New England Journal of Public Policy

Volume 5 | Issue 1 Article 6

1-1-1989

Medicaid and Medicaid Cost Containment in Massachusetts

Fredric A. Waldstein
Bentley College

Medicaid and Medicaid Cost Containment in Massachusetts

Fredric A. Waldstein

The purpose of this article is to describe Medicaid's financial structure and examine cost-containment efforts to limit future growth of the program, particularly pertaining to Massachusetts. The principal focus is the Massachusetts Department of Public Welfare and the Massachusetts Medicaid Fraud Control Unit, the two agencies most responsible for Medicaid cost containment in the commonwealth. Because elected officials are unwilling to face directly the troublesome issues surrounding Medicaid and its growth, the government agencies responsible for cost containment have been left to define the scope of the problem, design remedial strategies, and evaluate their success. This process is found wanting on several counts that are not necessarily the fault of the state agencies. What is needed is a national cost-containment policy fashioned by elected officials that provides a comparative framework for evaluation across states.

> The inclusion of Medicaid in the 1965 law evolved when Mr. Wilbur Mills [Chairman of the House Ways and Means Committee] asked me what his answer should be to the inevitable question he thought would be asked during the legislative debate: "Isn't Medicare an 'entering wedge' to a broader program of nationwide 'compulsory' insurance coverage for everyone?" I suggested that if he included some plan to cover key groups of poor people, he would have a possible answer to this criticism. Medicaid evolved from this problem and discussion.
>
> —Wilbur J. Cohen[1]

In all the scholarly literature on the origin and structure of Medicaid, perhaps nothing captures better the ad hoc manner in which the Medicaid program was conceived than these remarks by Wilbur Cohen, one of the principal architects of Medicare and Medicaid. Medicare was viewed as the principal health care legislation both substantively and symbolically. The Medicaid program was an afterthought born out of tactical maneuvers believed necessary to overcome political opposition to Medicare legislation. Medicaid has never stepped from the shadows of Medicare in the minds of the public, politicians, and the media, who persist in viewing it as a second-class, perhaps vestigial appendage of Medicare.

Fredric A. Waldstein is assistant professor of government at Bentley College, Waltham, Massachusetts. He was a fellow of the John W. McCormack Institute of Public Affairs at the time he undertook this study.

But the growth of Medicaid as a major budgetary item has been remarkable. Medicaid assistance payments for the nation in 1988* are projected to be a staggering $47.8 billion.[2] Medicaid is the largest single item in the Massachusetts state budget, accounting for between 13 and 15 percent of the total budget. Expenditures for the Massachusetts Medicaid program in 1988 are projected to reach $1.5 billion.[3]

The history of the Medicaid program may be divided into four eras.[4] In the start-up era, from 1965 through 1971, states began to develop their Medicaid programs with various benefit packages. It became clear that original estimates for Medicaid costs were severely underestimated. The Medicaid budget for 1971 was double the original estimate, and the budget from 1965 through 1971 grew 31 percent. The second era began with the 1972 amendments that expanded Medicaid services and broadened the definitions of eligibility. From 1972 to 1976 the annual average increase in cost was 23 percent. The third era, 1976–1980, may be identified as the era of Medicaid inflation. Costs continued to rise at an annual rate of 12 percent even though there was no significant expansion of medical services. Indeed, the number of Medicaid recipients actually decreased. The fourth and final era includes the 1980s and is characterized as one of fiscal retrenchment. Concern over growth in Medicaid expenditures has been exacerbated by a political climate hostile to government programs in general. The Reagan administration initiated a number of program changes, and Congress included restrictive provisions in the 1981 Omnibus Budget Reconciliation Act (OBRA). These efforts have been widely acknowledged as primarily cost-cutting measures, and the rate of growth has been reduced in recent years.[5] Between 1983 and 1987, the national Medicaid costs grew by an annual average of 8.4 percent, while total national spending for health care increased by an annual average of 8.6 percent.[6]

Medicaid Eligibility and Caseload

Medicaid was established by Congress under Title XIX of the Social Security Act as amended in 1965 to provide health care for the poor. Participation in the Medicaid program by the states is voluntary.[7] Benefit costs and administrative costs are shared by the states and the federal government, but the states are responsible for administering the program.

Because Medicaid is an entitlement, the program must pay for the covered health care costs of all eligible persons. Within federal guidelines, states are given substantial latitude to determine eligibility requirements, the range of services offered, and reimbursement policies. While eligibility requirements keep many poor people from taking advantage of the program, it nonetheless is the principal source of health care funding for the poor in Massachusetts and in the nation.[8]

Federal Medicaid regulations require states to provide certain benefits to recipients, including inpatient and outpatient hospital care; skilled nursing home care; physician services; laboratory and radiology services; home health care; dental care; and preventive health care for children. Massachusetts provides additional health care services to its Medicaid patients, including prescribed drugs; care in intermediate nursing homes; adult day health care; mental health care; and transportation to medical services. These options make the Massachusetts Medicaid program one of the most comprehensive in the country.

*All budgetary data are for fiscal years unless indicated otherwise.

Individuals may qualify for Medicaid if they meet the criteria defining either one of two recipient groups: the categorically needy and the medically need. The categorically needy include all persons who received cash assistance from the Supplemental Security Income program, the Aid to Families with Dependent Children program, or the Refugee Resettlement program. These individuals are automatically eligible for Medicaid. The medically needy are defined as individuals and families who are not categorically eligible but who fall below established income thresholds and have insufficient resources to meet their medical needs.

The Medicaid caseload in Massachusetts is expected to be approximately 273,100 cases per month in fiscal year 1989. Overall, the number of Medicaid cases increased approximately 4.2 percent from 1983 to 1987. Department of Public Welfare projections suggest that the rate of growth between 1987 and 1989 will be approximately 1.6 percent.[9] This leveling suggests that without either a major restructuring of the eligibility requirements or a major change in the economic status of a significant percent of the population, the Medicaid program has reached a caseload threshold.

About 65 percent of all Massachusetts Medicaid recipients are children in impoverished families and their parents. Elderly and disabled recipients account for approximately 35 percent. However, because a significant proportion of elderly and disabled require nursing home care or other costly treatment, they use a disproportionate share of the budget, accounting for 75 percent of total Medicaid expenditures.[10]

Program Costs

Medicaid is a vendor payment program operated as third-party coverage. That is, the patient is treated by a health care provider, who bills the government for the cost of the service. The government pays the provider's fee. A cost-sharing formula based on state per capita income is used to determine the percentage of costs carried by the state government and the federal government:

$$\text{State share} = \frac{(\text{State per capita income})^2}{(\text{National per capita income})^2} \times .45,$$

$$\text{Federal share} = 1.00 - \text{State share}.$$

This formula is designed so that the federal government pays a larger proportion of the program costs in poorer states (to a maximum of 83 percent) and a smaller proportion in wealthier states (to a minimum of 50 percent).[11] Because per capita income in Massachusetts during the past two decades has been high compared with that of the nation as a whole, the commonwealth has paid for 50 percent or slightly less throughout the history of the program. The federal share rose above 51 percent between October 1, 1977, and September 30, 1983, reaching a high of 53.56 percent between January 1, 1981, and September 30, 1983.[12] This corresponds with a time when the Massachusetts economy was quite sluggish. At the other end of the spectrum is Mississippi, which consistently ranks as the poorest state using the cost-sharing formula. The federal government has never paid for less than 77 percent of costs for the Medicaid program in Mississippi in those years for which data are readily available.[13]

Medicaid costs can be classified in three categories: the medical services offered, the program's eligibility policies, and the policies about reimbursement to providers. Table 1

illustrates how these categories have contributed to the rising cost of Medicaid over its four eras. By the beginning of the third era the primary concern was how to reduce Medicaid's costs, since they had escalated beyond anyone's anticipation.[14] At the same time, many state governments were under severe financial pressures induced by a lagging national economy.

While Congress and state legislatures felt obliged to maintain the Medicaid program, they nonetheless appeared unable or unwilling to address its problems. Kenneth Wing has characterized the status of the program this way: "Inadequate in its structure and design, unpopular and expensive, Medicaid in its programmatic adolescence was no more loved than it was wanted at birth."[15] Remedial measures were idiosyncratic and often inconsistent, reflecting the political ambivalence of the government and the public to the Medicaid program.

Cost-Containment Strategies

Because Medicaid is an entitlement, states cannot exercise fiscal control by such means as limiting the number of beneficiaries or putting a cap on the amount of total spending. If a person meets the eligibility requirements and the health-related service is covered, the state must pay. However, this does not mean that the states are incapable of containing program costs. The history of the Medicaid program reveals the consideration and use of four cost-containment strategies: cutting eligibility, cutting services, cutting provider fees, and making the system more efficient. The first two strategies could alienate constituencies, a risk that politicians prefer to avoid.

The third strategy traditionally has not been viable because physicians' fees and other provider fees for services to Medicaid patients customarily have been set by state governments at rates lower than non-Medicaid rates. Since participation by health care providers in Medicaid is voluntary, many simply opt not to participate. Reducing the fees creates the risk of further lowering participation. In addition, the health care professions are represented by many powerful interest groups that oppose even tangential threats to the financial security of their members.

The fourth strategy, increasing program efficiency, typically has meant a call to streamline the administration of the program and put an end to fraud and abuse.[16] This strategy is popular with politicians in part because the political risks are minimal. Advocating a reduction in fraud as a means for ensuring that tax dollars are spent for their intended purposes is unlikely to generate much opposition. And calls to streamline programs to make them more efficient places much of the burden on the bureaucracies that administer them. Bureaucracies rarely engender much sympathy from the public.

A major complaint among both critics and supporters of the Medicaid program is that the fee-for-service system is easily abused because it provides no incentives for either providers or recipients to be concerned about cost containment. Health care providers who are paid to give services to recipients are the principal source of Medicaid fraud and abuse.[17] Among the more frequent perpetrators of fraud are medical doctors, nursing home operators, hospitals, and pharmacists. Typical of the types of fraudulent activities that occur are filing claims for services not delivered, filing duplicate claims, overclassifying services to qualify for higher fees, and inflating the cost of services. A number of studies have documented various types of fraud and abuse in the Medicaid program.[18] This evidence of fraud, coupled with the large increase in provider costs as illustrated in Table 1, lent legitimacy to charges that the Medicaid system was rampant with fraud.

Table 1

National Medicaid Costs by Category, as a Percentage of Total Medicaid Costs

	Medical Services Offered (Utilization)	Reimbursement to Providers (Price)	Eligibility Policies (Population)	Total
Start-up era (1965–1971)	19.4	45.2	35.4	100.0
Amendment era (1972–1975)	43.5	30.4	26.1	100.0
Inflation era (1976–1980)	92.3	−7.7	15.4	100.0
Retrenchment era (1981–Present)*	91.7	0.0	8.3	100.0

* Data are from 1980–1981 only. But indicators suggest that they are respresentative of the entire decade.

Source: Medicare and Medicaid Data Book, 1984, Document No. 03210 (Baltimore: Health Care Financing Administration, June 1986), 31–32.

The Medicaid Fraud Control Unit

On October 25, 1977, President Jimmy Carter signed into law P.L. 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments. Among other things, the law authorized a Medicaid Fraud Control Unit (MCFU) responsible for investigating and prosecuting provider fraud in every jurisdiction operating a Medicaid program. The federal government agreed to pay 90 percent of the costs incurred in fiscal years 1978–1980 in establishing and operating state fraud control units. In December 1980 the federal contribution of 90 percent was limited to a unit's first three years of operation, after which the federal contribution would be reduced to 75 percent. Among the requirements established by the legislation were the following:

> To be eligible for the increased matching rate, the State Medicaid fraud control unit must be a single identifiable entity of state government which the Secretary [of Health, Education, and Welfare] certifies (and annually recertifies) as meeting specific requirements. Such entity must be: (1) a unit of the office of the State Attorney General or of another department of state government which possesses statewide prosecuting authority. . . . Any [MFCU] is required to be separate and distinct from the State Medicaid agency.[19]

The Office of Inspector General (OIG) within the Department of Health and Human Services (HHS) is responsible for the certification, annual recertification, and general supervision of the fraud units. To meet OIG certification requirements state MFCUs must investigate provider fraud only; spend 100 percent of their time on Medicaid fraud; have a lawyer, an accountant/auditor, and a chief investigator; and have a working agreement with the "single state agency," that is, the agency responsible for the Medicaid program in the state as defined by the Code of Federal Regulations.

The Massachusetts Medicaid Fraud Control Unit[20]

The Massachusetts Medicaid Fraud Control Unit was certified by the federal government in July 1978. Under the jurisdiction of the Massachusetts attorney general's office, the

Table 2

Massachusetts Medicaid Fraud Control Unit, by Professional Category: Number of Personnel and Percent Change from Previous Year (in Parentheses)

Fiscal Year	Lawyers	Investigators	Auditors	Administrative Staff	Total
1978	7	22	10	8	47
1979	11 (+57)	26 (+18)	14 (+40)	14 (+88)	65 (+38)
1980	11 (0)	25 (−4)	13 (−7)	13 (−7)	62 (−5)
1981	11 (0)	25 (0)	12 (−8)	11 (−15)	59 (−5)
1982	10 (−9)	7 (−72)	7 (−42)	8 (−27)	32 (−46)
1983	10 (0)	20 (+186)	11 (+57)	11 (+38)	52 (+63)
1984	7 (−30)	21 (+5)	11 (0)	9 (−18)	48 (−12)
1985	8 (+14)	16 (−24)	9 (−18)	8 (−11)	41 (−15)
1986	8 (0)	16 (0)	7 (−22)	7 (−13)	38 (−7)
1987*	7 (−14)	18 (+13)	6 (−14)	7 (0)	38 (0)

* First quarter only.

unit was an outgrowth of the attorney general's Nursing Home Task Force, which was initiated in 1977 to investigate fraud and abuse in nursing homes. The MFCU, headed by a unit chief, reports to the first assistant attorney general.

The budget of the MFCU in its first full year of operation, 1979, was just over $1.6 million. The state contributed 10 percent of total expenditures during the first three years of the unit's existence and has contributed 25 percent since 1982 as mandated by P.L. 95-142. In the transition year, 1982, the MFCU budget dropped to its lowest level — $1.53 million — as the state failed to compensate fully for the loss of federal funds. Beginning in 1983 Massachusetts significantly increased its contribution to the MFCU budget to ensure that it would continue to operate at full strength. The estimated budget for the MFCU in 1987 was slightly more than $2 million.

The MFCU has experienced significant changes in the number and type of personnel it has retained throughout its history. The most consistent personnel trend is a decrease in lawyers, perhaps because MFCU salaries have not kept pace with those in the private sector. This trend is particularly problematic because it takes approximately one year before a lawyer or an investigator is fully trained.

Table 2 indicates that from 1983 through 1987 the total number of personnel and the number of personnel across professional categories had stabilized, compared with 1983 and before. The reason, according to the MFCU unit chief, is that the MFCU has identified what it perceives to be its most effective personnel profile, given its resources. In addition, at least for the near future, the MFCU budget is expected to remain relatively stable, precluding the possibility of adding significantly to the size of the staff. To compensate for this perceived handicap, the unit has attempted to move more aggressively into electronic data processing to increase the efficiency of existing staff. Savings in personnel resources that derive from a more efficient managerial and administrative work force may be reallocated to investigatory and legal personnel.

Prosecuting Provider Fraud

As a prosecutorial unit within the attorney general's office, the MFCU is solely concerned with efforts to bring charges against individuals and corporations that have violated the law. Therefore, it is concerned only about activity that is statutorily defined as illegal and can be prosecuted. Even though the terms "fraud" and "abuse" are commonly

cited together when politicians and academicians speak about the causes of unnecessary expenditures in the Medicaid program, the two terms are distinct to the Massachusetts MFCU. Fraud is illegal and can be prosecuted; abuse is not illegal and, therefore, cannot be prosecuted.

There exist different types of fraud and remedies to address them.[21] The most significant sections of the Massachusetts General Laws that apply to Medicaid fraud and its prosecution are the Medicaid False Claim Acts; the Patient Abuse, Mistreatment, and Neglect Act; and the Nursing Home Receivership Act. The Medicaid False Claims Act is the most significant of these statutes in that it defines fraud and provides substantial penalties for providers who submit fraudulent claims to the Medicaid system. The Patient Abuse, Mistreatment, and Neglect Act makes it a crime to willfully neglect or mistreat a nursing home patient. The mandatory reporting clause requires persons responsible for providing care to report suspected abuse. The Nursing Home Receivership Act provides protection for the residents of a nursing home when an owner fails to maintain the facility and allows conditions to deteriorate to the point where residents are at risk.

Additional tools at the disposal of the Massachusetts MFCU include law enforcement authority to conduct investigations and seek indictments. A "home rule" provision grants to the unit the authority to prosecute cases either in the county where an alleged crime occurred or in Suffolk County, where the unit is located. Consequently, the unit has the flexibility to pursue its cases in the most expeditious manner. Another tool that the MFCU uses is the attorney general's ability to request the judiciary to convene a grand jury whose sole purpose is to examine Medicaid fraud cases. The rationale for the special grand juries is the complex and distinct nature of financial reimbursement fraud, which requires specialized knowledge and takes several months to investigate.

Table 3 provides an overview of the MFCU's activity over time by professional categories of health care providers.[22] Perhaps the most striking feature of Table 3 is the large number of investigations that did not result in either an indictment or a conviction. The unit chief said that as a prosecutorial agency the MFCU always prefers criminal dispositions. But in some cases unit investigators may feel that they do not have sufficient evidence to meet the burden of proof required for a criminal conviction. In that event the unit may turn over the evidence to another agency such as the Department of Public Welfare for civil proceedings. Or the unit may agree to a disposition of "commitment to probation without a finding of guilt" until the party has met whatever obligation it agreed to as part of a negotiated settlement, at which point the MFCU will simply have the case closed or dismissed. According to the chief, such a disposition is a hybrid between a criminal and a civil disposition.

The fact that some cases are closed without a criminal disposition does not mean that Medicaid fraud has gone undetected and unpunished. Frequently a case will be closed as the result of a negotiated settlement between the accused and the MFCU that specifically includes a noncriminal disposition. Each side has some motivation for such an outcome. An allegedly fraudulent provider often prefers to extract himself or herself from the process without the stigma attached to a criminal disposition. And the MFCU is amenable to a negotiated noncriminal disposition if the accused admits committing a misdeed and is willing to make some gesture of contrition such as repaying money owed. In either case, both the accused and the MFCU accept the certainty of a negotiated, noncriminal disposition rather than the uncertainty of a criminal trial.

The symbolic importance associated with punishing criminal offenses with jail terms cannot be overlooked, but in the American justice system most criminal convictions,

Table 3

Massachusetts Medicaid Fraud Control Unit: Number of Cases, Number of Indictments and Convictions, by Professional Category (July 1, 1978–March 31, 1987)

Professional Category	Cases Opened	Cases Closed	Indictments		Convictions	
			Individuals	Corporations	Individuals	Corporations
Medical doctor	137	127	15	1	14	1
Osteopath	1	1	0	–	–	–
Podiatrist	16	13	3	–	3	–
Dentist	116	103	12	1	11	1
Hospital	9	9	0	–	–	–
X-ray technician	101	101	29	–	27	–
Nursing home	293	275	68	16	61	8
Home health agency	2	2	0	–	–	–
Therapist	19	18	5	–	5	–
Clinic	17	17	0	–	–	–
Laboratory	39	37	1	–	1	–
Ambulance	20	17	2	–	1	–
Drug supplier	118	114	22	13	21	13
Chiropractor	1	0	–	–	–	–
Optometrist	14	14	1	–	–	–
Transportation	23	21	5	2	5	1
Durable medical equipment	15	14	2	1	2	1
Residual category	415	399	62	2	29	1
Total	1,356	1,282	227	36	181	26

Source: Massachusetts Medicaid Fraud Control Unit.

especially those involving white-collar crime, do not include periods of incarceration. Among other forms of disposition, one of the most important is some kind of financial settlement.

Table 4 provides data on the amounts of money owed by providers from all professional classifications in Massachusetts. The financial data are divided into several categories over time: overpayment; restitution; fines and penalties; costs and damages; and personal needs allowances.[23] According to the unit chief, the change in dollar amounts over time is simply a matter of chance. In 1984, for example, a number of investigations were undertaken that happened to result in major prosecutions.

Evaluating the Massachusetts MFCU

How well does the MFCU fulfill its responsibilities to reduce fraud in the Medicaid program? How do its efforts compare with those of other units across the country? These questions are difficult to answer because very little formal review is required or takes place. Conversations with personnel in the Office of Inspector General, the federal agency responsible for overseeing state MFCUs, indicate that reviews of MFCUs are without criteria or guidelines that might provide a framework for evaluating and comparing different state units. The only criteria are those that are required for the establishment of a federally supported MFCU.

The OIG cannot be held entirely responsible for this situation because no consensus has ever been reached about how to measure MFCU effectiveness. While there is ample anecdotal evidence of fraud and abuse in the Medicaid program, a reliable means has not been

Table 4

Amount of Money (in Dollars) Owed by All Health Care Providers, Resulting from Massachusetts Medicaid Fraud Contol Unit Investigations

Year	Overpayment	Costs	Restitution	Fines and Penalties	Costs and Damages	Personal Needs Allowance	Total
1978	1,500	–	723,091	30,173	15,375	26,027	796,166
1979	2,365,302	13,700	104,723	6,225	25,966	36,622	2,552,538
1980	148,086	1,700	109,575	16,075	13,625	56,376	345,437
1981	470,955	–	355,851	9,950	26,250	120,964	983,970
1982	758,514	25,000	201,612	26,925	5,375	95,997	1,113,423
1983	45,746	6,500	251,668	80,875	47,375	25,029	457,193
1984	158,887	–	811,829	145,800	20,250	20,411	1,157,177
1985	621,375	–	307,400	93,800	172,313	4,377	1,199,265
1986	408,430	–	147,281	58,345	107,219	18,911	740,186
1987*	279	–	40,338	71,250	52,850	4,575	169,292
Unknown	597,016	–	3,000	–	77,000	–	667,016
Total	5,576,090	46,900	3,056,368	539,418	563,598	409,289	10,191,663

* Data available for first quarter only.

Source: Massachusetts Medicaid Fraud Control Unit.

developed for determining just how much fraud exists and how much it costs in spite of periodic reports of estimates. For example, in 1978 the inspector general of the Department of Health, Education, and Welfare issued a widely cited report stating that "fraud, waste, and abuse, in HEW programs amount to $5.5 to $6.5 billion each year."[24] Yet according to one assistant inspector general, those numbers were purely a matter of speculation:

> We never could figure out how they came up with that figure. We got a call from the Secretary's office saying that he would be giving a speech in nine days, and wanted an estimate of fraud, waste, and abuse. We sure didn't know about our program, and I doubt that any of the people in other programs had better figures. We sent in some figures — we had to — and I guess the Secretary's people just added up all the guesses. Since 1978, we've been smart enough not to even try to come up with a figure.[25]

The unit chief of the Medicaid Fraud Control Unit in Massachusetts stated simply that he has "no idea" how much fraud and abuse there is. Indeed, no one does. In the absence of structured evaluation criteria and the availability of comparative data, it is difficult to evaluate MFCU performance. One can attempt to make some qualitative evaluations according to patterns of mechanisms used to resolve disputes compared with sanctions imposed on accused defrauders or according to the quality of remedial programs used to minimize fraud. But both have limited utility as tools for evaluation.

The tendency to evaluate the effectiveness of a prosecutorial agency solely by counting how many criminal convictions it obtains and the severity of sentences imposed on the guilty tends to obfuscate the agency's principal responsibility. The primary goal of the MFCU is to combat fraud, and devoting complete attention to criminal prosecution may not be the most effective means for reducing fraud. Much Medicaid fraud is too complex to prove "beyond a reasonable doubt." The MFCU must use the full range of sanctions

that are available. Efforts to negotiate or recommend noncriminal dispositions may prove very effective as a deterrent to Medicaid fraud.

A corollary to this point is a caution not to evaluate the effectiveness of the MFCU according to the amount of money it generates in terms of restitution, fines, penalties, and all other mechanisms that can be measured economically. The goal of the MFCU is to reduce fraud, not to pay for itself in funds recovered. If the unit's primary concern is accounting for itself economically, it is not giving priority to fraud prevention.

Two specific MFCU activities involving strategies and principles of operation can be qualitatively evaluated: maintaining open communications with state and federal agencies that can cooperate with the unit as it pursues its mission and developing investigatory and prosecutorial strategies that depend on analysis of past patterns of behavior rather than on random chance to attain successful results.

By all accounts, the relationship between the MFCU and the single state agency responsible for the Medicaid program, the Department of Public Welfare (DPW), is good. Without a professional relationship marked by a spirit of cooperation, the MFCU would have a difficult time fulfilling its responsibilities. Indeed, a number of MFCUs in different states have recommended that rules and regulations be implemented by the federal government requiring the state agencies to cooperate more fully with the units or giving the units the authority to access data without permission from the state agencies.[26] In Massachusetts the positive working relationship between the MFCU and the DPW fosters the goals of both organizations.

A typical example of the relationship between the Massachusetts MFCU and the DPW is their joint development and use of an antifraud computer system. The federal government has encouraged state agencies to participate in a computerized provider payment and user-oriented system, the Medicaid Management Information System (MMIS). A major feature of the MMIS is the Surveillance and Utilization Review Subsystem (SUSR), a computer program designed to detect aberrant billing patterns that may indicate fraud. The Massachusetts MFCU and DPW together developed and designed the state's system, which the MFCU believes to be very effective. In addition, the unit is sensitive to the need to maintain a high level of visibility and to keep the channels of communication open with other government agencies.

The MFCU acknowledges that it has not made an effort to analyze past patterns of behavior to determine whether it is operating as close to maximum efficiency as possible. The unit has not maintained statistical records on case referrals that designate the sources of its investigations. Without these data the unit does not have any way to monitor accurately where referrals originate or whether certain sources have a higher probability of uncovering and leading to prosecution of fraud.[27] Careful analysis of cases and case referrals could be used to maximize the yield of future investigations and make success less dependent on chance.[28]

The Role of the Department of Public Welfare (DPW)

In Massachusetts the single state agency identified to administer the Medicaid program is the Department of Public Welfare. Its responsibility, however, does not extend to determining what fees will be paid to health care providers. That is the responsibility of the Rate Setting Commission, which establishes reimbursements rates for all medical, educational, and social services purchased by the state.[29] Detection and prosecution of fraud in

the Medicaid program is the responsibility of the Medicaid Fraud Control Unit, under the jurisdiction of the state attorney general's office.

The question remains why responsibility for these two aspects of Medicaid — determining providers' fees and ending fraud and abuse — should be removed from the state agency responsible for administration of the program. At least part of the answer seems to be lack of faith by legislators and other government officials in the capacity or willingness of a large social welfare bureaucracy to cooperate in such ventures.[30] Because the Medicaid budgets of the state agencies increased so dramatically in the 1970s the agencies were perceived to be part of the problem and legislators turned elsewhere for development and implementation of cost-containment measures. In Massachusetts, developing cost-containment strategies did not appear to be a high priority within the DPW until the mid-1980s, when additional resources were provided by the legislature specifically to develop comprehensive cost-containment measures.

DPW Cost-Containment Efforts

Substantial changes in the state's administration of Medicaid in recent years reflect the DPW's efforts to respond to demands for greater efficiency. In 1979, the DPW developed what is now called the Medicaid Savings and Expenditure Control Agenda (SECA). Meaningful efforts to implement SECA did not occur until 1984, however, when additional resources to develop savings initiatives became available.[31]

Primary responsibility for the Medicaid program in the Department of Public Welfare rests with the Medical Assistance Division (MAD), which was authorized to employ 423 individuals in 1986. The changes that have occurred in the administration of Medicaid in recent years include adding resources, redeploying staff, and consolidating program management, administrative, and savings activities. Reorganization efforts were undertaken in response to four factors that were identified as exerting upward pressure on Medicaid expenditures: (1) provider rate increases, (2) lack of control over service utilization, (3) substantial long-term growth in the elderly population, and (4) expensive advances in medical technology.[32] Growth in the elderly population and advances in medical technology are constraints over which the DPW has no control. The department's cost-containment efforts have been focused on provider rate increases and service utilization.

The DPW's reorganization efforts resulted in a substantial budget increase for the Medical Assistance Division from $4.96 million in 1986 to $16.1 million in 1987. The substantial hike was due to a transfer of funds to the division to accompany the transfer of Medicaid-related responsibilities that had previously been performed by Contract Operations and Management and Support, two other DPW agencies. Table 5 presents a profile of MAD employees by professional category. The organizational structure of MAD is designed to facilitate both short-term and long-term goals, including

- restructuring Medicaid management to better coordinate program and reimbursement policies with savings policies;
- redirecting the emphasis of Medicaid expenditure control from managing a savings agenda alone to managing spending as well; and
- focusing attention on provider rates and inappropriate utilization of services.

The division has identified several strategies to help meet these goals.[33]

Among the strategies is selective contracting with cost-effective providers for specified services at a previously negotiated price. A typical contract is based on capitation; that is,

Table 5

Persons Employed by the Medical Assistance Division of the Massachusetts Department of Public Welfare for Fiscal Year 1988, by Professional Unit

Professional Unit	Employees
Provider Reviews	104
Long Term Care/Elderly Choices	80
Operations/Provider Relations	80
Third Party Liability	63
Program and Policy Development/Health Choices	40
Administration/Human Resources	22
Cost Control	11
Total	400*

* Total personnel employed by MAD is listed by the DPW as 423, the number authorized by the state legislature. Data were unavailable for the 23 individuals unaccounted for.

Source: Budget Narrative for FY89 (Boston: Department of Public Welfare, Commonwealth of Massachusetts, February 1988), 400.

providers agree to set fees in return for a guaranteed percentage of patient volume. A related strategy is to use the state's market leverage and purchasing power to require providers that do business with the state to accept Medicaid patients under specified conditions. For example, many health maintenance organizations (HMOs) have in the past been inaccessible to Medicaid recipients, forcing them to rely on hospital outpatient care and other more expensive services. The Group Insurance Commission now requires HMOs with contracts for state employee health insurance to contract for Medicaid recipients.

Much more emphasis is currently being placed on utilization review than was true in the past to help identify abuse of the system or inappropriate delivery of services. These reviews are taking place before, during, and after service delivery. A typical review includes pre-admission screening of all hospital admissions to ensure that a treatment or procedure is necessary and appropriately screened; ongoing case management of lengthy hospital stays to ensure against high costs incurred in a hospital when the home or some other setting is adequate for care; and systematic audits of providers' billing reports to identify providers whose practices deviate from those of their peers.

The division is also examining and experimenting with several different reimbursement strategies that move away from the fee-for-service system, which offers no incentive to providers to limit health care costs and, indeed, encourages the opposite. Capitation is one model that can give providers incentives to offer economical health care. A second model is based on prospective payments to nursing home providers according to the level of care that each patient requires, similar to the payment structure under Medicare. Such a system would encourage nursing homes to accept and treat elderly who require more than minimal long-term care, an option that is perceived to be more cost-effective than keeping such people in acute-care hospital settings.

A major effort is under way to identify and pursue any individual, institution, corporation, or public or private agency that is liable for all or part of the medical costs incurred by Medicaid patients. Federal and state law requires that Medicaid be the payer of last resort, yet it is estimated that 34 percent of Massachusetts Medicaid recipients have some form of health insurance through Medicare, Medex, Blue Cross, or other entity that is

liable for payment before Medicaid. MAD's Third Party Liability Unit is responsible for accumulating and processing third-party insurance information and collecting money from providers that has been inappropriately paid by Medicaid rather than by the legally responsible person or agency.

Another set of strategies focuses on developing service delivery systems that offer alternatives to institutional placement and care. Many patients are inappropriately placed or left in institutional settings, and finding more suitable settings can be cost-effective. Alternative models include community-based long-term care services that allow the elderly and disabled to live at home with an adequate support system; managed care programs that strive to achieve preventive and coordinated health care options for families, reducing the need for costly emergency, outpatient, and inpatient hospital services; and pilot programs such as the one at the East Boston Neighborhood Health Center, which offers capitated long-term care using a number of resources including Medicaid. The Massachusetts Medicaid program has traditionally been open to experimenting with pilot projects designed to determine if health care services can be provided more effectively and efficiently for a target group.[34]

According to the DPW, the "single most important tool in support of the Department's Medicaid savings agenda is the Medicaid Management Information System (MMIS), which processes approximately 24 million Medicaid claims annually from over 29,000 different medical providers."[35] MMIS is an electronic data processing system that has improved the efficiency of recording and processing Medicaid claims by simultaneously reducing the error rate and speeding up the provider claims process. But MMIS is more than a computerized accounting system; it is also a management tool that can be tailored by each professional unit in the Medical Assistance Division to meet its record-keeping needs.

In terms of cost containment, the Department of Public Welfare claims the following savings in the Medicaid program over time: fiscal year 1982, $11 million; fiscal year 1983, $32 million; fiscal year 1984, $106 million; fiscal year 1985, $155 million; fiscal year 1986, $217 million; fiscal year 1987, $288 million; and the fiscal year 1988, $338 million. It is difficult to evaluate the accuracy of these figures without detailed information about the methodology used to arrived at them. But one measure that suggests that savings are taking place is the annual rate of growth in cost of the Massachusetts Medicaid program compared with growth in health care costs generally. From fiscal year 1983 through 1987, total national spending for health care increased 8.6 percent, for Medicaid 8.4 percent, and for the Massachusetts Medicaid program 7.6 percent. This suggests that some substantial savings have been realized. However, a 7.6 percent annual growth rate can still mean an increase of more than $100 million per year in overall costs to the Massachusetts Medicaid program.

Effect of Cost-Containment Strategies on Medicaid Recipients

The prominence given to increasing the level of efficiency and to controlling costs in the Massachusetts Medicaid program apparently has not led to state policies, either intended or unintended, that have reduced the number of Medicaid patients. Indeed, as noted at the outset, the number of Medicaid cases has increased approximately 4.2 percent from fiscal year 1983 through 1987, although future growth is expected to be less.

A number of efforts have increased the access of the poor to health care facilities. For example, since 1985 the Medicaid program has enrolled approximately 6,300 new

providers, about 3,000 of whom are physicians. Success for increasing physician participation may be attributed to two factors: requiring HMOs who enrolled state employees to accept Medicaid patients and working with the Rate Setting Commission to bring physician fees close to market rates. The same strategies have been used to encourage participation by other health care providers. As a result, nearly 25,000 new recipients were placed in some managed health plan.

Justification for moving in this direction is the commonly held belief that preventive health care through HMOs is more cost-effective than services in acute-care hospitals and other institutions. Virtually all of the DPW's strategies are designed to remove as many recipients as possible to the least costly care facility that is appropriate to serve their needs.

Managing the Medicaid caseload in this way makes sense from the perspective of cost containment. What remains open to debate is how this strategy affects the quality of care recieved by Medicaid recipients. Very little systematic analysis of the question has been undertaken for the Massachusetts Medicaid program. The federal government has placed the burden of proof on those who claim that the provision of health care for Medicaid recipients has declined.

Conclusion

The history of the Medicaid program is an example of what can happen to a public policy initiated for political expediency. It was and, in the minds of many, remains a derivative program of Medicare without a strong political constituency. Consequently, it drifted along without adequate focus from 1965 until the 1970s, when it was perceived to be an example of wasteful government programs that unnecessarily burden taxpayers.

The simplest political solution for elected officials was to target fraud rather than other aspects of the program and to hold culpable the state and federal bureaucracies responsible for running the program. Because those bureaucracies were perceived to be part of the problem, another bureaucratic layer, the Medicaid Fraud Control Unit, was created to remedy the problem in each state.

Whatever the merits of the charge that fraud and abuse were principal causes of waste in the Medicaid program, the elected officials did not make credible estimates of how much fraud existed, nor did they reach any consensus concerning its causes. Consequently, no standards were set to measure efforts to combat fraud and abuse. The MFCUs were left largely to define their own missions and criteria for evaluation once they had conformed to the minimal standards necessary for federal government approval. In short, the MFCUs have been allowed to drift much as the Medicaid program itself has.

Because the single agency responsible for administering the Medicaid program in each state was intentionally superseded by the MFCUs in efforts to curb fraud and abuse, there was little reason to expect cooperation between these agencies and the MFCUs. Indeed, in several states the MFCUs reported a hostile relationship with their state agency. Such hostility should not be interpreted as evidence of the state agencies' lack of interest in fraud control or taken as a blanket justification for establishing independent fraud control units. Rather, it may reflect bureaucratic turf protection stemming from some combination of resentment by the state agency for being cut out of the fraud control process, disinterest by the state agency because it believes fraud control is no longer its problem, or the difficulties encountered in transferring information across bureaucratic boundaries.

In Massachusetts both the Medicaid Fraud Control Unit and the Department of Public Welfare, the agency that administers Medicaid, claim to give high priority to developing and implementing cost-containment strategies in the Medicaid program and to cooperating toward that end. The DPW has incentives to ensure that, in light of limited resources, services are allocated as efficiently as possible to their Medicaid clients. There is no evidence that the DPW ever opposed efforts to reduce fraud and waste. For both the MFCU and the DPW cost containment is consistent with their government mandate and professional pride. The DPW did not implement cost-containment strategies until the legislature allocated funds specifically for that purpose, but this behavior is rational from an organizational perspective.[36]

Whether or not the MFCU and the DPW have set realistic cost-containment goals and are effectively meeting them is much more difficult to determine. Because of the failure of elected politicians to adequately define cost-containment criteria for health care, the bureaucracies and those who would evaluate their performance have no standards on which to base judgments. Evidence is presented in this article that both the MFCU and the DPW are having a positive impact on cost containment in the Massachusetts Medicaid program. But a definitive judgment can be made only after evaluation methodologies are developed that can be used to assess performance across states. This will require leadership from elected officials to produce a national cost-containment policy with clearly defined goals and sufficient agreement about how to measure whether those goals are being met to permit a framework for comparative analysis. ❧

Notes

1. Wilbur J. Cohen, "Reflections on the Enactment of Medicare and Medicaid," in *Health Care Financing Review* (Baltimore: Health Care Financing Administration), 1985 Annual Supplement, 1.
2. *Medicare and Medicaid Data Book, 1986*, Document No. 03247 (Baltimore: Health Care Financing Administration, September 1987), 7.
3. *Budget Narrative for FY89* (Boston: Department of Public Welfare, Commonwealth of Massachusetts, February 1988), 231.
4. *Medicare and Medicaid Data Book, 1984*, Document No. 03210 (Baltimore: Health Care Financing Administration, June 1986), 31–32.
5. The debate rages about whether these changes have had a negative impact on the health of the poor. There is little doubt that some who were eligible for medical treatment under Medicaid no longer are. Whether this is "cutting the fat or the bone" is the focus of the debate.
6. *Budget Narrative for FY89,* 230.
7. At present every state with the exception of Arizona participates in the Medicaid program.
8. The number of people in the United States living below the poverty level in 1984 was approximately 33 million, and the ratio of Medicaid recipients to persons living below the poverty level was approximately .64. See M. Gornick et al., "Twenty Years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures," *Health Care Financing Review*, 1985 Annual Supplement, 34.
9. *Budget Narrative for FY89*, 256.
10. *Budget Narrative for FY89*, 222–23.
11. *Medicare and Medicaid Data Book, 1984*, 88.
12. *Medicare and Medicaid Data Book, 1984*, 99.

13. *Medicare and Medicaid Data Book, 1986*, 99.

14. By 1986 the total costs of the Medicaid program were $3.45 billion, which exceeded original estimates by almost $1.20 billion. Total costs for subsequent years in the 1970s are as follows: 1971, $6.35 billion; 1973, $8.71 billion; 1975, $12.09 billion; 1977, $16.35 billion; 1979, $19.66 billion. See *Data on the Medicaid Program: Eligibility, Service, Expenditures*, rev. ed. (Washington, DC: Medicaid Medicare Management Institute, 1979), 28.

15. Kenneth R. Wing, "The Impact of Reagan-Era Politics on the Federal Medicaid Program," *Catholic University Law Review* 33 (1983): 18.

16. In this article "fraud" is defined as a violation of a civil or criminal statute. The term "abuse" is much more difficult to specify. Here it refers to situations that are counter to the intention of the Medicaid program but that are not specifically prohibited by law.

17. Fraud among recipients does occur and includes such activities as purchasing excessive amounts of drugs, making false claims of eligibility, seeking unnecessary nursing home care, and the like. But the opportunities and potential gains for recipients engaging in fraud and abuse are minor compared with the opportunities for providers. See *Medicaid Fraud: A Case History in the Failure of State Enforcement*, A Staff Study by the House Select Committee on Aging (Washington, DC: U.S. Government Printing Office, 27 March 1982).

18. Examples include "ping-ponging" (referring a patient to a succession of practitioners); "ganging" (billing for multiple services to relatives who accompany a patient); "upgrading" (billing for a service more extensive than that provided); "steering" (directing a patient to a particular pharmacy); and billing for services not rendered. Investigators also concluded that fee splitting, percentage lease arrangements, and kickbacks were commonly associated with Medicaid mills. Considerable evidence of fraudulent and abusive practices was also uncovered in other settings. Kickbacks and improper billing arrangements were shown to exist in several clinical laboratories, and patient abuse, substandard facilities, deceptive real estate practices, false cost reporting, and kickbacks were found in a number of nursing homes. Jennifer O'Sullivan, "Medicare and Medicaid Anti-Fraud and Abuse Amendments: P.L. 95-142" (Washington, DC: Congressional Research Service, Library of Congress, 16 November 1977), 2–3.

19. O'Sullivan, "Medicare and Medicaid Anti-Fraud and Abuse Amendments," 29.

20. For a detailed longitudinal examination of the Massachusetts MFCU see Fredric Waldstein, "Controlling Medicaid Fraud in Massachusetts: A Report to the Attorney General" (Boston: John W. McCormack Institute of Public Affairs, University of Massachusetts at Boston, February 1988).

21. For a detailed discussion of Massachusetts laws, regulations, rules, and procedures that pertain to fraud and abuse in the Medicaid program, see Frank Bellotti and Donald Zerendow, "The Attorney General's Medicaid Fraud Control Unit: Protecting the Public from White Collar Crime and Patient Abuse in the Health Care System" (Boston: Massachusetts Attorney General's Office, 1 September 1985).

22. Some of the categories merit additional explanation. The residual category consists of all cases that could not be placed in the professional categories identified. "X-ray technician" refers to a specific type of investigation involving the theft of the silver residue found on old X-rays. "Home health agency" refers to at-home health care delivery such as that provided by a visiting nurse in a patient's home. "Therapist" refers to all forms of physical and psychological therapy. "Clinic" refers to any walk-in, nonhospital health care facility. "Durable medical equipment" concerns such items as wheelchairs and hospital beds; the primary type of fraud in this category is overbilling or not delivering goods paid for. "Laboratory" refers to testing facilities used for diagnostic purposes. "Ambulance" and "transportation" refer to transportation of the patient to and from the health care provider. "Drug supplier" refers to pharmacies and drug supply companies that dispense pharmaceuticals.

23. "Overpayment" is the amount of Medicaid funds improperly paid to providers and subject to recovery. "Costs" and "Costs and Damages" are costs that the MFCU incurred in the course of its investigations into fraudulent activity and that it may recover. This may include treble damages. "Restitution" is the amount of money recovered from providers that was improperly paid by the

Medicaid program. "Fines and Penalties" are the monetary sanctions imposed on those convicted of defrauding the Medicaid program. "Personal Needs Allowance" refers to the theft or misuse of a patient's personal discretionary funds by providers in nursing homes and rest homes.

24. "Office of the Inspector General Annual Report: January 1, 1978–December 31, 1978" (Washington, DC: Office of the Inspector General, 1979), 150.

25. John Gardiner and Theodore Lyman, *The Fraud Control Game: State Responses to Fraud and Abuse in the AFDC and Medicaid Programs* (Bloomington: Indiana University Press, 1984), 4.

26. "Medicaid: Results of Certified Fraud Control Units," GAO/HRD-87-12S (Washington, DC: U.S. General Accounting Office), Appendix X.

27. The unit chief estimated that approximately 35 percent are self-initiated or "proactive," 35 percent are referred by the Department of Public Welfare, and 15 percent are referred by other state and federal government agencies. These percentages are consistent with national data reported by the OIG for fiscal year 1985. See "Medicaid: Results of Certified Fraud Control Units," 10.

28. The unit chief recognized this as a legitimate concern and believed that increased electronic data processing capacity would allow the unit to move in this direction.

29. It should be noted that the DPW and the Rate Setting Commission collaborate on setting rates for the Medicaid program, but the authority to actually determine the rates is the sole responsibility of the Rate Setting Commission. The Department of Public Health (DPH) also plays a minor role in the Medicaid program because it licenses all individuals in the health care industry. But our attention here is directed only to the "single state agency," the Department of Public Welfare. The DPW, as the administrator of the Medicaid program, plays a substantially more significant role than either the Rate Setting Commission or the DPH.

30. For example, see Gardiner and Lyman, *The Fraud Control Game*, Chap. 6.

31. *Budget Narrative for FY89*, 399.

32. *Budget Narrative for FY89*, 409.

33. These are extensively described in the *Budget Narrative for FY89*.

34. For example, see Rosemary Gibson Kearn et al., eds., *Medicaid and Other Experiments in State Health Policy* (Washington, DC: American Enterprise Institute, 1986).

35. *Budget Narrative for FY89*, 416.

36. The rationality of such behavior has been developed by, among others, Herbert A. Simon, *Administrative Behavior*, 3rd ed. (New York: Free Press, 1976), 66, 95–96, 120; and Herbert Kaufman, *The Limits of Organizational Change* (University: University of Alabama Press, 1971), 29–30.