Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SUSPECTED MEDICAID FRAUD REFERRALS

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EXECUTIVE SUMMARY

OBJECTIVES

To determine (1) the sources and number of suspected fraud referrals that Medicaid Fraud Control Units (MFCU) reported receiving and (2) the number of these referrals that they accepted for investigation.

BACKGROUND

Recent events, such as the passage of the Deficit Reduction Act of 2005, have focused attention on Medicaid program integrity. Within most States, two agencies share primary responsibility for protecting the integrity of the Medicaid program. The State Medicaid agency is responsible for ensuring proper payment, recovering misspent funds, identifying suspected Medicaid fraud, conducting a preliminary review to determine the extent of potential fraud, and making referrals to its MFCU. The MFCU is responsible for reviewing the referrals it receives from the State Medicaid agency and other sources to determine if the issues involved merit criminal and/or civil investigation.

The Office of Inspector General (OIG) requested that MFCUs provide data on the number of suspected fraud referrals received and the number accepted for investigation from the State Medicaid agencies and from other sources for the period July 2002 through June 2005.

FINDINGS

Medicaid Fraud Control Units reported receiving a total of 13,733 suspected fraud referrals over a 3-year period, of which 29 percent came from State Medicaid agencies. Eighty-four percent of MFCUs providing information reported receiving less than half of all suspected fraud referrals from their respective State Medicaid agencies. Referrals from State Medicaid agencies ranged from 0 to 215 for any 1-year period and from 7 to 590 for the 3-year study period (July 2002 through June 2005).

Overall, State Medicaid agency contributions to total MFCU-accepted referrals remained constant over a 3-year period, but individual States fluctuated widely. The percentage contribution of MFCU-accepted referrals from State Medicaid agencies remained constant during the 3-year study period at 33 percent, yet the contributions from individual State Medicaid agencies to their respective MFCUs fluctuated greatly. Fifty-nine percent (26/44) of MFCUs reported accepting fewer referrals from their respective State Medicaid agency in the last year of our

review compared to the average number of referrals over all 3 years. This indicates that increases in accepted referrals are concentrated in less than half of the States. One State Medicaid agency contributed to 67 percent of the increase in MFCU-accepted referrals over the 3-year study period.

RECOMMENDATION

We recommended in our November 1996 report "Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units," OEI-07-95-00030, that the Centers for Medicare & Medicaid Services (CMS) establish fraud referral performance standards for State Medicaid agencies. While CMS concurred with this recommendation, it has not established these performance standards.

In the absence of CMS criteria specific to the referral of suspected fraud issues, we are unable to determine the adequacy of State Medicaid agencies' performance. Such criteria would assist State Medicaid agencies by providing specifics concerning the development and referral of suspected fraud issues to MFCUs. In addition, such criteria would help ensure that the content and manner of referring suspected fraud issues is consistent across States. However, some reported results, such as no fraud referrals for an entire year or only one accepted referral over 3 years, do not appear adequate given the State Medicaid agencies' access to Medicaid claims information and their designated role to identify and refer suspected fraud issues to MFCUs.

Given the findings in our report and our inability to assess the adequacy of State Medicaid agency performance, due to the absence of referral criteria, we reiterate this recommendation.

AGENCY COMMENTS

CMS concurred with our recommendation to work towards the establishment of fraud referral performance standards. CMS indicated that it is in the process of engaging a strategic contractor to conduct a comprehensive State program integrity assessment. CMS intends to consult with OIG regarding arriving at a commonly accepted definition of what constitutes an accepted referral.

OFFICE OF INSPECTOR GENERAL RESPONSE

CMS comments to the report were based on numbers contained in the draft report. However, one State advised OIG after reviewing the draft report that it had provided OIG incorrect information in response to the initial data request, and it was unable to provide information that completely responded to our request. The State was eliminated from our analyses. Although we still find that the number of referrals does increase in each year of our study, the increase is less dramatic than indicated in the draft report and the percentage of referrals coming from State agencies drops in the last year when compared to the prior year.

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INTRODUCTION

OBJECTIVES

To determine (1) the sources and number of suspected fraud referrals that Medicaid Fraud Control Units (MFCU) reported receiving and (2) the number of these referrals that they accepted for investigation.

BACKGROUND

The Deficit Reduction Act of 2005 created a new Medicaid Integrity Program (MIP) and provided additional funding for the Secretary of the Department of Health and Human Services (HHS) to conduct Medicaid program integrity activities.[1] The MIP funding will assist the Centers for Medicare & Medicaid Services (CMS) in these activities. As part of this funding, CMS will hire approximately 100 auditors to conduct Federal reviews of State Medicaid agency programs. In addition, funding received pursuant to the Deficit Reduction Act of 2005 will assist the Office of Inspector General (OIG) in its oversight of Medicaid integrity efforts.

Within most States, two agencies share primary responsibility for protecting the integrity of the Medicaid program. The State Medicaid agency is responsible for ensuring proper payment, recovering misspent funds, identifying suspected Medicaid fraud, conducting a preliminary review to determine the extent of potential fraud, and making referrals to its MFCU. The MFCU is responsible for reviewing the referrals it receives from the State Medicaid agency and other sources to determine if the issues involved merit criminal and/or civil investigation. The MFCU would then either accept the referral for investigation or decline the referral. In situations where the referral is declined, the referring agency can initiate appropriate administrative actions.

State Medicaid Agency Responsibilities

The State Medicaid agency must conduct preliminary investigations when questionable practices or complaints of suspected Medicaid fraud are identified or received.[2]

[1] Public Law 109-171.

[2] 42 CFR § 455.14.

When a preliminary investigation gives the State Medicaid agency reason to believe that an incident of fraud has occurred, it must refer the matter to the MFCU for investigation.[3]

State Medicaid agencies must have certain information processing systems, including a Medicaid Management Information System (MMIS), to accomplish the tasks for which they are responsible.[4] A vital part of the MMIS is the Surveillance and Utilization Review Subsystem (S/URS). Two of the primary functions of the S/URS are: (1) to develop a comprehensive statistical profile of health care delivery and utilization patterns by providers and recipients, and (2) to investigate and reveal misutilization of the State's Medicaid program by participants and promote correction.[5] Some State Medicaid agencies exclusively use staff within the S/URS unit to conduct analyses, while others have established comprehensive program integrity or Inspector General units to oversee these functions.

Medicaid Fraud Control Unit Responsibilities

MFCUs are responsible for conducting statewide programs for investigating and prosecuting violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the State Medicaid plan.[6] Forty-eight States and the District of Columbia (hereinafter referred to collectively as States) have established MFCUs.[7]

MFCUs are responsible for conducting criminal and/or civil investigations of suspected Medicaid fraud and are considered integrated law enforcement components. MFCUs must be single identifiable entities of the State government, composed of investigators, attorneys, and auditors.[8] Most MFCUs are located within the State

[3] 42 CFR § 455.15(a)(1) and 42 CFR § 433.116(h). In States without a MFCU, the State Medicaid agency must conduct a full investigation or refer the fraud issue to the appropriate law enforcement agency.

[4] 42 U.S.C. §§ 1903(a)(3) and 1903(r), 42 CFR § 433.110 and Part 11 of the State Medicaid Manual.

[5] Section 11335 of the State Medicaid Manual.

[6] 42 U.S.C. § 1396b(q)(3) and 42 CFR § 1007.11.

[7] The HHS Inspector General granted North Dakota and Idaho waivers of MFCU requirements; thus the State Medicaid agency in each of these States is responsible for conducting investigations and referring cases to State and local prosecutors.

[8] 42 U.S.C. § 1396b(q)(6).

Attorney General's office. OIG has been delegated responsibility for MFCU oversight and certifying and recertifying that each MFCU meets selected Federal requirements.[9]

Section 1902(a)(61) of the Social Security Act, as amended by section 13625 of the Omnibus Budget Reconciliation Act of 1993, required OIG to develop performance standards for assessing MFCUs. These standards became effective on September 26, 1994. One of these performance standards requires MFCUs to ensure they maintain an adequate workload of referrals from State Medicaid agencies and other sources (e.g., licensure authorities, insurance departments, providers, and private citizens).

Previous Studies

Since 1989, OIG has issued three reports addressing the referral of suspected fraud issues from State Medicaid agencies to MFCUs.[10] These reports identified variations among the State Medicaid agencies in their relationships with and methods of referral to MFCUs. Additionally, each of these studies identified deficiencies in the referral process, such as a lack of communication between State Medicaid agencies and MFCUs and a lack of understanding of roles and responsibilities.

The Government Accountability Office (GAO) has also conducted a number of studies that identified vulnerabilities in the Medicaid program and in State Medicaid agencies' efforts to detect and refer suspected fraud issues to MFCUs. In a 2004 report, GAO noted that CMS's efforts to ensure State Medicaid agency compliance might be ". . . disproportionately small relative to the risk of serious financial loss."[11]

METHODOLOGY

We requested suspected fraud referral data from both State Medicaid agencies and MFCUs in the 48 States that had MFCUs during the

[9] 42 U.S.C. § 1396b(q)(7).

[10] "Referrals by Medicaid agencies to Fraud Control Units," OAI-03-88-00170, October 1989; "Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units," OEI-07-95-00030, November 1996; "Medicaid Post Payment Safeguards," OEI-05-99-00072, July 2000.

[11] "State and Federal Efforts to Prevent and Detect Improper Payments," Government Accountability Office Report to the Chairman, Committee on Finance, U.S. Senate, GAO 04-707, July 2004.

3-year period July 2002 through June 2005. Idaho and North Dakota have not established MFCUs due to waivers and Nebraska established its MFCU toward the end of our study period. Therefore, these States were excluded from the study. The Kentucky, New York, Oregon, and Utah MFCUs responded to our request; however, the data provided was not sufficiently complete for comparable analysis. As a result, the responses from these MFCUs and the corresponding State Medicaid agencies were excluded from this report. This study reflects responses from the remaining 44 States with MFCUs.

We asked State Medicaid agencies to provide the number of suspected fraud referrals made to MFCUs; the number of those accepted for investigation; the number of those declined for investigation, thus allowing the State Medicaid agency to initiate administrative actions, as appropriate; and the number of those for which no investigative decision had been made by their MFCUs. We asked MFCUs to provide the number of suspected fraud referrals they received from State Medicaid agencies and other sources; the number of those accepted for investigation; the number of those declined for investigation, thus allowing another agency to initiate appropriate administrative action, as appropriate; and the number of those for which no investigative decision had been made. We asked the MFCUs for information on referrals received from State Medicaid agencies as well as those from all other sources for the 3-year period July 2002 through June 2005. We also requested the MFCUs to provide the general reasons that referrals were not accepted for criminal and/or civil investigation.

In our requests to State Medicaid agencies and MFCUs, we did not define the terms referral, accept, decline, and no decision made for respondents. Although they are not usually defined, these terms are used commonly in policies and procedures governing the work for State Medicaid agencies and MFCUs. We provided respondents the ability to contact us if they had any questions about the information we requested.

The common understanding of each of the terms is as follows:

- Referral – a matter that an outside entity brings to the attention of a MFCU regarding suspected Medicaid fraud. "Referrals" can range from something that is well researched and developed to simply an article mentioning potential wrongdoing clipped from the newspaper.

- Accept – matters that the MFCU retains for further investigation. According to internal policy, some MFCUs accept all referrals from all sources. Most MFCUs, however, accept for investigation only those matters that meet a certain threshold (e.g., indications that a crime had been committed, dollar threshold for prosecution).
- Decline – matters that the MFCU does not retain for further investigation, allowing another entity to initiate administrative actions, as appropriate. The term decline should not be confused with a declination on the part of the prosecutor to take a matter to court.
- No decision made – matters that, at the time of our inquiry, the MFCU had not yet made a determination of whether to accept or decline.

Limitations

We did not review individual preliminary investigations that State Medicaid agencies conducted for completeness or appropriateness. We also did not evaluate processes MFCUs used or results achieved as part of their acceptance, declination, and/or development of fraud issues for a criminal and/or civil investigation. We collected information from State Medicaid agencies and MFCUs. We elected to report the referral numbers from MFCUs, because they receive referrals from State Medicaid agencies and other sources, providing a more comprehensive representation of their investigative workload.

Some MFCU directors stated that they received suspected fraud referrals on the same matter from multiple sources. In such cases, the referral was credited to the entity that first referred the matter to the MFCU. Therefore, State Medicaid agencies could have referred additional suspected fraud issues that the MFCU would not have counted as a referral from them, when these issues had previously been received from other sources.

Data presented in the report are the raw referral statistics that MFCUs provided and are not adjusted for such factors as State Medicaid agency or MFCU operating budgets, State Medicaid program expenditures, beneficiary and provider populations, or claims volume.

Standards

This study was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

Medicaid Fraud Control Units reported receiving a total of 13,733 suspected fraud referrals over a 3-year period, of which 29 percent came from State Medicaid agencies

From July 2002 through June 2005, MFCUs reported receiving 4,034 referrals from State Medicaid agencies and 9,699 referrals from all other sources. State Medicaid agency referrals accounted for 29 percent of all MFCU-reported referrals for the 3-year study period.[12] Table 1 provides referral data for each of the years in our review. Previous reports examining Medicaid suspected fraud referrals found that State Medicaid agency contribution to total referrals was 35 percent in 1985 (36 States reporting) and 25 percent in 1994 (45 States reporting).[13]

Table 1: MFCU-Reported Fraud Referrals

Review Period	Referrals From State Medicaid Agencies	Referrals From Other Sources	State Medicaid Agency Percent of Total Referrals
2002–2003	1,161	3,040	28
2003–2004	1,403	3,045	32
2004–2005	1,470	3,614	29
Total	**4,034**	**9,699**	**29**

Source: Office of Inspector General analysis of MFCU data, 2006.

For the 3-year period from July 2002 to June 2005, the number of referrals that an individual MFCU reported receiving from a State Medicaid agency ranged from 0 to 215 for any 1-year period and from 7 to 590 for all 3 years. (See Appendix A.) MFCU-reported referrals from other sources ranged from 0 to 379 in any 1 year and from 6 to 859 for all 3 years. (See Appendix B.) Eighty four percent (37/44) of MFCUs reported receiving less than half of all referrals from their respective State Medicaid agencies.

MFCU-reported referrals from States varied greatly, but clustered to low and high ends. Twenty-one MFCUs reported receiving fewer than 12 referrals each from State Medicaid agencies (averaging less than 1 referral per month) in the last year of our study. These States were

[12] State Medicaid agencies reported sending 3,930 suspected fraud referrals to MFCUs over the 3-year period, while MFCUs reported receiving 4,034 suspected fraud referrals from State Medicaid agencies over the same period.

[13] "Results of Certified Fraud Control Units," GAO/HRD-87-12FS, October 1986, and "Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units," OEI-07-95-00030, November 1996.

rural, urban, small, large, from all regions of the country, and included Arkansas (2 referrals), Connecticut (2 referrals), South Dakota (4 referrals), Virginia (8 referrals), and Wyoming (11 referrals). Only 3 MFCUs reported receiving over 100 referrals from State Medicaid agencies in the last year of our study: Florida (215 referrals), Arizona (192 referrals), and Texas (180 referrals). During the same period, California, the largest Medicaid program based on enrollment, reported 79 referrals from the State Medicaid agency.

While referral data in Appendix A indicate an increase in the number of suspected fraud referrals overall from 1,161 in the 2002–2003 review period to 1,470 in the 2004–2005 review period, only 1 State Medicaid agency significantly contributed to this upward trend. During the period July 2002 through June 2005, Florida's reported referrals increased from 33 to 82 to 215 for each 12-month period, accounting for 59 percent (182/309) of the difference between the 2002–2003 and 2004–2005 reported number of referrals. In fact, more than half (24/44) of MFCUs actually reported receiving fewer referrals from their respective State Medicaid agency in the last year of our review compared to the average number of referrals over all 3 years. For 18 States, MFCUs also reported fewer referrals from other sources in the last year, compared to the 3-year average.

Overall, State Medicaid agency contributions to total MFCU-accepted referrals remained constant over a 3-year period, but individual States fluctuated widely

Although the total number of referrals MFCUs accepted from both State Medicaid agencies and other sources increased, the overall percentage contribution of accepted referrals that came from State Medicaid agencies remained relatively constant during our 3-year study period. (See Table 2 on the next page.) In contrast, the contributions of individual State Medicaid agencies to their respective MFCUs fluctuated greatly. Fifty-nine percent (26/44) of MFCUs reported accepting fewer referrals from their respective State Medicaid agency in the last year of our review, while 41 percent (18/44) reported an increase compared to the average number of referrals over all 3 years. This indicates that increases in accepted referrals are concentrated in less than half of the States.

Table 2: MFCU Reported Accepted Fraud Referrals

Review Period	Referrals Accepted From State Medicaid Agencies	Referrals Accepted From Other Sources	State Medicaid Agency Percent of Total Referrals Accepted
2002–2003	748	1,694	31
2003–2004	964	1,780	35
2004–2005	1,020	2,164	32
Total	**2,732**	**5,638**	**33**

Source: Office of Inspector General analysis of MFCU data, 2006.

Eight MFCUs accepted all referrals during our 3-year study period. (See Appendix C.) As an example, the Florida MFCU saw an increase in the number of referrals and accepted referrals by 182 from the first to last year of our study. As a result, Florida alone accounted for 67 percent (182/272) of increases in accepted referrals during this 3-year period.

Twenty-six MFCUs reported accepting, on average, no more than one referral a month from their respective State Medicaid agencies. MFCU-reported accepted referrals from State Medicaid agencies ranged from 0 to 215 for any 1 year and from 1 to 330 for all 3 years. (See Appendix A.) MFCU-reported accepted referrals from all other sources ranged from 0 to 372 in any 1 year and from 3 to 766 for all 3 years. (See Appendix B).

The most frequent reason that MFCUs cited for declining a referral from State Medicaid agencies was that the referral did not contain enough information to establish that a Medicaid crime had been committed (33 MFCUs).[14] Other reasons frequently cited include referral to another agency for administrative action (19 MFCUs) and the need for additional development by the respective State Medicaid agency (18 MFCUs). Only 50 referrals for the full 3-year period were reported to us as "no decision made," indicating that nearly all referrals were reviewed and were either accepted for investigation or declined, thus allowing the referring agency to take action it deemed appropriate.

[14] We recognize that fraud may ultimately be determined only through a judgment by a court of law. MFCUs noted that some referrals did not establish the necessary elements to proceed with a criminal investigation.

RECOMMENDATION

We recommended in our November 1996 report "Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units," OEI-07-95-00030, that CMS establish fraud referral performance standards for State Medicaid agencies. While CMS concurred with this recommendation, it has not established these performance standards.

In the absence of CMS performance standards or criteria specific to the referral of suspected fraud issues, we are unable to determine the adequacy of State Medicaid agencies' performance. Such criteria would assist State Medicaid agencies by providing specifics concerning the development and referral of suspected fraud issues to MFCUs. In addition, such criteria would help ensure that the content and manner of referring suspected fraud issues is consistent across States. However, some reported results, such as no fraud referrals for an entire year or only one accepted referral over 3 years, do not appear adequate given the State Medicaid agencies' access to Medicaid claims information and their designated role to identify and refer suspected fraud issues to MFCUs.

Despite the growth in Medicaid expenditures and the increased focus on Medicaid program integrity, 21 MFCUs reported receiving fewer than 12 referrals each from their respective State Medicaid agency in the last year of our study. More than half of MFCUs reported receiving fewer referrals from their respective State Medicaid agency in the last year of our review compared to the average number of referrals over all 3 years. More than half of MFCUs reported receiving an average of no more than one accepted referral per month from their respective State Medicaid agency during the period July 2002 through June 2005.

Given the findings in our report and our inability to assess the adequacy of State Medicaid agency performance, due to the absence of referral criteria, we reiterate this recommendation.

AGENCY COMMENTS

CMS concurred with our recommendation to work towards the establishment of fraud referral performance standards. CMS indicated that it is in the process of engaging a strategic contractor to conduct a comprehensive State program integrity assessment. The contractor will be tasked with determining the measures needed to accurately assess the program integrity performance of State Medicaid agencies and to develop a national database. Once these measures are established,

CMS can use this information to begin collaborative work in the development of national performance standards. CMS intends to consult with OIG regarding arriving at a commonly accepted definition of what constitutes an accepted referral, since the definition of this term varies widely from State to State. CMS noted that the Deficit Reduction Act of 2005 provides the necessary resources to implement OIG's longstanding recommendation. CMS comments are included in their entirety in Appendix D.

OFFICE OF INSPECTOR GENERAL RESPONSE

CMS comments to the report were based on numbers contained in the draft report. However, after reviewing the draft report, one State advised OIG that it had provided OIG incorrect information in response to the initial data request, and it was unable to provide information that completely responded to our request. The State was eliminated from our analyses and the data presented in the report are adjusted accordingly. Although we still find that the number of referrals does increase in each year of our study, the increase is less dramatic than indicated in the draft report and the percentage of referrals coming from State agencies drops in the last year when compared to the prior year.

APPENDIXES

The information contained in Appendixes A, B, and C is presented in alphabetical order by State. The order is not intended to suggest any ranking of performance for any State Medicaid agency or MFCU.

These data do not take into account factors such as State Medicaid agency or MFCU operating budgets, State Medicaid program expenditures, beneficiary and provider populations, or claims volume.

Additionally, these data do not reflect the entirety of workloads for either the State Medicaid agencies or MFCUs. State Medicaid agencies pursue overpayment cases in addition to making referrals to MFCUs. MFCUs self-generate work in addition to receiving referrals from State Medicaid agencies and external sources.

APPENDIX A

MFCU-Reported Fraud Referral Data From State Medicaid Agencies*

	Referrals Received From State Medicaid Agency			Totals	Referrals Accepted From State Medicaid Agency			Totals
State	**2002–2003**	**2003–2004**	**2004–2005**	**2002–2005**	**2002–2003**	**2003–2004**	**2004–2005**	**2002–2005**
Alabama	6	13	7	26	6	9	4	19
Alaska	34	20	94	148	2	7	13	22
Arizona	196	202	192	590	59	54	42	155
Arkansas	59	5	2	66	21	5	2	28
California	145	163	79	387	104	125	72	301
Colorado	6	13	7	26	5	8	5	18
Connecticut	45	5	2	52	26	4	2	32
Delaware	1	7	7	15	1	7	7	15
District of Columbia	2	5	5	12	2	4	5	11
Florida	33	82	215	330	33	82	215	330
Georgia	8	6	11	25	8	6	11	25
Hawaii	3	2	2	7	3	2	2	7
Illinois	47	90	83	220	39	49	55	143
Indiana	11	30	35	76	11	30	35	76
Iowa	1	2	11	14	1	0	4	5
Kansas	11	21	47	79	11	21	45	77
Louisiana	10	33	31	74	10	33	31	74
Maine	8	14	19	41	8	14	19	41
Maryland	7	11	9	27	2	8	5	15
Massachusetts	16	6	10	32	15	5	9	29
Michigan	24	47	26	97	17	26	18	61
Minnesota	10	9	13	32	6	6	4	16
Mississippi	25	11	5	41	16	6	3	25
Missouri	25	23	20	68	25	23	20	68
Montana	11	7	9	27	8	6	8	22
Nevada	4	8	7	19	4	4	2	10
New Hampshire	9	6	9	24	6	2	7	15
New Jersey	15	21	12	48	14	19	10	43
New Mexico	11	5	6	22	11	5	6	22
North Carolina	14	12	18	44	14	10	12	36
Ohio	60	97	63	220	58	90	58	206
Oklahoma	70	67	78	215	28	32	32	92
Pennsylvania	12	24	18	54	12	24	18	54
Rhode Island	9	6	3	18	8	5	3	16
South Carolina	14	12	12	38	14	11	11	36
South Dakota	0	7	4	11	0	1	0	1
Tennessee	11	5	30	46	6	3	5	14
Texas	81	205	180	466	40	135	142	317
Vermont	17	15	5	37	15	13	4	32
Virginia	13	11	8	32	12	6	7	25
Washington	25	13	17	55	25	13	17	55
West Virginia	22	23	22	67	22	23	22	67
Wisconsin	28	27	26	81	18	16	17	51
Wyoming	2	12	11	25	2	12	11	25
Total	**1,161**	**1,403**	**1,470**	**4,034**	**748**	**964**	**1,020**	**2,732**

Source: MFCU reported data, 2006.

*The Kentucky, New York, Oregon, and Utah MFCUs responded to our request; however, the data provided was not sufficiently complete for comparable analysis.

APPENDIX B

MFCU-Reported Fraud Referral Data From All Other Sources*

	Referrals Received From All Other Sources			Totals	Referrals Accepted From All Other Sources			Totals
State	2002–2003	2003–2004	2004–2005	2002–2005	2002–2003	2003–2004	2004–2005	2002–2005
Alabama	8	15	11	34	6	12	7	25
Alaska	72	67	34	173	11	18	3	32
Arizona	185	185	183	553	54	46	37	137
Arkansas	37	48	47	132	24	31	31	86
California	182	99	166	447	165	71	114	350
Colorado	65	46	36	147	27	21	16	64
Connecticut	103	23	55	181	8	23	55	86
Delaware	11	58	49	118	10	55	45	110
District of Columbia	27	36	53	116	27	34	51	112
Florida	193	201	372	766	193	201	372	766
Georgia	51	58	33	142	44	53	23	120
Hawaii	60	75	81	216	60	75	81	216
Illinois	9	29	84	122	9	25	62	96
Indiana	68	204	137	409	68	204	137	409
Iowa	39	68	78	185	17	12	17	46
Kansas	53	49	129	231	14	25	54	93
Louisiana	51	78	83	212	32	36	38	106
Maine	64	136	114	314	31	41	50	122
Maryland	31	27	23	81	10	10	9	29
Massachusetts	48	25	22	95	15	4	3	22
Michigan	379	264	216	859	81	46	30	157
Minnesota	18	22	15	55	11	16	11	38
Mississippi	36	33	30	99	13	16	6	35
Missouri	32	15	20	67	32	15	20	67
Montana	20	26	35	81	11	12	12	35
Nevada	78	91	85	254	17	17	18	52
New Hampshire	20	14	16	50	13	3	9	25
New Jersey	23	35	110	168	21	29	86	136
New Mexico	79	41	68	188	12	10	20	42
North Carolina	90	79	90	259	80	72	84	236
Ohio	161	160	195	516	83	98	146	327
Oklahoma	15	20	10	45	4	13	7	24
Pennsylvania	36	33	33	102	36	33	33	102
Rhode Island	2	1	3	6	2	1	3	6
South Carolina	28	45	64	137	28	39	58	125
South Dakota	11	9	20	40	7	4	8	19
Tennessee	92	78	137	307	20	26	34	80
Texas	212	290	326	828	73	96	110	279
Vermont	67	63	94	224	50	39	46	135
Virginia	35	18	58	111	30	18	19	67
Washington	164	154	170	488	164	154	170	488
West Virginia	10	12	10	32	10	12	10	32
Wisconsin	7	1	0	8	3	0	0	3
Wyoming	68	14	19	101	68	14	19	101
Total	**3,040**	**3,045**	**3,614**	**9,699**	**1,694**	**1,780**	**2,164**	**5,638**

Source: MFCU reported data, 2006.

*The Kentucky, New York, Oregon, and Utah MFCUs responded to our request; however, the data provided was not sufficiently complete for comparable analysis.

APPENDIX C

Comparison of MFCU Accepted Referral and Contribution Rates*

	Percentage Contribution of Accepted Referrals From State Medicaid Agency	Percentage of State Medicaid Agency Referrals Accepted	Percentage of Referrals From All Other Sources Accepted
State	**2002-2005**	**2002-2005**	**2002-2005**
Alabama	43.2	73.1	73.5
Alaska	40.7	14.9	18.5
Arizona	53.1	26.3	24.8
Arkansas	24.6	42.4	65.2
California	46.2	77.8	78.3
Colorado	22.0	69.2	43.5
Connecticut	27.1	61.5	47.5
Delaware	12.0	100.0	93.2
District of Columbia	8.9	91.7	96.6
Florida	30.1	100.0	100.0
Georgia	17.2	100.0	84.5
Hawaii	3.1	100.0	100.0
Illinois	59.8	65.0	78.7
Indiana	15.7	100.0	100.0
Iowa	9.8	35.7	24.9
Kansas	45.3	97.5	40.3
Louisiana	41.1	100.0	50.0
Maine	25.2	100.0	38.9
Maryland	34.1	55.6	35.8
Massachusetts	56.9	90.6	23.2
Michigan	28.0	62.9	18.3
Minnesota	29.6	50.0	69.1
Mississippi	41.7	61.0	35.4
Missouri	50.4	100.0	100.0
Montana	38.6	81.5	43.2
Nevada	16.1	52.6	20.5
New Hampshire	37.5	62.5	50.0
New Jersey	24.0	89.6	81.0
New Mexico	34.4	100.0	22.3
North Carolina	13.2	81.8	91.1
Ohio	38.6	93.6	63.4
Oklahoma	79.3	42.8	53.3
Pennsylvania	34.6	100.0	100.0
Rhode Island	72.7	88.9	100.0
South Carolina	22.4	94.7	91.2
South Dakota	5.0	9.1	47.5
Tennessee	14.9	30.4	26.1
Texas	53.2	68.0	33.7
Vermont	19.2	86.5	60.3
Virginia	27.2	78.1	60.4
Washington	10.1	100.0	100.0
West Virginia	67.7	100.0	100.0
Wisconsin	94.4	63.0	37.5
Wyoming	19.8	100.0	100.0
Total (weighted)	**29.4**	**67.8**	**58.3**

Source: Office of Inspector General analysis of MFCU reported data, 2006.

*The Kentucky, New York, Oregon, and Utah MFCUs responded to our request; however, the data provided was not sufficiently complete for comparable analysis.

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

DATE: OCT 16 2006

Administrator
Washington, DC 20201

TO: Daniel R. Levinson
Inspector General

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: The Office of Inspector General (OIG) Draft Report: "Suspected Medicaid Fraud Referrals" (OEI-07-04-00181)

Thank you for the opportunity to review and comment on the OIG draft report. The report determined the sources and number of suspected fraud referrals the Medicaid Fraud Control Units (MFCU) reported receiving and the number of these referrals they accepted for investigation.

CMS concurs with the study's recommendation to work toward the establishment of fraud referral performance standards. This recommendation dovetails with one of the objectives of the Medicaid Integrity Program, i.e., to establish baselines, metrics and standards against which all States can be evaluated in the future. As a first step toward the goal of establishing broad-based performance standards, CMS is in the process of engaging a strategic contractor to conduct a comprehensive State program integrity assessment. This contractor will, among other things, survey the landscape of State program integrity practices, identify baseline demographics needed to accurately assess State program integrity practices and procedures, develop a national database, and conduct a thorough program integrity literature review. Once a baseline is established for a variety of measures, one such measure being fraud referrals, CMS can use this baseline to begin the collaborative work on establishing standards. Even before such a standard can be finalized, CMS will work with State partners in improving performance by measuring rates and sharing best practices.

In order to successfully implement the recommendation, it will be important to arrive at a commonly accepted definition of what constitutes an acceptable referral and use that definition as a standard against which States can be measured. CMS will add this to the wide array of program integrity issues about which we consult with the OIG on a regular basis.

The CMS agree that the numbers of referrals received by MFCUs from Medicaid State Agencies (MSAs) vary widely. Some States produced few, if any, referrals, while others generated a prodigious number of referrals. The report delineates two findings: (1) over the three year period covered by the study, about a third of all referrals to MFCUs came from MSAs; and, (2) the acceptance rate for MSA referrals was similar to those received

from all other sources–61 percent for State agency referrals and 58 percent for those from all other sources.

However, the report should also highlight the fact that the number of reported fraud referrals from MSAs increased for each year of the three year period of the study–from 1195 in 2002-2003, to 1443 in 2003-2004, and to 1968 in 2004-2005. Commensurately, the percentage of MSA referrals also increased each year, from 28 percent in 2002-2003, to 32 percent in 2003-2004, and to 35 percent in 2004-2005.

The report notes that the OIG cannot assess the adequacy of MSAs' performance due to the absence of CMS criteria for referrals of suspected fraud. Therefore, the study reiterates a recommendation from a previous OIG report entitled, "*Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units*," (OEI-07-95-00030), that CMS establish fraud referral performance standards for MSAs. The previous report points out that CMS concurred with the recommendation but, to date, has not established these performance standards. Two issues need to be highlighted in addressing the recommendation. First, the definition or criteria for what constitutes an acceptable referral varies widely from State to State and there has never been a consensus on this issue. Second, the recent passage of the Deficit Reduction Act of 2005 which created the Medicaid Integrity Program within CMS has now provided the necessary resources for CMS to adequately implement the recommendation.

ACKNOWLEDGMENTS

This report was prepared under the direction of Brian T. Pattison, Regional Inspector General for Evaluation and Inspections in the Kansas City regional office, and Gina C. Maree, Deputy Regional Inspector General. Other principal Office of Evaluation and Inspections staff who contributed include:

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