Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEMS' CASE REFERRALS TO MEDICAID FRAUD CONTROL UNITS

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1996
OEI-07-95-00030

EXECUTIVE SUMMARY

PURPOSE

To assess the effectiveness of the Surveillance and Utilization Review Subsystems' development and referral of fraud issues to Medicaid Fraud Control Units.

BACKGROUND

The Medicaid statute authorizes funding for States to foster development and implementation of the Medicaid Management Information System (MMIS). One of the sub components of the MMIS is the Surveillance and Utilization Review Subsystem (S/URS). This subsystem applies automated post-payment screens to Medicaid claims adjudication to identify aberrant billing patterns, which may be fraud or provider abuse. The S/URS staff reviews systems output and conducts preliminary reviews of providers to determine whether they can substantiate a pattern of fraud. In such cases, they must refer the matter to the States' fraud control unit for investigation. The Health Care Financing Administration (HCFA) provides Federal oversight of the Medicaid State agency, including S/URS.

The statute also authorizes Federal matching funds for the establishment of State Medicaid Fraud Control Units (MFCUs). Forty-six States have established such fraud units as of January 1996. They investigate allegations of Medicaid fraud and patient abuse/neglect. For the four States not having MFCUs, the Medicaid State agency is responsible for investigating allegations and referring these cases to State or Federal prosecutorial authorities.

For this inspection we obtained data from 45 States and visited 7 of them to gain a better understanding of the interaction between S/URS and MFCUs.

FINDINGS

The number and percentage of suspected fraud referrals from S/URS has declined in the past 10 years.

In calendar year 1985, the 36 MFCUs received 996 potential S/URS fraud case referrals or 34.7 percent of the total MFCU fraud workload. In contrast, in 1994, S/URS for these same States referred 863 potential fraud cases, 24 percent of the total MFCU fraud workload, and for 45 States S/URS referred 956 cases, 24.6 percent of the total MFCU workload, a significant decline.

MFCU officials are divided in their opinion concerning the extent and quality of S/URS development of suspected fraud cases.

While officials from four MFCUs stated that S/URS development of cases is adequate, three commented that these referrals need improvement. We found that S/URS staff differ in their method for researching past complaints and developing current fraud issues prior to referring these matters to the fraud units. This can adversely affect the quality of the referrals. The MFCUs cited the following problematic issues:

- the allegation of fraud is not clear;
- the allegation is not developed enough to determine if it is an isolated instance or a pattern of practice;
- policies and/or correspondence at the State Agency is not clearly written, therefore adversely impacting on establishing provider intent; and
- the S/URS electronic and/or hard copy claims data needed to prove the fraud are not available.

The S/URS employees have not received sufficient training to assure that they develop and refer suspected fraud allegations in a consistent and appropriate manner.

States' S/URS staff cite inadequate training in the identification and development of fraud allegations and edits.

- Five S/URS staffs have not received training from Medicaid Fraud Control Units on desired content or process for case referrals.
- Three S/URS staffs have not attended any HCFA fraud or provider abuse training.

The HCFA does not routinely monitor S/URS development to establish whether potential fraud issues are being appropriately and consistently analyzed and referred.

Three States report that HCFA did not conduct any review of their S/URS operation, including their case development and referral process. Four States report that HCFA reviewed it, however, three of these said it was simply a part of the Systems Performance Review (SPR) which did not include case reviews and agency feedback.

RECOMMENDATIONS

Concerns regarding the effectiveness of MFCUs are similar to those discussed in our report entitled ***"Carrier Fraud Units," OEI-05-94-00470.*** As a result, we believe that a concerted effort addressing both Medicare and Medicaid fraud units is called for.

We are proposing a uniform team approach. We recommend that HCFA, in consultation with the Office of Inspector General should:

Convene a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud unit operations. This would include:

- Clarifying goals and objectives for program integrity efforts.
- Establishing guidelines for developing suspected fraud cases.
- Developing a universal protocol for appropriately referring fraud and abuse cases.
- Coordinating data systems to ensure that data are reliable and consistent across all entities in the fraud and abuse fighting network.
- Developing a training program designed to educate program integrity personnel on procedures, case referrals and best practices.

Develop and implement a comprehensive evaluation system for S/URS case identification, development and referral activities.

HCFA should consider establishing a system similar to the one used to evaluate Medicare contractors. Once the system is established it should be incorporated into periodic HCFA reviews of the Medicaid State agency and the Systems Performance Review.

AGENCY COMMENTS

We appreciate all the positive steps that HCFA has taken thus far to safeguard the Medicare program and we recognize the accomplishments of the Program Integrity Group. We are pleased that HCFA has concurred with our recommendations and we look forward to working with HCFA in their implementation.

We believe that the best approach would be a collaborative one involving HCFA and OIG, with consultation from high performing State Surveillance and Utilization Review Subsystem Units (S/URS) and carriers, to improve program integrity activities at the carrier and State level. We suggest that this effort focus on:

- Developing and implementing model practices to help carriers and S/URS decide which cases should be developed for medical review and overpayment recovery or for referral for fraud. In addition, existing protocols should be implemented for referral of fraud cases to appropriate investigative entities (the OIG for Medicare cases and Medicaid Fraud Control Units for Medicaid cases). We believe that together we can increase overpayment recovery

amounts and increase the number of successful prosecutions by law enforcement agencies.

- Revising current contractor performance measures that reward carriers for overpayment recovery but not for fraud and abuse referrals or efforts to improve claims processing safeguards.

- Identifying the most effective practices which carrier and State personnel use to eliminate claims processing vulnerabilities that enable providers to defraud health programs.

We believe that achieving the goals both HCFA and the OIG have established for improving program integrity functions at the carriers and in the States can best be accomplished by these kinds of collaborative efforts. We look forward to working with HCFA to bring about further measurable change.

Concerning the establishment of a comprehensive system for HCFA to evaluate S/URS case identification, development and referral, we are pleased that HCFA also concurs with this recommendation. We believe that this initiative is very important to the overall integrity of the Medicaid program. We are delighted to learn of HCFA's recent fraud and abuse initiatives and hope that the S/URS performance evaluation system will be implemented as soon as practical. We remain committed to collaborating with HCFA in their efforts to rapidly develop and implement this system.

The full text of HCFA's comments is contained in Appendix D.

TABLE OF CONTENTS

PAGE

EXECUTIVE SUMMARY

INTRODUCTION 1

FINDINGS 5

- Referrals 5
- Case development 6
- Training 7
- Monitoring 8

RECOMMENDATIONS 9

AGENCY COMMENTS 11

APPENDICES

A: MFCU sources--GAO sample States fraud case referrals CY 1994 . . . . . A-1

B: MFCU sources--national data fraud case referrals CY 1994 . . . . . B-1

C: MFCU sources--sample States fraud case referrals CY 1994 . . . . . C-1

D: Agency Comments D-1

INTRODUCTION

PURPOSE

To assess the effectiveness of the Surveillance and Utilization Review Subsystems' development and referral of fraud issues to Medicaid Fraud Control Units.

BACKGROUND

The Congress established the Medicaid Program in 1965. It is a State administered program, which receives Federal matching funds. Each State is required to designate the agency responsible for the management of the Medicaid program.

Surveillance and Utilization Review Subsystem

In 1972, Congress enacted Public Law 92-603. This law provides funding to States to foster development and implementation of the Medicaid Management Information System (MMIS). One of the sub components of the MMIS is the Surveillance and Utilization Review Subsystem (S/URS). This subsystem applies automated post-payment screens to Medicaid claims adjudication to identify aberrant billing patterns, which may be fraud or provider abuse. The S/URS staff reviews systems output and conducts preliminary reviews of providers to determine whether they can substantiate a pattern of fraud. In such cases, they must refer the matter to the States' fraud control unit for investigation. These units were designed to serve as major contacts/analysis points for detection and referral of potential fraud and provider abuse cases to assigned components within the States' that pursues investigation of alleged criminal fraud within the Medicaid Program, usually the Medicaid Fraud Control Units (MFCUs).

Federal Oversight of S/URS

The Health Care Financing Administration (HCFA) provides Federal oversight of the Medicaid State agency, including S/URS. It initially reviewed quality and quantity of State agency referrals to MFCUs as part of its overall State Assessment of the Agency. It discontinued this component of the review, as a result of Public Law 96-398, enacted in 1980, which mandated that all States have an approved MMIS system by September 30, 1985. The law also specified that HCFA evaluate States' system requirements and performance standards at least once every 3 years. In 1981, it implemented the Systems Performance Review (SPR) to comply with this legislation. The review evaluates the system, including the S/URS subsystem, and measures *process* performance but not *outcomes* from this process. It does not require formal monitoring or evaluation of S/URS staffs' development and referral of potential fraudulent claims to MFCUs.

Medicaid Fraud Control Units

In 1977, Congress enacted Public Law 95-142, which authorized Federal matching funds for establishment of State Medicaid Fraud Control Units. Forty-six States have now established such fraud units as of January 1996.[1] They investigate allegations of Medicaid fraud and patient abuse/neglect. For the four States not having MFCUs, the Medicaid State Agency is responsible for investigating allegations and referring these cases to State or Federal prosecutorial authorities.

To assure investigative independence, Congress prohibited MFCUs from being part of the same "umbrella" organization which contains the Medicaid State agency. Generally, they are located in the State's Attorney General's offices and most perform both investigatory and prosecutorial functions.

Memorandum of Understanding

Regulations require Medicaid State agencies and MFCUs to enter into a Memorandum of Understanding in which the agencies agree to refer all cases of suspected fraud to the unit. In addition, the agency must afford the fraud unit access to their records. The S/URS is the entity within the Medicaid State agency that performs these functions.

Prior Evaluations of Medicaid Fraud Referrals

In a prior report, titled *"Referral by Medicaid Agencies to Fraud Control Units," OAI-03-88-00170*, October 1989, we assessed the effectiveness of the process used by Medicaid agencies to refer possible fraud cases to the MFCUs and offered suggestions for improvements. In the report we highlighted the following problems:

- low number of State agency fraud referrals;
- lack of HCFA monitoring and oversight; and
- the need for additional technical assistance.

We recommended that the HCFA:

- hold State agencies accountable for making fraud referrals by measuring and evaluating their development of these cases;
- assure that State agencies are provided increased technical assistance in the areas of identification and referral of potential fraud cases; and
- designate a coordinator for technical assistance that would coordinate with the OIG.

---

[1] Idaho, Montana, Nebraska and North Dakota do not have MFCUs.

In response to this report, HCFA opposed including the review of S/URS development and referral of suspected fraud cases as part of the Systems Performance Review. It has not implemented the review as part of any State agency performance evaluation.

The General Accounting Office in their study, "*Medicaid: Results of Certified Fraud Control Units," HRD-87-12FS,* October 1986, obtained information concerning the volume of referrals from Medicaid State agencies to the fraud units. The report cited:

> "In fiscal year 1985, on the average, most of the (MFCU) cases were referred from the State Medicaid Agency–34.7 percent"

This is 996 of the 2,871 cases opened from all sources that year or 34.7 percent of the overall MFCU workload.[2]

METHODOLOGY

We researched Federal laws, regulations, and agency policies concerning development and referral of allegations of Medicaid fraud by S/URS to MFCUs. In addition, we developed and field tested data collection instruments which were administered on-site to officials of these agencies as part of the preinspection process. We designed these instruments to obtain the following information:

- States' policies and procedures used to develop and refer allegations of Medicaid fraud to the MFCU;
- the state of communication between the MFCU and S/URS;
- the quantity, quality and source of training;
- deterrence efforts;
- barriers to effective development and referral of cases;
- suggested improvements; and
- statistics concerning case referrals, case status and case outcomes.

From the universe of fraud units, we excluded the five States, (California, Florida, Illinois, New York and Texas) that participate in the national project, "***Operation Restore Trust,***" since the OIG is evaluating referrals to these units as part of that project. From the remaining States, we obtained fiscal year (FY) 1994 data. This data included the number of cases referred by S/URS and the number of fraud unit

---

[2] There were 36 certified Fraud Control Units by the end of calendar year (CY) 1985. The 14 States not certified were: Alaska, Georgia, Iowa, Kansas, Missouri, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, and Wyoming.

staff employed during each of the quarterly reporting periods. We compared this data to similar data from earlier years.

To select the States for more intensive review, we arrayed them from highest to lowest ratios of referrals per unit employee. We selected a purposive sample of seven States, using the following criteria:

- location within the array of States (upper or lower half);
- amount of Medicaid expenditures in the State;
- number of Medicaid beneficiaries in the State;
- known past or current problems involving either the MFCU or S/URS operations in States; and
- location in the United States, to account for any regional variances.

Using these criteria, we purposively selected four States from the upper half of the array (Michigan, Tennessee, Virginia, and Washington) and three from the lower half of the array (Massachusetts, New Mexico, and Utah).

Using data collection instruments, we personally interviewed staff in MFCUs and S/URS. We then compiled all of the information into a database and tabulated the results. Using this data, we prepared summary information which forms the basis for this inspection report.

We conducted our review in accordance with the ***Quality Standards for Inspections*** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Overall, we found little progress in quantity, quality and agency oversight of S/URS development and referral of suspected fraud cases since our 1989 review.

THE NUMBER AND PERCENTAGE OF SUSPECTED FRAUD REFERRALS FROM S/URS HAS DECLINED IN THE PAST 10 YEARS.

For CY 1994, S/URS in the 7 sampled States referred 268 cases, or 14 percent of the 1,965 cases they reviewed, to the Medicaid Fraud Control Units. Of these, 30 percent of referrals were accepted for full-scale investigation and 59 percent were declined. The remaining cases are pending initial MFCU evaluation.

For this same period, we also compared referrals received by MFCUs from Medicaid State agency S/URS and Medicaid State agency-other for the same States used by GAO in their 1987 report[3], for all MFCUs for CY 1994, and our sample States for CY 1994 (Table 1).

Table 1

Comparison of Single State Agency Referrals to the MFCUs--1985/1994

	GAO Report FY 1985 (36 States)	MFCU Reports CY 1994 (36 States)	MFCU Reports CY 1994 (45 States)	Sample MFCUs CY 1994 (7 States)
Total Fraud Referrals:	996	863	956	284
Total Case Load:	2,871	3,597	3,882	1,199
Percentage of Total Referrals:	34.7%	24%	24.6%	23.7%

Each of these comparisons demonstrates a significant decline in S/URS referrals as reflected in true numbers and in the percentage of total MFCU workload when comparing 1994 data against 1985 results. Appendices A, B, and C expand upon the data displayed in Table 1 to show respectively: sources of fraud referrals to Medicaid fraud units in CY 1994 for the same 36 States that were used in the 1987 GAO study; aligned data for 45 States that had fraud units in CY 1994; and data for the sample States used in this evaluation.

[3] The GAO report used data for FY 1985.

MFCU OFFICIALS ARE DIVIDED IN THEIR OPINION CONCERNING THE EXTENT AND QUALITY OF S/URS DEVELOPMENT OF SUSPECTED FRAUD CASES.

We found that S/URS staff differ in their method for researching past complaints and developing current fraud issues prior to referring cases to the Medicaid Fraud Control Unit as shown in Table 2.

Table 2

Development of Referrals

Method	Process Used	States Using the Process
Medical Records:	Examination of Medical records to substantiate claims.	6
Sampling:	Sample additional claims from the provider and/or conduct medical records review when appropriate.	5
Pre-Payment Review:	Place a provider being investigated on Pre-Payment review.[4]	5
Service Verification:	Contact beneficiaries to determine if services were rendered.	4
	Associate Previous complaints and S/URS cases with the current review.[5]	4
	Refer cases to the MFCU without development at the earliest indication of fraud.	1

This variance in development can adversely affect the quality of referrals. While four MFCUs stated that S/URS development of cases is adequate, three commented that these referrals need improvement. Problematic referral issues cited include:

- allegation of fraud is not clear;
- the S/URS has not developed the allegation beyond the initial fraud issue to determine if this is isolated or a pattern of practice;

---

[4] One State reported that its claims system was incapable of implementing pre-payment review, and that it could only suspend the provider's Medicaid billing number.

[5] One State reported that they cannot adequately research past provider complaints and/or educational efforts since there is not a central repository for filing provider information, educational contacts, and post S/URS development.

- the S/URS has not established through its files and correspondence that there is a basis that the provider knew, or should have known that this method of practice constituted fraud;
- only the complaint is sent with little if any supporting documentation; and
- the S/URS profiles are inadequate, and the MFCU has trouble obtaining electronic data.

We received a number of comments from MFCUs concerning S/URS case development. These include:

> "We receive only the complaint. We receive little, if any supporting material."
>
> "We would like S/URS to include more background material, educational correspondence, agency policy, etc., to show the extent of prior knowledge by the case target."

The MFCU's identified the following as actions which would make case referrals more effective and productive:

- provide adequate and clear case summaries which succinctly describes the analysis and basis for suspicion of fraud;
- sample additional claims of a similar type to see if they can establish a pattern of fraud in similar claims;
- provide additional data on total volume of claims, procedure codes in question, and analysis of other areas of the practice that appear aberrant; and
- provide copies of educational letters previously sent to providers.

The diversity of S/URS development methods and MFCU recommendations for improvement highlights the need for adoption of consistent standards for development and referral of these cases.

THE S/URS EMPLOYEES HAVE NOT RECEIVED SUFFICIENT TRAINING TO ASSURE THAT THEY DEVELOP AND REFER SUSPECTED FRAUD ALLEGATIONS IN A CONSISTENT AND APPROPRIATE MANNER.

States' S/URS staff cite inadequate training in the identification and development of fraud allegations and edits.

- Five S/URS staffs have not received training from Medicaid Fraud Control Units on desired content or process for case referrals.
- Three S/URS staffs have not attended any HCFA fraud training.

States note that staff turnover remains a consistent problem. Therefore, training of new staff and periodic refresher training of all staff is vital to the S/URS units' overall success.

THE HCFA DOES NOT ROUTINELY MONITOR S/URS DEVELOPMENT TO ESTABLISH WHETHER POTENTIAL FRAUD ISSUES ARE BEING APPROPRIATELY AND CONSISTENTLY ANALYZED AND REFERRED.

Three States reported that HCFA did not conduct any review of their S/URS operation, including their case development and referral process. Four States report that HCFA reviewed it, however, three of these said it was simply a part of the Systems Performance Review (SPR) which did not include case reviews and agency feedback.

The HCFA designed the SPR as a performance review of the Medicaid Management Information System (MMIS), including the S/URS subsystem. Standard 6 of this review specifies:

> "S/URS--The operation of a Surveillance and Utilization Review Subsystem (S/URS) must provide comprehensive health care delivery and utilization data for program management, reveal potential defects in the quality of care, and reveal suspected instances of provider or recipient fraud or abuse."

The S/URS component of the SPR remains an instrument to measure how well the Medicaid Management Information System (MMIS) identifies potentially fraudulent Medicaid claims. It does not, however, evaluate how well S/URS staff develops output from this system, or whether issues are appropriately referred to the MFCUs for full-scale investigation. Our 1989 OIG report brought this serious omission from HCFA's oversight process to their attention. However, HCFA opposed using the SPR for this purpose and offered no alternative remedies.

RECOMMENDATIONS

Efforts by the OIG and HCFA to identify and combat Medicaid fraud and abuse have intensified over the past several years. As part of these efforts, the Department is piloting a demonstration program entitled ***Operation Restore Trust***. Under this demonstration, the OIG in partnership with HCFA emphasizes interdisciplinary teamwork with other State and Federal agencies as an important component to enhance fraud and abuse activities.

The HCFA is focusing on improving S/URS and MFCU relations and increasing cooperation between the Medicare and Medicaid programs in the detection and referral of fraud and abuse issues. As part of these efforts, they have formed a permanent Medicaid fraud and abuse coordinating council which serves as a forum for problem discussion/resolution, training, and information exchange. In addition, they are cosponsoring with the Office of Managed Care, regional and national conferences/symposiums on fraud and abuse in managed care programs. Further, they are engaging in other ongoing projects designed to examine compliance and facilitate the exchange of fraud and abuse information among the Medicare program, Medicaid, S/URS and the MFCUs.

We commend HCFA for its efforts to improve fraud referrals from S/URS units to MFCUs. However, we believe HCFA should expand these initiatives and pursue additional actions to facilitate identification and removal of barriers that have hampered case detection, development, and referral activities.

Concerns regarding the effectiveness of MFCUs are similar to those discussed in our report entitled ***"Carrier Fraud Units," OEI-05-94-00470***. As a result, we believe that a concerted effort addressing both Medicare and Medicaid fraud units is called for. We are proposing a uniform team approach. We recommend that HCFA, in consultation with the Office of Inspector General should:

Convene a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud unit operations. This would include:

- Clarifying goals and objectives for program integrity efforts.
- Establishing guidelines for developing suspected fraud cases.
- Developing a universal protocol for appropriately referring fraud and abuse cases.
- Coordinating data systems to ensure that data are reliable and consistent across all entities in the fraud and abuse fighting network.
- Developing a training program designed to educate program integrity personnel on procedures, case referrals and best practices.

Develop and implement a comprehensive evaluation system for S/URS case identification, development and referral activities.

HCFA should consider establishing a system similar to the one used to evaluate Medicare contractors. Once the system is established it should be incorporated into periodic HCFA reviews of the Medicaid State agency and the Systems Performance Review.

These protocols should focus on determining whether S/URS development and referral of cases is in accordance with Federal laws, regulations, HCFA procedures and the Memorandum of Understanding with the Medicaid Fraud Control Unit. In addition, the review should strive to identify best practices that could be shared with other S/URS units and weaknesses that should be addressed by HCFA and/or the Medicaid State agency.

AGENCY COMMENTS

We appreciate all the positive steps that HCFA has taken thus far to safeguard the Medicare program and we recognize the accomplishments of the Program Integrity Group. We are pleased that HCFA has concurred with our recommendations and we look forward to working with HCFA in their implementation.

We believe that the best approach would be a collaborative one involving HCFA and OIG, with consultation from high performing State Surveillance and Utilization Review Subsystem Units (S/URS) and carriers, to improve program integrity activities at the carrier and State level. We suggest that this effort focus on:

- Developing and implementing model practices to help carriers and S/URS decide which cases should be developed for medical review and overpayment recovery or for referral for fraud. In addition, existing protocols should be implemented for referral of fraud cases to appropriate investigative entities (the OIG for Medicare cases and Medicaid Fraud Control Units for Medicaid cases). We believe that together we can increase overpayment recovery amounts and increase the number of successful prosecutions by law enforcement agencies.

- Revising current contractor performance measures that reward carriers for overpayment recovery but not for fraud and abuse referrals or efforts to improve claims processing safeguards.

- Identifying the most effective practices which carrier and State personnel use to eliminate claims processing vulnerabilities that enable providers to defraud health programs.

We believe that achieving the goals both HCFA and the OIG have established for improving program integrity functions at the carriers and in the States can best be accomplished by these kinds of collaborative efforts. We look forward to working with HCFA to bring about further measurable change.

Concerning the establishment of a comprehensive system for HCFA to evaluate S/URS case identification, development and referral, we are pleased that HCFA also concurs with this recommendation. We believe that this initiative is very important to the overall integrity of the Medicaid program. We are delighted to learn of HCFA's recent fraud and abuse initiatives and hope that the S/URS performance evaluation system will be implemented as soon as practical. We remain committed to collaborating with HCFA in their efforts to rapidly develop and implement this system.

The full text of HCFA's comments is contained in Appendix D.

APPENDIX A

MFCU Sources--GAO Sample States[1]
Fraud Case Referrals
CY 1994

Referral Source	Summary Total
Single State Agency (S/URS)	686
Single State Agency (Other)	177
HHS Office of Investigations	67
State Licensure Authorities	100
Insurance Department	4
Prosecutor	20
Law Enforcement	144
Provider	79
Provider Association	3
Private Citizen	956
Insurance Company	46
State Agency	344
Press/Media	8
Other	963
Grand Total:	**3,597**
Single State Agency Referrals as a percentage of total MFCU workload:[2]	**24%**

[1] This is a summary of referral sources for the 36 MFCU States used by the General Accounting Office in their 1987 report.

[2] This is S/URS and Single State Agency (Other) referrals as compared to Total referrals.

APPENDIX B

MFCU Sources--National Data[1]
Fraud Case Referrals
CY 1994

Referral Source	Summary Total
Single State Agency (S/URS)	743
Single State Agency (Other)	213
HHS Office of Investigations	70
State Licensure Authorities	106
Insurance Department	5
Prosecutor	21
Law Enforcement	162
Provider	88
Provider Association	3
Private Citizen	1,062
Insurance Company	46
State Agency	375
Press/Media	9
Other	979
Grand Total:	**3,882**
Single State Agency Referrals as a percentage of total MFCU workload:[2]	**24.6%**

[1] This is a summary of referral sources for the 45 States which had MFCUs in CY 1995.

[2] This is S/URS and Single State Agency (Other) referrals as compared to Total referrals.

APPENDIX C

MFCU Sources--Sample States[1]
Fraud Case Referrals
CY 1994

Referral Source	MA	MI	NM	TN	UT	VA	WA	Total
Single State Agency (S/URS)	2	161	1	27	3	31	13	238
Single State Agency (Other)	0	16	0	0	3	5	22	46
HHS Office of Investigations	0	0	0	0	1	3	2	6
State Licensure Authorities	1	0	0	1	0	0	0	2
Insurance Department	0	0	0	1	0	0	1	2
Prosecutor	0	0	0	1	0	0	3	4
Law Enforcement	1	7	4	11	0	3	10	36
Provider	0	0	3	4	4	1	0	12
Provider Association	0	0	0	1	0	0	0	1
Private Citizen	3	219	26	49	13	1	25	336
Insurance Company	0	13	0	1	1	2	0	17
State Agency	0	25	12	52	1	1	5	96
Press/Media	0	0	0	0	0	0	0	0
Other	13	366	2	8	4	6	4	403
Grand Total:	**20**	**807**	**48**	**156**	**30**	**53**	**85**	**1,199**
Single State Agency Referrals as a percentage of total MFCU workload:[2]								**23.7%**

[1] This is a summary of referral sources for the 7 sample States used in this study.

[2] This is S/URS and Single State Agency (Other) referrals as compared to Total referrals.

APPENDIX D

AGENCY COMMENTS

The Administrator
Washington, D.C. 20201

DATE: SEP 26 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report Entitled: "Surveillance and Utilization Review Subsystems' (S/URS) Case Referrals to Medicaid Fraud Control Units (MFCUs)," (OEI-07-95-00030)

We reviewed the above-referenced report concerning Medicaid fraud and abuse/neglect cases as it pertains to the S/URS. The report discusses specific factors which contribute to and work against successful program integrity operations.

Our detailed comments are attached for your consideration. Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments.

Attachment

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General (OIG) Draft Report Entitled: "Surveillance and Utilization Review Subsystems' Case Referrals to Medicaid Fraud Control Units"
(OEI-07-95-00030)

OIG Recommendation

HCFA should convene a Medicare and Medicaid fraud and abuse task force to plan and implement improvements in fraud unit operations. This would include:

- Clarifying goals and objectives for program integrity efforts.
- Establishing guidelines for developing suspected fraud cases.
- Developing a universal protocol for appropriately referring fraud and abuse cases.
- Coordinating data systems to ensure that data are reliable and consistent across all entities in the fraud and abuse fighting network.
- Developing a training program designed to educate program integrity personnel on procedures, case referrals and best practices.

HCFA Response

We concur. HCFA established the Program Integrity Group (PIG) to address fraud and abuse issues within the Medicaid/Medicare programs. The goals of this group are consistent with the report recommendations. The group's overall responsibilities include completing and monitoring the activities of short and long term projects, such as, changing the conditions of participation for home health agencies, developing a strategic plan with our law enforcement partners, clarifying program integrity language contracts, and determining how to better use data to reduce waste, fraud, and abuse. In addition, HCFA is working to address issues common to both programs. For example, Medicaid Surveillance and Utilization Review Subsystems Units are (or are planned to be) users of the recently developed Fraud Investigation database. The database ensures that information on cases developed by Medicare carriers is shared across a number of program and law enforcement organizations. Inputting fraud cases developed by the Medicaid program would allow tracking both Medicare/Medicaid fraud cases on the same system.

The OIG suggests that there is a need to develop standard guidelines for the development and referral of fraud cases; however, the OIG has already developed such guidelines. HCFA has provided these guidelines for case development and referral to the carrier fraud units and contractors. We encourage the use of these OIG guidelines by the states.

OIG Recommendation

HCFA should develop and implement a comprehensive evaluation system for S/URS case identification, development and activities.

HCFA Response

We concur. HCFA agrees with the recommendation to consider developing a comprehensive evaluation system for S/URS case identification, development and referral activities. However, Medicaid's Fraud and Abuse initiative is a new one and does not have the resources currently to pursue building a comprehensive evaluation system.