated by the computer. A 1978 study by the General Accounting Office concluded that states were having difficulty satisfying these requirements. (General Accounting Office, 1978: Chapter Four) There is disagreement or uncertainty as to the appropriate composition of comparison groups, as to whether "normal medical practice" should be defined statistically (e.g., by the average treatment

reflected in claims data) or by panels of experts, and as to methods of selecting which of the thousands of "exceptions" flagged by the computer are most likely to merit detailed investigation. (Thompson, 1981: 142-148) The GAO report concluded, "States are uncertain as to what indicates abuse and/or how many indicators are needed. This uncertainty is perpetuated because the [SURS] system has no capability to determine which indicators do the best job of identifying potential abusers who are found to be abusers when investigated. This missing link--identifying which indicators best identify abusers--has not been developed." (General Accounting Office, 1978: 34)

Fraud, Abuse, and Administrative Priorities. Scandals and fiscal crises have given Medicaid administrators incentives to try to control provider behavior. Further experience with MMIS and SURS will solve most of the logistical problems involved in high-volume claims processing systems and the diagnostic problems involved in selecting targets for audit and investigation. Slowly, cautiously, and with elaborate deference to the sensitivities of providers, Medicaid administrators have developed programs to monitor provider activities. In many ways, this deference says more about the social and political status of providers than the lethargy or incompetence of Medicaid agencies. As medical sociologist David Mechanic summarizes the issue,

> There is a great deal of abuse of the Medicaid program by unscrupulous practitioners, but such abuse is not unique, as exposes of Medicaid would suggest. The private practice of medicine and the existence of private insurance to cover medical care bills on a fee-for-service basis are open to a great deal of manipulation and chicanery by practitioners who desire to maximize their incomes. Physicians have been sufficiently powerful to make them relatively immune to monitoring or review, and both government and other third parties who pay the bulk of medical-care bills have been quite timid in questioning the manner in which practitioners and institutions charge for their services and justify their operating procedures. (Mechanic, 1978: 497)

While their incentives systems have changed so as to move administrators toward a control orientation, and technological developments

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

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

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

In Chapter Fourteen, we will consider a number of the evidentiary and procedural problems presented by each of these alternatives. With regard to the perspectives of administrators, however, we might note that pursuing these alternatives involves different costs. As Judith Feder and John Holohan point out, "Identifying and proving fraud, that is, willful intent, are difficult and expensive. Despite glaring examples in newspaper accounts, the line between abuse and 'defensive medicine' is difficult to

establish. It is not surprising that states are somewhat unwilling to devote extraordinary resources to the differentiation. Advocates of increased monitoring efforts often overlook the fact that the costs of limiting overprovision can be quite high once the most glaring problems are eliminated." (Feder, 1980:52).

While it is difficult and expensive to document and defend charges of fraud or abuse, it is comparatively simple to disallow claims (putting the burden of proof on the provider to establish that services were provided). It is also less difficult to terminate a provider from the program than to win a civil or criminal prosecution. The response selected in all likelihood is based on two factors--the nature and magnitude of the offense and whether the agency wishes to continue to utilize the provider. If the offense only involves a small amount, Stuart's first six options are likely to seem sufficient. If the offense involves large-scale and repeated transgressions, and/or there are indications that the provider is also practicing bad medicine, however, the agency is more likely to want to be rid of him or her. Termination, accompanied by disallowance of claims, will thus provide some measure of cost savings and prevent a large measure of future harm, and can be accomplished through the agency's internal sanction processes. Blatantly offensive behavior can be referred to prosecutors and the licensing agencies, even though the likelihood that they will act is small, as we shall see in the following chapters.

NOTES

1. The "single state agencies" administering Medicaid have a variety of homes on state organization charts. Twenty-one are housed in welfare departments, seven in health departments, twenty-one in "umbrella" human resources departments, and four elsewhere. (Health Care Financing Administration, 1979: 92)

2. The attractiveness to providers of Medicaid participation thus depended not simply on reimbursement rates but also on the speed of reimbursement and the mechanics of enrollment and claims processing. For a provider with a large payroll, mortgage, or operating budget, payment delays can be very expensive; until the practice was outlawed in 1977, many providers responded to payment delays by selling their claims, at a discount, to factoring firms. Provider complaints about delays were so strong that Congress in 1977 imposed fiscal penalties on any state which was unable to pay 90% of its "clean claims" within thirty days. (Thompson, 1981: 123) Mechanical issues include the processes of enrollment (providers can't be reimbursed unless they are specifically enrolled in the program), submitting claims, and providing documentation when claims are questioned. Most providers are equipped to submit claims for insurance reimbursement and, thus, didn't object to normal pre-payment claims screening; however, post-payment audits and investigations several years after the date of service were offensive. As an official of the Illinois State Medical Society put it, "Doctors can't stand haggling with clerks."

3. While there is a great deal of self-interest underlying their position (trying to avoid having to serve nonpaying or undesirable persons on an outpatient basis), there is some truth in the following Congressional testimony of the American Hospital Association: "'Medicaid mills,' despite the occurrence of fraudulent activities, provide a large volume of services which may be of questionable quality to poor people who have few alternative places to go for care....It should be recognized that the hoped-for closing of fraudulently operated Medicaid mills will increase the difficulties of those who are striving to serve the poor well and honestly." (Medicaid-Medicare Antifraud and Abuse Amendments, 1977: 232)

4. The rapid growth of nursing homes in response to the availability of federal funds and tax incentives is described in Mendelson (1974) and Vladeck (1980). The importance of government funding to nursing home operators gives the Medicaid agencies greater control over them than over other provider groups. (Problems of Medicaid Fraud and Abuse, 1976: 114)

5. It should be noted that Medicaid providers do not always act as a monolithic group. While in the early expansionist days the providers cooperated in supporting higher rates and lower supervision, they have become competitors in avoiding the budget-cutting axe in recent years. When they are unable to forestall Medicaid budget reductions, each group has fought on its own to protect its share of the Medicaid "pie." In such situations, less-esteemed or less frequently utilized providers such as nursing homes or dentists (Feder, 1980: 588-9) usually have less political power than physicians and hospitals (Feder, 1980: 311).

6. Cf. Feder and Spitz' comment about the agencies which set hospital reimbursement rates. Even without the threat of boycotts, "policy-makers tend to be more responsive to the particular interests of providers than to the general interest of taxpayers and consumers." (Feder, 1980: 311).

7. Issues of Medicaid eligibility are analyzed in detail in Rymer, 1979.

8. Difficulties in pursuing third-party liability are discussed in Rymer, 1979: 151.

9. The relative importance of different sources of errors in Medicaid payments is suggested by HCFA quality control findings. For the July-December 1978 period, "approximately $461 million was paid for health services to ineligible beneficiaries, $74 million was lost in unrecovered third-party liability, and $100 million was wasted through claims processing errors." (General Accounting Office, 1981:2). MQC analyses do not seek to identify provider fraud and abuse; claims processing errors only indicate that a payment was in violation of federal or state regulations.

10. DHHS openly opposes fiscal sanctions, feeling that they will only make the mismanaged states worse; GAO feels that the sanctions are too large, preferring a system in which smaller sanctions would actually be imposed. A GAO report, reviewing state MQC efforts, concluded that the states were being given incentives both not to cite errors (hoping that federal reviewers would not spot them) and to focus on reducing error rates rather than taking corrective action. "Because corrective action is the ultimate purpose of MQC, the threat of penalties has partially negated its expected benefits." (General Accounting Office, 1981: 7)

11. Similar disincentives face the firms holding contracts to pay state Medicaid claims. While they may have staffing and accounting capabilities which are superior to the states, these fiscal agents, like the intermediaries who process Medicare claims (Thompson, 1981: 171-2), are rewarded for speed, not accuracy, and they have little incentive to verify claims.

12. Eugene Bardach offers the following general comment about funding agencies: "Once the recipient has secured an inflated grant from the donor, the donor has little incentive to police the spending of the

grant beyond the point of satisfying itself that some acceptable minimum was spent on initially stipulated purposes. To police the expenditures too carefully would create a risk that it would have to withdraw funds and thereby undermine its own strategy in its Budget Game" (moving money somehow, somewhere, and fast). (Bardach, 1977: 73)

REFERENCES

ALLEN, P. (1979) "Remarks--Administrative Remedies" in U.S. Department of Health, Education, and Welfare, The Secretary's National Conference on Fraud, Abuse, and Error: Conference Proceedings (Washington: Government Printing Office)

BARDACH, E. (1977) The Implementation Game: What Happens After a Bill Becomes a Law (Cambridge: MIT Press)

CATTANI, J. (1976) Medicaid Fraud and Abuse Control: A Review of Selected Literature (McLean, VA: General Research Corporation)

DRUCKER, P.F. (1978) quoted in Paul Dickson, The Official Rules (New York: Dell)

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

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

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

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

MECHANIC, D. (1978) Medical Sociology, 2nd ed. (New York: Free Press)

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

MENDELSON, M. (1974) Tender Loving Greed: How the Incredibly Lucrative Nursing Home "Industry" Is Exploiting America's Old People and Defrauding Us All (New York: Vintage Books)

PROBLEMS OF MEDICAID FRAUD AND ABUSE (1976) Hearing before the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, United States House of Representatives, Serial 94-64 (Washington: Government Printing Office)

RYMER, M., C. OKSMAN, L. BALLIS, and D. ELLWOOD (1979) Medicaid Eligibility: Problems and Solutions (Boulder: Westview Press)

SPIEGEL, A. (1979) The Medicaid Experience (Germantown, MD: Aspen Systems Corporation)

STEVENS, R. and R. STEVENS (1974) Welfare Medicine in America: A Case Study of Medicaid (New York: Free Press)

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

VLADECK, B. (1980) Unloving Care: The Nursing Home Tragedy (New York: Basic Books)

CHAPTER THIRTEEN

CONTROL AGENCY PERSPECTIVES ON RECIPIENT FRAUD

> The administration of the criminal law is a highly selective process and involves the use of a wide range of discretion by the agencies responsible for enforcing the law. At every step of the law enforcement process, from deciding where to send patrolmen to look for crime to determining how many years a man should be sent to prison, the organizations that are responsible for enforcing the law make decisions that have the net effect of determining what types of offenses will come to the notice of officials, what kind of offenses and offenders will be processed, and precisely how far this processing will go. It is in the day-to-day practices and policies of the processing agencies that the law is put into effect, and it is out of the struggle to perform their tasks in ways which maximize rewards and minimize strains for the organization and the individuals involved that the legal processing agencies shape the law. (Chambliss, 1969: 85-86; emphasis in original)

Recipient Fraud Control as a Filtering Process. From the point at which a welfare recipient is initially suspected of fraud to the point at which the case is closed, a series of filtering decisions are made--decisions which move the case closer to civil or criminal adjudication, divert the case via administrative action, or end the process with nothing being done. Figure 15 provides a simplified view of the filtering process: investigators scan leads from a variety of sources, referring some to prosecutors; prosecutors scan these referrals and file formal civil or criminal charges on some; judges (and occasionally juries) determine guilt and pass sentence. (Frequently, judges simply ratify agreements made between prosecutors and defendants during plea negotiations.) At each stage in the process, decisionmakers can conclude that suspicions were unfounded, that further action is inadvisable or not cost-effective, or that other actions (grant reduction or termination, recoupment of overpayments through grant reductions, or voluntary repayment agreements) are appropriate dispositions.

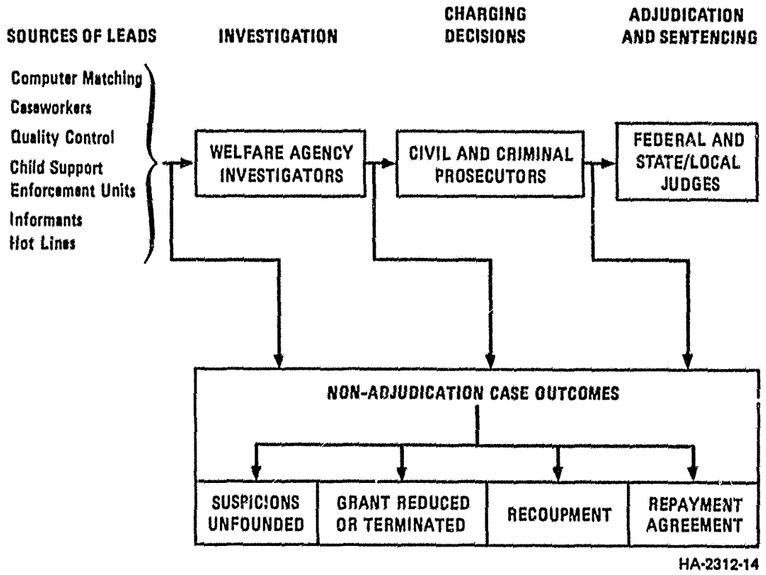

FIGURE 15 FILTERING PROCESSES IN RECIPIENT FRAUD CONTROL

The general effects of this filtering process can be seen in Table 13.1, which presents AFDC data for Fiscal Years 1971 through 1980 from the annual report, "Disposition of Public Assistance Cases Involving Questions of Fraud," compiled by the Department of Health and Human Services from data submitted by each state welfare agency. The columns headed "Administrative Disposition" list all cases in which a question of fraud has been raised ("Total Cases"), cases in which the agency has concluded that there is "sufficient evidence to support a question of fraud" ("Facts Indicating Fraud"), and cases which have been referred to a prosecutor. The "Legal Disposition" columns, while supplied to DHHS by the welfare agencies, are based on prosecutors' records; there is an unexplained loss of some cases between the cases referred for prosecution (B) and the total cases processed by the prosecutors (C), even allowing for a time lag. The "Dispositions/Families" columns divide referrals and prosecutions by the number of AFDC families supported each year.

In interpreting Table 15 , we must recognize that state agencies are very likely to vary in their definition of a "case" (some may list any case where a question has been raised, while others may include only those which have been checked out), on when they feel that there is supporting evidence, and on when the case has been "referred" (some agencies may list all cases where they have requested prosecution, and others may list only those which the prosecutor has agreed to take). If we assume that these problems remain constant over time, Table 13.1 shows that from 1971 to 1980, there was a seven-fold increase in the number of cases with "Facts Indicating Fraud," a five-fold increase in referrals for prosecution, and a four-fold increase in actual prosecutions. Controlling for the expansion of the AFDC population, referrals (B/E) and prosecutions (D/E) roughly tripled. Looking at <u>rates</u> of response to those cases in which there were facts indicating fraud, however, we can see that the rate of referral (B/A) fell from over 50% to less than 40%, and the rate of prosecutions (D/A) fell from 26.4% to 15.6%. <u>If</u> we assume that these data reflect actual policy changes rather than improved reporting systems or changing definitions,[1] then the welfare agencies were becoming more active in identifying fraud problems and, in absolute but not proportional terms, sending defrauders to court. Prosecutors were similarly increasing the number of fraud prosecutions, but continued to file charges on

Table 15

DISPOSITION OF SUSPECTED AFDC FRAUD CASES BY WELFARE AGENCIES AND PROSECUTORS

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

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

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

only 40-50% of the cases they considered. Overall, the proportion of the AFDC caseload referred for prosecution rose from .5% to a high of 1.5%, and actual prosecutions rose to a high of .7%.

Control Agency Perspectives on Recipient Fraud Cases. We noted in Chapter Eleven that welfare agency administrators are primarily interested in the cost containment aspects of recipient fraud; once grant awards have been corrected and recoupment procedures initiated, they have little incentive to seek additional penalties. This perspective may help to explain the fact, shown in the B/A column in Table 15 , that welfare agencies send less than one-half of their substantiated fraud cases to prosecutors for further action. People with control responsibilities (investigators, prosecutors, and judges), however, have somewhat different perspectives on recipient fraud. After analyzing their assessments of individual cases, we will consider the factors which shape control agency policies on recipient fraud.

Unlike the caseworkers in welfare offices, control personnel encounter recipients through grant files, computer crossmatch printouts, quality control reports, hot line tips, etc. Recipients thus are not seen as poor people needing help, but rather as impersonal objects of suspicion. The suspicions may prove to be unfounded, errors may have been unintentional, intentional errors may prove to be too minor to be worth pursuing, etc., but controllers rarely develop the personalized empathy with recipients which can lead caseworkers to deliberately overlook petty fraud. For investigators, prosecutors, and judges, cases are appraised more clinically in terms of legal issues, what outcome is "due" the recipient/defendant given the facts of the case, and probable outcomes if prosecution is pursued.

In appraising the legal issues in each case, controllers usually find clear indications that the recipient received excess assistance, providing a sufficient basis for recoupment or repayment actions.[2] To pursue civil or criminal fraud charges, however, controllers also need proof of mens rea or intent. An analysis of charging decisions in welfare fraud cases in Cook County noted, "The primary factor in the decision to prosecute is the Office's

perceptions of the recipient's intent. It is usually not too difficult to establish that the suspect has in fact received excess assistance. But whether the recipient's failure to report changed income or circumstances was an attempt willfully and knowingly to defraud the Welfare Department is not always clear, and the question usually cannot be answered by objective evidence." (Aikman and Berger, 1967: 296)

As investigators and prosecutors develop information about a case, facts emerge which may aggravate or mitigate the primary legal fact of intentional fraud. One such fact concerns the conduct of the welfare agency in handling the recipient's case--was the recipient informed of her duty to appraise the agency of the facts involved in the fraud (earned income, rent receipts, other benefits, changes in family structure, etc.)? Did the agency perform scheduled case redeterminations using appropriate verification procedures? While statutes and regulations clearly place reporting burdens on the recipient, agency negligence will weaken a case should it come to trial. Further mitigation, in practice if not in law, arises from the personal situation of the recipient. "People who are elderly, very ill, or seriously handicapped generally are not prosecuted." (Aikman and Berger, 1967: 297-98) If the recipient is a mother caring for small children, prosecutors are as loathe to haul her into court as the welfare agency is to pay for foster care should she be sent to prison.[3] Finally, the specific form of the recipient's fraud may mitigate its seriousness; failing to report casual earnings or short-term changes in family composition may be regarded as tolerable "chiseling," rather than culpable behavior deserving formal penalties. (On the issue of the "criminality" of white collar crime, see Shapiro, 1980: 26.)

Conversely, controllers may regard some cases as "aggravated offenses"--e.g., cases where the recipient systematically deceived the agency by setting up multiple grants with fictitious social security numbers, concealing a full-time job, claiming non-existent dependents, etc. Such aggravating factors ease the controllers' legal burden of proving intent to defraud. They may also lead the controllers to want to "get" a morally culpable recipient; rather than simply obtaining more aid than he or she

deserves, the recipient has gone out of the way to bilk the system.[4] A recipient who is secretly holding a government job is felt to be especially reprehensible.

Out of their assessment of the facts of each case, modified upward or downward by aggravating or mitigating circumstances, controllers form an impression of what should be done.[5] Whether they act accordingly, however, is influenced by their perceptions of how other controllers will look at the case: investigators in the welfare agency will try to anticipate the reactions of prosecutors, and prosecutors will try to anticipate the reactions of judges. Since each succeeding filter in the control process becomes more selective, investigators must consider whether prosecutors will agree to file charges and prosecutors must consider whether judges will convict and impose sentences worth the effort. Cases which clearly fit these expectations will be moved along, as will some cases whose fit is more ambiguous. Aggravated cases that anger controllers will be processed even if they are likely to be dropped, in order to punish the offender with the embarrassment and inconvenience of prosecution.

Finally, individual cases are assessed in terms of the amount of work involved in each possible disposition. Glancing at a case file and saying "no," of course, is easy; the file is sent back to the welfare office for administrative action. How much work is involved in seeking prosecution, and who will have to do the work, depend on the nature of the case and work assignments in the control system. A fraud case based on documents (unreported wage receipts, other government benefits, etc.) is simpler than a case which requires extensive interviews (e.g., to confirm cash income, a returned spouse, etc.) Some control agencies can call on welfare personnel to do this legwork and only have to fill out the necessary papers to issue an indictment; others have to do the work themselves, or want to corroborate conclusions reached by prior investigations.

Fraud Control Policies: The Costs and Benefits of Severity or Leniency. At each stage of the control process, investigators, prosecutors, and judges can alter the selectiveness of their filters, moving more or fewer of the

cases before them closer to adjudication and sentencing. Presumably, all major and aggravated cases proceed to prosecution and all unfounded or trivial cases drop out of the control process. But what determines whether intermediate cases proceed or drop out? In some situations, severity or leniency is not a matter of choice but is dictated by external factors. In our case studies, for example, we saw that Illinois fraud investigators were ordered to turn all cases over to the Department of Law Enforcement; decisions by the Colorado courts, conversely, essentially meant that no cases could be prosecuted. For all control agencies, of course, budgets and staffing set outer limits on how many cases can be processed; travel budgets limit the number of possible interviews; each investigator and prosecutor can handle only so many cases, etc. In addition to the quantity of resources, there may be problems of quality; some investigators or prosecutors may not have the training or competence to handle fraud cases.

In many control agencies, recipient fraud cases must compete for attention with other activities. Some welfare agencies have no specialized investigators, and caseworkers must handle fraud investigations along with their other case management duties. In many counties and states, civil and criminal fraud prosecutions are but part of the general caseload of a district attorney or Attorney General and most judges see only a few welfare fraud cases a year. Thus, unless there is a specialized unit which handles only recipient fraud cases (like the Medicaid Fraud Control Units to be discussed in the next chapter),[6] recipient cases must compete with provider cases, fraud cases must compete with property and violent crime cases, and so forth.

The leaders of control agencies, therefore, must deal with two basic policy issues regarding recipient fraud cases: what proportion of available resources[7] should be committed to them, and what level of severity (recommendations for prosecution, suggested sentences) should be sought. Four prototypical policies are possible--to handle a few cases leniently, a few cases severely, many cases leniently, or many cases severely. Which of these policies is adopted depends on agency perceptions of each policy's costs and benefits (strains and rewards, in Chambliss' statement at the beginning of this chapter).

In some situations, the perceived costs and benefits of control policies may be influenced by political expectations and community norms. While most control actions are low visibility decisions about which few people know or care, the bigger "welfare queen" cases will be covered by the media. To the extent that control policies become known, severity may be attacked by welfare lobbies and leniency may be attacked by conservatives. In rural and conservative areas, prosecutors and judges may be praised for "getting tough on welfare cheats." Recipient cases are an inexpensive way for control agencies to build a public record, at least to the extent that they involve processing cases which have already been assembled by the caseworkers. In the game of building agency statistics, recipient cases are virtually guaranteed successes, and the agency can claim astronomical "savings" for the taxpayers, even though few repayment orders will ever be honored.

Against this incentive for record-building must be balanced the fact that, in all but the most notorious cases, recipient fraud cases do not look like matters which will enhance the reputation of the control agency. In urban areas, severity may be seen as either "harassing poor people" or "wasting the time of courts when judges should be trying burglars."[8] Hauling a woman (often minority, often with a number of children, often poorly dressed) into court is not the stuff of which heroic reputations are built. Mrs. Smith may, although it is unlikely, be sent to jail, but her friends and neighbors will be around to vote next year. Unlike specialized recipient fraud control units, generalists face the additional disincentive that most recipient cases just don't seem as important as other cases. Unless you can combine enough of them to impress the media ("District Attorney Jones today announced the indictment of 23 women who defrauded the state of $173,000"), routine recipient cases are less visible than property, violence, or major white collar crime cases.

Unless recipient fraud control policies are currently a matter of public concern (e.g., because of a scandal attributed to official laxity or recipient complaints about harassment), however, it is likely that a control agency will be more concerned about the costs and benefits, if any, which might come from other official agencies. While formally independent, welfare

agencies, investigators, prosecutors, and judges in fact rely heavily on each other.[9] Welfare agencies are dependent on control agencies to process enough fraud cases to maintain some degree of deterrent threat and to act on the aggravated cases that the agencies want to punish. Control agencies are dependent on the welfare agencies for cases, supporting data and policy interpretations, and testimony in court. Each agency also needs help from the others in managing its work load: judges expect prosecutors to exercise a screening role to keep "garbage" off the court dockets, prosecutors want investigators to screen, and investigators want the welfare people to be selective in seeking action. From the opposite perspective, each agency wants some guidance from the next agency in the process so it won't waste its time. Because of these mutual needs and the fact that they will be working together over time, agencies are forced to cooperate and to understand each other's point of view.

Over time, as welfare and control agencies work together on cases and come to know each other's likes and dislikes, and abilities and limitations, expected patterns of behavior become clear. So long as each agency complies with these expectations and is satisfied with the results, the control process works smoothly. Within limits, agencies may be willing and able to modify their control policies to help out other agencies: prosecutors may agree to take more recipient cases if the welfare agency is under the gun after a scandal, or the welfare agency may agree to handle more cases administratively if the courts have a backlog problem. Following a review of welfare fraud prosecutions in Middlesex, New Jersey, for example, an SSA team concluded, "It appears that the courts are highly critical of the welfare system as a whole, and are inclined to view welfare fraud cases as a very low priority. Judges, who are sympathetic to recipients, often reduce the amount of fraud in a case and usually order no more than a token amount of restitution to be paid weekly or monthly. The low priority given to prosecuting cases of welfare fraud has resulted in a large backlog of cases to be presented to the Grand Jury. The reluctance of judges to hear cases of welfare fraud has resulted in a delay of two or more years before a case of welfare fraud comes to trial. Since the Prosecutor's Office and the courts have a limited amount of staff, most of

their efforts are concentrated on violent crimes." (Social Security Administration, 1981: 11)

Our Illinois case study showed similar instances of agency interdependence in the working out of understandings about control policies between the welfare agency and prosecutors in 1978 and 1979. It also showed, however, the dangers inherent in violating understandings: when the United States Attorney suddenly prosecuted one hundred recipient fraud cases in 1977, the judges told him in no uncertain terms to file charges only on very large cases. Since controllers work together over long periods of time and need to be able to call on each other for favors, however, such surprises are infrequent and warnings are quickly heeded.

Each agency's cost-benefit analysis of possible control strategies, therefore, will take into account the possibility that the community, the welfare agency, or other control agencies will want it to adopt one or another control strategy. If such requests materialize, the agency must also weigh their potential significance, either positive or negative. If the welfare lobby complains, will budgets be cut or the prosecutor lose in the next election? If the agency opts for a policy of severity, will budgets be expanded to provide additional staffing? Will conservatives show their support at election time? In short, the agency must ask both whether its policy choice will lead to reactions from outsiders and whether those reactions could be significantly valuable or costly.

For most control agencies, there is no relationship between workload or track record and budgets; repayments go to the government, not to the investigative or prosecuting agency, and it will take a very large increase in caseloads before budget-setters will be convinced that the staff should be expanded. Ultimately, the agency may conclude that it is <u>not</u> being evaluated on the basis of its recipient fraud control policies (e.g., if these cases are only a small share of total investigations or prosecutions) or that a few, inexpensive actions (e.g., processing very clear cases with substantial documentation) will provide an "adequate" record. If the statistics game can be played satisfactorily with recovery orders rather than actual recoveries,

with convictions rather than long sentences, etc., there is no incentive to pursue a more difficult path.

These assessments of the costs and benefits of alternative policies, and the efforts necessary to implement them, are likely to lead to different conclusions for different control agencies, and may vary as "get tough" pressures arise and subside. Reviewing four New Jersey recipient fraud control programs, for example, the Social Security Administration found a variety of emphases and strategies. In Gloucester County, an emphasis on recoveries led to regular use of civil actions. "Middlesex County, on the other hand, views the fraud unit as an organization whose purpose is the discovery and prosecution of violations of the criminal code as a deterrent. Recovery actions are seen as secondary to this goal. Monmouth County concentrates its efforts on the recovery of overpayments through recoupment from the assistance grant, while Union County is concerned with the prosecution of fraud cases as a deterrent and also to assure full restitution at the end of the probationary period by obtaining realistic payment amounts in the court order." (Social Security Administration, 1981: 16-17)

We would, expect, however, that several factors apply to all control agencies. First, they will uniformly be willing to process the aggravated cases, whether to accommodate the welfare agency, to reap the rewards of the accompanying publicity, or to wreak vengeance on an egregious cheat. Second, they will select, from among the non-aggravated cases, those which are simplest to process. Finally, they will attempt, as much as possible, to keep control over the disposition of each case; just as the welfare agency may prefer the certainty of an administrative disposition to the uncertainty of prosecution, investigators and prosecutors may prefer the certainty of a guilty plea on a reduced charge (e.g., based on a shorter period of overpayment) to the uncertainty of a court trial which might, despite conviction, lead to the same sentence.[11] Specialized agencies (investigators in the welfare department, joint investigation-prosecution units) will have every incentive to push recipient cases as far as resources permit, but generalists may find that there is little reward for doing more than a bare minimum to keep the welfare agency happy.

NOTES

1. An alternative explanation might be that the actual rate of fraud was increasing and that the welfare agencies were simply detecting and referring a constant proportion of it. While no longitudinal data on actual fraud rates exist, it is hard to believe that fraud increased by 700%.

2. If a recipient will remain on the welfare rolls, overpayments can be recaptured via recoupment (deductions from future AFDC grants). If the recipient has left the rolls, recovery via civil prosecution is only feasible if the recipient has assets (property, wages, etc.) which can be attached or garnisheed. (Aikman and Berger, 1967: 317). Administrative, ethical, and public policy issues involved in the recovery of legally awarded welfare benefits (i.e., payments made in states which require beneficiaries or their estates to repay benefits) are analyzed in Baldus (1973).

3. A study of four New Jersey counties concluded, "In all counties, the courts appear to be reluctant to incarcerate mothers of minor children, since a custodial sentence is viewed as an option that creates more problems than it resolves. With only one overcrowded correctional institution for women in the State, the courts feel that the limited space available would be better utilized for confinement of those convicted for violent crimes. The confinement of a mother with minor children also means that the State must make some provisions, usually in the form of foster care, for the children. Even if the social and emotional problems of the families involved could be discounted, the cost effectiveness of a custodial sentence for welfare fraud is highly questionable. A preferable approach used by some courts is the work release or weekend custody sentence for cases of flagrant or repeated violations." (Social Security Administration, 1981: 17).

   In Cook County, Aikman and Berger found, "The Office is wary of prosecuting when the result might be an increased dependency of the client on welfare; e.g., if the prosecution will cause the suspect to lose his job, which will in turn result in his return to the welfare rolls, the Office prefers not to prosecute." (1967: 298).

4. A similar assessment may underlie sanction policies in tax cases. Susan B. Long found that the average civil tax penalty assessed in Fiscal 1978 for federal income tax violations amounted to $4,957 in fraud cases, but between $22 and $154 in cases involving late payment, failure to pay estimated taxes, late filing, or negligence. (Long, 1981: 199).

5. David Sudnow, analyzing plea negotiation processes in a California metropolitan court, concluded "Both the public defender and the district attorney are concerned to obtain a guilty plea wherever possible and thereby avoid a trial. At the same time, each party is concerned that the defendant 'receive his due.' The reduction of offense X to Y must be of such a character that the new sentence will depart from the anticipated sentence for the original charge to such a degree that the defendant is likely to plead guilty to the new charge and, at the same time, not so great that the defendant does not 'get his due.'" (Sudnow, 1969: 245-46).

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

7. While extra federal funding is available to investigate and prosecute provider fraud cases (HCFA pays 75% of the costs of Medicaid Fraud Control Units), recipient fraud control costs only fall within the "administrative expense" classification for which HCFA and SSA contribute 50%. Extra funding can be obtained, however, if SSA (AFDC) or DOA (Food Stamps) approves an application for a demonstration project.

8. "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 when actual harm would be done by excluding the beneficiary from the project." (Lange and Bowers, 1979: 101).

9. On interdependencies among criminal justice agencies, see Cole (1970).

10. We wish to thank Robert Kagan for his observations on this trade-off issue.

11. Susan B. Long found a similar phenomenon in tax enforcement. "With criminal sanctions, the IRS can only recommend prosecution. The Justice Department Tax Division and U.S. Attorneys decide whether to prosecute. In court, the government must prove beyond a reasonable doubt that a criminal offense has occurred, and the ultimate decision to convict rests with a judge or jury.

"Imposing civil penalties presents few of these obstacles. The IRS alone controls the initial decision. It needs consult with no one, not even the Justice Department. Further, civil penalties are imposed administratively. They are assessed and collected just as any tax, without the necessity for any court determination." (Long, 1981: 208).

REFERENCES

AIKMAN, A., and J. BERGER (1967) "Prosecution of Welfare Fraud in Cook County," Journal of Urban Law 45 (Winter): 287-318

BALDUS, D. (1973) "Welfare as a Loan: An Empirical Study of the Recovery of Public Assistance Payments in the United States," Stanford Law Review 25 (January): 123-250

CHAMBLISS, W. (1969) Crime and the Legal Process (New York: McGraw-Hill)

COLE, G. (1970) "The Decision to Prosecute," Law and Society Review 4 (February): 331-343

LANGE, A., and R. BOWERS (1979) Fraud and Abuse in Government Benefit Programs (Washington: Government Printing Office)

LONG, S. (1981) "Social Control in the Civil Law: The Case of Income Tax Enforcement" in H.L. Ross, ed., Law and Deviance (Beverly Hills: Sage)

SHAPIRO, S. (1980) Thinking about White-Collar Crime: Matters of Conceptualization and Research (Washington: National Institute of Justice)

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

SUDNOW, D. (1969) "Normal Crimes: Sociological Features of the Penal Code in a Public Defender's Office" in W. Chambliss, ed., Crime and the Legal Process (New York: McGraw-Hill)

CHAPTER FOURTEEN

CONTROL AGENCY PERSPECTIVES ON MEDICAID PROVIDER FRAUD AND ABUSE

Responding to recipient fraud involves dealing with a large number of cases, most of which have relatively small dollar values but relatively clear violations of eligibility and payment level regulations. Responding to fraud and abuse by Medicaid providers, on the other hand, involves dealing with a smaller number of cases, each of which may have very large dollar amounts and complex evidentiary problems.[1] Provider fraud cases pose different investigation and prosecution problems and are often handled by different control agencies than the recipient cases. After a description of the processes involved in controlling provider fraud and abuse and the technical problems which they pose, we will turn to an analysis of the incentives and disincentives which control agencies face in designing and implementing control policies.

Fraud and Abuse Control Processes. Among the millions of claims submitted to Medicaid programs each day are some for fictitious office visits, drugs which were never dispensed, patients "ping-ponged" to every specialist in the clinic, whirlwind trips down the corridors of nursing homes (with each patient allegedly given a "full examination"), kickbacks to suppliers, inflated overhead costs, and so on. But like most forms of victimless crime,[2] provider fraud and abuse are not self-evident. Most claim forms are filled out correctly, covering recipients enrolled in the Medicaid program and services which the program provides. In a few cases, potential targets for investigation are identified by tips from disgruntled employees or suspicious patients or the exposes of investigative journalists. Other fraud investigations arise out of the work of tax auditors, health department assessments of hospitals or nursing homes, or

narcotics squads' surveillance of doctors and pharmacies which supply addicts.

While some potential fraud cases are thus handed to control agencies "on a silver platter," most have more prosaic beginnings. Some emerge almost serendipitously during claims processing, when a clerk notices something odd--"Didn't we pay the same claim two weeks ago?" "Why would this drug be prescribed for that ailment?" "Why would someone on the south side of town drive 15 miles to get new glasses?" Other cases come out of routine financial audits, when the provider does not have records to justify claimed charges or the paper trail simply "looks funny." Professional Standards Review Organizations (PSROs), in the course of examining Medicaid or Medicare utilization records, may report that a provider is offering or billing for medically unnecessary services, providing substandard care, or failing to document services, and recommend that HCFA or the Medicaid agency impose sanctions. Finally, particularly since the mid-1970s, many leads come out of computerized analyses (the Surveillance and Utilization Review Subsystem--SURS--of MMIS) of billing patterns which suggest provider or recipient misuse.

Once a target has been selected for detailed investigation, auditors and investigators must review the files of the Medicaid program and then the records kept by the provider. If doubts remain, investigators may interview patients or send undercover agents to seek treatment, comparing what actually happened with subsequent claims submitted to Medicaid. Investigations often expand beyond the particular claims with which they started to identify broader patterns of fraud or abuse.

Technical Issues In the Control Process. Unlike ordinary street crimes which have fairly uniform definitions from state to state and involve reasonably straightforward investigation and prosecution problems, Medicaid fraud and abuse are defined in different ways by regulations issued by HCFA and the state agencies, by federal laws, and by state statutes and common law fraud provisions. Variations exist in the behavior covered; in the

availability of civil, misdemeanor, and felony alternatives; and in the penalties which may be imposed. (For detailed analyses, see Lee, 1978, and Cattani, 1976.) "While each federal and state statutory fraud provision will have somewhat unique burden of proof requirements, generally the government must prove three elements when prosecuting alleged felonies arising from Medicare or Medicaid fraud: (1) a material misrepresentation, (2) made with knowledge and intent, and (3) which is relied upon by the government to its damage or injury (unauthorized benefits). If the statutory fraud provision provides only misdemeanor penalties, then there is normally no mens rea [criminal intent] required and the mere act may be a statutory violation regardless of the defendant's motives and lack of fraudulent intent.... Program abuse is a more nebulous concept than fraud and 'includes activity wherein providers...operate in a manner inconsistent with accepted, sound medical or business practices resulting in excessive and unreasonable financial cost to either Medicare or Medicaid.'" (Lee, 1978:9)

Satisfying these requirements, whether for a simple disallowance of a claim or for formal prosecution on fraud charges, is technically complex, very time-consuming, and often beyond the capacity of many control agencies. Unless a tip identifies a specific provider, the sheer volume of Medicaid claims tends to discourage analysis. A 1978 analysis of MMIS systems by the General Accounting Office concluded that SURS subsystems often have serious validity problems and, in the absence of sufficient staff to generate and analyze reports, have only limited ability to identify targets for investigation (General Accounting Office, 1978: Chapter 4). Federal and state prosecutors complain that even though SURS printouts improve the efficiency of investigations (there are fewer fruitless leads), they do not cut down on the work necessary to evaluate documents and interview sources.

The ability of a control agency to prove its case varies with the sanction sought: claims can be disallowed if the provider is unable to document the service, but a fraud prosecution requires the government to prove that the service was not delivered and (in a felony case) that the

provider had knowledge and intent. As Bruce C. Vladeck notes with regard to nursing home cases, many Medicaid patients are ineffective sources of corroboration of paper evidence. "[Nursing home] residents do not make good witnesses, which is a primary reason prosecutors have brought so few cases involving physical abuse. Families are easily intimidated. Difficulties in measuring, or even defining, the quality of care rendered provide a great obstacle to criminal prosecutions." (Vladeck, 1980: 184). Given the complexity of Medicaid regulations, it is relatively easy for a provider to argue that he did not know that X was a violation of the rules, or that he assumed that the bookkeeper was keeping track of what was or was not reimbursable.

Compounding the difficulties posed by these evidentiary problems is a fundamental staffing problem: Medicaid provider fraud and abuse cases involve technical problems which are unfamiliar to many of the professionals in control agencies. Auditors who are trained to conduct financial or compliance audits often lack experience in detecting or documenting fraud; investigators, prosecutors, and judges who normally handle street crime cases lack experience in dealing with more complex white collar crime cases. In addition, while program people don't understand the legal requirements for a civil or criminal fraud prosecution, many criminal justice personnel are unfamiliar with both Medicaid program regulations and medical issues (was X treatment justifiable given Y problem?). In 1977, a New Jersey Medicaid prosecutor testified before a Congressional committee on the importance of specialized expertise. "In the day-to-day priorities of many prosecutors' offices, other things may tend to come first. ... We found that by having a special unit which has nothing to do but specialize in this, they developed an expertise. They know how to build these cases. They know how to go through the paper. They know how to use computer applications to sift through thousands of claims." A former United States Attorney for the Southern District of New York added, "The average FBI special agent does not have the required knowledge of the workings of two complex programs--the Federal and State--nor should he be expected to, as he is a generalist responsible for investigating virtually every crime in the book. It is here that the specialized HEW investigator/auditor can

supplement an investigation. The ideal investigator, while having a thorough understanding of the Federal and State program, should be well-versed in auditing or paramedical skills. Working as teams, this mix of skills is ideally suited for Medicaid fraud investigation." (Medicare-Medicaid Antifraud and Abuse Amendments, 1977: 205, 209). Many agencies have been unable to find or keep auditors, investigators, and prosecutors with these skills.

Control Functions and Control Agencies. The various functions involved in controlling fraud and abuse are performed by persons who work in a number of agencies. Setting aside the individuals who report a single incident or the journalists or legislative committees who investigate a specific provider, the regular participants in control activities can be grouped in four categories.

(1) Audits, whether routine financial audits or targeted "fraud audits," are performed by the Medicaid agency or auditors working for it under contract, the state auditor, the Offices of Program Integrity in HCFA Regional Offices, and the Audit Agency of the DHHS Inspector General (which also contracts out much of its audit work). To a limited extent, these agencies coordinate their audit plans (either on general priorities or on specific targets) and may share findings (e.g., on the Medicaid and Medicare billings of a provider.)

(2) Investigations can be performed by the Medicaid agency, by a state law enforcement agency, investigators working for state and county prosecutors (including the specialized Medicaid Fraud Control Units), the FBI and postal inspectors (looking for mail fraud), the DHHS Office of Inspector General's Office of Investigations, HCFA's Baltimore-based Office of Program Validation, and the HCFA Regional Offices of Program Integrity.3

(3) Civil or criminal prosecution of provider cases can be pursued by county prosecutors, state attorneys-general, or Medicaid Fraud Control Units; federal prosecutions are handled by local United States Attorneys or

by the Civil or Criminal Divisions of the Justice Department. In some areas, combined county-state, state-federal, or county-state-federal task forces have been created to handle fraud investigation and prosecution, following the model set by organized crime and narcotics strike forces.

(4) In addition to recovery and prosecution, HCFA or the Medicaid agency can suspend or terminate a provider's participation in the program.[4] Other state agencies can suspend or revoke a provider's license to practice or operate within the state. Professional associations of providers such as the state medical society or hospital association can cancel a provider's membership; while this does not necessarily end his right to practice, it can seriously curtail his access to patients or institutions.

The agencies which participate in these control functions vary in a number of important respects. As can be seen in Table 16 , some agencies deal only with Medicaid issues while others handle a variety of programs or criminal justice problems. In addition, some (such as auditors, investigators, and prosecutors) deal only with control functions, while others also have program management or professional functions. Organizationally, some control agencies are parts of larger government agencies, while others are independent; as a result, control personnel may or may not need the concurrence of their agencies to pursue fraud or abuse cases. (This may also vary from state to state, either formally--one Program Integrity director may report to the welfare director while another reports to the Medicaid director--or informally, when one investigator is allowed to make his own decisions but another must get the approval of his boss.) In part because of these organizational factors, agencies also vary as to whether they play proactive or reactive roles in the control process; some initiate their own control efforts while others simply react to cases submitted to them by other agencies. Finally, these agencies vary in the potential sanctions which they can impose. Medicaid agencies can exercise the first nine intervention strategies described by Stuart (1980) in Chapter Twelve, (although they may need the assistance of prosecutors to seek civil penalities), and prosecutors and judges dominate the criminal justice

Table 16

SPECIALIZATION IN FRAUD CONTROL AGENCIES

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

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

process. (In individual cases, however, there is likely to be interaction between the two systems; prosecution may be threatened to encourage restitution, or a prosecutor may agree to recommend probation if a provider repays overcharges and withdraws from the Medicaid program.)

Incentives and Disincentives in Control Policy Formulation and Implementation. Within constraints established by available resources, legal requirements, etc., each control agency must determine the level of effort it will devote to controlling provider fraud and abuse, the types of misconduct to be stressed, and the sanction policies to be followed. Agencies can maximize control activities or merely react to problems which are brought before them; monitor all providers who participate in the Medicaid program or focus on specific problem areas; and emphasize administrative or judicial sanctions against identified abusers. While decisions in individual cases are influenced by such factors as the clarity of the evidence, the work necessary to develop the case, and the amount of overpayment involved, general control policies are shaped by a number of factors:

(1) As was discussed with regard to the Medicaid program agencies, recovering overpayments and containing program costs are major incentives to maximize control efforts. Unlike recipient fraud cases, most provider cases involve large sums of money; unlike judgment-proof recipients, most providers have assets which can be recovered, so a successful provider control effort will have a larger per-case impact than a recipient investigation. However, the goal of maximizing recoveries is of different importance to different agencies and does not by itself dictate the control strategy to be followed. Control groups working with the Medicaid agency are more likely to want to contain costs than are groups outside the agency. Particularly where the Medicaid director or the welfare director are able to establish control policies (i.e., the policies of auditors and investigators working with their agency), maximizing recoveries is likely to be a dominant policy. The goal of maximizing recoveries may therefore lead control agencies to focus on the most active providers and, particularly,

on hospitals and nursing homes. Since institutional cases are the most difficult to prove, however, this goal may also lead to seeking a high volume of easy cases rather than a few tough ones, or to accepting a repayment agreement in lieu of prosecution.

(2) Since the Medicaid program was created to improve the health of its clientele, quality of care issues may provide a second incentive to emphasize control efforts: correctly or incorrectly, control people believe that there is a correlation between poor care and financial abuse, so going after one may serve the other goal as well. There may also be a tactical relationship between the two issues: since, as Vladeck notes, it is often difficult to prove that a provider was offering substandard care, it may be simpler to prosecute a provider on financial grounds and then use that as a basis for terminating the provider's affiliation with the program. Like the recovery incentive, the quality of care incentive is likely to be more salient to control agencies working within the Medicaid program than to outsiders.

(3) Control agencies believe that aggressive control efforts have a deterrent effect on providers, encouraging them to offer higher quality care and submit accurate claims. While they do not pretend to have valid measures of deterrence, they frequently report that well-publicized sanctions or descriptions of agency control capabilities cause providers to be more circumspect in their subsequent dealings with the program.

(4) To some extent, control policies will be affected by desires to "build a record" for the agency, although agencies define their records differently. Auditors and investigators working for HCFA and the Medicaid agencies will take credit for "overpayments identified" and "investigations completed," while prosecutors count felony and misdemeanor convictions. Despite the interrelationship of their efforts, program agency auditors and investigators do not usually emphasize subsequent convictions, and prosecutors have little interest in the recoveries or administrative sanctions which follow convictions. As a result, we would expect that

rational auditors will pursue control policies which maximize recovery statistics and rational prosecutors will try to maximize conviction rates.

While this record-building incentive will face all control agencies, it is likely that some agencies will find it more important than others. Using the classification of Figure 16 , building a fraud and abuse control record will be essential to the Medicaid only/control only agencies, since it is their only activity. For Medicaid only/other functions groups, there are tradeoffs to be made between building a record for control, for speedy claims processing, and for encouraging provider participation. For control only/other programs agencies, Medicaid cases may be only a small and low-visibility component of the total workload of an investigative or prosecutorial agency; for other programs/other functions agencies, Medicaid control is likely to be a very peripheral activity.

Finally, the importance of the record-building incentive will vary from time to time. While all agencies will want to have some record available for budget examiners and legislators, outsiders may be unlikely to examine that record closely unless the "heat is on" for some other reason. If the heat is on because the Medicaid program is in financial difficulty, the aim may be to use control programs to cut costs; if the heat is on because of scandals about "Medicaid mills" or substandard care, the message may be to put the bad guys out of business. While heat may threaten control agencies, it may also provide an opportunity both to acquire new resources ("If you give me ten more investigators, I'll be able to crack down on those hospitals") and to exert pressure on other control agencies ("Tell those auditors to send us better cases"; "Tell the prosecutor to put more people on fraud cases".). Commenting on a massive 1974 nursing home scandal in New York State, former special prosecutor Charles J. Hynes told a Congressional committee, "We were fortunate in New York...that we had a scandal. I do not think we would have had the kind of enforcement we have had in New York State without the scandal." (Medicare-Medicaid Antifraud and Abuse Amendments, 1977: 57).

(5) A further incentive regarding control policies may come from the fact that other agencies are involved in the control process. Even though federal agencies have no real influence over state agencies, and the Medicaid agencies and criminal justice agencies are independent of each other, the fact that these agencies have long-term relationships usually generates at least a modicum of cooperation. While this cooperation may take the form of a higher level of control activity ("Let's put more prosecutors on fraud cases to help the welfare agency cut costs"), it also may mean less activity or at least fewer prosecutions ("The prosecutor is backed up on street crime cases, so let's settle as many cases as possible administratively.") In either instance, unless hostile relationships exist among agencies, they are likely to try to help each other out or, at least, not to cause problems.

(6) Finally, provider cases offer great professional satisfaction for auditors, investigators, and prosecutors. Whereas recipient cases, as the Illinois prosecutor noted in Chapter Three, are as simple as "shooting fish in a barrel," provider cases require assembling little bits of information to document kickbacks to suppliers, finding the hidden owners of nursing homes, or proving that a pharmacy couldn't have dispensed all the drugs it claimed--all matters necessitating substantial investigative and forensic expertise. "Nailing the bad guys" who took large sums of money and/or practiced bad medicine, particularly if they can be kicked out of the program or put in jail, can be as satisfying as convicting a mugger or burglar, and certainly is more satisfying than throwing Mrs. Smith off the AFDC or Food Stamps rolls.

While recovering overpayments, improving the quality of care, deterrence, building the agency's record, cooperating with other agencies, and solving complex cases provide incentives to expand control efforts, other factors carry very significant disincentives.

(1) Although a successful provider fraud case can generate publicity, a large recovery for the Medicaid agency, and professional satisfaction, the fact remains that provider cases often involve tactical difficulties. At

each stage of the audit-investigation-prosecution process, extensive work is required to build a case which will support a demand for recovery, for termination, or for prosecution. After an informant or a SURS computer analysis singles out a suspicious provider for attention, control agencies must dissect and reconstruct records, locate patients, and prove that it was the provider, rather than the bookkeeper, who knew that the claim was false. In many states, the capabilities of Medicaid program integrity units are frequently stretched to complete routine audit efforts, and there is little incentive to take the extra steps necessary to build a fraud case. A 1980 survey of Medicaid Fraud Control Units by the General Accounting Office found that "Medicaid agencies...generally had not provided adequately developed referrals. This occurred, at least in part, because the Medicaid agencies did not have an effective management information system and/or an adequate Medicaid utilization review staff. Because of the inadequacies of the referrals, the fraud units often had to perform detection work that should have been done by the State Medicaid agencies and spend effort on cases that did not have good fraud potential." (General Accounting Office, 1980: 23) Whether, from a system-wide perspective, it is more efficient to house the case-development function in the Medicaid agency or in the prosecutor's office, we must recognize that the agency people tend to feel that <u>their</u> work is done when a case for recovery has been established, and the prosecutors are likely to be more receptive to referrals in which a high probability of success has already been documented. As a result, agency people who want a case prosecuted must be prepared to lobby for it, selling prosecutors on both its importance and its provability.

(2) The benefit/cost ratio of provider control efforts is also reduced by the light penalties which are available or likely to be imposed. While felony penalties have been available to federal prosecutors since 1977, many state statutes provide only misdemeanor penalties and some states have no provisions specifically covering Medicaid fraud. (Cattani, 1976: Section 4; Lee, 1978) In some jurisdictions, it is unclear whether some forms of provider fraud <u>are</u> covered at all by available statutes. Many prosecutors, therefore, are likely to be uninterested in cases which may be thrown out or

at best lead to misdemeanor-level sentences. (The low sentences common in fraud and corruption cases are discussed in Ogren, 1973).

The sanction disincentive is further complicated by the fact that even where severe sanctions are available, they may not be desirable. While everyone presumably wants to be rid of the abusers who are also practicing poor medicine, they rarely are as certain that a competent physician with a large Medicaid practice should be terminated or put in jail or, even more troubling, that a hospital or nursing home in an area with a shortage of beds should be closed. As a result, control agencies (particularly those within Medicaid agencies) must weigh programmatic considerations along with control objectives; if it can be expected that administrative sanctions (recoveries and Stuart's first seven options) will produce the desired behavior, why take the terminal step of prosecution or termination?

(3) For many control agencies, workloads are defined in ways which militate against pursuing fraud cases. Claims processors and auditors, whether on government payrolls or working on contract, are often paid and evaluated by the number of claims or files processed, not by the problems they uncover. If they are told to complete so many claims or audit reports per day and are not rewarded either for "flagging" suspicious cases or for pursuing them, they cannot be expected to create more work for themselves.[5] When providers complain because payments are late or auditors are criticized because audit findings have not been resolved, the temptation is strong to keep the paperwork moving and let someone else worry about problems. (On the varying control duties assigned to fiscal intermediaries, see Cattani, 1976: 55-56.)

(4) Unless there is specific public pressure to crack down on provider abuses, many control agencies feel that the public wants them to place their priorities elsewhere; Medicaid state agencies are expected to keep providers' checks moving, HCFA Central and Regional Offices are expected to monitor and assist state efforts, and criminal justice agencies are expected to focus on street crime. Controllers within Medicaid agencies, although perhaps to a lesser extent than their colleagues who work directly with

providers, may feel a need to resolve ambiguities in favor of providers with whom their agencies wish to continue to work.

Arguing for federal funding for special prosecution units dedicated to Medicaid fraud, New York prosecutor Charles J. Hynes notes that "you are never going to get even a properly funded local office to handle this kind of investigation for a simple reason: the priority which gets people elected every four years is street crime, organized crime, corruption cases." (Medicare-Medicaid Antifraud and Abuse Amendments, 1977: 63)

Bruce C. Vladeck offers an even more pessimistic analysis:

> It has been widely observed that prosecuting agencies at all levels have been reluctant to vigorously pursue "white collar" crime. While that is largely accurate as an historic generalization, it was perhaps never more true than in the late 1960s and early 1970s, when the public appeared terrified by violent street crime and law-enforcement agencies were preoccupied with the phantom specters of political protest and counterculture radicalism.
>
> In the United states, most prosecuting agencies in most jurisdictions are headed by elected officials who, when they are not concerned with re-election, are generally running for higher offices. When newspaper headlines are filled with reports of murders, assaults, rapes, political demonstrations, and drug abuse, crimes such as Medicaid fraud are unlikely to be allocated a large share of law-enforcement resources--unless those frauds are committed by minority-group beneficiaries. Nor do most nursing homes fit the public stereotypes of dangerous criminals. They are neither young, black, nor, in most instances, Italian. Instead, they are typically moderately affluent small businessmen, a sociological type generally viewed favorably by the public. This is not just a matter of public appearance; one of the reasons judges are so often reluctant to impose stiff sentences on white-collar criminals, it has been argued, is that those criminals are so much like them in social and economic background. (Vladeck, 1980: 183)

Control agencies would expand Vladeck's analysis in two directions. First, nursing home operators are not the only Medicaid providers who are socially respectable. Except for the foreign-born doctors who dominate welfare medicine in some cities, most providers--hospital administrators, pharmacists, dentists, physicians, etc.--are, or appear to be, model citizens. Second, in addition to being respectable, many providers are

politically well-connected, contributing to election campaigns and participating in the professional associations whose voices are heard when medical issues are discussed. Unless a fraud case is both substantial and unambiguous, a control agency may expect to be asked why it is harassing the "good guys."

(5) Finally, for many control agencies, Medicaid provider fraud may seem to be someone else's problem, a problem that can be handled elsewhere as well or better, or a problem that someone else may even have caused. Many of the federal officials we interviewed felt that Medicaid fraud was basically a state problem, many officials in the Medicaid agencies felt that prosecution (as opposed to recoveries or other administrative sanctions) was something for the prosecutors to worry about, and many prosecutors felt that the Medicaid agencies are so fuzzy in writing regulations and lax in implementing them that they don't deserve help. These attitudes lead either to deference (offering assistance if sought, but not volunteering), or open hostility and turf fights. A HCFA investigator asked, "Why should we work up a case for criminal prosecution? If we give it to the Inspector-General or a U.S. Attorney, they'll take the credit; if we go the civil route, HCFA will get the credit and our people will have the satisfaction of seeing the case through to completion." In 1981, the president of the National Association of Medicaid Fraud Control Units noted the problems caused by Medicaid agency hostility toward the Units: "Before the Units could begin to understand the mechanics, the rules and regulations..., the Units had to overcome the resistance to fancied invasions of bureaucratic turf, assaults upon ego, and various other personality problems that were inevitable with the establishment of a new 'kid on the bureaucratic block.'" (Zerendow, 1981: 2) Surveying the fraud units' performance in 1980, the General Accounting Office concluded that "mutual distrust, concern over loss of control of fraud investigations, and personality conflicts" contributed to problems between the agencies and the MFCUs. (General Accounting Office, 1980: 32). Except for the MFCUs, which <u>have</u> to cooperate with both the Medicaid agencies and the courts to get anything done, control agencies may well decide to do as little as possible, or to follow strategies which do not require cooperation with other agencies.

Control Agency Priorities. How do control agencies react to these incentives and disincentives? To some extent, all control agencies have a minimum agenda set by forces beyond their control. Audit agencies have certain tasks which must be completed each year, investigators and prosecutors must act on major cases submitted to them, and so forth. Beyond this minimum level, however, control agencies have varying degrees of freedom to expand or contract the scale of control efforts and to emphasize one or another sanctioning strategy. While, as our case studies have shown, there are substantial variations among types of control agencies, among states, and over time (as external pressures escalate and subside), several general conclusions can be drawn.

(1) Just as "other functions" agencies must strike a balance between control and other functions, and "other programs" agencies must allocate resources between Medicaid fraud and other responsibilities, all agencies involved in the control process have a variety of goals which they seek to accomplish. Some of these goals concern desired outcomes, e.g., to maximize the recovery of overpayments to providers, to maximize the quality of care provided to recipients, and to deter future violations. Other goals concern the control process, e.g., to minimize control costs, to maximize the agency's reputation, and to minimize conflicts with other agencies. As is indicated in Table 17 , each of these goals has distinct, and at times conflicting, tactical implications. Maximizing recoveries, for example, implies directing control efforts at the highest volume providers with recoverable assets, while deterrence requires creating the impression that all providers are subject to scrutiny. The goal of deterrence implies seeking the maximum penalty in each case, while the health care goal may imply a more moderate penalty which will keep a valuable provider in the program. Easy and visible cases which are important to other agencies may not be those which are the most costly to the public or dangerous to recipients. Finally, maximizing the breadth and depth of control activities necessarily conflicts with the goal of minimizing control costs.

(2) Given these inherently irreconcilable conflicts, control agencies are forced to publicly state that they are trying to maximize all of these

Table 17

CONTROL GOALS AND TACTICAL IMPLICATIONS

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

goals, while in practice they concentrate their efforts on what are expected to be "big cases." The ideal "big case" for any control agency involves a combination of a large dollar amount, bad medicine, and unambiguous guilt (both a clear violation of regulations and a clear intent to defraud the program). With luck, each big case will also involve favorable publicity for the agency and major penalties for the provider--actual recovery of overpayments, termination from the program, and/or a felony conviction. While many big cases may turn out to be small or unwinnable, they are pursued as far as possible; any case estimated not to be big is quickly classified as being worth only minimal effort.

(3) Throughout the processing of individual cases, easy and safe solutions are preferred to difficult and doubtful ones. Within the Medicaid agency, a negotiated settlement is preferred to a civil suit which might yield a larger recovery, and an administrative sanction is preferred over prosecution. For prosecutors, a plea bargain is usually preferable to a trial which might lead to a more severe sentence, although folk wisdom has it that "you have to take some cases to trial just to maintain your credibility." If a suspicious claim has not yet been paid, of course, the easiest and safest solution is to defer payment until the provider submits "adequate documentation."

(4) Control agencies tend to defer action if someone else is willing to handle a case. Federal agencies will step aside if a state agency is investigating a provider (Lee, 1978:4), prosecutors will not act if the Medicaid agency is satisfied with recovery or termination, and control agencies will be less likely to act if a licensing agency or professional association is taking steps to end a provider's right to practice. (Cf. Ogren, 1973: 979, on the superiority of bar association disbarment actions over prosecution of attorneys.)

These four factors combine to produce a very selective screening process, a process in which most cases are settled informally with warnings or recovery agreements, and very few cases lead to prosecution. Unless the heat is on in a specific case (e.g., because of a public expose), cases will

drop out of the system unless they involve large amounts of money, blatantly poor health care, or a provider that someone wants to "get." While up-to-date statistics on provider fraud cases do not exist, two sets of statistics illustrate this process. In Fiscal Year 1977, Medicaid agencies disposed of 4,567 suspected fraud and abuse cases; 4,176 were closed by the state agency and only 391 were referred to law enforcement officials. In the same year, 144 "law enforcement actions" led to 91 convictions, and 149 providers were terminated or suspended by administrative action. (Health Care Financing Administration, 1979: 106).

A more wide-ranging 1981 report by the General Accounting Office provides similar figures for federal control agencies. Analyzing "fraud and other illegal activities" cases processed by federal agencies between 1976 and 1979 (excluding state efforts on AFDC, Medicaid, and Food Stamps), GAO found a heavy emphasis on administrative actions, with very few civil or criminal prosecutions. In 11,657 cases involving the Social Security Administration in which a suspect was identified, 8,854 (76%) led to administrative action only and 783 (7%) led to legal or legal and administrative action; no action was taken in 2,020 (17%) of the cases. Where administrative action was taken, 4,654 cases led to a formal loss recovery plan, 2,653 individuals or organizations were declared ineligible for future participation in the program, and reimbursement was being negotiated in 1,524 cases (multiple responses were counted). Somewhat incredibly, all 636 cases involving legal action led to conviction or a guilty plea. (General Accounting Office, 1981c: 36). Of 38,182 closed cases from twenty-one federal agencies in which the suspect was identified, 25,987 (67%) were not referred for prosecution, prosecution was declined in 7,843 cases (20%), and 5,052 cases (13%) were accepted for prosecution or pre-trial diversion. Ninety-two percent of criminal prosecutions and 89% of civil prosecutions led to convictions. (General Accounting Office, 1981b: 88-89).

The United States Department of Justice's response to the GAO report perhaps summarizes the position of most control agencies concerned with Medicaid provider fraud and abuse. Acknowledging that the amount of loss

was a primary factor underlying its decisions to accept or decline prosecution, the Criminal Division has set a "national priority" on federal program fraud schemes with losses of $25,000 or more. The Civil Division noted that while it receives approximately 5,000 reports of potential fraud each year, only 685 referrals over the two and one-half year period studied by GAO "contained enough evidence of a monetary loss to justify assignment to a Division attorney for further review. Many of these matters were later closed because additional evidence demonstrated that the government suffered no monetary loss, the case lacked a solvent defendant, adequate administrative sanctions existed, or the cases were plagued by material legal insufficiencies." (General Accounting Office, 1981a: 73).

These findings support Bruce Stuart's conclusion that, while legal sanctions play a valuable psychological role, payment sanctions may be economically preferable. (Stuart, 1980: 467). They also confirm the dismal observation of former federal prosecutor Robert W. Ogren:

> Common sense dictates that a con man, businessman, or public official contemplating theft or corruption will not engage in illegal activity if he is relatively certain to be caught, exposed, and harshly punished. Hidden in this simple and self-evident proposition are a number of factors relevant to the functioning of deterrence. Of these, at least three pose major problems for white-collar enforcement efforts: (1) instead of a credible threat of harsh punishment, there is in fact a pattern of light sentences and a limited number of prosecutions; (2) although any fraud or bribery offense should be threatened by swift and certain detection and prosecution, there is no such threat; and (3) although deterrence theory assumes that the potential offender will function predictably, many potential or actual white-collar criminals are not ideal psychological models, either because they function irrationally or because they are motivated by considerations which make the possibility of punishment or detection an acceptable risk. (Ogren, 1973: 961)

NOTES

1. In addition, a provider fraud prosecution is likely to be contested by very talented lawyers, while a recipient case will be uncontested or contested by a less-experienced poverty lawyer.

2. Some types of provider fraud involve very real victims, such as patients whose health is damaged by excessive drug prescriptions or incompetent diagnoses.

3. In 1978, following the creation of the DHHS Office of Inspector General, criminal investigation functions were transferred from HCFA to the IG's Office of Investigations. It is somewhat difficult to differentiate between IG/OI's investigations and the "abberrant cost studies" and "systematic abuse reviews" conducted by HCFA's Office of Program Validation and the regional Offices of Program Integrity. In general, HCFA is supposed to concentrate on cases which will be handled civilly, turning "full scale investigations" over to the IG, but both agencies can initiate both types of cases. HCFA's program validation efforts are described in Nicholson (1980).

4. As a result of the Medicare-Medicaid Anti-Fraud and Abuse amendments of 1977, HCFA can, at its discretion, suspend providers suspected of abusing the program, and must suspend those convicted of defrauding the program; the length of suspensions is at the discretion of the Secretary of DHHS.

5. Speaking of the financial disincentives facing claims processing contractors, a former director of the New Jersey State Commission of Investigations told a Congressional committee in 1976, "To some extent, the insurance company is motivated to do a minimal level of filtering work because the more it maximizes its filter work, its screening function, the more personnel and the more money this insurance company has to commit to filter and screen the claim. The insurance company knows that it is only going to get X number of dollars a year with its contract from New Jersey. So query, how motivated are the fiscal intermediaries to aggressively pursue effective screening practices?" (Problems of Medicaid Fraud and Abuse, 1976: 107).

REFERENCES

CATTANI, J.A. (1976) Medicaid Fraud and Abuse Control: A Review of Selected Literature (McLean, VA: General Research Corporation).

GENERAL ACCOUNTING OFFICE (1978) Attainable Benefits of the Medicaid Management Information System Are Not Being Realized (Washington: GAO).

_____ (1980) Federal Funding for State Medicaid Fraud Control Units Still Needed (Washington: GAO).

_____ (1981a) Fraud in Government Programs--How Extensive Is It? How Can It Be Controlled? Volume I. (Washington: GAO).

_____ (1981b) Volume II.

_____ (1981c) Volume III.

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

LEE, B. G. (1978), "Fraud and Abuse in Medicare and Medicaid," Administrative Law Review, 30 (Winter): 1-43.

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

NICHOLSON, D. (1980), "Watching the Reimbursement Dollars," HCFA Forum, 4 (August): 18-21.

OGREN, R. W. (1973), "The Ineffectiveness of the Criminal Sanction in Fraud and Corruption Cases: Losing the Battle against White-Collar Crime," American Criminal Law Review, 11 (Summer): 959-988.

PROBLEMS OF MEDICAID FRAUD AND ABUSE (1976) Hearing before the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, United States House of Representatives, Serial 94-64. (Washington: Government Printing Office).

STEVENS, R. and R. STEVENS (1974) Welfare Medicine in America: A Case Study of Medicaid (New York: Free Press).

STUART, B. (1980), "Utilization Controls," in Judith Feder, John Holahan, and Theodore Marmor, eds., National Health Insurance: Conflicting Goals and Policy Choices (Washington: Urban Institute), 423-473.

VLADECK, B.C. (1980) Unloving Care: The Nursing Home Tragedy (New York: Basic Books).

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

CHAPTER FIFTEEN

CHANGING THE FRAUD CONTROL GAME: STRATEGIES TO ENHANCE FRAUD CONTROL EFFORTS

> We might be better served if government policy was made and implemented not by Ph.Ds in economics but by grandmothers employing the skills they practice at the butcher's. (Vladeck, 1980: 101)
>
> Investment in reliability will increase until it exceeds the probable costs of errors, or somebody insists on getting some useful work done. (Gilb, 1975)

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

The perspectives of the participants in these programs help to explain the fact that fraud control efforts are limited. While agencies are under pressure to cut costs and reduce errors, their ability and motivation to control fraud are constrained by several factors. Chapters Eleven and Twelve showed that program agencies' control goals often conflict both operationally and politically with their service goals. Operationally, Medicaid administrators fear that fraud control techniques will substantially reduce provider participation in their programs. AFDC and

Food Stamp administrators may find unacceptable the application procedures or monthly reporting requirements that deter applicants who are in fact eligible for benefits (Mendeloff, 1977; Piliavin, 1978). Some measures to verify recipient and provider statements may be viewed as intolerable invasions of privacy or violations of civil liberties. Politically, control orientations may antagonize legislators who are sympathetic to recipients or to providers, possibly leading to budget cuts for the agencies.

Even where a decisionmaker has decided that he wants to effect a change, he may find that it is illegal or that he is unable to do so. Federal and state statutes and constitutions spell out the roles of administrative and judicial agencies, procedures for civil and criminal adjudication, how supervisors may control their subordinates, and standards and procedures for the termination of recipient benefits or provider participation.[1] The legislation which created AFDC and Medicaid emphasized provision of services rather than tight control. AFDC grants and medical assistance were defined as entitlements rather than privileges; at least until the mid-1970s, legislative messages to the program agencies stressed the ease and speed of service delivery, not the development of prevention and enforcement efforts.

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

Federal agencies, including the Social Security Administration and the Health Care Financing Adrinistration, have encouraged state efforts to improve program operations, but they have had little direct control. The Quality Control programs permit the states to concentrate corrective action

efforts on technical or trivial errors such as WIN registration or social security numbers, rather than on the fundamental fraud problems which are more difficult to solve. While federal agencies have some leverage over the program agencies, the incentives and sanctions which they have to offer are irrelevant to the control agencies which would have to process fraud prosecutions.

Except for such specialized federally-subsidized programs as MMIS, Child Support Enforcement, and Medicaid Fraud Control Units, state agencies are unable to secure additional funding for control efforts. Particularly in states hard hit by the recession, legislatures have been unwilling to increase administrative budgets, and many states have reduced personnel ceilings and budgets. As AFDC applications and provider claims have grown, therefore, the program agencies have not received commensurate staff increases, and have been forced to allocate existing resources between program and control functions. As one Illinois administrator said, "I know that our investigations unit could use more men, but I can't take anyone away from ourlocal offices; they're short of staff as it is."

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

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

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

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

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

> Of these eight states, California regularly collects and analyzes by far the most information on local office performance. Yet California officials know very little about what effects specific error reduction techniques have on the costs of the program, its efficiency, accuracy, or the quality of services provided to clients.
>
> However, except for major changes, such as a computer system, it is not feasible to assess specific error reduction techniques. The system is so much like a Chinese wooden puzzle that it is difficult to know the effects of one action on the system. The demographics of the AFDC client (e.g., urban vs. rural) and the other forces external to state administrative control (such as the status of the state-local economy) appear to have as much or more impact on error as a new worker's handbook, or an improved training program. Since these factors are different from office to office, and are constantly changing, scientific experiments may mislead rather than assist the welfare administrator. (Zeller, 1981: 84-85)

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

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

Control agencies have somewhat different reasons to be unenthusiastic about fraud cases. Confined by low salary scales, control agencies have found it difficult to recruit, train, and retain competent auditors, investigators, and prosecutors to handle fraud cases in its Medicaid fraud control unit. Most recipient fraud cases are easy to document, but unraveling a nursing home or hospital's records to prove provider fraud requires a great deal of sophisticated work. Particularly when they expect

that judges are likely to dismiss cases or impose light sentences, controllers are apt to proceed cautiously or even unenthusiastically.

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

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

Opportunities to Improve Fraud Control

If program and control agencies have so many incentives not to prevent or investigate violations, and not to seek formal sanctions against violators, can more significant fraud control programs nonetheless be designed and implemented? So long as welfare benefits are tied to "need," and medical assistance is provided on a fee-for-service basis, recipients and providers will continue to have strong incentives to cheat. The emerging oversupply of providers and institutional capacity will only increase competition for income, legal or illegal, although it will reduce agency fears that control efforts will inhibit provider participation. So long as taxpayers resent the costs of government in general and of welfare programs in particular, it is unlikely that significant amounts of new money

will be made available for fraud control. So long as the criminal courts are overwhelmed by the street crime cases which are given high priority in the minds of the public, we cannot expect the criminal justice system to handle most fraud cases.

Despite these problems, the experiences of the 1970s (see Zeller, 1981) suggest that agencies can make substantial progress by paying attention to program operations. The basic maxims of administration--"Hire good people." "Train them well." "Tell them to be alert for possible problems." "Check their work." "Praise the workers who are doing a good job and push the ones who aren't."--are fundamental to this effort, and need not be discussed further here. Four specific implications of our research, however, require special emphasis and elaboration.

(1) Focusing Priorities. As AFDC and Medicaid programs have grown and come under fire, administrators have responded to criticisms by multiplying the instructions issued to their staffs, creating policy directives, forms, and paperwork to serve every conceivable purpose. Being told to do so much, agency personnel are in effect being told nothing; not knowing which tasks take precedence, they do not know how to allocate their time. By contrast, priority-setting directives such as the Illinois Local Office Performance Indicators system identify a general hierarchy of duties for agency employees. Priorities also must be set regarding types of cases. Agencies might decide, for example, not to monitor single-headed households with small children, or providers who receive less than $20,000 per year from Medicaid, in order to concentrate on the larger providers and on households which are more likely to have unreported income. The Seattle and Denver research reported in Chapter Two for instance, suggests that control efforts should concentrate on households with teenaged children or with adults who may be holding regular jobs. Priority categories could be supplemented by specific leads provided by Hot Line tips, computer crossmatches, and indications that a provider is practicing poor medicine.

(2) Targeting Resources. Once an agency has decided which control problems should be given priority, it must allocate resources to address those targets. At one level, reinforcing official priorities requires modifications in agency incentive systems; employees who perform well must be recognized for their efforts. More broadly, targeting may require the reallocation of personnel and funds if new resources are not available for fraud control.

In our case study states, for example, computerized and manual screening systems identified many recipients and providers who might be committing fraud, but very few leads were actually investigated, and crossmatch and SURS printouts lay unread in agency storerooms. Simple systems analyses of agency fraud control operations would suggest that resources should be transferred from the generation of new leads to the analysis of existing information on priority categories of recipients and providers.

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

Going beyond specialization at the level of individual front-line workers, separate units should be created to investigate and take action against likely fraud cases. Several organizational models might be considered. Prosecutors could be added to the staffs of welfare agencies, auditors and investigators can be employed by prosecutors, or the three skills can be combined in free-standing units. In Jefferson County, Colorado, the welfare agency created a fraud unit in cooperation with the county prosecutor). On several occasions, federal, state, and local agencies in Chicago have formed short-term task forces to deal with recipient fraud (see Chapter Three, note 14.) The model recommended for federally-funded Medicaid Fraud Control Units brings audit and investigation capabilities into the office of the state attorney-general. The specialization model could also be carried to the court system where "welfare courts" could be modeled after traffic courts and juvenile courts.

Regardless of which organizational arrangement is employed to centralize fraud control expertise and reduce role conflicts, two potential dangers must be anticipated. First, designating certain units as fraud specialists may lead everyone else to ignore the problem; while enforcement can best be handled on a specialized basis, everyone in the agency must be repeatedly reminded of his or her role in fraud prevention. To avoid the pitfalls mentioned earlier, agency workers who do not specialize in fraud control should be given specific tasks relating to application and claim verification which will regularly remind them of the importance of fraud issues. Second, specialization may lead to rivalries and

turf wars; as the Medicaid Fraud Control Unit in the state of Washington discovered, generalists may withhold information from specialists to keep them from stealing the glory or harming favored recipients or providers. Unless the leaders of the generalist and specialist units agree to share information, the specialists will require the capability to collect information on their own.

(4) Developing Alternative Sanctions. Ordering recipients and providers to repay excess receipts probably has no deterrent value, and criminal prosecution is a realistic possibility only in the most aggravated cases. Between these two extremes lie many sanction possibilities which can be invoked rapidly, less expensively, and without the need to prove criminal intent. Civil fraud statutes permit prosecution without recourse to the clogged criminal justice system; administrative sanctions bypass the judicial system entirely. In Washington, the welfare agency can administratively impose a 25% penalty on top of the excess assistance which a recipient must repay, and treble damages may be imposed for provider fraud.[2] In the Omnibus Budget Reconciliation Act of 1981, Congress gave the Secretary of DHHS authority to impose administrative penalties on Medicaid and Medicare providers; penalties of up to $2,000 and twice the amount of the submitted claim can be imposed for each service not provided, or provided in violation of regulations. Under both the Washington and the federal statutes, the provider must have had knowledge of the claim, but it need not be proved that he or she had fraudulent intent.

The four strategies--identifying agency priorities, allocating resources to support those priorities, creating specialized control units, and diversifying fraud sanctions--are based on two related conclusions from our research. First, many instances of fraud and abuse in government benefit programs defy detection and are not worth pursuing. For understandable political reasons--to give the appearance of control--agencies have created administrative systems which have inundated them with information they cannot utilize; they would be better off admitting (to themselves, if not publicly) that many abuses are uncontrollable. Second, however, we believe that welfare agencies can focus their efforts on cases which are worth pursuing, and can do a far more credible job in imposing sanctions in the cases they know about. Neither recipients nor providers can regard criminal prosecution as a real threat at present; sanctions such as a 25% repayment penalty on recipients or treble damages against providers, imposed swiftly through administrative

proceedings, would both increase the funds recovered by the agency and provide a more credible deterrent threat.

Encouraging Utilization of Fraud Control Techniques

Techniques such as these would significantly increase the ability of welfare agencies to control fraud, but they say nothing about the problem of motivation. If the current limited response to fraud and abuse reflects the incentives and disincentives which program and control agencies now face,[3] why would they want to act any differently? Efforts to encourage more effective fraud control must not only convince decision-makers that a specific technique is an improvement over current practices, but must also demonstrate that in terms of all of the games in which the decision-maker is involved, such as those described in Chapter Nine enhanced fraud control will be more advantageous than staying with the status quo. Finally, strategies to encourage the utilization of fraud control techniques ("utilization strategies") must combat the inertia which is produced by decision costs ("I haven't got time to worry about that now.") and the costs of other opportunities which must be foregone ("If I put in a fraud control unit this year, I won't have money to increase welfare grants or provider reimbursement rates or staff salaries.")

In recent years, many of the changes which have occurred in welfare programs have been the result of sudden scandals or fiscal crises, often producing short-term anti-fraud crusades which temporarily disrupt program operations and then fade away. Longer term improvements require the development of fraud control orientations within both program agencies and the political systems and legislatures which influence their operations.

Our research does not permit us to identify the specific individuals who can stimulate changes in each welfare and criminal justice system,[4] or the specific fraud control techniques which are most appropriate for each system's specific problems.[5] We also cannot--and do not wish to--suggest that systems adopt fraud control techniques which will tend to exclude

eligible recipients or competent providers, or violate individuals' privacy or civil liberties. We can, however, suggest general strategies which might bring about more widespread efforts to control fraud and abuse.

Information Strategies. While some changes occur accidentally or involuntarily, intentional change requires a recognition that a problem exists (that current behavior is somehow unsatisfactory), that alternatives are available and possible (i.e., that legal or resource problems do not preclude change), and that an alternative is preferable to the current activity. Figure 16 suggests a simplified model of the stages involved in information processing. If a decision-maker (legislator, program administrator, prosecutor, etc.) does not believe that a problem exists, he will neither search for information about alternatives nor seriously consider information which is given to him ("Why should I read that? It doesn't apply to me."). Even if he recognizes a problem, he may not search for information because of feelings that alternatives are impossible, that none exist, or that he can't afford the decision costs ("I won't be able to check this problem out until my desk is clear/the budget is submitted/next year," etc.). If he does search for and find information, he may reject it if either the source is not credible ("Why should I believe what he says? He doesn't know anything about our situation."), or the information is incredible ("There's no way that doing that will cut our error rates by 50%!") Finally, even credible information may not lead to change if the decision-maker concludes that the specific alternative is not possible or, as we will discuss later, is inferior to current practices.

If this model is correct, then one basic strategy to increase the utilization of fraud control techniques must center around the improvement of the information-processing systems of relevant decision-makers, especially legislators, program administrators, and control personnel. Current data systems impede problem recognition; many decision-makers are unable to collect and analyze relevant information; and much of the information which they have received lacks credibility. Problem recognition, for example, requires an awareness of both the costs of fraud

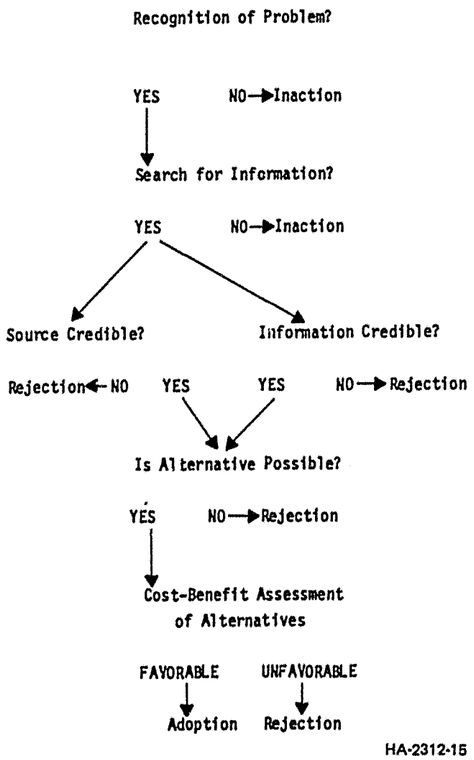

FIGURE 16 STAGES OF INFORMATION PROCESSING

and abuse and the deficiencies of current control programs. At present, public perceptions of fraud and abuse are shaped by the exposes of welfare queens and Medicaid mills which capture the headlines, and officials' estimates of the extent of fraud and abuse are based upon quality control reports and provider audits; as was shown in Chapter Two, these sources both include irrelevant data (technical errors, unintentional client errors, etc.) and exclude fraud and abuse which auditors and investigators never discover. Neither the newspaper headlines nor current data sources, therefore, accurately indicate for decision-makers the scale of fraud and abuse or whether administration and enforcement efforts should be improved.

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

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

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

1. Limited federal staff resources-- both at the central office and regional offices;

2. Lack of clear focus on assistance programs addressing priority areas of need (as defined by state and local officials and administrative reviews);

3. Lack of timeliness;

4. Inadequate depth and follow-through;

5. Absence of programs directed at state and local policy-makers (e.g., state agency leadership, legislators);

6. Insufficient state-of-the-art knowledge;

7. Limited incentives for technology transfer;

8. Inadequate dissemination and application of both practical research findings and existing technology (or expertise). (Taddiken, 1978: 219)

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

Recognizing these failings in past efforts, several approaches might be taken to provide information about fraud control. To assist in public and official problem recognition, statistical systems (or reports based on them)

might be revised to stress decision-relevant data (e.g., separating technical and trivial errors from those which are significant and worth reducing). Federal funding for research and analysis units within state and local welfare units would provide focal points for data collection, problem analysis, experimentation and evaluation, and the dissemination of information about alternatives. With a specific mandate to analyze problems and define alternatives, the units should have both the time and the resources to bring issues to the attention of the legislators and administrators who can deal with them, creating audiences for information and institutionalized mechanisms for information utilization. To facilitate contact with sources of information, federal agencies might develop rosters of experts on various topics, and either fund their utilization by state agencies or support state travel to observe exemplary projects in action.

Even if such steps expand the demand for information, it will be necessary to improve the credibility of information suppliers. Since federal agencies are often viewed as uninformed or as "policemen" who are more interested in furthering their own ends than in assisting the states, better results will be achieved by using existing channels of communication among target audiences. If the Medicaid director from State X is recognized by peers as the best in that part of the country, for example, he or she should be used to disseminate information about specific tactics to prevent provider fraud; a respected fraud prosecutor should address prosecutors and investigators, etc.). In many situations, a "two-stage" communications process may be necessary. Federal agencies, for example, might hold a training session for ten nationally recognized leaders in AFDC administration, who would then be able to "pass the word" on to others in their regions. Alternatively, the National Governors Association or the National Conference of State Legislators might be used to generate general interest in fraud control, relying on members to push local officials to "get the details" from federal sources. To the extent that existing "opinion leaders" can be built into information strategies, the credibility problem arising from the attitude that "the feds don't know what they're talking about" will be reduced.[6]

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

Incentives Systems Strategies. Improving information systems can provide decision-makers with better data about the nature and extent of fraud and abuse, and with information about alternative approaches to fraud control. They can only be expected to adopt alternatives, however, if they see[7] net advantages in doing so. Adopting an alternative approach would offer a net advantage if its benefits (less costs) exceed the benefits (less costs) of retaining current approaches. Strategies to enhance utilization of fraud control techniques could therefore seek to increase the costs of current approaches or the benefits of alternatives, or to decrease the benefits of current approaches or the costs of alternatives. Table 18 provides illustrations of current federal strategies intended to have these effects.[8]

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

Table 18

PENALTY AND INCENTIVE STRATEGIES

Strategies Aimed at Discouraging Current Approaches	Strategies Aimed at Encouraging Alternative Approaches
Rejection or Modification of Annual Plans or Corrective Action Plans	Routine FFP in Administrative Costs
Audit Exceptions and Cost Disallowance	State Savings from Reduced Erroneous Payments
Quality Control Systems	Additional FFP for Costs of MMIS, Medicaid Fraud Control, Child Support Enforcement, Food Stamp Enforcement
Fiscal Sanctions for High Error Rates	Fiscal Sanctions for Failure to Implement MMIS or Child Support Enforcement Programs
	Fiscal Incentives for Low Error Rates

provide settings in which federal agencies can point out potential (plan) or actual (audit exception) deficiencies in current state practices.

The central, and most controversial, part of the federal government's effort to stimulate changes in welfare management practices has been the quality control system, initially developed as a diagnostic tool and subsequently selected as a yardstick for the imposition of fiscal sanctions. HEW first required states to conduct quality control reviews of public assistance programs in 1964. This initial system, based only upon reviews of the information contained in case files, was revised in 1970 to require both field investigations and the use of statistically valid samples, and states were required to develop corrective action plans in response to identified problems. A 1973 review of the system concluded that state efforts were not generating valid measures of the quality of administration and that federal agencies were not taking action against unresponsive states. As a result, HEW issued new QC regulations and for the first time threatened fiscal sanctions against states which did not reduce AFDC error rates to 3% for ineligible cases, 5% for overpaid (but eligible) cases, and 5% for underpaid cases. In 1976, however, before fiscal sanctions were imposed, the United States District Court for the District of Columbia ruled that the 3% and 5% tolerance levels were "framed in an arbitrary and capricious manner" and that the regulation was "an abuse of discretion" (Richardson, 1977). When HEW developed new regulations requiring error rate improvements on a sliding scale, Congress in 1979 (the "Michel Amendment") required all states to meet a 4% payment error rate goal by September, 1982, making one-third progress toward that goal by 1980 and two-thirds by 1981. While FFP is to be reduced for erroneous payments in excess of these standards, the Michel Amendment authorizes the Secretary of DHHS to waive penalties if he determines "in certain limited cases, that states are unable to reach the required reduction in a given year despite a good faith effort." DHHS regulations give as examples of mitigating circumstances, natural disasters, personnel strikes, sudden workload changes, erroneous policy interpretations by federal officals, reasonable corrective action plans, management commitment to error reduction, information systems, and effective management of the corrective action

process. (Federal Register, 1980: 6320) The Medicaid error rate system similarly provides for fiscal sanctions which can be waived by DHHS; the eighteen states whose 1979 error rates exposed them to fiscal sanctions submitted corrective action plans which were acceptable to DHHS. (General Accounting Office, 1981: 5)

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

Assessments of Incentives Strategies. The impact of these federal efforts over the past ten years to improve welfare management and focus

attention on fraud and abuse problems is unclear. Case studies of eight AFDC programs in 1980 found that managers are taking steps to reduce their error rates (Zeller, 1981), most error rates have decreased since the mid-1970s, and states are taking more actions against fraud cases (see, e.g., Table 13.1). States have established Quality Control and Child Support Enforcement Systems, most states have developed or are in the process of developing MMIS systems, twenty-eight states are using Medicaid Fraud Control Units, and so forth. In short, many things have been tried over the past ten years to deal with fraud and abuse problems. It is impossible to say, however, how much of this effort is due to federal incentives and threats, how much is due to local concerns about welfare costs, etc.; many events have occurred over a short period of time, and their effects are too interconnected to assess their separate roles.

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

Second, federal strategies based on incentives were, not surprisingly, accepted more readily than strategies based on threatened penalties. When special federal funding (75% of administrative costs) became available for fraud (Medicaid Fraud Control and Food Stamp Fraud Enforcement) and fraud-related programs (MMIS and Child Support Enforcement), it became easier for fraud control proponents to compete for state and local

funds.[9] Perhaps more important, funding for specialized units such as Medicaid Fraud Control Units and the New Jersey AFDC fraud control demonstration project discussed in Chapter Thirteen ameliorated problems caused by conflicting responsibilities and inter-agency rivalries. Yet the availability of federal funding has not led to uniformly widespread adoption of fraud control techniques. A 1978 study, by the Center for Governmental Research, of state reactions to a number of DHHS initiatives suggested that the following factors may discourage state adoption of voluntary programs or may cause reluctance to comply with federal requirements:

a. non-applicability of program--subjective or objective

b. insignificance of problems intended for treatment relative to administrative machinery needed

c. lack of sympathy for aims of programs (e.g., value differences)

d. fear that federal standards will push up state costs

e. lack of sufficient local knowledge and acceptance of a new program. (Taddiken, 1978: 184)

Several of these factors seem particularly applicable to the adoption of fraud control techniques. Many states and communities, as was noted earlier in this chapter, simply no longer have the fiscal capacity to match federal funding. As uncontrollable costs (e.g., state payments for welfare) rose in the falling economy of the late 1970s and early 1980s, states could not even consider partial investment in additional activities of any form, no matter how cost-effective they might seem. In states in which the beneficiaries of welfare programs (recipients and providers) had powerful political supporters, it was especially difficult for fraud control advocates to mobilize support to apply for federal funding. Some of the specific techniques endorsed by the federal agencies seemed irrelevant or wasteful; many states concluded that MMIS wouldn't work, that forcing recipients to register for the WIN program was a waste of time when there

were no jobs available (Taddiken, 1978: 86-7), or that the negotiations necessary to bring about inter-agency cooperation (e.g., for WIN registration, Child Support Enforcement, or Medicaid Fraud Control Units) weren't worth the effort. Fiscal incentives for states whose error rates fall below 4% (AFDC) or 5% (Food Stamps) probably seem irrelevant to states which can't break a 10% barrier, and incentives programs directed at welfare agencies mean nothing to the prosecutors and judges who receive fraud referrals from those agencies (Taddiken, 1978: 145). In many states, criminal justice agencies are funded by counties, but it is the state agencies whose administrative costs are subsidized by SSA and HCFA. Furthermore, recovered overpayments to recipients and providers are returned to the general treasury (Federal, state, and in some states, county), not to the agencies whose efforts brought about the recovery. If Congress wants control agencies to deal with fraud cases, it should reimburse them for their costs, or allow them to share in recoveries. These policies are currently followed in the Child Support Enforcement program, and should be adopted for AFDC and Medicaid.

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

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

Like the incentives strategies, recent penalty-based strategies have stimulated state attention to their error rate problems (Taddiken, 1978: 162-4; Zeller, 1981). Nevertheless, a number of real or potential problems with this approach should be noted. Many states and more neutral analysts have pointed to weaknesses in proposals to base penalties on error rates.

As presently defined, error rates include technical errors (e.g., failure to register for WIN or obtain a social security number) and do not include other factors such as the quality of client service, timeliness of awards, or administrative costs which also indicate managerial effectiveness. Measuring only results (errors), they ignore real questions about the ability of agencies to comply (available resources, legal, and civil service restrictions, etc.) or the availability of the technological means to solve verification problems. Furthermore, many have questioned the accuracy and uniformity of the error-measurement process (General Accounting Office, 1980: ii), and it is widely argued that further utilization of QC programs as a basis for sanctions will lead the states to hide the errors they do find, or to contest federal error findings endlessly rather than addressing corrective action needs. (Richardson, 1977: 246; General Accounting Office, 1980: Chapter Two).

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

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

Finally, serious questions remain in the minds of many states as to whether the fiscal sanctions threatened in the late 1970s will ever be imposed. In the early years of the AFDC program, the Social Security Board

frequently vetoed noncompliant state practices; however, the last time a fiscal sanction was actually imposed on a state was in 1951 (see Steiner, 1966: Chapter Four; Advisory Commission on Intergovernmental Relations, 1980). State reactions against the 1951 sanction (in which the Federal Security Agency terminated AFDC funding for Indiana because it opened relief rolls to public inspection) were so strong that Congress amended the Social Security Act to overrule the FSA position. A 1966 analysis of federal welfare policy termed the 1951 dispute a "turning point in the activities and authority of the federal agency in relation to state policy-makers...Now it appeared that a state with clean hands might achieve a desired change in federal law even if that change ran contrary to the predilections of the administrative agency. The success of the Jenner amendment (overruling FSA) suggested that in the making of categorical relief policy politicians could be no less influential than welfare professionals" (Steiner, 1966: 97).

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

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

Perhaps the only safe conclusion about the impact of federal utilization strategies concerns the variations among welfare and criminal justice systems which were so evident in our research. Some officials in

some agencies have long been strongly committed to fraud reduction and have implemented extensive and sophisticated prevention and enforcement programs; limitations on their effectiveness may only suggest the limitations of control technology, the limitations of all public bureaucracies, and the inevitability, as Gilb phrased it earlier, of "getting some useful work done." Other officials and other agencies have consistently displayed lower motivation, lower competence, and less interest in fraud and abuse problems. As one senior DHHS official summarized his experience, "There are perhaps three groups of states--the very best which have always been well run and innovative, the worst which don't even try, and those in the middle which are trying hard to shape up." Any federal policies which assume that states have uniform problems may, therefore, be misguided--the best states may not need help or may only be slowed down by federal involvement, and the worst states may be incapable of using state-of-the-art techniques. As the 1980 study of AFDC programs concluded:

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

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

Conclusion. Not surprisingly, our research has found a variety of heroes and villains, incompetents and creative problem-solvers. We have also found that the Fraud Control Game is being played for many different reasons. In some areas, fraud control is seen as an adjunct to the goals of welfare systems, e.g., as a vehicle to penalize recipients who do not deserve public assistance or providers who exacerbate the health problems of the poor. In other areas, fraud control is primarily a cost-containment

mechanism, serving alongside limitations on eligibility and reimbursement rates as a way to cut total welfare costs. For some actors, fraud control is a form of political theatre, a device to appeal to anti-welfare or anti-crime constituencies. Ultimately, fraud control is all of these things and cannot be understood or improved if thought of as an isolated issue. Fraud control is part of welfare administration, is part of public budgeting, and is part of a continuing debate over the purposes of government. Even more troubling is the inescapable fact that fraud and abuse is committed both by people anyone would condemn (welfare queens and Medicaid mills) and by desperate people who cheat to survive on the margins of society. Prevention and enforcement systems aimed at the big crooks also catch the widows who conceal assets to get Food Stamps and the inner city doctors who abuse Medicaid when their private patients don't or can't pay their bills. Fraud and fraud control, in other words, are morally ambivalent issues. Fraud and abuse can be controlled more effectively than they now are, but control should not be at the expense of other social goals.

NOTES

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

2. See Chapter Five, Note 9, and Chapter Eight, Note 3.

3. In assuming rationality, we are omitting discussion of such real world phenomena as laziness, caprice, stupidity, or feelings of helplessness (e.g., that I can't alter current activities.) All such phenomena exist, and increase the difficulties involved in engineering changes. For more detailed analysis of the factors affecting utilization decisions, see Gardiner and Balch (1980).

4. Given the diversity of political, administrative, and criminal justice systems in the United States, many different combinations of utilization-supporting forces ("fraud control lobbies") are possible. In some states, welfare agencies may strongly support fraud control but need additional resources; in other states, the impetus for fraud control must come from the legislature, citizen groups, or federal agencies. Our emphasis in the text on the role of government actors should not be taken as downplaying the role of nongovernmental actors (citizen organizations, the mass media, schools of social work, etc.) in influencing government policies. In each state and locality, different combinations of private groups, legislators, administrators, and criminal justice officials will be predisposed toward, and in a position to facilitate, improvements in fraud control.

5. Research on the adoption of innovations (see Rogers with Shoemaker, 1971; Rothman, 1974; Zaltman et al, 1973; Zaltman and Duncan, 1977) suggests that many characteristics of a proposed change affect its value relative to current practices. Its attractiveness will be decreased by higher costs or complexity (people will avoid things which are difficult to comprehend); relative values will be increased by accessibility (things which are easy to understand and use), potential for success, compatibility with current practices,

trialability (can the change be used temporarily to see if it works?), and divisibility (can the change be tested in part or must it be adopted in toto?) (Gardiner and Balch, 1980). These findings suggest both the attributes of fraud control techniques which will facilitate or inhibit adoption and the attributes which should be stressed in "marketing" techniques to potential adopters.

6. Other research has suggested the long-term payoffs which may arise from directing communications strategies at "natural points of entry" in organizations (Yin et al, 1976: 25). Members of organizations are already attuned to receiving information in the course of training, meetings, etc. Fraud control information built into such channels of communication will not have to face the problem of catching an audience's attention as well as selling the message. DHHS, for example, might prepare a unit on fraud prevention to be used in caseworker training, a unit on MMIS data analysis for fraud control unit investigators, etc.

7. Just as our analysis assumes rationality in decision-making (see note 3, above), it must also assume that decision-makers will accurately perceive the costs and benefits associated with each alternative. In real life, of course, perceptions are clouded by uncertainties and by differing evaluations of what are costs and what are benefits in their own value systems.

8. A 1978 study of several DHHS programs provided the following taxonomy of incentives programs (Taddiken, 1978: 182):

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

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

REFERENCES

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

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

GARDINER, J., and G. BALCH (1980) "Getting People to Protect Themselves: Information, Facilitation, Regulatory, and Incentives Strategies," in J. Brigham and D. Brown, eds., Policy Implementation: Penalties or Incentives (Beverly Hills: Sage)

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

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

GILB, T. (1975) "The Laws of Unreliability," Datamation (March), quoted in P. Dickson, ed., The Official Rules (New York: Delta), 1978), 71.

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

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

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

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

ROGERS, E., with F. SHOEMAKER (1971) Communication of Innovations: A Cross Cultural Approach (New York: Free Press)

ROTHMAN, J. (1974) Planning and Organizing for Social Change: Action Principles from Social Science Research (New York: Columbia University Press)

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

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

VLADECK, B. (1980) Unloving Care: The Nursing Home Tragedy (New York: Basic Books)

YIN, K. et al (1976) A Review of Case Studies of Technological Innovations in State and Local Services (Santa Monica: Rand Corporation)

ZALTMAN, G., and R. DUNCAN (1977) Strategies for Planned Change (New York: Wiley)

ZALTMAN, G., R. DUNCAN, and J. HOLBECK (1973) Innovations and Organizations (New York: Wiley)

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

APPENDIX

ADMINISTRATIVE INFORMATION AND METHODOLOGY

Administrative Information

This project was funded by a grant (80-IJ-CX 0110) from the National Institute of Justice. The work was undertaken by three organizations:

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SRI International was the grantee; the University of Illinois and Rhodes Associates held subcontracts.

Methodology

The SRI grant application provided an overall design framework for the study. Fraud control issues in three government benefit programs (Medicaid, Aid to Families with Dependent Children, and Veterans Education programs)

were to be analyzed as they operated in three states (Colorado, Illinois, and Washington). A joint decision during the first few months of the project resulted in further study of the Veterans Education programs being discontinued (the programs were of insignificant interest to state and local officials where most of the field work was focussed). The principal research methods used during the project included literature review, field interviews, case study development, and qualitative analysis.

Early work focussed on establishment of a project library at SRI where materials relating to fraud control, the benefit programs, and the three states were drawn together from a variety of sources. They were read, annotated, and then categorized in terms of project issues. Subsequent meetings of the project staff resulted in the preparation of a research framework for analyzing issues in fraud and abuse control.

A project advisory panel was also established during the early stages of the project (see list of members in Acknowledgments). At the first meeting of this group, the research framework was discussed and modified. Plans were discussed for interviews and other means of data collection at the three state sites as well as in Federal agencies. The first advisory meeting ended in agreement on the research framework and with general plans for a series of interviews with staff of the Inspector General Offices, OMB, GAO, and program officials in HHS.

Field work commenced in Washington, D.C. with non-structured interviews and other data collection with the previously targeted federal agencies. Meetings were also held with officials of public interest groups (e.g., APWA) and research organizations (e.g., University City Science Center). These informal meetings and the review of old and new material formed the basis for development of instruments to guide field work in the states.

Interview guides were developed, structured along the topic outlines established in the research framework document. Contact was made with officials in the three states and a schedule of visits set up. Over a

period of three months, lengthy, face-to-face interviews were undertaken with state legislators, state AFDC and Medicaid program officials, fraud control/investigative personnel, local social service directors and prosecutors, and local legal and welfare rights organizations. Table A-1 indicates how many interviews were held with what type of official, by state. Interview notes were subsequently organized by state and by topic, and were then reviewed by the entire project team. A case study outline was prepared and six case studies drafted (one study per program per state).

The six case studies were subsequently reviewed and a general framework prepared to guide the analysis of policy issues--the objective of the second half of the project. A second meeting of the advisory panel focussed on the analytical framework. The analytical framework as well as a final report outline was approved at this second advisory panel meeting.

Each case study was then re-analyzed with respect to the framework (recipients' perspectives, providers' perspectives, control agency perspectives, etc.) and general themes established for each of the analytical chapters. Writing began immediately on the final report, drawing on library materials, the six case studies, interview materials and, in some cases, follow-up telephone contacts with people in the field. A final chapter of strategies for overcoming barriers to implementing remedies and an executive summary were prepared after a third advisory panel meeting.

TABLE A-1

PROJECT SITE CONTACTS

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

END