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Report to the Chairman, Committee on Energy and Commerce, House of Representatives

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MEDICAID

State Efforts to Control Improper Payments Vary

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Contents

Abbreviations

DOJ	Department of Justice
FBI	Federal Bureau of Investigation
HCFA	Health Care Financing Administration
HCFAC	Health Care Fraud and Abuse Control Program
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
MCFU	Medicare Fraud Control Unit
MMIS	Medicaid Management Information Systems
OIG	Office of Inspector General
SURS	Surveillance and Utilization Review Subsystem

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

June 7, 2001

The Honorable W. J. "Billy" Tauzin
Chairman, Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

Both the federal government and states have a strong financial interest in assuring accurate payments in the jointly funded Medicaid program. About 40 million low-income Americans—parents and children, as well as elderly, blind, and disabled individuals—receive preventive, acute health care, and long-term care services paid through the Medicaid program, administered by the Health Care Financing Administration (HCFA). In fiscal year 2001, the program is projected to cost the federal government $124 billion, and the states about $95 billion, in program payments and administrative expenses. Within states, two agencies share responsibility for protecting the integrity of their state Medicaid programs. The state Medicaid agency is responsible for ensuring proper payment and recovering misspent funds, while the Medicaid Fraud Control Unit (MFCU) is responsible for investigating and ensuring prosecution of Medicaid fraud.

Improper payments in government health programs such as Medicaid drain vital program dollars, hurting beneficiaries and taxpayers. Such payments include those made for treatments or services that are not covered by program rules, that are not medically necessary, or that were billed but never actually provided. Improper Medicaid payments can result from inadvertent errors as well as intended fraud and abuse. Unlike inadvertent errors, which are often due to clerical errors or a misunderstanding of program rules, fraud involves an intentional act to deceive for gain, while abuse typically involves actions that are inconsistent with acceptable business and medical practices.

Given the importance of Medicaid to millions of Americans and the financial resources at stake, in response to your request, we assessed whether the states had estimated the risk of, or losses due to, improper payments in the program. We also reviewed state Medicaid agencies' activities to prevent or identify and respond to improper payments, and state MFCUs' efforts to investigate and prosecute possible fraud. Finally, we reviewed the federal guidance and support provided to states as they pursue their program integrity efforts.

We specifically focused on efforts to safeguard fee-for-service payments, which represented 86 percent of program payments in fiscal year 1998 and are the focus of most state program integrity activities.[1] We reviewed state Medicaid payment accuracy measurement studies and conducted site visits to state Medicaid agencies and MFCUs in Georgia, New Jersey, Texas, and Washington. We chose these states to provide regional diversity and because agencies within those states were among the ones considered by federal officials to be particularly active in efforts to identify and respond to improper payment practices—either through the use of new technology or other means. In addition, we surveyed officials from all state Medicaid agencies and MFCUs. Fifty-three of the 56 state Medicaid agencies and 46 of the 47 MFCUs responded to our surveys[2] (see aggregated survey results in appendix II). We also interviewed officials in other states and federal agencies, including HCFA, which oversees Medicaid at the federal level, and the Department of Health and Human Services (HHS) Office of Inspector General (OIG), which oversees MFCUs at the federal level. Finally, we interviewed health care provider, supplier, and insurer groups, and analyzed HCFA, state Medicaid agency, and MFCU program reports and other documents. Details of our scope and methodology are in appendix I. Our work was conducted from September 1999 through April 2001 in accordance with generally accepted government auditing standards.

Results in Brief

State Medicaid programs make a wide variety of payments to many individuals, institutions, and managed care plans for services provided to a beneficiary population whose eligibility status may fluctuate because of changes in income. Due to the size and nature of the program, Medicaid is at risk for billions of dollars in improper payments. The exact amount lost is not known because few states measure the overall accuracy of their payments. A portion of states' improper Medicaid payments are made because of fraudulent activities on the part of those billing or participating

[1] Under fee-for-service, Medicaid programs make payments to providers for specific services provided to eligible beneficiaries. To receive payment, a provider files a claim with the state that includes both the provider's and the beneficiary's identification numbers, a list of the treatments and services provided, and diagnostic information to justify the treatments and services being billed.

[2] An additional MFCU in the District of Columbia, which had lost its federal certification in 1983, was recertified in March 2000 after we had fielded our survey; it was not included in our survey.

in the program, but such improper payments are even harder to measure because of fraud's covert nature. States' efforts to identify billing mistakes or abuses of various kinds are limited—even with claims reviews and other screening efforts—because it is impossible to thoroughly check every claim and payment. However, lax administration increases the risk, as was seen in California, where investigations have revealed widespread payment for drugs, equipment, and supplies that were either not delivered or not needed.

Efforts by state Medicaid programs to address improper payments are modestly and unevenly funded. Half of the states spend no more than one-tenth of 1 percent of program expenditures on activities to safeguard program payments. Few secure all available federal funds earmarked for antifraud efforts because states would have to increase their own spending to do so. States also differ in their use of tools to help prevent improper payments, such as computerized checking of claims before payment is made and site visits to providers whose billing might be questionable, as well as the degree to which they coordinate their efforts to investigate and then prosecute fraud. There are, however, promising recent activities. Some states are devoting more resources to program integrity activities than they had previously and are obtaining more sophisticated computer analytic capacity to review payment trends and spot improper billing. Others are implementing stricter health care fraud and abuse control laws and policies.

Federal efforts to help guide the states rely to a large extent on technical assistance, and to a lesser extent on guidance on how to conduct their activities. HCFA has recently taken a more active role to facilitate states' efforts and provide a national forum for sharing information. The agency has helped states exchange best practices, held conferences on issues such as computer technology, and provided guidance on fraud and abuse in managed care. Until recently, HCFA has lacked consistent information on how states were conducting their program integrity efforts, which would be needed to actively guide their efforts, but it has begun to systematically review states' activities. In regard to the MFCUs, the OIG annually reviews them to certify that they are in compliance with federal regulations and eligible for federal funding. It also assists MFCUs by providing technical assistance and training opportunities. In its written comments on a draft of this report, HHS provided information on the Department's most recent efforts to control improper payments.

Background

Medicaid is the third largest social program in the federal budget and is also one of the largest components of state budgets. Although it is one federal program, Medicaid consists of 56 distinct state-level programs—one for each state, District of Columbia, Puerto Rico, and each U.S. territory.[3] Each state has a designated Medicaid agency that administers its program under broad federal guidelines. The federal government matches state Medicaid spending for medical assistance according to a formula based on each state's per capita income. The federal share can range from 50 cents to 83 cents of each Medicaid dollar spent.

HCFA administers the Medicaid program at the federal level. In accordance with the Medicaid statute, it sets broad guidelines for the states, but within them, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of covered services; sets payment rates; oversees the integrity of its program; and develops its administrative structure. States are required to describe the nature and scope of their program in a comprehensive written plan submitted to HCFA—with federal funding for state Medicaid services contingent on HCFA's approval of the plan. HCFA is responsible for ensuring that state Medicaid programs meet all federal requirements. In addition to Medicaid, HCFA also has responsibility for administering Medicare, a federal health insurance program for certain disabled persons and those 65 years and older. While Medicaid and Medicare have different structures and governance, some low-income beneficiaries and many providers participate in both programs.

[3] Hereafter referred to as states.

There are also—in 47 states and the District of Columbia—separate MFCUs[4] that are responsible for investigating and prosecuting Medicaid provider fraud, patient abuse, and financial fraud. In 1999, MFCUs received authority to investigate cases involving Medicare fraud as well.[5] Most MFCUs are part of the state Attorney General's office, and most prosecute the cases they investigate. MFCUs that have been federally certified for more than 3 years receive 75 cents in federal funding for every dollar they spend, up to a limit established by federal regulations.[6]

[4] All states are required to have an MFCU or obtain a waiver from the HHS Secretary. Currently, Idaho, Nebraska, and North Dakota have such waivers. States granted waivers have similar units already in place.

[5] Section 407 of the Ticket to Work and Work Incentives Improvement Act of 1999, P.L. 106-170, expanded the jurisdiction of MFCUs to investigate Medicare fraud in cases primarily related to Medicaid and to investigate patient abuse or neglect in non-Medicaid board and care facilities.

[6] The federal government pays 90 percent of a federally certified MFCU's budget—up to a limit—for its first 3 years, and 75 percent thereafter. For an MFCU that has been operating for more than 3 years, the maximum federal budget contribution is the greater of $125,000 or one-fourth of 1 percent of the total federal, state, and local expenditures of a state Medicaid program during its previous quarter.

In addition to state Medicaid agencies and MFCUs, other state and federal agencies assist in dealing with Medicaid improper payments. Because of their responsibilities to ensure sound fiscal management in their states, state auditors or state inspectors general may become involved in Medicaid payment safeguard activities through efforts such as testing payment system controls or investigating possible causes of mispayment. At the federal level, the Federal Bureau of Investigation (FBI) and the OIG investigate, and U.S. Attorneys prosecute, certain Medicaid fraud cases, such as those that involve multiple states or also involve fraud against other health care programs. Funding for these agencies to pursue fraud and abuse in federal health care programs is available from the Health Care Fraud and Abuse Control Program (HCFAC). Established in 1996 by Section 201 of the Health Insurance Portability and Accountability Act (HIPAA), it funds, consolidates, and strengthens federal fraud control efforts under the Department of Justice (DOJ) and HHS. This fund provided $154.3 million in fiscal year 2000 to the OIG and DOJ. Separately, the FBI received an additional $76 million in HIPAA-specified funding for fiscal year 2000. Medicare has been the major focus of this effort, but Medicaid has also benefited. In its joint report with DOJ on the HCFAC fund,[7] HHS reported returning nearly $45 million dollars to Medicaid as a result of these fraud control activities for fiscal years 1997 through 1999.

Medicaid Is at Risk for Improper Payments but the Amount Lost Is Unknown

With state and federal Medicaid payments projected to total $221.6 billion this fiscal year, even a small percentage loss due to improper payments represents a significant loss to taxpayers. The magnitude of improper payments throughout Medicaid is unknown, although a few states have attempted to determine the level by measuring the accuracy of their program's payments. An even more difficult portion of improper payments to identify are those attributable to intentional fraud—recent cases in California and other states provide examples of losses due to fraudulent activities.

Few States Have Measured Improper Payments

There are no reliable estimates of the extent of improper payments throughout the Medicaid program. However, at least three states have conducted studies to try to measure their program's payment accuracy

[7] For more detail, see *The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for FY 2000*, January 2001.

rates and pinpoint where payment vulnerability occurs, with varied success.

- Illinois, in 1998, reported an estimated payment accuracy rate of 95.3 percent, with a margin of error of +/- 2.3 percentage points, of total dollars paid. The estimate was based on a sample of individual paid claims, for which the state reviewed medical records and interviewed patients to verify that services were rendered and medically necessary. As a result of this audit, the state identified key areas of weakness and targeted several areas needing improvement. For example, because the Illinois payment accuracy review indicated that nearly one-third of payments to nonemergency transportation providers were in error, the Illinois Medicaid program has taken a number of steps to improve the accuracy of payments to this provider type.
- Texas, also in 1998, reported an estimated payment accuracy rate of 89.5 percent in the acute medical care fee-for-service portion of the program. However, in making that estimate, reviewers had trouble locating many patients and records due to statutorily imposed time constraints. Further work led the state, in 1999, to revise the estimate to between 93.2 and 94 percent. In developing the estimate, the state identified ways to reduce improper payments through expanded use of computerized fraud detection tools, such as matching Medicaid eligibility records with vital statistics databases to avoid payments for deceased beneficiaries. In January 2001, Texas reported that a more recent study estimated a payment accuracy rate of 92.8 percent in its acute medical care fee-for-service payments.
- Kansas, in 2000, reported an estimated payment accuracy rate of 76 percent with a margin of error of +/- 9 percentage points. The estimate was based on a sample of individual paid claims, as in Illinois. The payment accuracy study recommended increased provider and consumer education, as well as improvements to computerized payment systems. In addition, Kansas officials undertook focused reviews of certain types of claims that were identified as vulnerable to abuse.

In their payment accuracy studies, these states commonly identified errors such as

- missing or insufficient documentation to show whether the claim was appropriate;
- claims for treatments or services that were not medically necessary;
- claims that should have been coded for a lower reimbursement amount; and

- claims for treatments or services that the program did not cover.

Because payment accuracy studies can provide useful guidance toward developing cost-effective measures to reduce losses, HCFA has sought HCFAC funding for grants to states for such efforts. HCFA also has established a workgroup to develop guiding principles, definitions, and reporting protocols for payment accuracy studies. HCFA and its workgroup of state officials are also trying to assess whether, given the many differences among the various Medicaid programs, a common methodology can be developed that would allow valid comparison of error rates across states.

Fraud and Abuse Represent a Portion of Improper Payments That Is Even More Difficult to Quantify

State payment accuracy studies may not fully identify improper payments that might be related to fraud, due primarily to fraud's covert nature. Losses due to fraudulent billing and other related practices are difficult to quantify. However, these amounts can be significant, as was demonstrated recently in California's program, in which millions of dollars were paid to numerous fraudulent providers. Since July 1999, a state-federal task force targeting questionable pharmaceutical and durable medical equipment suppliers for improper billing has charged 115 providers, wholesalers, and suppliers in cases involving about $58 million in fraud. At least 69 individuals have been convicted and paid about $20 million in restitution. An additional 300 entities are being investigated for suspected fraud that could exceed $250 million. In one case, a family-run equipment company defrauded the program out of more than $9 million by submitting thousands of claims for equipment and supplies that were never delivered to patients. Investigators also found the following.

- "Bump and run" schemes in which individuals bill for a few months for services that are not rendered, stop billing before being detected, and then start again under a new name.
- Wholesalers who gave pharmacies and suppliers false invoices to substantiate false claims.
- Use of "marketers" who recruit and pay beneficiaries $100 or more to lend their Medicaid identification cards for use in improper billing.
- Use of beneficiary identification numbers stolen from a hospital to bill for services not provided.
- Use of identification from providers who had retired or moved out of the state.
- Purchase of an established business in order to fraudulently bill under its name.

Administrative weaknesses in the California Medicaid program made these activities easier to accomplish. For example, the program was issuing new billing numbers to individuals with demonstrated histories of current or past questionable billing practices. The program allowed providers to have multiple numbers, and applicants did not have to disclose past involvement in the program or any ongoing audits. As a result, in some cases, individuals who had past questionable billings applied for a new provider number and were reinstated with full billing privileges. In addition, applicants for a billing number for a business that needed a license—such as a pharmacy—did not have to disclose that actual owners were not the licensed individuals. This allowed unlicensed individuals to pay medical professionals for the use of their licenses to obtain a provider number. California has taken steps to try to close such loopholes.

In addition to single-state schemes, fraudulent activities sometimes involve large-scale multistate schemes. One case led to a $486 million civil settlement in early 2000—one of the largest health care settlements ever. It followed a 5-year investigation of a dialysis firm billing Medicare and several state Medicaid programs for intradialytic parenteral nutrition[8] that was not necessary or not provided in the quantity claimed. The company had an ownership interest in a laboratory that also double-billed for unnecessary tests and paid kickbacks to nephrologists and clinics that used the laboratory. In another case, a national laboratory headquartered in Michigan was ordered to pay $6.8 million in a multistate settlement for billing Medicare and five Medicaid programs for bogus medical tests.

Improper billing schemes such as the ones discussed above are the principal types of fraud cases developed by MFCUs, according to MFCU directors responding to our survey. Improper billing includes "upcoding," in which the provider misrepresents treatment provided and bills for a more costly procedure; "ghost" or "phantom" billing, in which a provider bills for services never provided; and delivering more services than are either necessary or appropriate for the patient's diagnosis. However, other types of fraud occur, including improper business practices—such as kickbacks for steering services to a provider—or misrepresentation of qualifications, such as an individual falsely claiming to be a physician. MFCU directors

[8] Parenteral nutrition is a liquid food mixture given intravenously. Intradialytic parenteral nutrition is a form of parenteral nutritional therapy that is provided to a dialysis patient during the hemodialysis procedure. The nutrients are infused into the blood returning from the dialyzer to the patient.

have found a wide variety of providers involved in fraud, including physicians, dentists, pharmacies, durable medical equipment providers, and transportation providers. Beneficiaries also engage in fraud, either by misrepresenting assets to become eligible for the program, lending or selling their identification numbers for another's use, or obtaining products such as pharmaceuticals for resale.

Fraud is not merely a financial concern—it can also pose a risk to the physical health of beneficiaries. For example, providers have drawn blood unnecessarily in order to better substantiate billing for tests that were not performed, and dentists have conducted extensive unnecessary dental work on beneficiaries in order to bill the program.

States' Efforts to Control Improper Payments Are Uneven

The amount of resources and effort that state Medicaid programs devote to protecting the integrity of their programs varies. Some states have focused their efforts on preventing improper payments by strengthening their prepayment claims checking. States' abilities to detect improper payments also vary, in part because some lack sophisticated information technology that can help them analyze and track instances of inappropriate billing. Strong leadership in certain states is resulting in stricter laws and restructured operations to better ensure that the Medicaid program pays claims appropriately.

Resources Devoted to Program Protection Efforts Are Generally Modest

Resources for addressing improper Medicaid payments are generally modest. In our survey, 25 state Medicaid agencies reported spending one-tenth of 1 percent or less of program expenditures on these efforts. Others, such as California, spend about one-fourth of 1 percent of program expenditures on preventing and detecting improper payments. However, this is not unique to Medicaid. As we recently reported, the Medicare program devotes little more than one-fourth of 1 percent of its program expenditures to safeguarding payments. As a result, we recommended that the Congress increase funding for these important activities.[9]

All states forgo some of the federal funds available to help their MFCUs investigate and prosecute fraud. MFCUs, once federally certified and in operation for 3 years, are eligible for 75 cents in federal funds for every dollar they spend, up to a maximum federal contribution of the greater of $125,000 per quarter or one-fourth of 1 percent of the state Medicaid program's total expenditures in the previous quarter. However, only 10 percent of MFCUs receive enough state funding to obtain even half of the allowed federal match. States ranged from having enough state funding to obtain less than 7 percent to having up to 86 percent of their allowed federal match.

Many Medicaid state agency fraud control and MFCU officials reported gaps in staff, staff training, or technology acquisition. Many state officials said that they wanted to increase their workforce by hiring staff with specific skills, such as auditing, computer analysis, and clinical knowledge, and adding the technology to analyze large amounts of claims data. For example, in our survey, only 14 of 53 state agencies reported that they have statisticians to help collect, organize, and analyze data to spot improper billing practices. Further, although information technology to store and analyze large amounts of data easily has improved significantly in recent years, some states reported using very old information technology to assess program billing. Four state Medicaid agencies reported using software that is at least 15 years old to assess claims before payment, and three state Medicaid agencies reported using software at least that old to analyze claims after payment to ensure the billings were proper.

[9] *Medicare: HCFA Could Do More to Identify and Collect Overpayments* (GAO/HEHS/AIMD-00-304, Sept. 7, 2000).

While about half of the state agencies and a third of MFCUs reported that their program integrity unit budgets were steady or declining in the previous 3 years,[10] we did learn that other states showed a more promising trend. In our survey, 8 state Medicaid agencies and 4 MFCUs reported that their budgets for program integrity activities had increased significantly, while another 15 state agencies and 27 MFCUs reported that their budgets had increased somewhat. As a result, they reported that they were able to hire additional staff and increase program safeguards. For example, Connecticut's increased funding allowed the state Medicaid agency to hire additional staff to increase audits and site visits to providers. Georgia's state Medicaid agency also received increased funding, which allowed it to increase staffing levels and to make a number of additional improvements, such as opening an office to cover the southern part of the state.

Prevention Efforts Emphasized in Certain States

Preventing improper payments can be a cost-effective way to protect program dollars. Prevention can help avoid what is known as "pay and chase" in which efforts must be made to detect and attempt to recover inappropriate payments after they have been made. Such postpayment efforts are often costly and typically recover only a small fraction of the identified misspent funds, although they can identify parts of the program where controls, such as on payments, may need strengthening. States use a variety of preventive approaches—such as prepayment computer "edits," manual reviews, provider education, and thoroughly checking the credentials of individuals applying to be program providers—and the scope and effectiveness of these activities varies among the states.

States Use Prepayment Edits and Reviews to Help Prevent Improper Payments

All 41 of the state Medicaid agencies responding to our survey about prepayment claims review reported that they use such reviews to varying degrees. These include automated computer "edits" and manual reviews to help ensure payment accuracy. Typically, their edits check the mathematical accuracy of claims, the correct use of payment codes, and patients' Medicaid eligibility. Such reviews help ensure that the services listed on the claim are covered, medically necessary, and paid in accordance with state and federal requirements. For example, an edit can be used to deny a claim for obstetrical care for a male beneficiary. Some states have thousands of such edits in their payment systems that identify

[10] This was current as of the dates of their completed surveys, which were generally completed by March 2000.

duplicate claims, invalid dates, missing codes, or claims for services that conflict with previous care provided to the beneficiary.

Although widely used, recent experiences from several states that are aggressively working to detect overpayments suggest that their existing prepayment edits have not been catching various types of improper payments. A few states have hired a private contractor to help analyze claims data to uncover overpayments. For example, with the aid of this contractor, Florida learned that it was paying some pharmacies 10 times more than it should for asthma inhalant because its edit did not stop claims listing the amount in unit doses rather than in grams, as required. Following this contractor's overpayment review, Kentucky made edit changes it estimates will prevent $2 million in improper payments. This same contractor assisted Washington in making edit and other policy changes that are anticipated to save $4 million.

Investigations in other states have also identified the need for new and revised edits. Some MFCU officials reported that they had advised their state agencies to strengthen certain edits based on the cases they had investigated. For example, the North Carolina MFCU suggested an edit to its state agency to identify and bundle laboratory services that should not have been billed separately.[11] Also, the Louisiana MFCU reported that it had recommended that its Medicaid agency develop an edit to prevent duplicate payment of children's medical screenings and physician visits and to ensure that physicians and certified nurse practitioners working together do not send in duplicate claims for the same services.

Manual reviews before claims are paid can further help prevent improper payments, but they are resource-intensive, thus limiting the number of such reviews that can be done cost effectively. Manual reviews involve a trained specialist—such as a nurse—examining documentation submitted with a claim and possibly requesting additional information from providers, beneficiaries, and other related parties. Because of the cost and time involved, manual prepayment review is often targeted to certain providers. For example, if a provider's claims pattern is substantially different from his or her peers, or if there is a sudden increase in claims volume for a given provider, or if there is substantial evidence of abuse or wrongdoing,

[11] From its work with several state Medicaid programs, one contractor estimates that use of the prepayment edits to address laboratory services unbundling would allow a Medicaid program with 800,000 enrollees to avoid costs of about $420,000 annually.

payment may be withheld until a reviewer determines whether the aberrations or increases are appropriate and can be substantiated. Table 1 shows examples of prepayment reviews currently being used by some states.

Table 1: Examples of Prepayment Reviews

Action	State efforts
Focused review of certain providers	California bars providers with previously questionable billing patterns from submitting claims electronically and performs a manual review before making payment. This saved more than $17 million in fiscal 1998 and 1999.
Review checks prior to disbursement	California analyzes and refers questionable claims to audit and on-site review before payments are made. New Jersey uses off-the-shelf software to analyze claims for aberrant patterns before payments are made.
Point of sale review system	Washington uses an on-line drug claims management system to finalize pharmaceutical claims when the pharmacist fills the beneficiary's prescription. The system screens for duplicate claims and drugs requiring prior authorization, and provides alerts to such factors as insufficient or excessive dosages and interactions with other drugs. If appropriate, it approves payment.

Source: GAO.

Educating Providers Is Another Approach Used by States to Prevent Billing Errors

Because billing mistakes can be inadvertent, educating providers on how to comply with program rules and file claims correctly can often prevent errors. For example, in our survey, almost all state Medicaid agencies reported initiating meetings with providers, usually to discuss coding and policy changes. Seventeen state Medicaid agencies reported that their staff met with providers to discuss safeguarding the confidentiality of provider and beneficiary Medicaid numbers. In addition, 17 state Medicaid programs alerted providers to prevalent fraud schemes.[12] State Medicaid agencies also reported conveying information on proper billing procedures to providers through a variety of other means, such as letters, bulletins, Internet sites, and professional meetings.

[12] Eleven states reported both meeting with providers to discuss safeguarding provider and beneficiary numbers and alerting providers to fraud schemes.

Provider Enrollment Screening Processes Are Often Limited

Some states use more extensive provider enrollment measures to help prevent dishonest providers from entering the Medicaid program and to ensure better control over provider billing numbers. While all states collect some basic information on providers, states have considerable latitude in how they structure their provider enrollment processes. In addition, states are required to check if those providers who should be licensed are licensed and whether the provider has been excluded from participating in other federal health programs. Checking a provider's criminal record and business site has been found to be important by states such as Florida to ensure that providers entering the program are legitimate. Nine of the states responding to our survey reported having a provider enrollment process that included all four of these checks—licensure, excluded provider status, criminal record, and business location verification—in their provider enrollment processes. Table 2 provides examples of these activities.[13]

Table 2: Selected State Efforts to Ensure Legitimacy of Providers

Action	State efforts
Enhanced background checks	Florida requires providers such as physicians, pharmacists, dentists, and others who are not employees of institutions like hospitals, to undergo fingerprinting and criminal background screening. All officers, directors, managers, and owners of 5 percent or more of a provider business must be screened. Fingerprints are checked with both state and federal law enforcement agencies.
Strengthened provider agreements	Connecticut, Florida, Georgia, and Texas revised provider agreements so they can terminate providers from the program without cause, allowing for more expeditious removal of providers who are billing inappropriately.
Reenrollment under tightened standards	Florida and Texas tightened enrollment standards—through enhanced background checks and strengthened provider agreements as well as other methods—and has required existing providers to reenroll under the new standards.
Special procedures for select providers	New Jersey has more stringent enrollment procedures for provider categories with higher risk of payment problems, such as pharmacies, independent laboratories, and transportation companies.
Preenrollment site visits	Some states—including Florida, Georgia, and New Jersey—conduct preenrollment site visits, usually to higher-risk provider types, such as pharmacies and durable medical equipment suppliers.

Source: GAO.

[13] For more detail, see *Medicaid: HCFA and States Could Work Together to Better Ensure the Integrity of Providers* (GAO/T-HEHS-00-159, July 18, 2000).

Most Medicaid agencies reported checking whether applicants whose practice requires licensure had a valid license and whether they had been excluded from participating in other federal health programs.[14] However, less than half of the states responding to our survey reported checking whether applicants have criminal records. While conducting such checks on a targeted basis might be useful in helping to protect the program, they can be time-consuming and difficult to perform, according to states that have attempted them. This is due in part to often inaccurate and incomplete statewide databases containing records on criminal convictions. Nineteen of 52 state Medicaid programs reported that they conducted site visits to determine if an applicant had a bona fide operation. Of those that do conduct site visits, most limit them to particular types of providers they believe have a greater likelihood of abusing the program. For example, Kansas Medicaid officials reported that, based on a risk analysis, there is a greater risk that durable medical equipment suppliers are not legitimate providers and, therefore, the Medicaid program conducted site visits of these applicants.

Many states allow providers, once enrolled, to bill the program indefinitely without updating information about their status. Poor control over provider billing numbers can make Medicaid programs more vulnerable to improper payment. In our survey, 26 states reported allowing providers to continue to bill indefinitely while other states had an enrollment time limit, which often varied by provider type. However, 33 states reported that they cancel inactive billing numbers—generally for providers who have not billed the program for more than 1 to 3 years. Such efforts can be important, as questionable providers have been known to keep multiple billing numbers "in reserve" in case their primary billing number is suspended. In California, some individuals falsely billed the Medicaid program using the numbers of retired practitioners.

States' Postpayment Detection Activities and Capabilities Differ

Just as states are uneven in their efforts to prevent improper payments, they also vary in their ability to detect improperly paid claims. Because prepayment reviews cannot catch all erroneous claims, Medicaid programs must have systems in place to retrospectively review paid claims. While some states are using software from the early 1980s to analyze paid claims,

[14] These two checks are related to federal requirements that states use only qualified providers and that the federal government not pay for medical services provided by excluded providers.

other states—such as Texas and Washington—are implementing state-of-the-art systems to improve their ability to detect and investigate potential improper payments.

Each Medicaid state agency is required to have an automated claims processing and retrieval system that can be used to detect postpayment errors. These automated claims processing systems, known as Medicaid Management Information Systems (MMIS), contain a Surveillance and Utilization Review Subsystem (SURS) that state agency officials can use to identify providers with aberrant billing patterns. For example, these might include providers with a large increase in Medicaid activity or with billing patterns that are significantly different from their peers and that result in enhanced reimbursement. Almost all states reported conducting focused reviews or investigations when a provider's billing was aberrant to determine if any improper payments had been made. State Medicaid officials told us that when their state Medicaid agency discovers that improper payments have been made, it takes action to recover the improper payment, and, if warranted, refers the provider to its state MFCU for possible criminal investigation and prosecution. Providers who have been identified as having significant billing problems generally receive continued scrutiny if they remain in the program.

The systems used to uncover such aberrant billing—MMIS and SURS—were developed in the early 1980s when computer algorithms to identify potentially inappropriate claims were less sophisticated and analysis required more programming skill. Newer systems allow staff to use desktop computers to directly query large databases of claim, provider, and beneficiary information, without requiring the assistance of data processing professionals. Several state officials reported that buying or leasing these upgraded computer systems and hiring staff skilled in their use would be their top priority if they had more funding. Other states are already purchasing or leasing such systems, as the following examples illustrate.

- Texas is using private contractors to design, develop, install, and train staff to use a state-of-the-art system intended to integrate detection and investigation capabilities. It is intended to allow the state to uncover potentially problematic payment patterns that old SURS profiling methodologies would have missed. It also includes a "neural network" that is intended to "learn" from the data it analyzes and adjust its algorithms to identify previously overlooked aberrant payment patterns. The system is further enhanced with modules designed to help develop

cases for prosecution. The first 2 years of the project cost Texas $5.8 million, but according to state Medicaid officials, Texas had already collected $2.2 million in overpayments in the system's first year of operation.

- Kentucky has hired a private contractor to use an advanced computer system to analyze claims payment data. It is paying that contractor through contingency fees based on overpayment collections related to these efforts. Using claims data from January 1995 through June 1998, the contractor identified $137 million in overpayments, of which the state has collected between $4 and $5 million. That compares to previous recovery efforts by the state that, on average, netted about $75,000 a year.
- Under its new Payment Integrity Program, Washington is using a private contractor to design, develop, install, and train staff to analyze data on an advanced computer system. The system improves access to data and includes fraud and abuse identification software with prepackaged algorithms to analyze the data and identify overpayments, as well as develop leads that would need further investigation. It also allows agency staff to develop algorithms and perform their own online reviews. Since the program started in June 1999, the contractor and state agency staff have identified overpayments totaling more than $2.95 million.

Some states have developed detection strategies that combine the use of advanced technology with special investigative protocols. For example, New Jersey conducted special audits of transportation services, cross-matching data on transportation claims to beneficiary medical appointments, and sometimes contacting providers to confirm that the beneficiary actually arrived and was treated. Also, using billing trend reports, New Jersey audited pharmacies with abnormally large numbers of claims for a newly covered high-priced drug, and then audited the pharmacies' purchases from wholesalers, thus discovering that these pharmacies were billing for a larger amount of this drug than had been shipped to them.

Beneficiaries can also play a role in helping state Medicaid agencies detect improper payments. Forty-two states reported having hotlines that beneficiaries could use to report suspected improprieties. Fourteen states reported alerting beneficiaries to certain types of fraudulent schemes. Twenty-seven reported taking other types of actions. For example, some states commented that they mail explanation-of-benefit statements to beneficiaries to increase awareness of the services being billed in their

names, so that if beneficiaries are not receiving billed services, they will be able to inform the state.

Fraud Investigation and Prosecution Is a Shared Responsibility

State Medicaid agencies are primarily responsible for conducting program integrity activities, but they share this responsibility with other agencies. For example, they are required to refer potential fraud cases to the MFCUs for investigation and prosecution. Cases that may involve improper billing of Medicare or private insurers as well as Medicaid may also require investigation by the OIG or the FBI, and may involve prosecution by DOJ. In addition, other state agencies, such as those responsible for licensure, can become involved in an investigative effort.

Federal regulations require Medicaid agencies and MFCUs to have an agreement to cooperate; however, the actual level of cooperation between state Medicaid agencies and MFCUs varies. State Medicaid agencies are required to refer suspected fraud cases to MFCUs for investigation and possible prosecution, provide needed records to the MFCUs, and enter into a Memorandum of Understanding establishing procedures for sharing information and referring cases.

In our survey, MFCUs generally reported that about one-third of the cases that they open are referred by their state Medicaid agency. The most common criterion reported by state agencies for referring cases to MFCUs was a belief of an intent to commit an impropriety on the part of a provider. The number of cases state agencies reported referring in their previous fiscal year varied substantially. This is not surprising because Medicaid agencies differ in size, organization, scope of services, and beneficiary eligibility requirements. They also operate in different states, each of which has its own legal system and business climate, differences that can affect the number and quality of fraud referrals made by the state agency.

In addition to differences in referral patterns, the reported level of interaction between states' Medicaid agencies and MFCUs also varied. For example, meetings between the two organizations to discuss pending cases are important for preventing agency actions that could compromise a fraud unit investigation or for alerting MFCU officials to cases the state agency is developing. Most state Medicaid agencies reported having joint meetings at least six times a year; however, eight states reported that they conduct such meetings only one to three times each year.

New Jersey is a state where the Medicaid agency and MFCU have worked together to further each agency's efforts through close cooperation. Medicaid agency staffers are sometimes detailed to the MFCU to continue working cases they have developed. The state agency and MFCU hold joint meetings monthly to discuss developing cases, case progress, and to plan strategies for investigations, prosecutions, and administrative actions. The MFCU tries to use search warrants and other methods to gather evidence in suspected fraud cases so that information can be shared with the Medicaid agency. This is in contrast to the use of another MFCU tool—grand jury investigations—which have secrecy rules to prevent disclosure of evidence. This level of cooperation allows the state Medicaid agency to take immediate administrative action to stop improper payments without disrupting criminal case development. The MFCU also works to have defendants who are pleading guilty sign a consent order debarring or disqualifying them from participating in Medicaid,[15] eliminating the need for state agency debarment or disqualification proceedings. In contrast to New Jersey, in another state, the director of an MFCU reported to us that MFCU investigators were denied access to state Medicaid agency meetings, which made it more difficult for both agencies to develop potential fraud cases.

State Medicaid and MFCU officials told us that close collaboration among state agencies or state and federal law enforcement agencies was particularly important for certain types of cases. In the handful of states whose MFCUs lack authority to serve warrants or prosecute cases, MFCUs must work with other agencies to ensure that these activities take place. When dealing with individuals whose fraudulent or abusive activities cross state lines, one MFCU may need to work with other states' agencies or with federal officials. Some cases involve efforts to defraud both Medicare and Medicaid, which can require an MFCU to work with the OIG or FBI. Such interagency collaboration has been fostered by the HCFAC program, which has increased funding for federal health care law enforcement efforts. Implementing section 407 of the Ticket to Work and Work Incentives Improvement Act of 1999, which authorized MFCUs to address cases that involve Medicare as well as Medicaid fraud, will also likely necessitate enhanced cooperation between MFCUs and federal law enforcement officials.

[15] Debarred providers cannot participate in New Jersey's Medicaid program for a period generally not to exceed 5 years; providers disqualified for an indefinite period of time cannot apply for reinstatement for a minimum of 8 years.

Nearly all MFCUs responding to our survey reported that they have conducted joint investigations with other organizations in the last 3 years. Most commonly, this involved conducting joint investigations with their state agency, state licensing boards, the OIG, FBI, or a federal task force. Cooperative efforts have led to joint prosecutions. Twenty-seven states reported jointly prosecuting criminal cases with federal attorneys in the previous 3 years—about half doing so at least four times.

Such cooperation can augment state officials' activities. This was demonstrated in California, where members of a task force created by the FBI, the U.S. Attorney's office, the California State Controller's office, the Attorney General's office, and the state Department of Health uncovered numerous fraud and abuse cases in the Los Angeles area. The Controller's staff audited suppliers and referred to the FBI those with insufficient inventories or purchase records to substantiate claims volume. The FBI investigated further and made referrals to the U.S. Attorney. Meanwhile, the governor created a fraud prevention bureau within the state agency that worked closely with on-site FBI agents to investigate provider operations. Once a case was developed, the FBI referred it to the MFCU and U.S. Attorney's office for prosecution.

Some States Have Taken Additional Steps to Enhance Medicaid Program Integrity

During our review, we found that several states—including Georgia, New Jersey, North Carolina, and Texas—have enacted stricter rules or restructured operations to better ensure the integrity of their Medicaid programs. A few examples of their accomplishments follow.

Legislative changes: Some states are enacting health-care-specific criminal and civil legislation—often modeled after federal law. With these statutes, prosecutors no longer must develop cases based on more generic mail fraud, racketeering, theft, or conspiracy statutes. For example, New Jersey enacted the Health Care Claims Fraud Act, which creates the specific crime of health care claims fraud and provides for 10-year prison sentences, fines of up to five times the amount gained through fraud, and professional license revocation.[16] Meanwhile, civil statutes—such as one enacted in North Carolina and other states authorizing action against providers who "knowingly" submit false Medicaid claims for payment—allow prosecutors to take advantage of less stringent evidentiary requirements than those required by criminal statutes.[17]

Restructuring operations: Some states are enhancing their program safeguard operations through restructuring. Texas created an Office of Investigations and Enforcement in 1997 within the state Medicaid agency, giving it power to take administrative actions against providers. These actions cannot be appealed when the Office has tangible evidence of potential fraud, abuse, or waste. It also can impose sanctions and recover improper payments. Meanwhile, Georgia established an MFCU in 1995 that differs from most in that it includes auditors from the state Department of Audits, investigators from the state Bureau of Investigation, and prosecutors from the state Attorney General's office. They work together as a discreet entity under memoranda of understanding signed by the three agencies.

Current Federal Role Focuses on Technical Assistance

HCFA and the OIG—the agencies that are responsible for the Medicaid program at the federal level—are taking steps to promote effective Medicaid program integrity by providing technical help to the states to facilitate states' efforts. These federal agencies also conduct some information gathering on state activities in order to guide state efforts. Many state agency and MFCU officials reported that their agencies had benefited greatly from federal technical assistance, guidance, and training, and would welcome more assistance.

[16] N.J. Stat. Ann. 2C§21-4.3, N.J. Stat. Ann. 2C§51-5.a.(1998).

[17] North Carolina's Medical Assistance Provider False Claims Act was signed into law by the governor July 25, 1997, (N.C. Gen. Stat. §108A-70.10 et seq.).

HCFA Has Increased Efforts to Facilitate State Program Integrity Activities

In 1997, HCFA began a new approach as a facilitator, enabler, and catalyst of states' program integrity efforts. To do so, HCFA established the National Medicaid Fraud and Abuse Initiative, led by staff from HCFA's southern consortium[18] and headquarters, with designated, part-time coordinators for the Initiative in each of HCFA's 10 regional offices. The strategy for the Initiative was to partner with the states and have state representatives work with HCFA staff to set the agenda and goals for the effort. The Initiative provides networking, information sharing, and training opportunities for state agencies and their program integrity partners. Participants in early Initiative meetings identified 10 major focus areas—including payment accuracy measurement, managed care, and information technology. Workgroups are developing recommendations in each area.

The Initiative also includes the Medicaid Fraud and Abuse Control Technical Advisory Group, consisting of HCFA and state officials, which serves as an ongoing forum for

- sharing issues, solutions, resources, and expertise among states;
- advising HCFA on policies, procedures, and program development; and
- making recommendations on federal policy and legislative changes.

The Initiative has resulted in several tangible products and events, including a fraud statute Web site, managed care guidelines, seminars on innovations and obstacles in safeguarding Medicaid, and a technology conference. These efforts are described in table 3.

[18]This comprises the Atlanta and Dallas regional offices.

Table 3: National Medicaid Fraud and Abuse Initiative Activities

State fraud statutes Web site	This Internet site—at *http://fightfraud.hcfa.gov/mfs*—includes a database of state statutes used to combat program fraud and abuse that other states can use as models.
Managed care guidelines	HCFA issued *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*, which includes information on how to identify managed care fraud and abuse, and outlines key components of an effective managed care fraud and abuse control program.
Seminars on innovations and obstacles	HCFA sponsored four regional "executive seminars," attended by program executives from 49 states and other program integrity partners, to discuss innovations and obstacles in safeguarding Medicaid. A report on the findings was published in 1999, and a follow-up "Commitment Conference" was held in the Washington, D. C. area in 2000.
Technology conference	HCFA, with DOJ, cosponsored a conference, *Combating Health Care Fraud & Abuse: Technologies and Approaches for the 21st Century*, to advance understanding of how technological tools such as data mining and neural networks can help detect fraudulent or abusive payments.

Source: GAO.

State Medicaid officials that we spoke with reported that Initiative activities are helping them with their program safeguard efforts by providing important networking, information sharing, and training opportunities. Our survey results indicated that staff from 41 state Medicaid agencies attended Initiative-sponsored training last year, and more than 40 percent of state agencies had staff serve on Initiative panels. In fact, nearly 75 percent of state Medicaid agency survey respondents would like more of the types of assistance HCFA has been providing, including additional

- training;
- technical assistance on use of technology;
- guidance on managed care fraud detection and prevention; and
- information on innovative practices in other states.

According to HCFA and some state officials, this approach has been more effective than previous efforts to guide state activities. Prior to 1997, HCFA reviewed information systems—including state SURS unit activities—through formal "systems performance reviews" of program controls. These controls included those related to payment and program safeguard activities. HCFA could impose penalties on states that failed these reviews, and some HCFA and state officials told us that states found the reviews burdensome. Section 4753 of the Balanced Budget Act of 1997[19] repealed HCFA's authority to conduct such reviews. State and federal officials agree that federal attention to state program protection efforts declined after these mandatory reviews were eliminated. HCFA officials told us that staff in HCFA's regional offices continued to provide some oversight of state efforts, but not in a coordinated way.

However, without a regular review of state activities to address improper payments, HCFA staff had little information with which to guide states where more effective efforts were needed. To get a more comprehensive and systematic view of state antifraud efforts, the regional Initiative coordinators conducted structured site reviews of certain program safeguards in eight states in fiscal year 2000. These reviews examined how state Medicaid agencies identify and address potential fraud or abuse, whether state agencies are complying with appropriate laws and regulations—such as how they check to ensure that only qualified providers participate in the program—and potential areas for improvement. Reviews in another eight states are being conducted in fiscal year 2001. However, these reviews, as with all of HCFA's Initiative endeavors, focus only on state efforts to address potential fraud and abuse; they do not address all of the ways states may be trying to prevent or detect improper payments, and whether these efforts could be improved.

OIG Reviews MFCUs' Reported Activities and Provides Training Opportunities

The OIG initially certifies, and each year recertifies, that MFCUs are complying with federal requirements and are eligible for federal funding.[20] The OIG determines whether an MCFU should be recertified primarily based on reports the MFCUs submit on their activities. The OIG assesses these reports to determine whether each unit has used federal funds

[19] P. L. 105-33.

[20] Initially, HCFA had responsibility for certifying MFCUs and monitoring their activities. In 1979, the responsibility was transferred to the OIG because MFCU activities are more closely related to the OIG's investigative functions.

effectively and has met a set of 12 performance standards. These standards, which the OIG developed in conjunction with the National Association of Medicaid Fraud Control Units, cover areas such as staffing, training, types of cases (whether they constitute potential fraud or physical abuse of beneficiaries), case flow, and monitoring of case outcomes. For example, in the area of staffing, the OIG checks whether an MFCU has the minimum number of staff required. This includes at least one attorney experienced in investigating criminal cases or civil fraud, one experienced auditor capable of supervising financial records reviews and assisting in fraud investigations, and one senior investigator with substantial experience in conducting and supervising criminal investigations.

The OIG may also conduct site visits to observe MFCU operations or provide guidance. Eight MFCUs received such visits in fiscal year 1999. OIG officials said they rarely decertified MFCUs. If decertified, an MFCU can reapply for federal certification when officials believe it will meet the required standards. Such is the case with the District of Columbia's MFCU, which was decertified in 1983 for "lack of productivity." It was recertified in 2000.

The MFCUs generally reported being satisfied with OIG oversight and guidance, but indicated several areas where the OIG could provide more assistance—especially by providing more training. More than 45 percent of MFCUs reported that their staff attended OIG-sponsored training in the past fiscal year. MFCUs also would like the OIG to do the following.

- MFCU officials wanted the OIG to provide more training and assistance in their new authority to address cases that involve both Medicare and Medicaid fraud. Survey respondents were particularly interested in learning more about Medicare program rules, how Medicare claims processing contractors operate, and recent Medicare fraud schemes. They also wanted help in working with HCFA and Medicare claims processing contractors to get timely, online access to Medicare claims data. The OIG has begun to provide training on Medicare related issues.
- MFCUs would like the OIG to increase the number of OIG staff in regions and local areas to increase their participation in joint investigations.

Concluding Observations

Medicaid remains vulnerable to payment error and, while most states are taking steps to address their programs' vulnerabilities, their efforts are uneven. Some states have worked diligently to prevent or detect improper

payments, while others have not been as proactive. The federal government has provided technical assistance and a forum for information exchange for the states, as well as some guidance. Given that states are responsible for administering Medicaid and investigating and prosecuting any fraudulent activities, states must set their own course to ensure the integrity of their Medicaid programs. But the federal government has a responsibility to actively partner with states to ensure that they succeed. In recent years, HCFA and other federal investigative organizations have played a more active role as partners in this endeavor.

Agency Comments and Our Evaluation

We provided draft copies of this report to HHS for comment. HHS officials provided written comments (see appendix III). We also provided excerpts from the draft report that dealt with state activities to states that we had visited. The reviewing officials suggested some technical corrections, which we incorporated into the report where appropriate.

In its written comments, HHS provided information on the Department's most recent efforts to prevent improper payments and to combat fraud and abuse in the Medicaid program. Among other activities, these efforts include a resource guide for states, a summary report of the joint HHS-DOJ technology conference, and a data exchange project between Medicaid and Medicare. HHS highlighted efforts to review program integrity activities in states and indicated that it intends to broaden the scope of the review in future fiscal years. Both the OIG and HCFA have developed training for state officials, including training for MFCU officials on Medicare. Finally, HHS reported that it has established a Web site at *www.hcfa.gov/medicaid/fraud* to provide states with additional technical assistance and guidance in their efforts to prevent and detect improper payments and to address fraud and abuse.

As agreed with your office, unless you announce this report's contents earlier, we plan no further distribution until 30 days after the issue date. We will then send copies to the Honorable Tommy G. Thompson, Secretary of HHS; the Honorable Thomas Scully, Administrator of HCFA; Mr. Michael Mangano, Acting Inspector General; and other interested parties. We will make copies available to others upon request. If you or your staff have any questions about this report, please call me at (312) 220-7600 or Sheila K.

Avruch at (202) 512-7277. Other major contributors to this report were Barrett Bader, Bonnie Brown, Joel Grossman, and Elsie Picyk.

Sincerely yours,

Leslie G. Aronovitz
Director, Health Care—Program
Administration and Integrity Issues

Scope and Methodology

As we developed our work on this report, we focused on the risk of improper Medicaid fee-for-service payments, states' efforts to address improper payments—including efforts to investigate and prosecute fraud—and the guidance and oversight the states are receiving from federal oversight agencies. To do this work, we used information from our surveys, state visits, interviews, and analyses of agency program integrity documents and literature.

To address the risk of improper fee-for-service payments, we reviewed studies that Illinois, Kansas, and Texas have conducted to measure payment accuracy in their Medicaid programs, and we interviewed state officials on the studies' methodologies, findings, and limitations. To gain information on the types of improper billing schemes and other types of fraud cases, we interviewed state officials and reviewed state and HCFA documents. We also used results from our state survey, described below.

To find out about state activities and federal oversight from the states' perspective, we analyzed the results of surveys we sent to the 56 state Medicaid agencies and the 47 federally certified MFCUs then in existence. Fifty-three of the 56 state Medicaid agencies and 46 of the 47 MFCUs responded to our surveys. An additional MFCU in the District of Columbia, which had been decertified in 1983, was recertified in March 2000 after we sent out our survey. To facilitate their answering our questionnaire, we asked respondents, in several questions on the surveys, to base their answers on data from their most recently completed fiscal years, whether state or federal. (See appendix II for copies of our questionnaires and results.)

To supplement the survey analyses, we visited state Medicaid programs and MFCUs in four states: Georgia, New Jersey, Texas, and Washington.[1] We chose these states to provide regional diversity, and because they were among the ones considered by federal officials to be particularly active in efforts to identify and respond to improper payment practices—either through the use of new technology or by other means. Also, by telephone, we interviewed Medicaid, MFCU, and state government officials in other states that have taken steps to strengthen their Medicaid program integrity efforts.

[1] We also conducted an initial visit in Tennessee.

To better understand efforts to control improper payments at the national level, we interviewed officials at HCFA's Central Office and leaders of the agency's National Medicaid Fraud and Abuse Initiative in HCFA's Atlanta and Dallas regional offices, as well as officials at the OIG. To gain a more broad-based perspective on other joint agency investigations and prosecutions, we interviewed representatives of the FBI, the U.S. Attorneys office, and the Civil and Criminal Divisions of DOJ. In addition, we participated in several meetings on control of improper payments, including fraud, which were sponsored by HCFA and others. Finally, we interviewed representatives of provider and supplier groups and technology companies that have developed software that is useful in the detection of improper payments. In addition, we reviewed literature on health care fraud and abuse, including studies by the OIG, HCFA, and others.

We performed our work from September 1999 through April 2001 in accordance with generally accepted government auditing standards.

Aggregated Results From State Medicaid Agency and MFCU Questionnaires

U.S. General Accounting Office

Questionnaire for State Medicaid Agencies

The U.S. General Accounting Office (GAO), an agency of the Congress, is studying states' strategies for preventing, detecting and investigating fraud and abuse in the Medicaid program. As part of this study, we are surveying state Medicaid agencies in the 50 states, the District of Columbia and the U.S territories.

To assist us, we ask that you complete and return this questionnaire to us within the next two weeks. When responding, you may consult with others who are also familiar with these topics, if you think it will help you give a more precise answer. The questionnaire should take less than two hours to complete. For those questions that ask for specific numbers such as cases, dollars, beneficiaries, or percentages, it is not necessary to provide actual numbers. Your best estimate will suffice. The questionnaire asks you to provide information about…

- The Medicaid program in your state,
- The activities state Medicaid agencies engage in to prevent and detect fraud and abuse, including those associated with managed care organizations (MCOs),
- The types of fraud and abuse state Medicaid agencies encounter,
- The relationships between state Medicaid agencies and other state and federal agencies, and
- The practices and technologies state Medicaid agencies are implementing to improve the detection of fraud and abuse.

Please return the questionnaire to us in the enclosed pre-addressed business reply envelope. Alternatively, you may fax your completed questionnaire to us to the attention of Barrett Bader on (202) 512-5805.

If you have any questions about this questionnaire, please call Bonnie Brown on (202) 512-3773 or Barrett Bader on (202) 512-8084. In the event that the business reply envelope is misplaced, or your fax fails to get through, please return the questionnaire to:

U.S. General Accounting Office
Attn: Barrett Bader
441 G Street, N.W., Room 5A14
Washington, DC 20548

Note: This questionnaire was sent to the 56 separate Medicaid programs (including the District of Columbia, Puerto Rico, Virgin Island, Guam, American Samoa & the Northern Marianas). All but three programs returned the questionnaire. However, some did not respond to all the questions. The "N" for each question is the number of respondents who answered that question.

PASTE ID # HERE

Definitions

Fraud is a willful act to deceive for gain.

Abuse is an action that is inconsistent with acceptable business practices.

Managed care involves coordination of the financing and delivery of health care by a central organization, which is usually called a managed care organization (MCO). The MCO, or its providers, must be willing to accept a pre-set payment for services provided, even though the cost of providing those services might, at times, exceed that amount.

1. Please enter the name, title, and telephone number of the person completing this questionnaire.

   _____
   Name

   _____
   Title

   _____
   (Area Code) Number

Medicaid Program

2. In your most recently completed fiscal year (FY), about how many people were enrolled in your state's Medicaid program? (ENTER NUMBER.) **(N=53)**

   _____ people

Range	Mean	Median[1]
5,335-5,060,900	643,214	409,300

[1] Median is the value 50 percent of the responses fall above & 50 percent fall below.

3. Consider all of the payments made, with both state and federal funds, for services received by beneficiaries in your state's Medicaid program in your most recently completed FY. What was the total dollar amount of those payments? (ENTER DOLLARS.) **(N=52)**
$_____

Range	Mean	Median
$3,098,128-28,500,000,000	$3,028,247,362	$1,868,388,863

4. Including both federal and state funds, what was your state Medicaid agency's total administrative budget in your most recently completed FY? (ENTER DOLLARS.) **(N=50)**
$_____

Range	Mean	Median
204,913-1,310,443,000	103,379,319	54,083,006

5. Consider your state Medicaid agency's total administrative budget in your most recently completed FY. About what percentage of that budget was for activities related to controlling fraud and abuse? (ENTER THE PERCENTAGE.) **(N=42)**
_____%

Range	Mean	Median
0-35	5	2

6. Compared to three years ago, has your agency's budget for activities related to controlling fraud and abuse increased, decreased or remained about the same? (CHECK ONE.) **(N=50)**

1. **8** Greatly increased compared to three years ago
2. **15** Somewhat increased compared to three years ago
3. **23** Remained about the same as three years ago
4. **3** Somewhat decreased compared to three years ago
5. **1** Greatly decreased compared to three years ago

7. About how many fee-for-service claims were submitted to your agency in your most recently completed FY? (ENTER NUMBER.) **(N=46)**
_____ fee-for-service claims

Range	Mean	Median
0-200,000,000	30,868,445	17,250,000

8. Were those fee-for-service claims processed by state employees or by a contractor? (CHECK ONE.) **(N=50)**

1. **13** State employees
2. **35** Contractor
3. **2** Both

9. Of those people enrolled in your state's Medicaid program in your most recently completed FY, about what percentage participated in managed care plans? (ENTER THE PERCENTAGE. IF NONE, ENTER "O.") (IF "0," GO TO QUESTION 22 ON PAGE 4.) **(N=51)**
_____% in managed care plans

Range	Mean	Median
0%-100%	37%	41%

10. Consider all of the payments made to Managed Care Organizations (MCOs), with both state and federal funds, for services received by beneficiaries in your state's Medicaid program in your most recently completed FY. What was the total dollar amount of those payments? (ENTER DOLLARS.) **(N=43)**
$_____

Range	Mean	Median
1,129,773-3,689,779,000	444,840,265	216,463,686

11. About how many MCOs did your agency have contracts with in your most recently completed FY? (ENTER NUMBER.) **(N=42)**
_____ MCOs

Range	Mean	Median
1-37	9	5

Activities Related to Managed Care Organizations

12. In your state, which one of the organizations listed below is primarily responsible for identifying cases of possible Medicaid fraud associated with managed care? (CHECK ONE.) **(N=43)**

1. **26** State Medicaid agency
2. **3** Medicaid Fraud Control Unit (MFCU)
3. **12** MCOs
4. **2** Other (PLEASE SPECIFY.)

2 respondents provided comments

13. Do MCOs refer cases of suspected fraud to any state agencies? (CHECK ONE.) **(N=43)**

    1. **3** No (IF "NO," GO TO QUESTION 15.)
    2. **40** Yes

14. To which of the organizations listed below does the MCO refer cases of suspected fraud? (CHECK ONE.) **(N=40)**

    1. **22** State Medicaid agency
    2. **11** Medicaid Fraud Control Unit (MFCU)
    3. **3** Other (PLEASE SPECIFY.)

       5 respondents provided comments

    4. **2** All of the above organizations
    5. **2** State Medicaid agency & MFCU

15. Do your agency's contracts with MCOs require that they have a fraud prevention and detection unit within their organization? (CHECK ONE.) **(N=44)**

    1. **27** No
    2. **17** Yes

16. Does your agency receive encounter data from the managed care plans with which it has contracts? (CHECK ONE.) **(N=44)**

    1. **3** No (IF "NO," GO TO QUESTION 19.)
    2. **41** Yes

17. How often does your agency receive encounter data from the managed care plans with which it has contracts? (CHECK ONE.) **(N=41)**

    1. **0** Less than once a year
    2. **7** One to three times a year
    3. **5** Four to six times a year
    4. **17** Seven to twelve times a year
    5. **12** More than twelve times a year

18. In the space below, please describe how, if at all, your agency verifies the data on patient encounters it receives from managed care plans. Also describe how, if at all, your agency analyzes those data to detect fraud and abuse. **(N=39)**
39 respondents provided comments

19. Does your agency offer incentives to MCOs to encourage them to report suspected cases of fraud to you? (CHECK ONE.) **(N=44)**

1. **41** No
2. **3** Yes→ Please describe these incentives in the space below.

3 respondents provided comments

20. Do any of the contracts your agency has with its MCOs require that the MCO have a training program in Medicaid fraud control for its employees? (CHECK ONE.) **(N=44)**

1. **37** No
2. **7** Yes

21. Does your agency routinely share with the MCOs with which it has contracts information on providers who have become ineligible to receive Medicaid payments? (CHECK ONE.) **(N=44)**

1. **7** No
2. **37** Yes

Fraud and Abuse Units

22. Which, if any, of the units in your agency listed below are responsible for controlling fraud and abuse in the Medicaid program? (CHECK ALL THAT APPLY.) **(N=52)**

1. **44** Surveillance and Utilization Review Subsystems (SURS)
2. **29** Program Integrity Unit
3. **17** Investigations and/or Compliance
4. **13** Other (PLEASE SPECIFY.)

13 respondents provided comments

23. In your most recently completed FY, about how many of your agency's full-time equivalent (FTE) staff were assigned to activities related to controlling fraud and abuse? (ENTER NUMBER.) **(N=53)**
_____ FTE staff

Range	Mean	Median
0-400	32	10

24. Compared to three years ago, has the number of full-time equivalent staff your agency assigned to activities related to controlling fraud and abuse increased, decreased or remained about the same? (CHECK ONE.) **(N=51)**

1. **7** Greatly increased compared to three years ago
2. **13** Somewhat increased compared to three years ago
3. **21** Remained about the same as three years ago
4. **8** Somewhat decreased compared to three years ago
5. **2** Greatly decreased compared to three years ago

25. Which of the types of professionals listed below does your agency employ in activities related to controlling fraud and abuse? (CHECK ALL THAT APPLY.) **(N=51)**

1. **14** Statisticians
2. **36** Analysts
3. **24** Physicians
4. **2** Physician's assistants
5. **45** Registered nurses
6. **28** Investigators
7. **29** Other (PLEASE SPECIFY.)

28 respondents provided comments

Fraud and Abuse Control Activities

26. Including those cases that you referred to the Medicaid Fraud Control Unit, about how many cases of possible fraud and abuse were identified as a result of your agency's efforts to detect fraud and abuse in your most recently completed FY? (ENTER NUMBER.) **(N=51)**
_____ cases

Range	Mean	Median
0-2,288 Cases	415 Cases	119 Cases

27. Of those cases, about what percentage were in each of the categories of possible fraud and abuse listed below? (ENTER THE PERCENTAGES.) **(N=45)**

		Range %	Mean %	Median %
1.	Beneficiary fraud _____%	0-83	10	0
2.	Provider self-referrals _____%	0-11	0	0
3.	Kickbacks to providers who make referrals _____%	0-22	1	0
4.	Misrepresentation of qualifications by providers _____%	0-14	1	0
5.	Inappropriate billing by providers _____%	0-100	74	92
6.	Under-provision of services by MCOs _____%	0-2	0	0
7.	Enrolling Medicaid ineligible or non-existent beneficiaries in medical plans _____%	0-20	1	0
8.	Encouraging patients who frequently use services to leave the plan _____%	All 0's	0	0
9.	Other (PLEASE SPECIFY.) _____%	0-68	13	0

19 respondents provided comments

28. Again, consider the number of cases of possible fraud and abuse that were identified as a result of your agency's efforts to detect fraud and abuse in your most recently completed FY; that is, your answer to Question 26 above.

Of those cases, in about what percentage was the suspected perpetrator each of the types of providers listed below? (ENTER THE PERCENTAGES.) **(N=45)**

		Range %	Mean %	Median %
1.	Physicians _____%	0-81	25	20
2.	Dentists _____%	0-33	8	3
3.	Durable medical equipment, or other suppliers _____%	0-85	9	5
4.	Home Health Agencies _____%	0-61	7	3
5.	Pharmacies _____%	0-58	10	6
6.	Chiropractors _____%	0-8	1	0
7.	Behavioral health providers _____%	0-65	10	4
8.	Non-emergency transportation providers _____%	0-40	7	2
9.	Other (PLEASE SPECIFY.) _____%	0-100	23	20

36 respondents provided comments

29. Listed below are some activities that Medicaid agencies might perform to detect fraud and abuse. Which of these activities does your agency perform? (CHECK ALL THAT APPLY.) **(N=51)**

1. **42** Verifying the qualifications of providers that apply for enrollment in the Medicaid program, that is, "provider enrollment"
2. **38** Conducting pre-payment reviews of claims
3. **50** Conducting post-payment reviews of claims

30. Do representatives of your agency ever meet with individual providers? (CHECK ONE.) **(N=52)**

1. **2** No (IF "NO," GO TO QUESTION 32.)
2. **50** Yes

31. Which, if any, of the topics listed below do representatives from your agency meet with individual providers to discuss? (CHECK ALL THAT APPLY.) **(N=51)**

1. **45** Use of proper codes on claims
2. **45** Changes in Medicaid policy
3. **17** Prevalent types of fraud and their perpetrators
4. **17** Safeguarding providers' and beneficiaries' Medicaid numbers
5. **25** Other (PLEASE SPECIFY.)

25 respondents provided comments

32. Listed below are some areas in which state Medicaid agencies might try to increase beneficiaries' awareness. Which, if any, of these areas are ones in which your agency tries to increase beneficiaries' awareness? (CHECK ALL THAT APPLY.) **(N=48)**

    1. **42** Existence of hotlines
    2. **14** Prevalence of certain types of fraud
    3. **27** Other (PLEASE SPECIFY.)

    26 respondents provided comments

Provider Enrollment/Re-enrollment

33. In total, about how many providers applied to become Medicaid providers in your state over the last three completed fiscal years? (ENTER NUMBER.) **(N=42)**
    _____ providers

Range	Mean	Median
24-117,000	15,747	7,434

34. Consider all those providers who applied to become Medicaid providers in your state over the last three completed fiscal years. About what percentage of those providers became enrolled? About what percentage were denied enrollment? (ENTER THE PERCENTAGES.)

	Range %	Mean %	Median %
a. _____% enrolled **(N=39)**	37-100	91	98
b. _____% denied enrollment **(N=37)**	0-63	6	2

35. Listed below are some factors state Medicaid agencies might consider in determining whether or not a provider is eligible to participate in the Medicaid program. Does your agency check each of these factors in determining whether or not a provider is eligible to participate in the Medicaid program? (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. Licensing status (N=52)	**52**	**0**
2. Criminal record (N=46)	**23**	**23**
3. Whether the provider has been excluded from other federal programs (N=50)	**46**	**4**
4. Whether the provider actually has a site at the address cited (N=48)	**21**	**27**
5. Other (PLEASE SPECIFY.) (N=15)	**15**	

15 respondents provided comments

36. Does your agency ever conduct site visits when a provider initially applies to become enrolled in your state's Medicaid program? (CHECK ONE.) **(N=52)**

1. **33** No (IF "NO," GO TO QUESTION 38.)
2. **19** Yes

37. Does your agency conduct these site visits with all providers or just certain providers? (CHECK ONE.) **(N=19)**

1. **1** All providers
2. **18** Certain providers (PLEASE SPECIFY.)

17 respondents provided comments

38. Once a provider is approved to participate in the Medicaid program, can they participate indefinitely, only for a specific period of time, or does this vary by provider? (CHECK ONE.) **(N=48)**

1. **26** Indefinitely
2. **6** For a specific period of time (PLEASE SPECIFY.)

5 respondents provided comments

3. **16** Varies by provider

39. Does your agency conduct site visits to help determine whether or not providers should remain in the Medicaid program? (CHECK ONE.) **(N=49)**

1. **31** No (IF "NO," GO TO QUESTION 42.)
2. **18** Yes

40. For those site visits, does your agency's staff visit all providers, only certain providers, a random sample of providers, or some other group? (CHECK ONE.) **(N=19)**

1. **2** All providers
2. **10** Only certain providers
3. **1** A random sample of providers
4. **6** Other (PLEASE SPECIFY.)

6 respondents provided comments

41. Overall, on average, about how often does your agency conduct those site visits? (CHECK ONE.) **(N=16)**

1. **1** At the times when the participation period is ending
2. **4** Less than once a year
3. **4** Once a year
4. **1** Twice a year
5. **6** More than twice a year

42. Do you cancel the billing number of providers in your state who have not submitted a bill to Medicaid for a specific period of time? (CHECK ONE.) **(N=52)**

    1. **19** No (IF "NO," GO TO QUESTION 44.)
    2. **33** Yes

43. How much time must elapse before your agency cancels the billing number of an enrolled provider who has not submitted a bill to Medicaid? (CHECK ONE.) **(N=33)**

    1. **1** Less than a year
    2. **15** One year to less than two years
    3. **12** Two years to less than three years
    4. **5** Three years or more

Pre-Payment Claims Review

44. Does your agency conduct pre-payment claims reviews? (CHECK ONE.) **(N=51)**

    1. **10** No (IF "NO," GO TO QUESTION 48 ON THE NEXT PAGE.)
    2. **41** Yes

45. Consider all of the fee-for-service claims that were submitted to your agency in your most recently completed FY. About what percentage of those claims were subjected to pre-payment review by your agency or its contractors? (ENTER THE PERCENTAGE.) **(N=37)**
    _____%

Range	Mean	Median
1-100%	58%	100%

46. Listed below are some dimensions that might be checked to determine whether fee-for-service claims are correct prior to payment. Does your agency, or its contractor, check each of these dimensions to determine whether claims are correct? (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. Mathematical accuracy **(N=39)**	**37**	**2**
2. Correct use of codes **(N=40)**	**39**	**1**
3. Medicaid eligibility of patients **(N=40)**	**38**	**2**

47. Excluding fee-for-service claims rejected for mathematical inaccuracy, consider all the other fee-for-service claims that were found to be in error as a result of pre-payment reviews conducted by your agency in the most recently completed fiscal year.

    About how many dollars, if any, did your agency save the Medicaid program as a result of the detection of those errors? (ENTER DOLLARS.) **(N=15)**
    $_____

Range	Mean	Median
$14,200-1,317,866,084	$192,719,022	$6,818,118

Post-Payment Claims Review

48. Listed below are some activities state Medicaid agencies might engage in after they have identified instances of possible fraud and abuse as a result of conducting post-payment claims reviews. Does your agency engage in each of those activites? (CHECK ONE FOR EACH.)

	Yes (1)	No (2)
1. Interview providers at your agency **(N=42)**	**26**	**16**
2. Conduct focused medical reviews **(N=49)**	**47**	**2**
3. Audit providers **(N=51)**	**49**	**2**
4. Refer cases to the MFCU **(N=48)**	**45**	**3**
5. Other **(N=23)** (PLEASE SPECIFY.)	**23**	

23 respondents provided comments

49. Including those cases that you referred to outside agencies, how many cases of possible fraud and abuse were identified as a result of your agency's post-payment claims review process in your most recently completed FY? (ENTER NUMBER.) **(N=45)**
    _____ cases

Range	Mean	Median
0-3,882 cases	363 cases	66 cases

50. Now, for this question, please exclude those cases that you referred to outside agencies. In your most recently completed FY, about how much money did your agency's post-payment review activities identify as overpayments? (ENTER DOLLARS.) **(N=44)**
$_____

Range	Mean	Median
0-134,000,000	8,128,563	2,500,000

51. About what percentage of that money did your agency recover? (ENTER THE PERCENTAGE.) **(N=39)**
_____%

Range	Mean	Median
0-105%	71%	74%

Coordination with Your State's MFCU

52. Does your state have a Medicaid Fraud Control Unit (MFCU)? (CHECK ONE.) **(N=51)**

1. **4** No (IF "NO," GO TO QUESTION 58, ON THE NEXT PAGE.)
2. **47** Yes

53. Listed below are some criteria that state Medicaid agencies might use to determine which cases to refer to their MFCU. Which, if any, of these criteria does your agency use? (CHECK ALL THAT APPLY.) **(N=47)**

1. **20** Potential fraud resulting in a dollar amount above a certain threshold
2. **42** Clear impression of the intent to commit an impropriety
3. **24** Make a judgement that sufficient evidence could be developed to sustain a conviction
4. **12** Substantial likelihood of recovery
5. **15** Other (PLEASE SPECIFY.)

15 respondents provided comments

54. In your most recently completed FY, about how many cases did your agency refer to the MFCU? (ENTER NUMBER.) **(N=45)**
_____ cases

Range	Mean	Median
1-468 cases	38 cases	15 cases

55. Of those cases, what percentage were accepted by the MFCU, returned for further development, or rejected? (ENTER THE PERCENTAGES.)

	Range %	Mean %	Median %
_____% accepted **(N=42)**	6-100	76	82
_____% returned **(N=40)**	0-88	14	0
_____% rejected **(N=42)**	0-94	10	0

56. Which, if any, of the types of meetings listed below does your agency's staff have with MFCU staff? (CHECK ALL THAT APPLY.) **(N=47)**

1. **46** Meetings to discuss ongoing cases
2. **42** Meetings to discuss new cases
3. **23** Meetings to receive or provide training
4. **11** Other (PLEASE SPECIFY.)

   10 respondent provided comments

5. **0** No meetings with MFCU staff (IF CHECKED, GO TO QUESTION 58.)

57. Overall, on average, how frequently are those meetings with MFCU staff held? (CHECK ONE.) **(N=47)**

1. **0** Less than once a year
2. **8** One to three times a year
3. **7** Four to six times a year
4. **17** Seven to twelve times a year
5. **15** More than twelve times a year

The Health Care Financing Administration (HCFA)

58. In your state's most recently completed FY, did your agency receive any visits from HCFA related to fraud and abuse, or submit any reports on this subject to HCFA? (CHECK ONE.) **(N=53)**

    1. **27** No, neither (IF "NO," GO TO QUESTION 60.)
    2. **9** Yes, received at least one visit, but submitted no reports
    3. **10** Yes, submitted at least one report, but received no visits
    4. **7** Yes, both received at least one visit and submitted at least one report

59. As a result of those interactions, did HCFA ask, or require, your agency to make any modifications to your fraud and abuse activities? (CHECK ONE.) **(N=25)**

    1. **22** No, neither asked for nor required modifications
    2. **2** Yes, asked for modifications
    3. **1** Yes, required modifications

60. In your state's most recently completed FY, did any of your agency's staff attend fraud related training seminars sponsored by HCFA? (CHECK ONE.) **(N=52)**

    1. **11** No
    2. **41** Yes

61. In your state's most recently completed FY, did any of your agency's staff serve as members with HCFA personnel on any anti-fraud technical advisory groups? (CHECK ONE.) **(N=53)**

    1. **30** No
    2. **23** Yes

Improving Fraud Prevention and Detection

62. Is there any additional authority that your agency believes it should have to better protect the integrity of the Medicaid program in your state? (CHECK ONE.) **(N=53)**

    1. **33** No (IF "NO," GO TO QUESTION 64.)
    2. **20** Yes

63. In the space below, please describe that additional authority.

    20 respondents provided comments

64. Is there any way in which HCFA could be of additional help to your state's Medicaid program integrity efforts? (CHECK ONE.) **(N=51)**

    1. **13** No (IF "NO," GO TO QUESTION 66.)
    2. **38** Yes

65. In the space below, please describe how HCFA could be of additional help.

    39 respondents provided comments

66. During the past three years, has your agency recommended that the state legislature enact any legislative changes that you believe would significantly enhance your state's Medicaid program integrity efforts? (CHECK ONE.) **(N=52)**

    1. **31** No (IF "NO," GO TO QUESTION 68.)
    2. **21** Yes

67. Please describe in the space below those recommended changes and the extent to which they have been enacted.

    21 respondents provided comments

68. Are there any changes in federal regulations or mandates that you believe would significantly enhance your state's Medicaid program integrity efforts? (CHECK ONE.) **(N=50)**

    1. **22** No (IF "NO," GO TO QUESTION 70.)
    2. **28** Yes

69. In the space below, please describe those changes.

    28 respondents provided comments

70. Consider the responsibility your agency has for preventing and detecting fraud and abuse in the Medicaid program in your state. In your opinion, is the total amount of funding available to your agency for those purposes more than adequate, adequate, or less than adequate? (CHECK ONE.) **(N=53)**

    1. **0** Much more than adequate
    2. **0** More than adequate
    3. **19** Adequate
    4. **25** Less than adequate
    5. **9** Much less than adequate

    (IF YOU ANSWERED "MUCH MORE THAN ADEQUATE," "MORE THAN ADEQUATE," OR "ADEQUATE," PLEASE GO TO QUESTION 72.)

71. If your agency were to receive additional funding for preventing and detecting fraud and abuse, would you be most likely to spend those funds on purchasing computer hardware and software, hiring new staff, or providing training for existing staff? (CHECK ONE.) **(N=30)**

    1. **10** Buying computer hardware or software
    2. **16** Hiring new staff
    3. **1** Providing training for existing staff
    4. **1** Other (PLEASE SPECIFY.)

       1 respondents provided comments

    5. **2** Hiring new staff & providing training for existing staff

72. Which of the factors listed below would be the **most** helpful in enhancing the effectiveness of your agency? (CHECK ONE.) **(N=52)**

    1. **3** State legislative changes
    2. **8** Changes in federal regulations and mandates
    3. **38** Increased funding
    4. **2** Changes in federal regulations & mandates plus increase funding
    5. **1** State legislative changes & changes in federal regulations & mandates

Technology

73. Does your agency use computer software to conduct pre-payment reviews? (CHECK ONE.) **(N=51)**

    1. **23** No (IF "NO," GO TO QUESTION 79 ON THE NEXT PAGE.)
    2. **28** Yes

74. Does your agency use some types of software more often than others to conduct pre-payment reviews? By types of software we mean commercial products such as Word, Excel, Access, SPSS, or MEDSTAT, etc., as well as any software your agency might have developed. (CHECK ONE.) **(N=26)**

    1. **5** No (IF "NO," GO TO QUESTION 79 ON THE NEXT PAGE.)
    2. **21** Yes

75. What is the name of the type of software your agency uses most often to conduct pre-payment reviews? (ENTER NAME.)

    20 respondents provided comments

76. In what year did your agency acquire that software? (ENTER YEAR.) **(N=21)**
    19____

1978-1980	1981-1985	1986-1990	1991-1995	1996-2000
3	1	3	7	7

77. Was the software you named in Question 75 developed in-house, by a contractor, or purchased off the shelf? (CHECK ONE.) **(N=23)**

    1. **3** In-house
    2. **15** By a contractor
    3. **5** Purchased off the shelf

78. How satisfied are you with the software you named in Question 75 on page 11? (CHECK ONE.) **(N=21)**

    1. **7** Very satisfied
    2. **10** Somewhat satisfied
    3. **3** As satisfied as dissatisfied
    4. **0** Somewhat dissatisfied
    5. **1** Very dissatisfied

79. Does your agency use computer software to conduct post-payment reviews? (CHECK ONE.) **(N=50)**

    1. **8** No (IF "NO," GO TO QUESTION 88 ON THE NEXT PAGE.)
    2. **42** Yes

80. Does your agency use some types of software more often than others to conduct post-payment reviews? By types of software we mean commercial products such as Word, Excel, Access, SPSS, or MEDSTAT, etc., as well as any software your agency might have developed. (CHECK ONE.) **(N=43)**

    1. **4** No (IF "NO," GO TO QUESTION 88 ON THE NEXT PAGE)
    2. **39** Yes

81. What is the name of the type of software your unit uses most often to conduct post-payment reviews? (ENTER NAME.)

    38 respondents provided comments

82. In what year did your agency acquire that software? (ENTER YEAR.) **(N=33)**
    19____

1978-1980	1981-1985	1986-1990	1991-1995	1996-2000
1	2	0	11	19

83. Was the software you named in Question 81 developed in-house, by a contractor, or purchased off the shelf? (CHECK ONE.) **(N=37)**

    1. **5** In-house
    2. **16** By a contractor
    3. **16** Purchased off the shelf

84. How satisfied are you with the software you named in Question 81? (CHECK ONE.) **(N=37)**

    1. **12** Very satisfied
    2. **16** Somewhat satisfied
    3. **4** As satisfied as dissatisfied
    4. **2** Somewhat dissatisfied
    5. **3** Very dissatisfied

85. Does your agency want to update the software you named in Question 81? (CHECK ONE.) **(N=38)**

    1. **11** No (IF "NO," GO TO QUESTION 88 ON THE NEXT PAGE.)
    2. **27** Yes

86. How likely is it that your agency in the near future will be able to update the software package it uses most often to conduct post-payment claims reviews? (CHECK ONE.) **(N=27)**

    1. **14** Very likely
    2. **7** Somewhat likely
    3. **4** As likely as unlikely
    4. **1** Somewhat unlikely
    5. **1** Very unlikely

(IF YOU ANSWERED "VERY LIKELY "SOMEWHAT LIKELY OR "AS LIKELY AS UNLIKELY," PLEASE GO TO QUESTION 88 ON THE NEXT PAGE.)

87. Listed below are some possible reasons why state Medicaid agencies might be unlikely to update the computer software they use to conduct post-payment claims reviews. Is each, a major reason, a minor reason, or not a reason, why your unit is unlikely to update the software package it uses to conduct post-payment claims reviews? (CHECK ONE FOR EACH) **(N=2)**

	Major reason (1)	Minor reason (2)	Not a reason (3)
1. Lack of state funding	**2**	**0**	**0**
2. Lack of information about software	**0**	**1**	**1**
3. Lack of qualified personnel to operate or maintain the new software	**0**	**2**	**0**
4. Resistance from management	**1**	**0**	**1**

88. Which, if any, of the technologies listed below does your agency use to determine if individuals are eligible for Medicaid services? (CHECK ALL THAT APPLY.) **(N=51)**

1. **22** Electronic cards for beneficiaries
2. **40** Pharmacy edit screens, that is, drug utilization review
3. **38** Instant on-line beneficiary eligibility information for providers
4. **13** Other (PLEASE SPECIFY.)

13 respondents provided comments

Sharing Practices

89. In the past three years, have you adopted any practices from another state to enhance your agency's program integrity efforts? (CHECK ONE.) **(N=52)**

1. **42** No (IF "NO" GO TO QUESTION 91 ON THE NEXT PAGE.)
2. **10** Yes

90. Please tell us in the space below what the practices were and from which states they were adopted.

10 respondents provided comments

91. During the past three years, has your agency developed any practices that you believe would enhance other state Medicaid agencies' program integrity efforts? (CHECK ONE.) **(N=48)**

1. **27** No (IF "NO," GO TO QUESTION 93.)
2. **21** Yes

92. In the space below, please describe those practices.

24 respondents provided comments

93. If you have any other comments about the topics discussed in this questionnaire, please write them below.

13 respondents provided comments

Thank you for your cooperation.

U.S. General Accounting Office

Questionnaire for Medicaid Fraud Control Units

The U.S. General Accounting Office (GAO), an agency of the Congress, is studying states' strategies for preventing, detecting and investigating fraud and abuse in the Medicaid program. As part of this study, we are surveying Medicaid Fraud Control Units (MFCUs) in the 47 states that have one.

To assist us, we ask that you complete and return this questionnaire to us within the next two weeks. When responding, you may consult with others who are also familiar with these topics, if you think it will help you give a more precise answer. The questionnaire should take less than two hours to complete. For those questions that ask for specific numbers such as cases, dollars, or percentages, it is not necessary to provide actual numbers. Your best estimate will suffice. The questionnaire asks you to provide information about…

- Your unit and its activities,
- The relationships between your unit and other federal and state agencies,
- The results of your unit's investigations,
- The types of fraud and abuse your unit encounters,
- Federal agency oversight and guidance, and
- The steps your unit is taking to improve Medicaid fraud and abuse control.

Please return the questionnaire to us in the enclosed pre-addressed business reply envelope. Alternatively, you may fax your completed questionnaire to us to the attention of Barrett Bader on (202) 512-5805.

If you have any questions about this questionnaire, please call Bonnie Brown on (202) 512-3773 or Barrett Bader on (202) 512-8084. In the event that the business reply envelope is misplaced, or your fax fails to get through, please return the questionnaire to:

U.S. General Accounting Office
Attn: Barrett Bader
441 G Street, N.W., Room 5A14
Washington, DC 20548

Note: This questionnaire was sent to the 47 Medicaid Fraud Control Unit directors (the District of Columbia unit had not been certified at the time of questionnaire mailing). All but one unit returned the questionnaire. However, some did not respond to all the questions. The "N" for each question is the number of respondents who answered that question.

PASTE ID # HERE

Definitions

Fraud is a willful act to deceive for gain.

Abuse is an action that is inconsistent with acceptable business practices.

Patient Abuse involves adverse actions of either a physical, psychological, or financial nature inflicted upon a patient. Either individuals or institutions can be responsible for these actions.

Managed care involves coordination of the financing and delivery of health care by a central organization, which is usually called a managed care organization (MCO). The MCO, or its providers, must be willing to accept a pre-set payment for services provided, even though the cost of providing those services might, at times, exceed that amount.

2. Please enter the name, title, and telephone number of the person completing this questionnaire.

_____
Name

_____
Title

_____
(Area Code) Number

Unit Information

2. In what year was your unit certified? (ENTER YEAR.) **(N=46)**
19_____

1978-1980	1981-1985	1986-1990	1991-1995	1996-2000
24	9	4	7	2

3. Is your unit a separate agency or is it part of a larger agency or department? (CHECK ONE.) **(N=46)**

   1. **0** Separate agency (IF "CHECKED," GO TO QUESTION 5.)

   2. **46** Part of a larger agency or department

4. Which agency or department is your unit a part of? (ENTER NAME.) **(N=46)**

   46 respondents provided comments

5. Including both federal and state funds, what was your unit's total operating budget in your most recently completed fiscal year (FY)? (ENTER DOLLARS.) **(N=45)**
   $_____

Range	Mean	Median[1]
$278,935-29,609,200	$2,358,042	$1,189,680

6. Compared to three years ago, has your unit's operating budget increased, decreased or remained the same? (CHECK ONE.) **(N=46)**

   1. **4** Greatly increased compared to three years ago

   2. **27** Somewhat increased compared to three years ago

   3. **11** Remained about the same as three years ago

   4. **4** Somewhat decreased compared to three years ago

   5. **0** Greatly decreased compared to three years ago

7. For the current FY, about how many full-time equivalent (FTE) staff are assigned to your unit? (ENTER NUMBER.) **(N=46)**
   _____ FTE staff

Range	Mean	Median
4-292 staff	29 staff	16 staff

[1] Median is the value 50 percent of the responses fall above & 50 percent fall below.

8. About how many of those staff are in each of the categories of professionals listed below? (ENTER NUMBERS.)

		N	Range	Mean	Median
1. ____	Investigators who are law enforcement officers	36	0- 89	12	6
2. ____	Other investigators	23	0- 42	9	6
3. ____	Attorneys	46	1- 43	5	3
4. ____	Auditors	45	1- 89	4	2
5. ____	Data analysts	23	0-6	1	1
6. ____	Medical professionals	17	0-2	1	1
7. ____	Other (PLEASE SPECIFY.)	40	1-77	6	3

39 respondents provided comments

9. Compared to three years ago, has the number of full-time equivalent staff assigned to your unit increased, decreased or remained the same? (CHECK ONE.) **(N=46)**

1. **4** Greatly increased compared to three years ago
2. **17** Somewhat increased compared to three years ago
3. **23** Remained about the same as three years ago
4. **1** Somewhat decreased compared to three years ago
5. **1** Greatly decreased compared to three years ago

Unit Activities

10. Does your unit have a hotline? (CHECK ONE.) **(N=46)**

1. **29** No
2. **17** Yes

11. Listed below are some types of information that might help MFCUs investigate possible fraud and abuse. Which, if any, of these types of information does your unit have access to? (CHECK ALL THAT APPLY.) **(N=46)**

1. **46** Medicaid claims data
2. **12** Medicare claims data
3. **45** A list of providers who have been exluded from participation in Medicaid
4. **32** A list of providers who have been exluded from participation in Medicare
5. **17** Other information that might help (PLEASE SPECIFY.)

12. Which, if any, of the mechanisms listed below does your unit use to disseminate information to beneficiaries on fraud and abuse schemes and the providers who perpetrate them? (CHECK ALL THAT APPLY.) **(N=46)**

    1. **6** Newsletters
    2. **4** Bulletins posted in Medicaid or welfare enrollment offices
    3. **15** Postings on your unit's Web site
    4. **24** Alerts released to the media
    5. **21** Other (PLEASE SPECIFY.)

       20 respondents provided comments

    6. **10** None of the above

13. In your most recently completed fiscal year, about how many referrals for investigation did your unit receive? (ENTER NUMBER.) **(N=45)**
    _____ referrals

Range	Mean	Median
11-19,849 referrals	819 referrals	143 referrals

14. For about what percentage of those referrals did your unit conduct an investigation? (ENTER THE PERCENTAGE.) **(N=44)**
    _____%

Range	Mean	Median
1-100%	53%	54%

15. Regardless of whether the cases originated from referrals or in some other way, about how many new cases did your unit open in your most recently completed fiscal year? (ENTER NUMBER.) **(N=46)**
    _____ cases

Range	Mean	Median
9-1,042 cases	124 cases	55 cases

16. Over the last three years, has the total number of cases opened by your unit increased, decreased or remained the about same? (CHECK ONE.) **(N=46)**

    1. **26** Increased
    2. **5** Decreased
    3. **15** Remained about the same

17. Consider those cases your unit opened on the basis of referrals in your most recently completed fiscal year. About what percentage of those cases were referred to you by each of the entities listed below? (ENTER THE PERCENTAGES.) **(for1-10, N=44); (for 11, N=41)**

	Range %	Mean %	Median %
1. ____% State Medicaid agency	0-98	36	30
2. ____% Law enforcement agencies	0-31	6	2
3. ____% Federal prosecutors	0-25	3	1
4. ____% State prosecutors	0-18	1	0
5. ____% Local prosecutors	0-5	1	0
6. ____% Managed Care Organizations (MCOs)	0-7	0	0
7. ____% Offices of Inspector General	0-37	4	1
8. ____% Federal task forces	0-35	3	0
9. ____% State professional licensing boards	0-20	4	1
10. ____% Hotlines	0-50	8	0
11. ____% Other (PLEASE SPECIFY.)	2-88	36	30

41 respondents provided comments

18. Again, consider those cases your unit opened on the basis of referrals in your most recently completed fiscal year. About what percentage of those cases involved fraud associated with managed care? (ENTER THE PERCENTAGE.) **(N=46)**
_____%

Range	Mean	Median
0-100%	6%	0%

19. Now, consider your answer to Question 18 on the preceding page. About what percentage of those cases were referred to you by each of the entities listed below? (ENTER THE PERCENTAGES.) **(for 1-11, N=17); (for 12, N=10)**

	Range %	Mean %	Median %
1. ____% State Medicaid agency	0-100	24	0
2. ____% Law enforcement agencies	0-30	3	0
3. ____% Federal prosecutors	0-45	3	0
4. ____% State prosecutors	0-38	2	0
5. ____% Local prosecutors	All 0's	0	0
6. ____% Employees of the identified provider	0-100	9	0
7. ____% Offices of Inspector General	0-100	10	0
8. ____% Federal task forces	All 0's	0	0
9. ____% State professional licensing boards	0-20	1	0
10. ____% Managed Care Organizations (MCOs)	0-100	17	0
11. ____% Hotlines	0-75	8	0
12. ____% Other (PLEASE SPECIFY.)	0-100	29	18

9 respondents provided comments

20. Does the potential monetary recovery from an investigation have to reach a certain dollar amount before your agency opens that investigation? (CHECK ONE.) **(N=46)**

1. **43** No (IF "NO," GO TO QUESTION 22.)
2. **3** Yes

21. What is this dollar amount? **(N=3)**
$_____

Range	Mean	Median
$500-20,000	$7,833	$3,000

22. Does your unit have subpoena power? (CHECK ONE.) **(N=46)**

    1. **36** Yes
    2. **10** No

23. Does your unit prosecute its own cases or does it refer cases to another organization for prosecution? (CHECK ONE.) **(N=46)**

    1. **36** Prosecutes its own cases
    2. **6** Refers cases to another organization (PLEASE SPECIFY THE ORGANIZATION AND THEN GO TO QUESTION 27 ON THE NEXT PAGE.)

       12 respondents provided comments

    3. **4** Both

24. Can your unit prosecute statewide or only in specific locations? (CHECK ONE.) **(N=42)**

    1. **40** Statewide
    2. **2** Only in specific locations

25. Over the last three years, have attorneys from your unit ever jointly prosecuted criminal cases with federal attorneys? (CHECK ONE.) **(N=43)**

    1. **16** No (IF "NO," GO TO QUESTION 27 ON THE NEXT PAGE.)
    2. **27** Yes

26. Over the last three years, how many times did attorneys from your unit jointly prosecute criminal cases with federal attorneys? (CHECK ONE.) **(N=27)**

    1. **14** 1 to 3 times
    2. **6** 4 to 6 times
    3. **2** 7 to 9 times
    4. **5** 10 or more times

Coordination with Other Agencies

27. Does your unit ever refer cases to each of the organizations listed below for whatever degree of investigation that organization might wish to pursue? (CHECK ONE FOR EACH.) **(N=46)**

	Yes (1)	No (2)
1. State Medicaid agency	**45**	**1**
2. Federal agencies such as the Health and Human Services Department's Office of Inspector General (OIG) or the Federal Bureau of Investigation (FBI)	**46**	**0**
3. State professional licensing boards	**45**	**0**
6. Other (PLEASE SPECIFY.)	**26**	

25 respondents provided comments

28. Over the last three years, did your unit ever conduct joint investigations with other organizations? (CHECK ONE.) **(N= 44)**

    1. **0** No (IF "NO," GO TO QUESTION 30 ON THE NEXT PAGE.)
    2. **44** Yes

29. Over the last three years, about how many joint investigations did your unit conduct with each of the organizations listed below? (CHECK ONE FOR EACH.)

	10 or more (1)	7 - 9 (2)	4 - 6 (3)	1 - 3 (4)
1. State Medicaid agency **(N=30)**	14	3	4	9
2. Managed Care Organization **(N=13)**	2	1	2	8
3. HHS' OIG **(N=41)**	14	4	6	17
4. FBI **(N=45)**	16	2	11	16
5. State professional licensing boards **(N=28)**	5	3	8	12
6. Federal task force **(N=32)**	11	3	7	11
7. Other (PLEASE SPECIFY.) **(N=24)** **24 respondents provided comments**	9	2	3	10

30. Overall, on average, how frequently, if at all, do members of your staff meet with members of the Medicaid state agency's staff? (CHECK ONE.) **(N=46)**

    6. **0** Not at all (IF CHECKED, GO TO QUESTION 32.)
    7. **0** Less than once a year
    8. **3** One to three times a year
    9. **6** Four to six times a year
    10. **6** Seven to twelve times a year
    11. **31** More than twelve times a year

31. Which, if any, of the types of meetings listed below does your unit's staff have with Medicaid state agency staff? (CHECK ALL THAT APPLY.) **(N=46)**

    1. **43** Meetings to discuss new cases
    2. **46** Meetings to discuss ongoing cases
    3. **37** Meetings to receive or provide training
    4. **19** Other (PLEASE SPECIFY.)

    15 respondents provided comments

32. In your most recently completed FY, did any of the beneficiaries enrolled in your state's Medicaid program participate in managed care plans? (CHECK ONE.) **(N=46)**

    1. **8** No (IF "NO," GO TO QUESTION 36 ON THE NEXT PAGE.)
    2. **38** Yes

33. Overall, on average, how frequently, if at all, do members of your staff meet with members of Managed Care Organizations' (MCOs) staffs to discuss issues related to fraud control? (CHECK ONE.) **(N=41)**

    1. **17** Not at all (IF CHECKED, GO TO QUESTION 35.)
    2. **6** Less than once a year
    3. **12** One to three times a year
    4. **1** Four to six times a year
    5. **2** Seven to twelve times a year
    6. **3** More than twelve times a year

34. Which, if any, of the types of meetings listed below does your unit's staff have with staff from MCOs who are involved in Medicaid fraud control? (CHECK ALL THAT APPLY.) **(N=23)**

1. **12** Meetings to discuss new cases
2. **12** Meetings to discuss ongoing cases
3. **14** Meetings to receive or provide training
4. **6** Other (PLEASE SPECIFY.)

7 respondents provided comments

35. How easy or difficult is it for your agency's staff to obtain provider records and other data from MCOs? (CHECK ONE.) **(N=31)**

1. **4** Very easy
2. **4** Somewhat easy
3. **5** As easy as difficult
4. **7** Somewhat difficult
5. **11** Very difficult

Results of the Fraud Investigations

36. Over the past three years, about how many cases that had been opened by your unit have resulted in each of the outcomes listed below? (ENTER NUMBERS.)

	N	Range	Mean	Median
1. Convictions on criminal charges, including those resulting from plea bargains	45	1-357	39	21
2. Acquittals on criminal charges	26	0-46	4	2
3. Discontinuation of investigation	40	0-929	111	60
4. Settlements	42	2-121	23	14
5. Other (PLEASE SPECIFY.)	13	2-35	9	4

16 respondents provided comments

37. In your most recently completed fiscal year, about how much money has your unit recovered as a result of settlements, restitution and fines combined? (ENTER DOLLARS.) **(N=46)**
$_____

Range	Mean	Median
$10,529-14,000,000	$2,112,766	$862,774

38. Does your unit have the authority to bring a civil case in those instances in which it lacks sufficient evidence for a criminal conviction? (CHECK ONE.) **(N=45)**

1. **9** No (IF "NO," GO TO QUESTION 40.)
2. **36** Yes

39. Over the last three years, about how many civil cases did your unit bring? (ENTER NUMBER.) **(N=35)**
_____ cases

Range	Mean	Median
0-96	16	4

Types and Sources of Fraud and Abuse

40. Consider the cases that resulted in settlements, restitution and criminal convictions during the past three years. About what percentage of those cases involved each of the categories of fraud and abuse listed below? (ENTER THE PERCENTAGES.) **(for 1-7, N=43); (for 8, N-19)**

	Range %	Mean %	Median %
1. _____% Provider self-referrals	0-15	1	0
2. _____% Inappropriate billing by providers	14-100	77	80
3. _____% Provider misrepresentation of qualifications	0-40	4	0
4. _____% Under-provision of services by MCOs	0-5	0	0
5. _____% Enrolling Medicaid ineligible or non-existent patients in medical plans	0-15	0	0
6. _____% Encouraging patients who are frequent users to disenroll	All 0's	0	0
7. _____% False cost reports	0-35	3	0
8. _____% Other (PLEASE SPECIFY.)	0-86	33	28

19 respondents provided comments

41. Of the cases that resulted in settlements, restitution and criminal convictions during the past three years, about what percent involved each of the categories of provider listed below? (ENTER THE PERCENTAGES.) **(for 1-8, N=44); (for 9, N=38)**

	Range %	Mean %	Median %
1. _____% Physicians	0-50	14	10
2. _____% Dentists	0-46	7	4
3. _____% Durable medical equipment or other suppliers	0-48	7	5
4. _____% Home Health Agencies	0-65	6	1
5. _____% Pharmacies	0-53	9	7
6. _____% Chiropractors	0-30	2	0
7. _____% Non-emergency transportation providers	0-79	10	2
8. _____% Behavioral health providers	0-35	6	3
9. _____% Other (PLEASE SPECIFY.)	8-91	45	50

39 respondents provided comments

42. Consider the cases involving MCOs that resulted in settlements, restitution and criminal convictions during the past three years. About what percentage of those cases involved each of the categories of fraud and abuse listed below? If none of your Medicaid patients are enrolled in managed care plans, please check "not applicable." (ENTER THE PERCENTAGES.) **(for 1-6, N=3); (for 7, N=2)**

30 Not applicable

OR

	Range %	Mean %	Median %
1. _____% Falsifying data on the number of patient encounters with providers →	All 0's	0	0
2. _____% Failing to report complaints and grievances →	All 0's	0	0
3. _____% Not reporting cases of suspected fraud →	All 0's	0	0
4. _____% Under-provision of services by MCOs →	All 0's	0	0
5. _____% Enrolling Medicaid ineligible or non-existent beneficiaries in medical plans →	0-100	33	0
6. _____% Encouraging patients who are frequent users to disenroll →	All 0's	0	0
7. _____% Other (PLEASE SPECIFY.) →	Both 100	100	100

2 respondents provided comments

Patient Abuse

43. Does your unit investigate allegations of physical or financial abuse of Medicaid patients? (CHECK ONE.) **(N=46)**

1. **1** No (IF "NO," GO TO QUESTION 48 ON THE NEXT PAGE.)
2. **45** Yes

44. During your most recently completed fiscal year, about how many investigations of each of the kinds of abuse listed below did your unit initiate? (ENTER NUMBERS.) **(N=43)**

	Range	Mean	Median
1. _____ Physical abuse investigations →	0-2,536	126	30
2. _____ Financial abuse investigations →	0-89	12	5

45. About what percent of the allegations of patient abuse received by your unit during your most recently completed fiscal year came from each of the sources listed below? (ENTER THE PERCENTAGES.) **(for 1-6; N=44) (for 7; N=18)**

	Range %	Mean %	Median %
1. _____% Other state agencies	0-100	75	85
2. _____% Patients or their relatives	0-83	11	2
3. _____% Law enforcement agencies	0-50	5	1
4. _____% Employees of the provider involved	0-90	4	0
5. _____% Competitors of the provider involved	0-1	0	0
6. _____% TV or other media	0-17	1	0
7. _____% Other (PLEASE SPECIFY.)	0-38	9	5

15 respondents provided comments

46. About what percentage of the allegations of physical abuse of patients investigated by your unit during your most recently completed FY were substantiated? About what percentage were unsubstantiated? About what percentage are still under investigation? (ENTER THE PERCENTAGES.) **(N=40)**

	Range %	Mean %	Median %
_____% substantiated	0-80	21	18
_____% unsubstantiated	0-100	51	51
_____% still under investigation	0-100	28	26

47. About what percentage of the allegations of financial abuse of patients investigated by your unit during your most recently completed FY were substantiated? About what percentage were unsubstantiated? About what percentage are still under investigation? (ENTER THE PERCENTAGES.) **(N=38)**

	Range %	Mean %	Median %
_____% substantiated	0-100	30	25
_____% unsubstantiated	0-100	38	29
_____% still under investigation	0-100	33	24

Federal Agency Oversight and Guidance

48. In your state's most recently completed fiscal year, did your unit receive any visits from the Office of Inspector General (OIG) of the Department of Health and Human Service (HHS)? (CHECK ONE.) **(N=46)**

    1. **38** No (IF "NO," GO TO QUESTION 50.)
    2. **8** Yes

49. As a result of those visits, did the OIG ask, or require, your unit to make any modifications to your fraud and abuse activities? (CHECK ONE.) **(N=8)**

    4. **7** No, neither
    5. **0** Yes, asked for modifications only
    6. **1** Yes, required modifications

50. In your most recently completed FY year, did your unit's staff members attend any training seminars sponsored by the OIG? (CHECK ONE.) **(N=46)**

    1. **25** No
    2. **21** Yes

51. Is there any way in which the OIG could be of additional help to your unit's fraud control efforts? **(N=44)**

    1. **19** No
    2. **25** Yes (IF "YES," PLEASE DESCRIBE HOW.)

    25 respondents provided comments

Technology

52. Does your unit use computer software to develop fraud cases? (CHECK ONE.) **(N=45)**

    1. **6** No (IF "NO," GO TO QUESTION 61 ON PAGE 11.)
    2. **39** Yes

53. Does your unit use some types of software more often than others to develop fraud cases? By types of software we mean commercial products such as Word, Excel, Access, SPSS or MEDSTAT, etc., as well as any software your unit might have developed. (CHECK ONE.) **(N=40)**

    2. **1** No (IF "NO," GO TO QUESTION 61 ON PAGE 11.)
    3. **39** Yes

54. What is the name of the type of software your unit uses most often to develop fraud cases? (ENTER NAME.)

    38 respondents provided comments

55. In what year did your agency acquire that software? (ENTER YEAR.) **(N=35)**
    19_____

1989-1991	1992-1994	1995-1997	1998-2000
5	4	13	13

56. Was the software you named in Question 54 developed in-house, by a contractor, or purchased off the shelf? (CHECK ONE.) **(N=38)**

    1. **2** In-house
    2. **7** By a contractor
    3. **29** Purchased off the shelf

57. How satisfied are you with the software you named in Question 54? (CHECK ONE.) **(N=30)**

    1. **11** Very satisfied
    2. **18** Somewhat satisfied
    3. **1** As satisfied as dissatisfied
    4. **0** Somewhat dissatisfied
    5. **0** Very dissatisfied

58. Does your unit want to update the software it uses to develop fraud cases? (CHECK ONE.) **(N=31)**

    1. **1** No (IF "NO," GO TO QUESTION 61 ON THE NEXT PAGE.)
    2. **30** Yes

59. How likely is it that in the near future your unit will be able to update the software it uses to develop fraud cases? (CHECK ONE.) **(N=31)**

    6. **12** Very likely
    7. **14** Somewhat likely
    8. **1** As likely as unlikely
    9. **4** Somewhat unlikely
    10. **0** Very unlikely

(IF YOU ANSWERED "VERY LIKELY "SOMEWHAT LIKELY OR "AS LIKELY AS UNLIKELY," PLEASE GO TO QUESTION 61 ON THE NEXT PAGE.)

60. Listed below are some possible reasons why MFCUs might be unlikely to update the computer software they use to develop fraud cases. Is each, a major reason, a minor reason, or not a reason, why your unit is unlikely to update the software it uses to develop fraud cases? (CHECK ONE FOR EACH.) **(N=5)**

	Major reason (1)	Minor reason (2)	Not a reason (3)
5. Lack of state funding	**2**	**2**	**1**
6. Lack of information about software	**2**	**2**	**1**
7. Lack of qualified personnel to operate or maintain the new software	**2**	**2**	**1**
8. Resistance from management	**1**	**1**	**3**

Improving Fraud Control

61. During the past three years, has your unit recommended any policy changes to the State Medicaid agency? (CHECK ONE.) **(N=46)**

    1. **8** No (IF "NO," GO TO QUESTION 63.)

    2. **38** Yes

62. Please describe in the space below those changes and the extent to which they have been implemented.

    37 respondents provided comments

63. During the past three years has your unit recommended any legislative changes to be acted upon by your state legislature? (CHECK ONE.) **(N=46)**

    3. **10** No (IF "NO," GO TO QUESTION 65.)

    4. **36** Yes

64. In the space below, please describe those changes and the extent to which they have been enacted.

    35 respondents provided comments

65. Are there any actions that you think the state Medicaid agency should take to better control fraud and abuse? (CHECK ONE.) **(N=45)**

    1. **4** No (IF "NO," GO TO QUESTION 67 ON THE NEXT PAGE.)

    2. **41** Yes

66. In the space below, please list those actions.

    39 respondents provided comments

67. Are there any additional capabilities, analytical or investigative tools, or authorities that you believe would significantly enhance the effectiveness of your unit? (CHECK ONE.) **(N=43)**

    1. **13** No (IF "NO," GO TO QUESTION 69.)

    2. **30** Yes

68. Please list those capabilities, tools or authorities in the space below.

    31 respondents provided comments

69. Are there any changes in federal regulations or mandates that you believe would significantly enhance the effectiveness of your unit? (CHECK ONE.) **(N=45)**

    3. **22** No (IF "NO," GO TO QUESTION 71.)

    4. **23** Yes

70. In the space below, please describe those changes.

    23 respondents provided comments

71. Consider the responsibility your unit has for controlling fraud and abuse in the Medicaid program in your state. In your opinion, is the total amount of funding available to your unit for those purposes more than adequate, adequate, or less than adequate? **(N=44)**

    6. **0** Much more than adequate

    7. **0** More than adequate

    8. **20** Adequate

    9. **16** Less than adequate

    10. **8** Much less than adequate

    (IF YOU ANSWERED "MUCH MORE THAN ADEQUATE," "MORE THAN ADEQUATE," OR "ADEQUATE," PLEASE GO TO QUESTION 73 ON THE NEXT PAGE.)

72. If your unit were to receive additional funding for controlling fraud and abuse, would you be most likely to spend those funds on buying computer hardware and software, hiring new staff, or providing training for existing staff? (CHECK ONE.) **(N=26)**

    5. **1** Buy computer hardware or software

    6. **23** Hire new staff

    7. **2** Provide training for existing staff

    8. **0** Other (PLEASE SPECIFY.)

    2 respondents provided comments

73. Which of the factors listed below would be the **most** helpful in enhancing the effectiveness of your unit? (CHECK ONE.) **(N=45)**

    6. **14** State legislative changes

    7. **5** Changes in federal regulations and mandates

    8. **23** Increased funding

    4. **1** State legislative changes & increased funding

    5. **1** Changes in federal regulations & mandates plus increased funding

    6. **1** Changes in state & federal requirements

Sharing Practices

74. In the past three years, have you adopted any practices from another state's MFCU? (CHECK ONE.) **(N=46)**

    1. **27** No (IF "NO," GO TO QUESTION 76.)

    2. **19** Yes

75. Please tell us, in the space below, what practices were adopted and from which states.

    19 respondents provided comments

76. During the past three years, has your unit developed any practices that you believe would be helpful to other MFCUs? (CHECK ONE.) **(N=46)**

    3. **15** No (IF "NO," GO TO QUESTION 78 ON THE NEXT PAGE.)

    4. **31** Yes

77. In the space below, please describe those practices.

    28 respondents provided comments

78. If you have any other comments about the topics discussed in this questionnaire, please write them below.

    16 respondents provided comments

Thank you for your cooperation.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

MAY 23 2001

Ms. Leslie G. Aronovitz
Director, Health Care--Program
Administration and Integrity Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Aronovitz:

Enclosed are the Department's comments on your draft report, "Medicaid: State Efforts to Control Improper Payments Vary." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely,

Michael Mangano

Michael F. Mangano
Acting Inspector General

Enclosure

The Office of Inspector General (OIG) is transmitting the Department's response to this draft report in our capacity as the Department's designated focal point and coordinator for General Accounting Office reports. The OIG has not conducted an independent assessment of these comments and therefore expresses no opinion on them.

Comments of the Department of Health and Human Services
on the GAO Report, Medicaid: State Efforts to Control
Improper Payments Vary (GAO-01-662)

The Department has taken a number of steps to combat and prevent fraud and abuse in the Medicaid program. To better enable States to detect fraud, we are preparing to release a resource guide of State fraud and abuse systems. This guide is intended to be an easy reference tool which will provide States with information on available automated systems that are being used to control fraud and abuse. States will be able to review the types of systems other States are using and learn about new and effective fraud detection features. In addition, we have recently released a report titled "*Combating Health Care Fraud & Abuse: Technologies and Approaches for the 21st Century,*" which is a synopsis of a technology conference, held in June 2000 and cosponsored by the Department's Health Care Financing Administration (HCFA) and the U.S. Department of Justice (DOJ). The conference explored technologies and approaches to combat health care fraud and abuse in the 21st century. Participants in the conference included representatives from HCFA senior staff, State agencies, DOJ, the Federal Bureau of Investigation, and the public sector.

States have often asked for more information sharing between the Medicare and Medicaid programs. To that end, we have recently undertaken a major Medicare and Medicaid data exchange project. The goal is to use a fraud and abuse mining tool to query across data from both programs in order to find fraudulent or abusive patterns. We are also attempting to provide States with access to fraud-related Medicare databases so that States can more easily compare information from both programs and more easily identify excluded providers.

The report notes that, we concluded program integrity (PI) reviews in eight States during Fiscal Year (FY) 2000 and are conducting eight more during FY 2001. The FY 2001 reviews have been expanded to include more emphasis on how States deal with fraud and abuse in managed care. We anticipate that we will continue to broaden the scope of our PI reviews in future fiscal years. We will soon be releasing a national report that summarizes the PI reviews we conducted in FY 2000.

Furthermore, we are currently conducting training sessions for HCFA regional office staff on the "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care." This training will enable HCFA regional staff to provide technical assistance to States on current and potential fraud and abuse issues related to managed care. Other current projects include the formation of a Federal and State work group whose goal is to make recommendations on how to strengthen the provider enrollment processes for both the Medicare and Medicaid programs.

The Department's Office of Inspector General (OIG) Medicaid Fraud Control Units (MFCUs) are responsible for investigating and ensuring prosecution of Medicaid fraud. Currently, the OIG is providing training to the MFCUs in the area of Medicare fraud. In

addition, the OIG has developed a Health Care Fraud Training program, taught at the Federal Law Enforcement Training Center, that specifically addresses Medicare program rules, how Medicare claims are processed, and recent Medicare fraud schemes. This training is available to all the MFCUs, and OIG pays 75 percent of the cost. Second, the OIG conducts annual conferences addressing current Medicare and Medicaid provider fraud schemes. The MFCUs have attended these conferences. Again, OIG pays 75 percent of the MFCUs cost associated with attending these conferences.

Medicaid has recently established a web site at www.hcfa.gov/medicaid/fraud. This web site provides up-to-date information about Medicaid PI and includes technical assistance and guidance through links to State Medicaid fraud statutes, relevant reports, and other professional contacts charged with the detection and prevention of health care fraud and abuse.

Related GAO Products

Major Management Challenges and Program Risks: Department of Health and Human Services (GAO-01-247, Jan., 2001).

National Practitioner Data Bank: Major Improvements Are Needed to Enhance Data Bank's Reliability (GAO-01-130, Nov. 17, 2000).

Medicaid: State Financing Schemes Again Drive Up Federal Payments (GAO/T-HEHS-00-193, Sept. 6, 2000).

Financial Management: Improper Payments Reported in Fiscal Year 1999 Financial Statements (GAO/AIMD-00-261-R, July 27, 2000).

Medicaid: HCFA and States Could Work Together to Better Ensure the Integrity of Providers (GAO/T-HEHS-00-159, July 18, 2000).

Medicaid In Schools: Improper Payments Demand Improvements in HCFA Oversight (GAO/HEHS/OSI-00-69, Apr. 5, 2000).

Medicaid: Federal and State Leadership Needed to Control Fraud and Abuse (GAO/T-HEHS-00-30, Nov. 9, 1999).

Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments (GAO/AIMD-00-10, Oct. 29, 1999).

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