
**REFERRALS BY MEDICAID
AGENCIES TO FRAUD CONTROL
UNITS**

**Richard P. Kusserow
INSPECTOR GENERAL**

EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection was twofold: to assess the effectiveness of the process by which Medicaid agencies refer possible fraud cases to Medicaid Fraud Control Units, and to suggest methods to improve the process.

BACKGROUND

Established in 1967, Medicaid is a State administered program which receives Federal matching funds and pays medically related benefits to needy beneficiaries. Almost all Medicaid agencies contain a surveillance and utilization review subsystem (SURS) which serves as the focus for identifying fraud and abuse by Medicaid providers and beneficiaries. Federal oversight of the Medicaid program is vested in the Health Care Financing Administration (HCFA).

Responsibility for investigating and prosecuting of Medicaid fraud, however, is vested in a Medicaid Fraud Control Unit (MFCU). Fraud units have now been established in 38 States and are generally part of the States' Attorney General's office. Federal oversight of MFCU activity is vested in the Office of Inspector General (OIG).

Medicaid agencies and fraud units are required by regulation to enter into a Memorandum of Understanding (MOU) in which the Medicaid agency agrees to refer all cases of suspected fraud to the fraud unit. Fraud Control Units are also prohibited by regulation from duplicating efforts by Medicaid agencies to identify providers for investigation. Identifying possible fraud by Medicaid agencies and investigating and prosecuting by independent fraud units is the system clearly envisaged by this legislative/regulatory structure.

FINDINGS

State Medicaid Agencies Are Failing To Refer A Significant Number Of Potential Fraud Cases.

We selected a sample of over 150 unreferral cases in six Medicaid agencies. We determined that 36.5 percent of these cases should have been referred to the fraud control units. In three of these agencies, the rate was over 40 percent.

The HCFA Is Not Monitoring Fraud Referrals By Medicaid Agencies.

The HCFA's oversight of the Medicaid agency's surveillance and utilization subsystem (SURS) does not include monitoring this system to assure appropriate referrals of possible fraud cases to the Medicaid Fraud Control Units.

A Close Working Relationship Results In The Most Effective Referrals.

This inspection found that a significant difference between effective and ineffective referral systems was how closely Medicaid agencies and fraud units cooperated. Those States where the fraud unit staff works directly with Medicaid staff to select potential cases seem to have the best results.

Not All Potential Sources Of Referral Are Used In Medicaid Agencies.

In addition to SURS, some States have established special investigative units to develop fraud and abuse cases. Also States characteristically perform their financial audits in a unit other than the SURS unit. Both of these functions are potential sources of fraud referrals which are not integrated into the referral process.

Medicaid Agencies Would Benefit From Technical Assistance In Identifying Or Referring Potential Fraud Cases.

There has been little technical assistance to Medicaid agencies in identifying and referring potential fraud. As a result and because of competing concerns, State Medicaid agencies have not emphasized identifying or referring cases in their screening systems.

RECOMMENDATIONS

The HCFA Should Hold State Medicaid Agencies Accountable For Making Fraud Referrals To MFCU's.

This can be done by measuring and evaluating fraud referrals by Medicaid agencies as part of its systems performance review (SPR) and taking appropriate monetary penalties for poor referral performance as provided by the SPR.

The HCFA Should Encourage State Medicaid Agencies To Develop A Close Working Relationship With MFCU's, Including MFCU's Involvement In Actually Selecting Fraud Cases And Developing Effective Guidelines For Referring Of Possible Fraud Cases.

The HCFA Should Assure That All Possible Sources Within The Medicaid Agencies Are Making Appropriate Referrals, Including Separate Financial Audit And Investigative Units.

The HCFA Should Assure That Medicaid Agencies Are Given Increased Technical Assistance For Identifying And Referring Of Potential Fraud. The HCFA Should Also Designate A Coordinator To Focus This Assistance And To Coordinate With The OIG In Connection With Related OIG Activities Outlined In This Report.

OIG OVERSIGHT OF MFCU'S

As a result of this inspection, the OIG will be working directly with MFCU's to help the units interact with the Medicaid agencies. Many of our activities will be parallel to our recommendations in this report, and consequently, we have indicated these activities after related recommendations to the HCFA.

COMMENTS BY THE HEALTH CARE FINANCING ADMINISTRATION

The Health Care Financing Administration generally agreed with our findings and recommendations. However, the actions they are proposing to take, while constructive, are not fully responsive to our recommendations that HCFA:

- (1) hold State agencies accountable for making referrals to MFCU's;
- (2) encourage State agencies to include in their MOU's provisions that would strengthen the relationship between State agencies and MFCU's and;
- 3) provide increased technical assistance for the identification of fraud and abuse.

The HCFA comments and the OIG response to those comments are contained on pages 12-14 of this report.

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INTRODUCTION

BACKGROUND

Both the Medicare and Medicaid programs were established in 1967 by Act of Congress. Unlike Medicare which is federally administered, Medicaid is a State administered program which receives Federal matching funds. Each State is required to designate a State agency (SA) which is the organization in State Government responsible for Medicaid management.

Surveillance and Utilization Review Subsystem (SURS) - In 1972, when it became apparent that many State Medicaid agencies were experiencing difficulties in managing the Medicaid program, Federal funds were made available for developing Medicaid management information systems (MMIS). States were reimbursed at 90 percent of costs for developing and implementing the system.

One of the subsystems of MMIS is the Surveillance and Utilization Review Subsystems (SURS) which is designed to apply post payment screens to identify patterns which could indicate fraud or abuse. (All but four small States now have SURS; in these states responsibility for referrals lies with the overall operation of the SA.) While the States also have other detection methods available such as financial audits and explanation of Medicaid benefits mailed to beneficiaries, the focus of identifying fraud and abuse is in the SURS area in most States.

Federal oversight of all State Medicaid agencies' functions including MMIS, is vested in the Health Care Financing Administration (HCFA). Initially, HCFA conducted State assessments of Medicaid agencies which included an element measuring the number of referrals to the Medicaid Fraud Control Unit. In 1981, however, HCFA instituted Systems Performance Reviews (SPRs) which are performed at least once in every 3-year period and used as the basis of reapproval for MMIS funding. However, these reviews do not measure identifying possible fraud. Also, the SPRs examine the SURS *process* but do not measure the *results* of SURS activity.

Medicaid Fraud Control Units (MFCU's) - In 1977, Congress established MFCU's to investigate and prosecute cases of Medicaid fraud. The MFCU's are now in 38 States. During the period of October 1, 1987, to September 30, 1988, MFCU's produced 465 convictions and \$11.4 million in fines, overpayments, and restitutions.

The MFCU's are funded at 90 percent matching for the first three years of operation and 75 percent Federal funding for ongoing operations. During Fiscal Year 1989, the OIG administered approximately \$45 million in grants to the MFCU's.

To assure investigative independence, Congress prohibited these units from being part of the same "umbrella" organization which contained the Medicaid single State agency. Generally, the MFCU's are located in the States' Attorney General's office and 30 of the 38 MFCU's perform prosecutive as well as investigative functions.

While HCFA was originally responsible for MFCU oversight, since 1978 Federal oversight of MFCU's has been vested in the Office of Inspector General, Department of Health and Human Services. Responsibility for OIG oversight of MFCU's is vested in the State Fraud Branch, Office of Investigations. This branch is scheduled to conduct biennial recertifications of all MFCU's as well as providing technical assistance and advice on an ongoing basis. Currently a system of performance indicators is being developed in cooperation with the National Association of Medicaid Fraud Control Unit Directors to enhance the effectiveness of Medicaid fraud control activities.

Memorandum of Understanding - Each MFCU is also required by regulation to enter into a Memorandum of Understanding with the SA. The MOU's are required by regulation to include an agreement by the SA to refer all cases of suspected fraud to the MFCU and to provide the MFCU access to SA records. The MOU's have now been executed in every State which has a fraud unit.

PROBLEMS WITH THE PROCESS

Recently, indications are that the SA referral process may not be working as designed. For example, a General Accounting Office (GAO) report issued in October 1986 indicated that on the average only about 35 percent of all MFCU cases are based on Medicaid agency referrals. Staff of the OIG's Office of Investigation, in recertification visits to over 20 MFCU's, found that many MFCU's believe a problem exists with both the quantity and quality of SA referrals. In a recent OIG inspection, 20 of the 38 MFCU directors indicated this same problem.

We decided to focus this inspection on the process of referring suspected fraud cases rather than on the processes for identifying such cases. Methods for improving the Medicaid SURS activity including the Medicaid agency-fraud unit relationship are the subject of a best practices project that the Health Care Financing Administration is now conducting.

WHAT WE DID

Because little comparative data was available to gauge the quantity or quality of Medicaid referrals, we contacted every unit to obtain such information.

To measure quantity, we asked each unit to tell us the number of referrals it had received from the State agency in 1987. To obtain a standard measure, we then divided this number by the number of professional staff in the unit. The following table depicts the spread that was reported:

MEDICAID REFERRALS PER PROFESSIONAL STAFF

<i>Quartile</i>	<i>Quartile Medians</i>
Highest 25%	4.44/Professional
Second 25%	1.93/Professional
Third 25%	1.00/Professional
Lowest 25%	.50/Professional

Thus in 1987 the median State in the highest referral quartile received almost nine times as many referrals for each professional staff member as the median State for the lowest quartile.

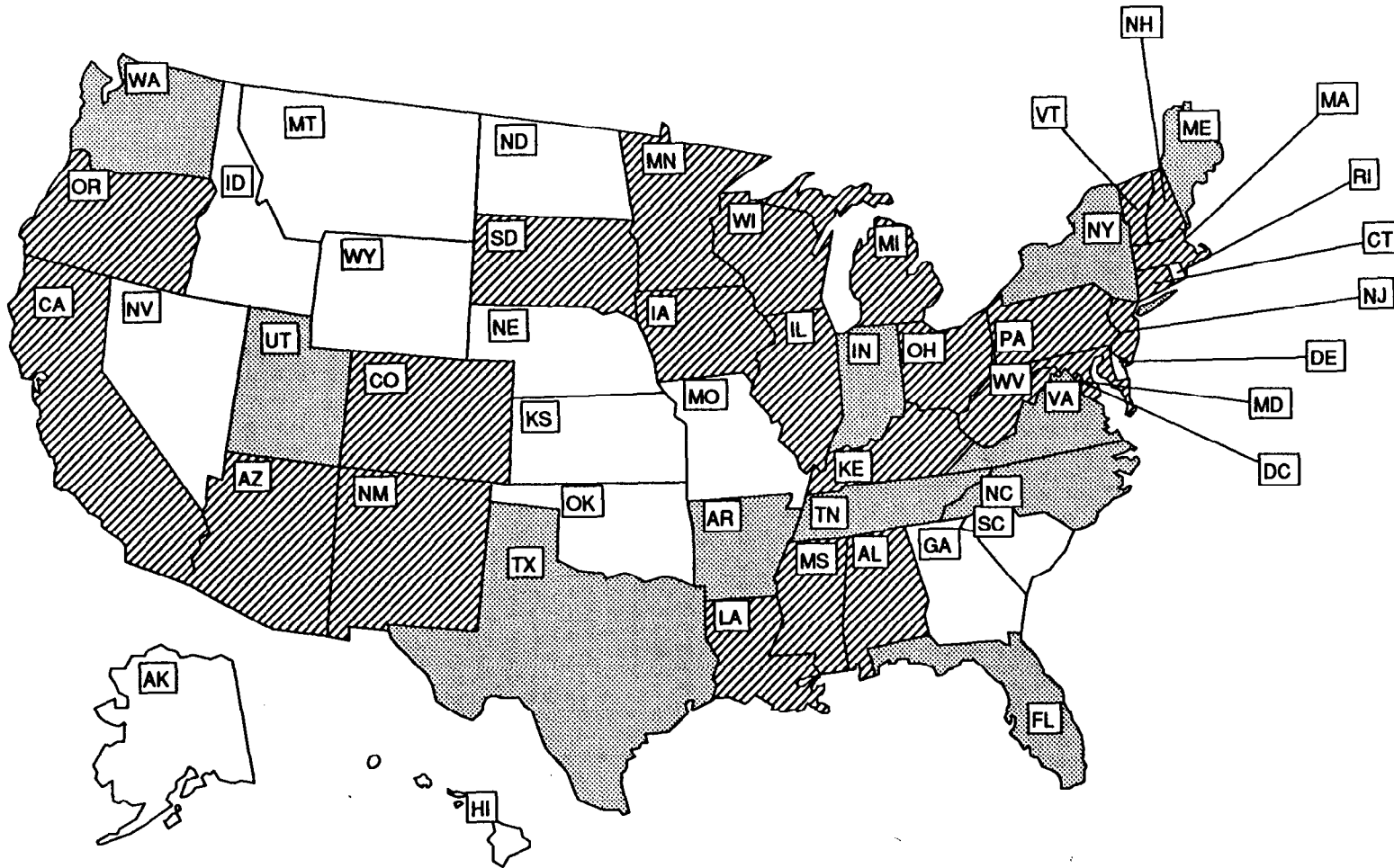
We also attempted to obtain a measure of quality by asking each unit to tell us the percentage of its indictments in 1987 which resulted from the State agency referrals. Since only about one-half of the units could provide us with this information, we used our quality measure to supplement our more complete measure of quantity, also taking into account unit size and the desirability of geographic distribution in selecting a sample.

Based on this information, we selected five States which ranked in higher quartiles for quantity/quality. We studied these States to determine effective practices that can be adopted by other fraud units and Medicaid agencies working together with Federal officials to improve their referral systems.

Also, we selected six other States which our indicators placed in the lowest quartiles for quantity/quality. In these States, in addition to holding discussions with fraud unit and Medicaid officials, we also reviewed overpayment cases which had been developed by the Medicaid agencies but which had not been referred by the fraud units. Our review was intended to determine whether a substantial number of these cases should have been referred.

We visited Medicaid agencies and fraud units in eleven states: Arkansas, Florida, Indiana, Maine, New York, North Carolina, Tennessee, Texas, Utah, Virginia, and Washington. We also held discussions with the HCFA central office staff and regional office staff in four regions. In addition, we presented on the study's goals and methodology to a meeting of the MFCU Directors' Association and the SURS Units' Association.

LOCATION OF MEDICAID FRAUD CONTROL UNITS



■ MFCU STATES VISITED DURING INSPECTION
▨ MFCU STATES

FINDINGS

STATE MEDICAID AGENCIES ARE FAILING TO REFER A SIGNIFICANT NUMBER OF POTENTIAL FRAUD CASES

We visited six States which ranked in the lower quartiles in the quantity/quality of referrals. In these States, in addition to discussions, we performed a case review to determine if there were cases closed by the Medicaid agency which should have been referred. Our review teams in each State included professional staff of our Office of Investigations (OI) as well as analyst staff from our Office of Analysis and Inspections. Our case reviews consisted of analyzing the material in the folder maintained by the Medicaid agency and did not involve independent development or additional contacts. Our sample concentrated on cases involving large overpayments since such cases generally have the clearest prosecutive appeal.

We found a significant number of unreferred cases should have been referred to the Medicaid Fraud Control Unit. Such non-referrals exist even though State agency staff is aware of the requirement in their Memorandum of Understanding to refer cases of suspected fraud to the MFCU and, as noted below, even in some cases where specific referral criteria have been developed to supplement the MOU. We reviewed over 200 cases in six States. In 156 of the cases we reviewed, we could definitely determine that the case should or should not have been referred. See the following table.

RESULTS OF CASE REVIEWS		
<i>State</i>	<i>Number Reviewed</i>	<i>% That Should Have Been Referred</i>
S	26	73%
T	29	20.7%
W	32	40.6%
X	19	52.6%
Y	27	29.6%
Z	23	4.3%
TOTAL	156	36.5%

Examples of our findings are as follows:

- In one State, the State agency and the Fraud Control Unit had developed specific referral criteria in addition to their MOU. We found, however, a significant number of cases in which these criteria were not applied, including cases where services could not be documented or which involved persistent upcoding.
- In another State, little communication of any kind existed between the Fraud Unit and the State agency. Although the Fraud Unit had specifically requested the State agency to provide it with copies of all overpayment letters, we found cases in which this request had not been carried out. These cases involved large overpayments which the State collected but did not inform the Fraud Unit.
- In another State, the Medicaid agency structure included a investigative unit whose staff were criminal investigators. Cases investigated by this unit had not been referred to the Medicaid Fraud Control Unit. Also State agency management has moved to limit referrals that had been made through informal staff contacts and discussions.

Conflicting Concerns and Priorities

We discussed conflicting concerns and priorities with both State agency and Fraud Unit management which may be interfering with effective referrals. The definiteness of our analysis is limited by the obvious sensitivity on this issue by Medicaid agency management and the clearly speculative nature of opinions offered by Fraud Unit staff. However, we were able to discern common elements in many of our interviews in what are believed to be State agency perceptions which may influence referral decisions:

- Medicaid agencies make many referrals that do not result in prosecutions but which involve considerable work on the State agency's part.
- Referring a case involving a significant overpayment to the Fraud Unit where it may undergo a time-consuming investigation may delay or even prevent the Medicaid agency from claiming that overpayment.
- Medicaid agencies are liable for the Federal matching share of an overpayment as soon as that overpayment is identified. Referring the identified overpayment to the Fraud Unit, however, may delay collecting of the overpayment from the provider until long after the State agency has reimbursed the Federal matching. (This problem, however, is being dealt with by a proposed regulation which will require the Federal matching adjustment only when the overpayment is recovered.)

- Fraud investigations could affect the access of Medicaid beneficiaries to a full range of medical services by discouraging provider participation in the program. This could be especially serious where there was already limited participation by a particular specialty.
- Medicaid fraud convictions could be seen as reflecting on the administration of the Medicaid program. Publicized fraud convictions could be interpreted as resulting from loose administration of the Medicaid program.

THE HCFA IS NOT MONITORING FRAUD REFERRALS BY MEDICAID AGENCIES

Until 1982, the HCFA conducted State assessments of Medicaid agencies which included referrals to Medicaid Fraud Units as a performance factor. However such State assessments are generally no longer performed. Rather HCFA has selected as the sole measure of performance of the SURS unit a Systems Performance Review (SPR) performed by regional HCFA systems staff. The SPR, however, measures the compliance of the SURS *process* with Federal requirements (for instance, whether a pre-assigned number of hospitals were reviewed). Measurement of *outputs* is not part of the SPR. Thus, fraud referrals are not being evaluated on a systematic basis.

We believe the HCFA should use the SPR to measure the Medicaid agency's referral activities. While such a measurement introduces a new element into the SPR, this element clearly adds to the overall meaningfulness of the evaluation process.

The HCFA should also consider contacts with Fraud Unit as part of their evaluation. These units are systems users and thus should be in a position to offer the HCFA insights in improving the process.

In addition to measuring SURS performance, the SPR also provides for financial penalties for Medicaid agencies out of compliance with systems requirements. In view of the relationship between process and output, it would be totally appropriate to apply such penalties to agencies consistently below par in their fraud referrals.

RECOMMENDATION

The HCFA Should Hold State Medicaid Agencies Accountable For Making Fraud Referrals To MFCU's.

This can be done by measuring and evaluating fraud referrals made by Medicaid agencies as part of its Systems Performance Review and taking appropriate monetary penalties for poor performance as provided by the SPR.

Related OIG Activities: The OIG is developing a system for comparative indicators of referrals received from the State agencies by Fraud Units. This indicator system should streamline the process and allay Medicaid agency concerns as to wasted effort on their part as well as delays in MFCU actions.

The OIG is also expanding its MFCU recertification guide to cover the area of referrals in greater depth. In addition, as part of its recertification visits the OIG staff will regularly contact the parallel State agency for an in-depth discussion of referrals to the Fraud Unit. These discussions can serve as the basis for joint State agency Fraud Unit's efforts to resolve differences between the two organizations.

A CLOSE WORKING RELATIONSHIP RESULTS IN THE MOST EFFECTIVE REFERRALS

We visited five States which ranked among the top quartiles in the quantity or quality of 1987 referrals. Examples of the basic working arrangements we found in these States are below:

- In one State, SURS exceptions are discussed at regular meetings between the SURS director and the MFCU director. The MFCU director then selects cases for fraud development. In addition, the MFCU has furnished the Medicaid financial audit staff with specific criteria for referring cases to the fraud unit; these criteria resulted in a significant number of audit referrals. By combining these sources of referral, this State has achieved the highest referral rate in the nation, with over 8 referrals for every MFCU professional staff member.
- In another State, the State agency and the MFCU have worked out a method giving the Fraud Unit direct access to the Medicaid agency's database. In addition, the unit receives copies of all recovery letters sent by the agency. As a result, the unit receives approximately four referrals for each MFCU staff member which ranks it in the top quartile in quantity of referrals.

We found staff contacts in each of these States are not limited to formal meetings. Rather, staff members are encouraged to contact their counterparts to discuss and assist in identifying and investigating cases. The MFCU staff is provided on-line access to the Medicaid data base.

We believe the working relationship in these States bears a definite relation to their effective referral systems. Involving MFCU's in actually identifying referrals also contributes to such effectiveness. (This working relationship is in clear contrast to the poor relationships we discuss in some of the examples in the previous section.)

RECOMMENDATION

The HCFA Should Encourage State Medicaid Agencies To Develop A Close Working Relationship With MFCU's, Including MFCU's Involvement In Actually Selecting Fraud Cases And Effective Guidelines For Referring Possible Fraud Cases.

Related OIG Activity: The OIG will be working with MFCU's to encourage them to take all possible measures to bring about a close working relationship. Such measure could include having formal and informal national meetings between MFCU and State agency leadership, developing process for resolving differences between the two organizations, and assuring that MOU's which meet the needs of both organizations are being effectively implemented.

NOT ALL POTENTIAL SOURCES OF REFERRAL ARE USED IN MEDICAID AGENCIES

Although the SURS unit is the most likely source of referrals, we found that State Medicaid agencies contain other possible sources. Every Medicaid agency contains a separate Provider Financial Audit Section which is a potential source of referrals. In addition, some of the large State Medicaid agencies we visited have established fraud investigative units which are organizationally distinct from the SURS unit.

We found that with one exception the referral potential of the Financial Audit Units has not been recognized in the States we visited. Thus in most of these States there was little contact between the SURS staff and the Financial Audit staff and in only one State agency were there guidelines for financial auditors for recognizing, developing, and referring fraud cases. As a

result, in these States there have been no referrals from this area to the Fraud Unit. (By contrast, the one State which has arranged to tap this source has received a large number of referrals from the Financial Audit Unit.)

There was a similar lack of integration into the referral process of the special investigative units established in a few of the larger States we visited. These units had apparently been established to supplement the SURS unit activities but the activities of these units were not coordinated with the Fraud Control Units.

RECOMMENDATION

The HCFA Should Assure That All Possible Sources Within The Medicaid Agencies Are Making Appropriate Referrals, Including Separate Financial Audit And Investigative Units.

This can be done by the HCFA sending a reminder to all Medicaid agencies that all possible sources of referrals within the agency should be used. Also, the HCFA regional staff can confirm such a tie-in has taken place in subsequent contacts with Medicaid agency.

Related OIG Activity: The OIG will be asking Fraud Units to explore other sources of referrals in the Medicaid agencies and to arrange for such sources to be included in the Memorandum of Understanding between the Fraud Units and the Medicaid agencies.

MEDICAID AGENCIES WOULD BENEFIT FROM TECHNICAL ASSISTANCE IN IDENTIFYING AND REFERRING POTENTIAL FRAUD CASES

While our discussions with State agencies focused on referring of possible fraud cases rather than identifying them, the methods for identifying fraud were also touched on. We found that, in general, State Medicaid agencies consider detecting fraud as one possible result of the SURS system which, however, is designed to detect overpayments.

As a result, in none of the States we visited have screens specifically designed to detect fraud been incorporated in the SURS system, and State Medicaid management was not confident that the expertise to design such screens was available to the State agency. In addition, MFCU management in every State we visited indicated they saw a need for additional training of State agency staff in the recognizing program fraud. The HCFA has provided little technical

assistance to develop such expertise. (The General Accounting Office, in their report of September 1987 entitled, *Improvements Needed in Programs to Prevent Abuse*, GAO/HRD-87-75, also recommended that State agencies be provided with technical assistance to improve abuse prevention).

RECOMMENDATION

HCFA Should Assure That Medicaid Agencies Are Given Increased Technical Assistance For Identifying And Referring To Potential Fraud. The HCFA Should Also Designate A Coordinator To Focus This Assistance And To Coordinate With The OIG In Connection With Related OIG Activities Outlined In This Report.

Related OIG Activities: The OIG staff is available to provide HCFA with support in this technical assistance effort. Also the OIG is working with the Fraud Control Units to develop a training package for use by Fraud Units in training of Medicaid agencies in the area of program fraud.

In addition, the OIG will be requesting MFCU's to include a clause in their MOU's calling for Medicaid agencies to consult with the Fraud Units concerning changes in the SURS screens. Where such a clause is already present in the MOU and not being implemented, the OIG will be urging MFCU's to take steps to implement that agreement.

AGENCY COMMENTS

OIG RECOMMENDATION

The HCFA Should Hold State Medicaid Agencies Accountable For Making Fraud Referrals To MFCU's.

HCFA COMMENTS

We agree that increased emphasis on State Surveillance and Utilization Review (SUR) activities will significantly improve the fraud referral process. We plan to publish and disseminate the *SUR Best Practices Guide* by the end of this fiscal year. States will be able to use these exemplary practices to improve their analysis of cases for fraud referral. We are also considering a *State Medicaid Manual* (SMM) instruction outlining States accountability for making referrals to MFCUs. However, we do not believe the System Performance Review (SPR) is the appropriate vehicle for measuring and evaluating fraud referrals by Medicaid agencies because the developmental work required for a fraud referral is completed outside the Medicaid Management Information System (MMIS).

OIG RESPONSE

The proposed HCFA actions are clearly directed at improving the State agencies' own capacities to identify fraud referrals. We believe such actions, while helpful, are not a substitute for holding the State responsible for making appropriate fraud referrals to MFCU's.

The HCFA is correct in pointing out that the SURS system is only a part of the fraud referral process. However, the SURS system is commonly the center of this process and it is therefore entirely appropriate to measure its contribution to fraud referrals as part of the Systems Performance Review.

In addition, HCFA at this time has no other method for gauging State agency performance. Our recommendation for greater accountability could also be implemented if HCFA chose to design and install a more general monitoring and penalty system.

OIG RECOMMENDATION

The HCFA Should Encourage State Medicaid Agencies To Develop A Close Working Relationship With MFCU's, Including MFCU's Involvement In Actually Selecting Fraud Cases And Developing Effective Guidelines For Referring Possible Fraud Cases.

HCFA COMMENTS

The HCFA is developing a workplan that will focus on strengthening HCFA's oversight of State SUR unit activities and improving the relationship between MFCUs and the SUR units. A significant phase of this workplan for Fiscal Year 1990 will be to conduct regional SUR conferences that will facilitate the exchange of information between the MFCUs and the SUR units. We also plan to participate in the annual conference conducted by the national association of SUR officials next spring.

Concerning the OIG's recommendation for direct access to the SUR data base, we believe that the MFCUs should use the Memorandum of Understanding process to negotiate direct access to the SUR data abase.

OIG RESPONSE

We agree that HCFA's Best Practices project which coincides with our findings on an effective State Agency MFCU relationship, will give States helpful information for improving the referral process. We believe, however, that HCFA should also directly encourage State agencies to include in their MOU's the close involvement by MFCU's in the identification of likely referrals.

OIG RECOMMENDATION

The HCFA Should Assure That All Possible Sources Within The Medicaid Agencies Are Making Appropriate Referrals, Including Separate Financial Audit And Investigative Units.

HCFA COMMENTS

The HCFA agrees with the recommended action and will send a Program Memorandum to all Medicaid agencies communicating the OIG's concern that all possible sources of fraud detection within the agency should be used for fraud referral.

OIG RESPONSE

We would appreciate receiving a copy of the HCFA Program Memorandum so that we can share it with the fraud units.

OIG RECOMMENDATION

The HCFA Should Assure That Medicaid Agencies Are Given Increased Technical Assistance For Identifying And Referring Potential Fraud. The HCFA Should Also Designate A Coordinator To Focus This Assistance And To Coordinate With The OIG In Connection With Related OIG Activities Outlined In This Report.

HCFA COMMENTS

We agree with the recommendation that HCFA appoint a coordinator, but believe the appointment should follow a meeting between our Bureau of Quality Control and OIG's Office of Investigations staff to determine specifically the duties of the coordinator. We will arrange for such a meeting shortly.

OIG RESPONSE

We note the comments do not address our recommendation that HCFA assure increased technical assistance to State agencies. We would be glad to work with HCFA on implementing this recommendation.

Our Office of Investigations looks forward to the meeting HCFA mentions in their comments.

