

ANALYSIS OF MEDICAID  
FRAUD INVESTIGATION IN  
THE COMMONWEALTH  
OF VIRGINIA



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## **EXECUTIVE SUMMARY**

In October 2010, the Virginia Joint Legislative Audit and Review Commission (JLARC) completed a preliminary study on the status of Medicaid fraud investigation efforts in the Commonwealth. One of the results of this study demonstrated that there are differences in the investigation practices of the Local Departments of Social Services (LDSS), as demonstrated by variation in investigation and referral rates. This paper examines some of the possible reasons for these differences between the LDSS and also compares Virginia's investigation process to the processes of other states.

A small sample of in-person interviews with LDSS staff were conducted and the knowledge gained from the interviews was employed to create a survey that was then distributed to all the LDSS offices in the Commonwealth. There were 103 valid responses to the survey out of the 121 total departments (85% response rate). Differences were demonstrated in two different areas: LDSS investigation process and LDSS relationships. In the investigative process, particular differences were noticed between LDSS offices in computerized detection sources, whether to conduct interviews in-office, and how to deal with uncompensated asset transfer. The LDSS offices reported good relationships with local Commonwealth's Attorneys and local law enforcement, but only fair relationships with local employers and citizens, and poor relationships with DMAS.

Analysis of other states showed that most states have similar Medicaid fraud investigation processes to Virginia. The border states of Maryland and North Carolina, as well as the successful state of New York, have both local and central investigation components. In the research, only the state of Texas exhibited a completely central investigation process. Although Wisconsin and Illinois had mostly similar investigation processes, these states employed an electronic system that may ease the process of Medicaid fraud investigation.

The survey results did not suggest that any sweeping changes be made to the process of investigating Medicaid recipient fraud by the LDSS in Virginia. The recommendation made obvious from the survey data and the state studies is to increase communication between the LDSS and all of the other agencies and groups they interact with, and to increase communication between LDSS offices.

## **I. INTRODUCTION**

In October 2010, the Virginia Joint Legislative Audit and Review Commission (JLARC) completed a preliminary study on the status of Medicaid fraud investigation efforts in the Commonwealth. The study outlined the Medicaid fraud investigation process in the Commonwealth, and noted several areas where the process could be improved to increase the integrity of the Medicaid program. One of the results of this study demonstrated that there are differences in the investigation practices of the Local Departments of Social Services (LDSS), as demonstrated by variation in investigation and referral rates. This paper examines some of the possible reasons for these differences between the LDSS and also compares Virginia's investigation process to the processes of other states. Recurring themes from variation between LDSS offices and between Virginia and other states are combined into a general set of recommendations to improve the Medicaid fraud investigation process in Virginia.

### **1. Medicaid Fraud Investigations at the LDSS**

The LDSS detects potential Medicaid fraud cases through a number of different methods, including computerized systems and local community referrals. When an investigation is opened, the LDSS must first determine if the recipient has committed fraud in just the Medicaid program or also in other public assistance programs such as the Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF). If the recipient has committed Medicaid-only fraud, then the LDSS refers the case to the Department of Medical Assistance Services (DMAS). However, if the recipient has committed fraud in multiple programs, then the LDSS keeps this joint case and investigates it locally. The LDSS must then prove that the recipient has committed an Intentional Program Violation (IPV). An IPV demonstrates that the recipient intended to commit fraud, rather than simply making a mistake on an application, and is usually handled by a Fraud Investigator. When the

IPV has been asserted by the LDSS, there are two options for the LDSS to recover the fraudulent payments. The first is an Administrative Disqualification Hearing (ADH), where an impartial review by a hearing officer renders a decision of guilty or not guilty of committing an IPV. An ADH is available for any joint fraud case that includes Medicaid fraud, but all Medicaid overpayments collected by the LDSS are returned to DMAS (See Appendix 2). The second is referral to the local Commonwealth's Attorney, who has sole discretion as to which cases will or will not be accepted for prosecution (see Figure 1). The recipient can face disqualification from the programs, fines, and/or jail time for a guilty verdict.

## **2. Variation in the LDSS**

The LDSS vary greatly in terms of total Medicaid investigations, numbers of investigations that were referred for prosecution, and rates of investigations that ended in prosecutions. Areas with high total Medicaid investigations seem to be mostly located around urban cities (Richmond, Roanoke, Hampton), but also include more rural areas such as Washington and Prince William Counties (Figure 2). Numbers of referrals for prosecutions to the Commonwealth's Attorneys are concentrated in the southwest area of the state, with Wise and Montgomery having the most referrals (Figure 3). However, the ratio of prosecutions to total Medicaid investigations shows less variation, with only Greene County referring more than 50% of its cases (Figure 4).

A quick analysis of these variations plotted against general locality demographic variables demonstrated that some statistical explanations for the variations might exist. For instance, an initial graph of prosecution rate by DMAS Region showed a fair amount of variation by region (Figure 5). Another initial graph illustrates a possible negative relationship between prosecution rate and unemployment rate (Figure 6). However, no demographic indicators – population, age, gender, ethnicity, education, disability, income, poverty, unemployment, general region, DMAS region, or

payment structures significantly explained any of the variation of prosecution rate between localities.

Therefore, a methodology was created to further examine reasons for the variations between localities.

## **II. METHODOLOGY**

In order to understand how the LDSS offices specifically investigated Medicaid recipient fraud cases as a part of public assistance fraud cases, LDSS directors and Fraud Investigators were contacted directly. A small sample of in-person interviews with LDSS staff were conducted and the knowledge gained from the interviews was employed to create a survey that was then distributed to all the LDSS offices in the Commonwealth.

### **1. Interviews**

The primary purpose of the in-person interviews was to obtain a broad understanding of the fraud investigation process in the LDSS offices. Initial questions dealt with types of fraud investigated by the LDSS office and how potential cases of fraud were detected. Further questions covered guidelines the office would use to investigate fraud, such as threshold amounts that would have to be reached for an investigation to be opened. The next set of questions was directed at the resources available to investigate fraud, such as the number of full time investigators and the budget for fraud investigation programs. Other questions explored the offices' relationships with their local Commonwealth's Attorney, as well as with DMAS. The interviews were concluded with several open ended questions about how the local offices thought investigations could be improved and why localities had such wide variation in their investigation and prosecution rates.

The interviews were conducted in seven localities in two regions of the Commonwealth, Hampton Roads and Southwest. The Hampton Roads localities were chosen to sample across all levels of population density. Charles City and Gloucester Counties were chosen to represent rural localities, James City County was chosen to represent suburban localities, and Newport News City was chosen to

represent urban localities. The three Southwest interviews were conducted in Montgomery, Tazewell, and Wise Counties. These localities were chosen because DMAS data had indicated that they may be outliers in terms of a high rate of Medicaid recipient fraud prosecutions.

Several preliminary conclusions were drawn from the interviews that would aid in the creation of the survey. First, it became clear that the localities do not handle any Medicaid-only cases, but rather all of these cases were referred to the DMAS fraud unit. The LDSS offices will only investigate a Medicaid fraud case when it is linked to another form of public assistance fraud. Second, the LDSS placed heavy emphasis on its relationships with other entities, such as the local Commonwealth's Attorney or local employers.

## **2. Survey Creation**

The survey was created by tailoring the interview questions based on initial findings. Any questions dealing with Medicaid-only cases were removed because the localities have little involvement in these investigations. Other questions removed included questions for which the answer was likely uniform across all localities, such as the percentage of investigation funding that originated from Federal, State, and Local sources. Based on some interview confusion, questions were reworded so that the respondents would give a more direct and useful answer. Length was also a prominent consideration so questions that were interesting but not the most relevant were cut. A few questions were added based on the interview experience, including questions about deputy Commonwealth's Attorneys and employers that only pay cash to their employees.

The survey is divided into the two major sections of investigation process and LDSS relationships. The process section covers questions such as available resources, how to prove various types of fraud, the types of electronic systems used to detect fraud, and general guidelines for

investigation. The relationship section focuses on four major interactions between the LDSS and the local Commonwealth's Attorney, DMAS, local community, and VDSS.

The survey, which opened on November 9<sup>th</sup>, 2010 and closed on December 3<sup>rd</sup>, 2010, was completed 107 times. However, three responses were duplicates (likely due to a lack of communication between Director and Fraud Investigator) and one response was deemed to be unusable (See Appendix 5). These four responses were separated from the final analysis, leaving 103 valid responses out of the 121 total departments (85% response rate). There were no significant demographic indicators that might lead to non-response bias of the departments.

### **III. SURVEY RESULTS**

#### **1. Investigation Process**

##### **a. Detecting Fraud**

There was little variation between localities in the types of non-computerized sources used for detecting Medicaid fraud. The most prevalent sources of this type were reviews of applications/redeterminations and anonymous referrals (Table 1). Family referrals were less prevalent than the top two sources, and law enforcement referrals and employer referrals were the least prevalent. Other non-computerized sources included other agencies (mentioned by 21% of LDSS), other LDSS staff (7%), schools (5%), and landlords (2%).

While non-computerized systems were mostly similar, responses about computerized detection sources showed a high amount of variation. The most prevalent computerized source was the Virginia Employment Commission (VEC) System (Table 2). The DMV and PARIS systems were not particularly prevalent, and after the VEC there was no clear second-most prevalent system. Most of the variation in this question came from the lists of the other types of computerized sources that are employed by LDSS Staff. There were six different computerized detection sources – SPIDeR, Work

Number, SOIQ, SVES, APECS, and LIDS (Table 3) – mentioned by at least 10% of respondents, and there were 50 different types of computerized sources listed in all. The amount of variation in these types of sources is likely causing the LDSS to have varying detection rates, and therefore investigation rates.

b. Types of Fraud and How They Are Investigated

As discovered in the interviews and confirmed by the survey, unreported income and changes in household composition are the most common types of Medicaid recipient fraud. While unreported income is a common cause of fraud across many types of programs, changes in household composition is limited mostly to Medicaid fraud. At least 90% of respondents listed these types of fraud as the top two most prevalent (Table 4). There is an interesting pattern in how these two types of fraud are investigated: some LDSS take the time to do more in-depth investigations while others do not. For unreported income, 43.69% of LDSS feel that a review of an application is satisfactory to prove the intent to commit fraud, while 49.51% of LDSS also interview the recipient to determine the intent. Of the 49.51% of LDSS that perform face-to-face interviews, 17.39% stated that the purpose of the interview is for the client to explain the possible fraudulent behavior. For changes to household composition, 34.95% of LDSS contact a third party to prove intent, while 52.42% do not contact third parties. The extra time it takes to conduct interviews or contact third parties might decrease the number total Medicaid fraud investigations, but might also reduce the number of cases that are investigated but there is no fraudulent activity and increase the effectiveness of the investigators.

Although uncompensated asset transfer is not highly prevalent across the Commonwealth, there is little agreement between the LDSS about how to deal with these types of cases. Uncompensated asset transfer occurs when a recipient gives personal property away or sells it to anyone, including family members, for less than it would bring on the open market. Of the respondents, 53.40% listed a



procedure for investigating this type of fraud. However, 20.39% of LDSS stated that they always refer this kind of fraud to DMAS, and 23.30% of LDSS commented that they have never seen this kind of fraud. It does not appear that DMAS and the LDSS follow the same procedure regarding uncompensated asset transfer; the relationship between these agencies will be discussed later.

c. Resources for Investigation

Many respondents implied or outright stated that their fraud departments are underfunded or understaffed. The average budget for the total public assistance fraud programs in the LDSS was \$45,368.86, and there were 17 LDSS that did not spend any money whatsoever on fraud investigation in FY 2009. The LDSS do not average a full FTE position dedicated to general public assistance fraud in each department. The average for LDSS fraud FTEs in FY 2009 was 0.76, and there were 33 offices that had zero FTEs. There are several Fraud Investigators who are employed by multiple LDSS, including one who splits time 40%-40%-20% between three offices. The maximum values for both categories came from the same office, which employed 4.25 FTEs on a budget of \$300,000. Although there might not be very many employees, the ones who are employed are very experienced: the average experience of the Fraud Investigators was 10 years, and there were 15 LDSS who stated that their Fraud Investigators averaged more than 20 years of experience.

d. How to Improve the Investigation Process

Unsurprisingly, most respondents (51.46%) stated that the best way to improve the investigation process would be to increase the amount of available resources. However, after the general agreement on that point, there was little agreement on much else. The second most common request was that the Commonwealth's Attorney be more willing to take cases (7.77%), followed by a request for an increase in training (6.80%) and increased public awareness (4.85%). Changing policies, returning a percentage

of collections to the LDSS, allow LDSS to investigate all cases, and better technology were all mentioned by less than 2% of LDSS.

## **2. Relationships**

Respondents were asked to rate their relationships with a number of different groups, and then were asked several specific questions about the level of cooperation between each group (Table 5).

### **a. Commonwealth's Attorney**

The early interviews in Hampton Roads demonstrated that one of the largest challenges facing LDSS offices was the relationship with the local Commonwealth's Attorney. These localities did not appear to receive much cooperation from the Commonwealth's Attorney, and did not have formal agreements for prosecution. However, these concerns were not replicated in the second set of interviews. The southwestern localities all had strong relationships with their Commonwealth's Attorneys, including formal agreements and dedicated deputies assigned to the fraud investigator.

The survey respondents proved to be remarkably consistent with the results from the southwestern localities. Only six respondents reported having no agreement with the Commonwealth's Attorney regarding fraud prosecution. However, only 48.5% of LDSS had formal written agreements, while more than half the LDSS had verbal agreements. Additionally, 41.7% of LDSS have a specific deputy prosecutor assigned to the fraud investigator. This practice appears to be related to locality wealth: the likelihood of having a deputy increased with age, education, and median income, and decreased with unemployment. This is important for stability because the deputy is not an elected position like the Commonwealth's Attorney, and therefore the deputy can be in the same office for many years. A dedicated prosecutor also indicates that the Commonwealth's Attorney's office takes fraud prosecution seriously. However, some localities are so small that there are no deputy Attorneys, so this is not a perfect measure of dedication on the part of the Commonwealth's Attorney.

When considering when to refer a case to the Commonwealth's Attorney for prosecution, 63.1% of respondents reported that there was a minimum amount of fraud required. The most common threshold amount was \$200, with a median of \$500, and an average of \$802. Twenty-six localities had thresholds of \$1000 or more. When there was a specific threshold established, 44.6% reported that exceptions existed. The most common exception was if the recipient had a previous conviction (55.2%), followed by falsification of application, and blatant fraud (10.3% each). In another 10.3% of respondents reporting exceptions, it was up to the discretion of the Commonwealth's Attorney to prosecute or not based on any given exception.

When asked how the relationship with the Commonwealth's Attorney could be improved, 67% of respondents indicated that the relationship was working well and no improvement was needed. This indicates that the relationship is not the point of concern it initially appeared to be in the early interviews. However, there were a few areas where the minority of respondents felt the relationship could be improved. More communication between the two offices was requested by 14.6% of respondents, and another 8.7% of LDSS wanted prosecutors to be more serious in handling public assistance fraud cases because they feel that prosecutors do not make fraud cases a priority.

b. DMAS

The LDSS relationships with DMAS also appeared problematic during the interviews in Hampton Roads. These localities did not have positive views of the agency, and were unhappy with the relationship overall. Again the Southwestern localities proved contrary, with each of the localities noting a positive relationship, especially with their regional representative. However, in this situation, the survey results mirrored the Hampton Roads interviews, not the Southwestern interviews.

The survey respondents were generally displeased with their relationships with DMAS: only 35.9% of the LDSS felt that there was nothing to be improved in the relationship. More than one third

of respondents (37.9%) wanted more communication with the agency. The most common complaint was that DMAS did not notify the LDSS office when it had received a referral for investigation. Although the Interagency Agreement on Medical Assistance Services does not require this type of notification, the VDSS Medicaid Manual does require such notifications. In fact, 59.2% said that they received no notification when they sent a referral to DMAS. For those that did receive notification, it took DMAS an average of 9.7 weeks to respond, with a median response of 4 weeks. For three departments, it took DMAS 52 weeks to respond. DMAS does a better job notifying the LDSS offices about the outcome of their referrals, with 66% of respondents reporting they receive notification of the outcome of their referrals.

Another common complaint from the LDSS offices was that the investigation process is convoluted and difficult. These respondents felt that it would be better if the localities handled the investigations themselves, especially since they already did much of the investigation at the request of DMAS. The localities also wanted DMAS to pass documents to the appropriate people rather than requesting the LDSS office to produce them multiple times.

There were a few unique complaints that stood out in this relationship. Several respondents (5.8%) wanted DMAS to provide them with a list of contact points within the agency, so that they would know who to contact with specific complaints. Several respondents wanted more civility, as they felt that DMAS was impatient and impolite to the LDSS workers who contacted the agency. Finally, one responding LDSS office expressed frustration that they did most of the investigation, but DMAS recovered all the funds during prosecution.

#### c. Local Relationships

The survey results indicate that LDSS offices have a fairly high opinion of the local law enforcement. In fact, several offices indicated that their local sheriff provides investigation support.

The ratings that law enforcement received were even slightly higher than the Commonwealth's Attorneys, which, as was shown above, have a good relationship with the LDSS offices.

Local citizens and employers, however, do not receive ratings as high as law enforcement. This may be due to the fact that citizens and employers are not as well informed about public assistance programs, what constitutes fraud, and how to report fraud. This is consistent with the results from both sets of interviews. One locality even suggested the use of public service announcements to try and increase awareness about public assistance fraud to boost local cooperation.

Another challenge that the LDSS face in the local community is employers that pay their employees in cash. Nearly half of the respondents (49.5%) stated that they do not receive cooperation during investigations from employers that pay employees in cash, while only 31.1% stated that they do receive cooperation.

#### **IV. STATE COMPARISONS**

The interview and survey results have been very useful in bringing subtle problems to light, such as the extremely high number of different computerized detection sources. However, the results can only discover problems within the system currently in place in the Commonwealth, but cannot determine if it is the system itself that is responsible for the variation between localities. To see if some of the variation can be explained this way, Virginia's general Medicaid fraud investigation program must be compared to other states' investigation programs (See Appendix 4 for all sources).

##### **1. Border States: Maryland and North Carolina**

The border states Maryland and North Carolina both have similar Medicaid fraud investigation processes to Virginia. In both states fraud investigations are begun at a local level by local offices with functions similar to Virginia's LDSS offices. Medicaid cases specifically are referred to a central office similar to DMAS for further investigation. In North Carolina, the central agency even has a similar

name to DMAS: the Division of Medical Assistance (DMA). Cases warranting prosecution are then forwarded to the equivalent of Commonwealth's Attorneys for prosecution.

However, North Carolina in particular does approach some minutiae of the Medicaid fraud investigation process slightly differently than Virginia. North Carolina has regulated that its health providers must prominently place a poster in their offices detailing Medicaid fraud and how it is reported. These posters are intended to educate the general community about the prevalence of Medicaid fraud and how to combat it. Furthermore, the state has also announced the use of a dedicated IBM computer system to sort through claims for unusual usage patterns among both providers and recipients, and has gained national press for its introduction to the system. North Carolina is not expending additional resources to pay for this new computerized system, but rather the state will pay IBM based on a percentage of the funds recovered. Both of these measures have received state and national press, which might increase public awareness about Medicaid fraud in North Carolina.

## **2. Successful State: New York**

New York is a state that has gained national acclaim for its Medicaid fraud investigation process. In fact, the state has won a national award for its record-setting performance in 2009, when its Medicaid Control Fraud Unit (MCFU) obtained 168 criminal convictions and recovered over \$283 million. This amount refers to funds awarded by a court, otherwise called "ordered recoveries." The Governor and the Attorney General are extremely proud of the recovery efforts, and each has lauded the programs on their personal websites. Although New York does not have agencies with similar names to Virginia, the basic process is still the same. Local agencies in New York investigate Medicaid fraud at the local level, while the central level investigations are handled by the Office of the Medicaid Inspector General, which is within the New York Department of Health under the authority of the Governor. Within this office is the Recipient Fraud Unit (RFU), which acts similarly to DMAS's Recipient Audit Unit. It is part of the

RFU's stated mission to increase communication and collaboration between itself and local offices of the Department of Health in New York. The RFU encourages local offices to meet regionally at least once a year so that best practices can be shared and implemented on a wider scale. The survey results demonstrated that the LDSS and DMAS struggle with clear communication, so it is possible that the success in New York is dependent on its interagency communication. However, it is difficult to make more direct comparisons between Virginia and New York, because New York's Medicaid program completely dwarfs Virginia's. New York has more than five times as many Medicaid enrollees that Virginia, and therefore will by default have much more Medicaid fraud.

### **3. Different Processes: Texas and Wisconsin/Illinois**

The Medicaid fraud investigation process in Texas is markedly different from the process in Virginia. Texas is one of the only states in the country to investigate all public assistance fraud at the central level. The investigation process is overseen completely by the Office of the Inspector General, and is taken out of the hands of any local agencies. However, this centralization does not mean consolidation of staff. The Texas Office of the Inspector General employs hundreds of FTEs, compared to just the 78 FTEs recorded in the survey results. By completely centralizing fraud investigation in the Office of the Inspector General, Texas significantly reduces, if not completely eliminates, the duplication of effort that occurs when both local and central agencies are simultaneously investigating recipient fraud. The survey results illustrated that a main complaint of the LDSS regarding the relationship with DMAS is repeatedly sending documents back and forth from agency to agency. Limiting investigations to only one central agency prevents this redundant communication from occurring, saves time and money, and streamlines the entire investigation process. Like New York, Texas has also been extremely successful with its Medicaid fraud investigations, recovering over \$338 million in fraudulent total public assistance funds in 2009.

Unlike Texas, the Midwestern states of Wisconsin and Illinois have local and central agencies similar to Virginia. However, these two states differ because they have implemented revolutionary electronic systems that allow their local and central agencies to upload and view documents in real time. Therefore, documents do not have to be sent back and forth between agencies, notifications of receipt of referral happen instantaneously, and the outcomes of cases are immediately apparent. The electronic systems in these two states are still in pilot programs, so the final data determining how useful the systems actually are has not yet been published. However, any progress might be able to improve upon the lack of interagency communication that is occurring in Virginia. Although Federal law requires the use of a Medicaid Management Information System, the survey results illustrate that the efficacy of a system of this sort in Virginia is negligible.

## **V. CONCLUSIONS**

### **1. Recommendations**

The survey results did not suggest that any sweeping changes be made to the process of investigating Medicaid recipient fraud by the LDSS in Virginia. Although there was quite a bit of frustration directed towards DMAS, less than 4% of LDSS recommended making the policy or agency changes that might separate the LDSS from DMAS or dissolve DMAS completely. On top of this survey evidence, the case study of New York, which has the same structure as Virginia but has been significantly more successful, proves that the general model of local offices working in concert with a central agency can be effective.

The recommendation made obvious from the survey data and the state studies is to increase communication. Based on the survey responses, the respondents are hoping for more clear and frequent communication between LDSS and DMAS. Notifications should be increased, contact information should be made very accessible, and guidelines about which agency is handling what type of fraud



should be revisited. Procedural streamlining would ensure that all players are on the same page, so that differences between departments would reduce and hopefully lead to similar outcomes across all localities regardless of size, population, or region. Although a new electronic system like the ones implemented in Wisconsin and Illinois would drastically help improve communication, New York has managed to win a national award simply by encouraging its staff to communicate with each other and making fraud investigations a priority. This is a simple and low cost way to increase investigations, which could then be built on the solid foundation that already exists between LDSS and Commonwealth's Attorneys to increase prosecutions.

Not only should the LDSS communicate more frequently with DMAS, LDSS staff should communicate more often with other LDSS staff. The LDSS staff have many investigation methods, such as using a wide variety of computerized detection sources, and communication between staff will help the entire agency develop an idea of which methods are working and which are not. Inter-department communication and a discussion of best practices would also work to reduce differences between outcomes and create more similar outcomes. Furthermore, the LDSS should reach out into the local community to try to increase education about Medicaid fraud and cooperation from various groups, such as employers. This is likely occurring on a small scale - one respondent mentioned that the department hands out brochures about Medicaid fraud to every applicant – but nothing quite on the scale of the poster regulations in North Carolina. This could work to increase community cooperation, such as employer and law enforcement referrals, and add general integrity to the Medicaid program as a whole.

## **2. Further Study**

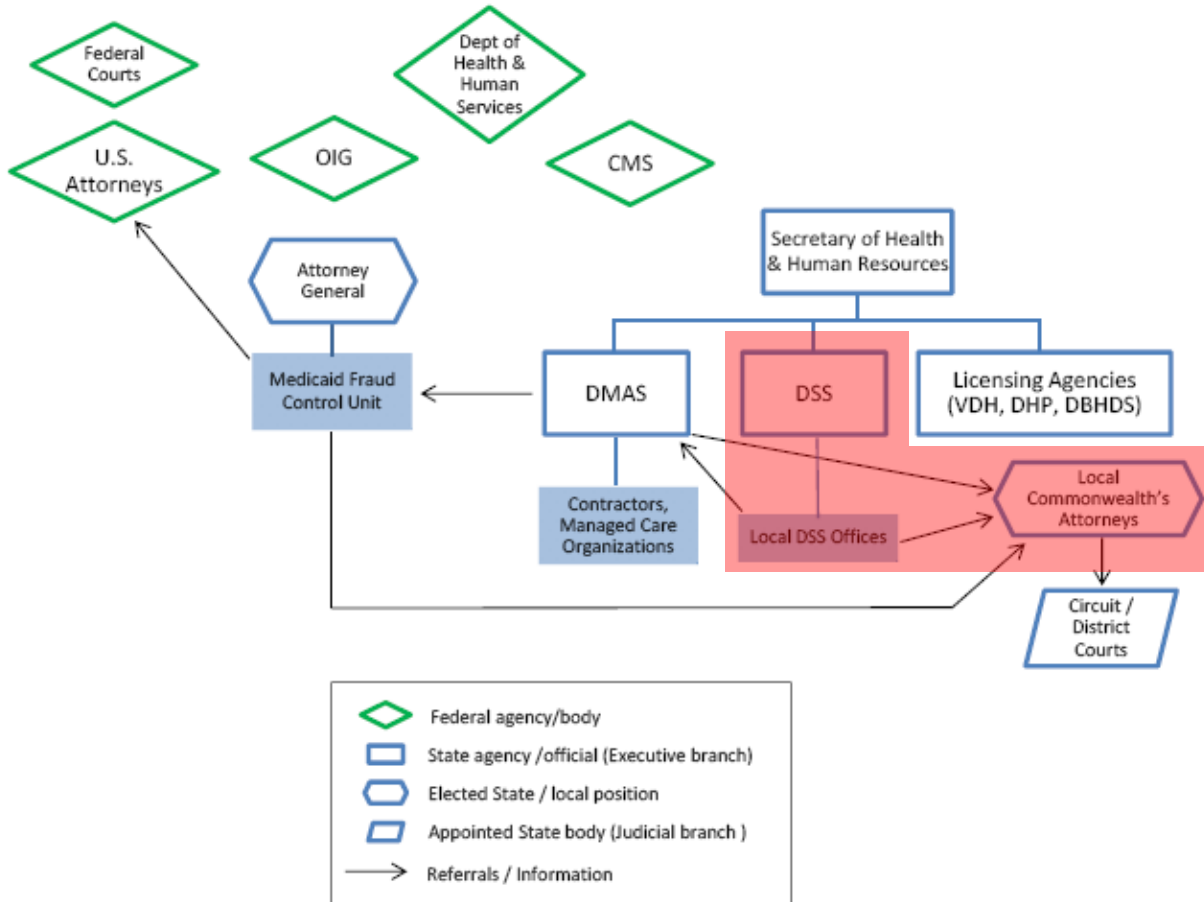
One area that decidedly requires further research is the process for reaching an outcome for a Medicaid fraud case as part of a joint public assistance case. The LDSS do not receive any part of the

Medicaid collections from a resolved joint fraud case, so there might be an incentive not to investigate these types of cases but rather refer them to DMAS immediately. Furthermore, other public assistance fraud, such as SNAP and TANF, can be resolved through the process of an Administrative Disqualification Hearing (ADH), but it is not entirely clear in agency agreements what happens when a joint public assistance fraud case with Medicaid fraud attached to it has an ADH. One interesting piece of information that was noted in the interviews but left out of the survey due to length concerns was that Fraud Investigators sometimes spend more than 50% of their time preparing for court by writing documents or briefing Commonwealth's Attorneys. If an ADH is an easier and more viable option for Fraud Investigators, they might be incentivized to pursue ADH more frequently so that they could have more time to deal with their extensive case loads.

# APPENDIX 1: FIGURES

Figure 1

**Responsibility for Medicaid Program Integrity Is Dispersed Among Many Agencies and Levels of Government**



Source: JLARC staff.

Figure 2: Total Medicaid Cases (2009)

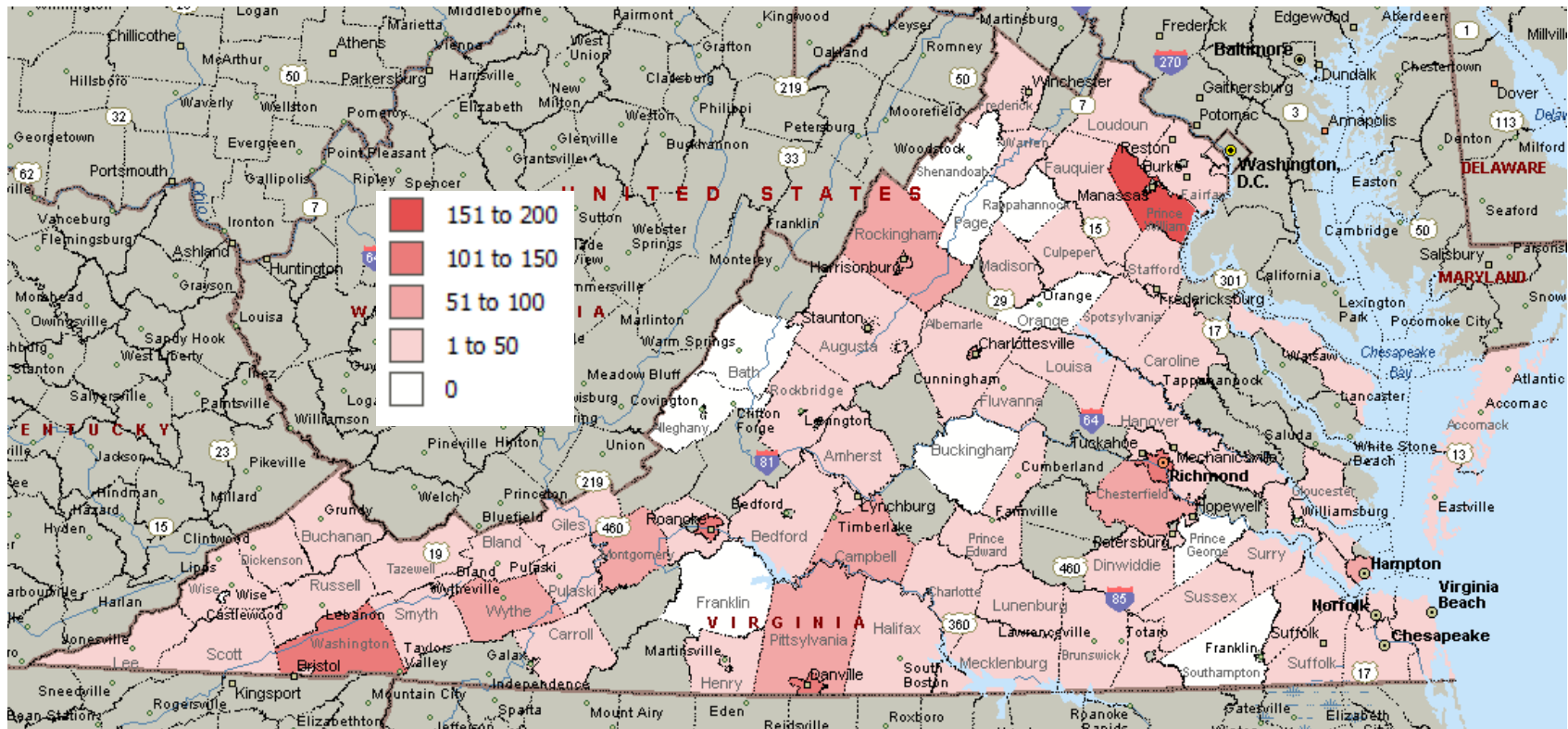






Figure 5

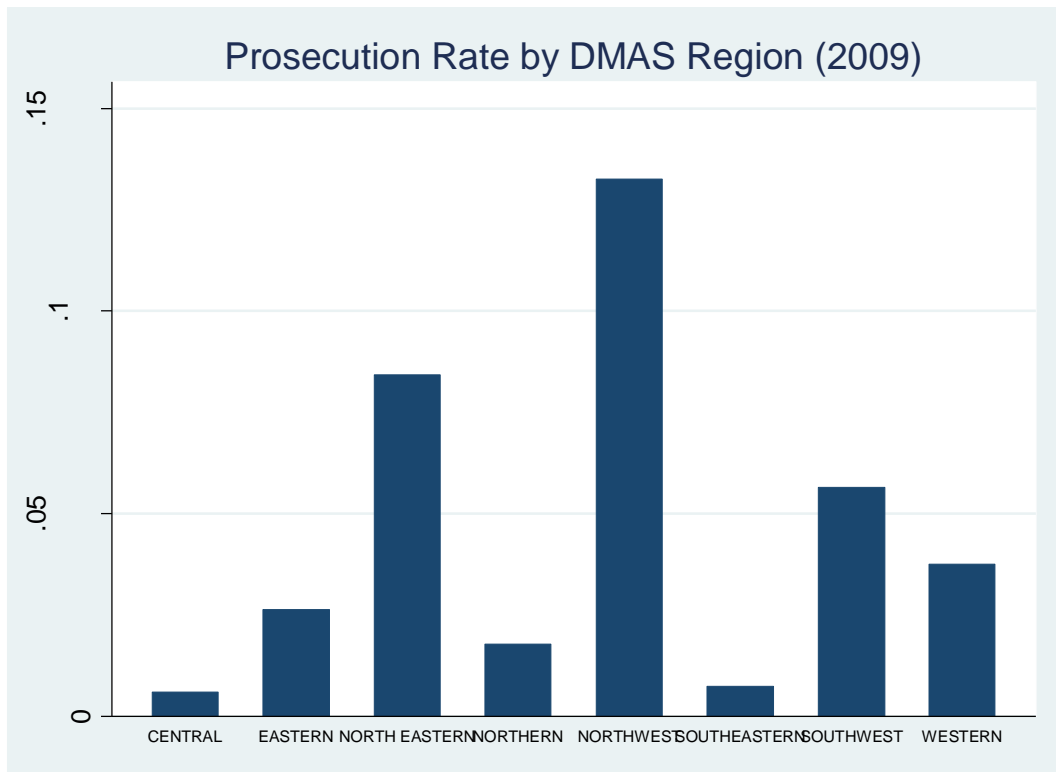
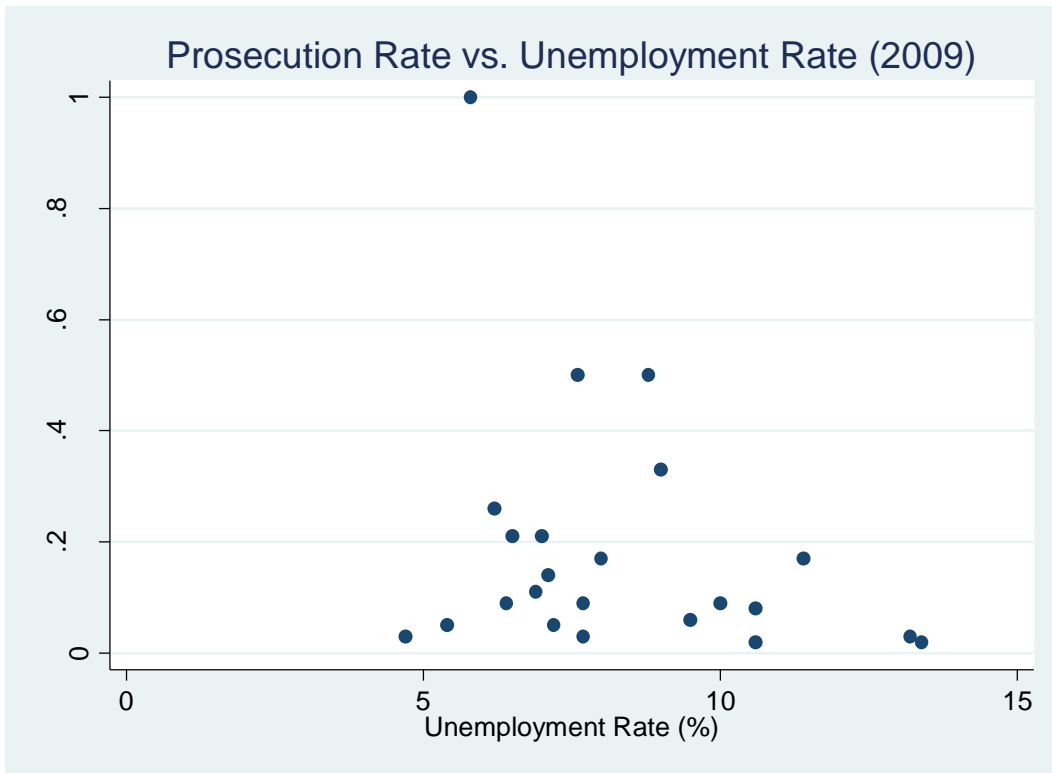




Figure 6



\*Localities where Prosecution Rate=0% were dropped from this graph

APPENDIX 2:  
ADMINISTRATIVE  
DISQUALIFICATION  
HEARING

Email communication with Sandy Smith, VDSS:

**Mark:** Do both prosecution of fraud in court and disqualification through ADH lead to collection of overpayments? Is there something other than the legal part (i.e. other than getting charged with a misdemeanor/felony) that separates prosecution from ADH? Is one conceivably better for the State than the other? And if there is a collection of overpayments as a result of a joint case that has both Medicaid and other public assistance fraud, does the Medicaid overpayment go back to DMAS?

**Sandy:** I offer the following clarifications in answer to your questions. Generally, fraud investigations result in a program overpayment, which must be repaid. If an agency investigates an allegation at the point of application for benefits and the application is denied as a result of the investigation, there is no overpayment, but there may still be a false application to pursue. When a case is prosecuted, the court addresses restitution. If the case is handled through the Administrative Disqualification Hearing (ADH) process, restitution is pursued based on the specific program guidance. Even if fraud is not substantiated, an overpayment may occur and may need to be repaid.

When the local agency determines there is evidence to support an Intentional Program Violation (IPV) or fraud (they are one in the same) for SNAP and TANF, program guidance directs the agency to pursue the case through prosecution or through the ADH process, which can include the individual signing a Waiver to an actual ADH. There is no ADH process for Medicaid. The agency determines if prosecution or ADH is the route to take based on the agency's verbal or written agreement with the locality's Commonwealth's Attorney's Office. For example, a CA might not accept a case for prosecution unless the amount defrauded exceeds a specified amount, and in that situation, the agency is required to go the ADH route. So, there is really no answer to which one is better than the other for the State. A court conviction, Waiver to an ADH, or a finding of IPV after an ADH all result in the same outcome – disqualification from the program for a specified period of time. We do know there are more cases handled through the ADH process than prosecuted, and there are more Waivers signed than actual ADHs. Again, please remember, there is no ADH process for Medicaid.

If a TANF or SNAP case with a companion Medicaid case is prosecuted, any restitution ordered by the court for the Medicaid is collected by the LDSS and returned to DMAS. All Medicaid overpayments collected by LDSS are returned to DMAS.

# APPENDIX 3: RESPONSE TABLES

Table 1

<b>Non-Computerized Detection Sources</b>						
Source	Most Prevalent					Least Prevalent
Anonymous Referrals	37.86%	33.98%	15.53%	4.85%	5.83%	1.94%
Law enforcement referrals	2.91%	4.85%	9.71%	20.39%	28.16%	33.98%
Family referrals	3.88%	19.42%	42.72%	22.33%	8.74%	2.91%
Employer referrals	0.97%	6.80%	5.83%	26.21%	36.89%	23.30%
Review of applications or redeterminations	53.40%	23.30%	15.53%	2.91%	2.91%	1.94%
Other Sources	0.97%	11.65%	10.68%	23.30%	17.48%	35.92%
Total	100%	100%	100%	100%	100%	100%

Table 2

<b>Computerized Detection Sources</b>				
Source	Most Prevalent			Least Prevalent
Virginia Employment Commission (VEC) System	78.64%	16.50%	2.91%	1.94%
DMV System	0.97%	32.04%	33.98%	33.01%
PARIS Matching	13.59%	23.30%	33.01%	30.10%
Other Computer-based Systems	6.80%	28.16%	30.10%	34.95%
Total	100%	100%	100%	100%

Table 3

<b>Other Computerized Sources</b>	
Source	Mentions
Spider	16.50%
Work Number	19.42%
SOLQ	22.33%
SVES	13.59%
APECS	11.65%
LIDS	9.71%
Total	100%

Table 4

<b>Types of Fraud</b>				
Source	Most Prevalent			Least Prevalent
Unreported Income	84.47%	13.59%	0.00%	1.94%
Household Composition	11.65%	78.64%	8.74%	0.97%
Uncompensated Asset Transfer	2.91%	2.91%	41.75%	52.43%
Other	0.97%	4.85%	49.51%	44.66%
Total	100%	100%	100%	100%

Table 5

<b>LDSS Relationships</b>				
Group	Excellent	Good	Fair	Poor
Local Law Enforcement	55.3%	35.9%	5.8%	2.9%
Local Citizens	14.6%	62.1%	21.4%	1.9%
Local Employers	15.5%	64.1%	18.4%	1.9%
VDSS	35.9%	54.4%	8.7%	1.0%
Fraud Management	62.1%	34.0%	2.9%	1.0%
Program Consultants	50.5%	44.7%	4.9%	0%
Commonwealth's Attorney	55.3%	31.1%	9.7%	3.9%
DMAS	17.5%	44.7%	26.2%	11.7%

# APPENDIX 4: STATE RESEARCH SOURCE LIST

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"Healthcare and Family Services - Office of Inspector General." Web. 05 Dec. 2010. <http://www.state.il.us/agency/oig/>

"Wisconsin Department of Health and Family Services 2007-2012 Strategic Information Technology Plan March 2007." Mar. 2007. Web. 5 Dec. 2010. <http://www.dhs.wisconsin.gov/publications/p8/P80045.pdf>