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HEALTH CARE WASTE, FRAUD, AND ABUSE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

OCTOBER 9, 1997

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HEALTH CARE WASTE, FRAUD, AND ABUSE

THURSDAY, OCTOBER 9, 1997

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisories announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE CONTACT: (202) 225–3943
April 29, 1997
No. HL–13

Thomas Announces Hearing on Health Care Waste, Fraud, and Abuse

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on waste, fraud, and abuse in the health care system. The hearing will take place on Tuesday, May 6, 1997, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Health care fraud accounts for a significant percentage of national health care costs, by as much as 10 percent, according to GAO. To fight fraud and abuse, the Congress included landmark reforms in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104–191) . HIPAA establishes and provides funding for the Health Care Fraud and Abuse Control Program, under the direction of the Attorney General and the Secretary of Health and Human Services (HHS). The program combats fraud and abuse committed against both public and private health plans by coordinating law enforcement efforts among Federal, State, and local officials. In addition, HIPAA creates new health care crimes for criminal conduct involving health care programs and significantly increases penalties for health care fraud and abuse.

At the same time, HIPAA attempts to recognize significant changes in the marketplace and address some of the confusion in the application of current fraud statutes. This is done by: (1) providing an exception to the anti-kickback provisions for arrangements in which providers assume significant financial risk for their treatment decisions, (2) requiring HHS to issue binding advisory opinions regarding specific proposals, and (3) requiring HHS to develop additional broadly applicable safe harbors and modifications to existing safe harbors.

The Administration has proposed in its budget to fight fraud and abuse through a number of proposed revisions in the Medicare program. This includes instituting consolidated billing for nursing homes, eliminating periodic interim payments for home health providers, requiring that non-physician practitioners provide diagnostic information on all claims, and increasing the number of laboratory tests paid on an automated basis.

In March, President Clinton announced a supplemental package of additional waste, fraud, and abuse reforms. This proposal includes new requirements for individuals and companies that wish to participate in Medicare and Medicaid, technical modifications to HIPAA, and some increased sanctions.

In announcing the hearing, Chairman Thomas stated: "Nothing is more important to the integrity of Medicare than combating fraud. I look forward to working with the Administration and others who wish to build on the significant progress we made during the 104th Congress in passing the landmark anti-fraud and abuse initiatives in the Health Insurance Portability and Accountability Act."

FOCUS OF THE HEARING:

The hearing will focus on the implementation of HIPAA, President Clinton's Medicare waste, fraud, and abuse proposals, and additional recommendations for combating waste, fraud, and abuse in the health care system.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement and a 3.5-inch diskette in WordPerfect or ASCII format, with their address and date of hearing noted, by the close of business, Tuesday, May 20, 1997 to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on a 3.5-inch diskette in WordPerfect or ASCII format.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS__MEANS/'.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

NOTICE—HEARING POSTPONEMENT

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE CONTACT: (202) 225–3943
May 2, 1997
No. HL–13-Revised

Postponement of Subcommittee Hearing on Health Care Waste, Fraud, and Abuse Tuesday, May 6, 1997

Congressman Bill Thomas, (R–CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on the health care waste, fraud, and abuse, previously scheduled for Tuesday, May 6, 1997, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, has been postponed and will be rescheduled at a later date.

(See Subcommittee press release No. HL–13, dated April 29, 1997.)

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE CONTACT: (202) 225–3943
September 16, 1997
No. HL–16

Thomas Announces Hearing on Health Care Waste, Fraud, and Abuse

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on the waste, fraud, and abuse in the U.S. health care system. The hearing will take place on Tuesday, September 30, 1997, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

In view of the limited avaiable to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not

scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

There has been considerable attention focused during the past several years on the problem of waste, fraud, and abuse in the Medicare program and in the U.S. health care system generally. The U.S. General Accounting Office has estimated that waste, fraud, and abuse account for up to 10 percent of Medicare costs, and the Inspector General of the Department of Health and Human Services (HHS) announced at a recent Subcommittee hearing that the Medicare program made improper payments totaling $23 billion in fiscal year 1996.

In the past two years, Congress has passed significant legislation designed to address these growing concerns about waste, fraud, and abuse. The health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104–191) established and provided funding for the Health Care Fraud and Abuse Control Program, under the direction of the Attorney General and the Secretary of HHS. The program is designed to combat fraud and abuse committed against both public and private health plans by coordinating law enforcement efforts among Federal, State, and local officials. In addition, HIPAA created new health care crimes for criminal conduct involving health care programs and significantly increased penalties for health care fraud and abuse.

The Balanced Budget Act of 1997 (BBA) (P.L. 105–33) significantly expands upon HIPPA's anti-fraud and abuse measures. Among other reforms, the BBA: (1) requires that providers convicted of three program-related offenses be excluded permanently from Medicare and other Federal health programs, (2) provides new civil monetary penalties for violations of the anti-kickback statute, (3) requires home health agencies, durable medical equipment suppliers, and other providers to post a surety bond of at least $50,000 in order to provide items and services to Medicare beneficiaries, (4) requires the Inspector General to establish a toll-free hotline for Medicare beneficiaries to report fraud and billing irregularities, (5) requires hospitals to disclose to beneficiaries requiring post-acute care any provider in which the hospital has a financial interest, and (6) provides the Secretary with new authority to reduce or increase Medicare reimbursement where the current payment amount is "grossly excessive or grossly deficient and not inherently reasonable." In addition, the BBA modernized Medicare by establishing prospective payment systems designed to minimize opportunities for fraud and abuse.

In announcing the hearing, Chairman Thomas states: "Congress must assure Medicare beneficiaries and the taxpayers that Medicare is not frittering away precious program dollars on waste, fraud, and abuse. To meet our obligations, we passed landmark anti-fraud and abuse legislation in both the 104th and 105th Congress. Now, we must ensure that these reforms are implemented and that the Health Care Financing Administration makes combating fraud and abuse its top priority."

FOCUS OF THE HEARING:

The hearing will assess implementation of the BBA and HIPPA initiatives aimed at combating waste, fraud, and abuse in the health care system. It also will identify those areas of the Medicare program where waste, fraud, and abuse challenges still lie ahead.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-space legal-size copies of their statement, along with an IBM compatible 3.5-inch diskette in ASCII DOS Text format only, with their name, address, and hearing date noted on a label, by the close of business, Thursday, July 31, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on

Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on an IBM compatible 3.5-inch diskette in ASCII DOS Text format.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

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NOTICE—CHANGE IN DATE

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE CONTACT: (202) 225–3943
September 25, 1997
No. HL–16–Revised

Change in Date for Subcommittee Hearing on Health Care Waste, Fraud, and Abuse Tuesday, September 30, 1997

Congressman Bill Thomas, (R–CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee hearing on health care waste, fraud, and abuse, previously scheduled for Tuesday, September 30, 1997, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, will now be held on Thursday, October 9, 1997.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-space legal-size copies of their statement, along with an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format only, with their name, address and hearing date noted on a label, by the close of business, Thursday, October 23, 1997, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, DC 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

All other details for the hearing remain the same. (See Subcommittee press release No. HL–16, dated September 16, 1997.)

Chairman THOMAS [presiding]. The Subcommittee will come to order. I want to welcome you to today's hearing on waste, fraud, and abuse in our Nation's health care system.

Unfortunately, waste, fraud, and abuse is pervasive in the system. The General Accounting Office estimates that waste, fraud, and abuse account for up to 10 percent of Medicare costs, and the Inspector General of the Department of Health and Human Services announced at a recent hearing of the Health Subcommittee that the Medicare Program made improper payments, perhaps totaling $23 billion in fiscal year 1996 alone.

It's important to point out that these problems have existed for a long time and they've been exacerbated by the escalating Medicare costs. The General Accounting Office and Office of Inspector

General have highlighted weaknesses that made the Medicare system vulnerable to waste, fraud, and abuse as early as 1986. Nevertheless, these reports were largely ignored, with some exceptions, for over a decade until the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997, when Medicare had tripled in outlays from $71 billion to nearly $200 billion.

The new Congress, in a bipartisan fashion, has responded forcefully by enacting legislation containing 65 concrete steps to stamp out waste, fraud, and abuse. In the past 2 years, the Congress has passed significant legislation developed by the Committee on Ways and Means, and other Committees of jurisdiction, to address these growing concerns about waste, fraud, and abuse in the Medicare Program and the health care system generally.

In HIPAA, Congress dedicated over $5 billion for law enforcement through fiscal year 2003; it increased civil penalties fivefold for providers who commit health care fraud, added new criminal penalties for false statements, theft, embezzlement, obstruction of justice, and money laundering, and established new programs to coordinate antifraud efforts among State, local, and Federal officials, the private sector, and Medicare beneficiaries.

The recently enacted Balanced Budget Act expands on the progress made under HIPAA. In addition to other reforms, the BBA requires the Secretary to kick providers out of the Medicare Program if they are convicted of three health care infractions—the so-called three strikes and you're out provision—and in the case of serious crimes, you only get one strike. We also required the Inspector General to establish a new toll-free hotline and put this number on every Medicare bill, so that Medicare beneficiaries can directly report fraud and billing irregularities. We'll hear from a witness today who thinks that's a valuable improvement.

Together, these reforms have increased the number of Federal fraud investigators on the streets by 31 percent over the last 2 years. You can see the chart over on the left. I would tell my colleagues the blue is OIG, the green is FBI, but in just 2 years we've put almost one-third more investigators on the streets. We will never ever be able to have enough investigators without the fundamental reforms in the structure that we've done as well.

Despite our efforts, there are still examples of blatant waste, fraud, and abuse in the system. The American people today still believe, by better than 90 percent, that health care fraud is widespread, and I couldn't disagree with them. Just a couple of examples of how outrageous some of these abuses are:

It is tragic that we have the photo of this woman who suffers from extreme arthritis and who, through the effort of a durable medical equipment supplier, received an orthotic body jacket; the woman is 5 feet tall, weighs 86 pounds. This orthotic jacket is designed the body, back and front, very rigidly. This particular model was for a male, well over 6 feet tall and more than 180 pounds.

She was recruited at an adult recreation center and supplied with this jacket. Medicare was billed more than $2,000 for this particular item, and the durable medical supplier under her name billed for an additional $6,000 of equipment the beneficiary never received. Incidentally, the beneficiary didn't know how to use the

body jacket, didn't think it was appropriate, and didn't know to whom to return it, and so she eventually turned it over to the Inspector General. The case against that particular DME supplier is currently pending.

Let me give you another example. Take a look at this store in Van Nuys, California. It says "pawnshop," and it looks fairly familiar in terms of that type of an operation. What you need to know is that this also happens to be the headquarters of a home health agency. After responding to complaints, Federal inspectors found that at this home health agency—which as you can see bears little resemblance to what one would expect a home health agency to look like—the previous owner's health care experience consisted of his ownership in management of this pawnshop, a cab company, and a restaurant, and that the home health agency was out of compliance with 11 of 12 required conditions of participation in the Medicare Program. I have asked the OIG which one they were in compliance with. I have not yet received the information back; it may be that there must be a roof on the building, but we don't know which was the one that they were in compliance.

Based on this onsite review, the agency's provider number was revoked. Had it not been revoked, in a single year, more than $2 million in Medicare billing would have gone through this "home health care agency."

Then, finally, let me give you about as graphic an example as I can of the kind of graft that is pervasive as part of the waste, fraud, and abuse. What you will see is a videotape. It's a videotape with an undercover informer working through the Office of Inspector General and the FBI. What you will see is a doctor, and through this, the audio is not as clear as we would like, apparently sufficiently clear for conviction, but what you get is a bantering between the informer and the doctor about his wife, and he inquires of her condition and the informer then proceeds to provide cash in a relatively obvious way for the cameras, and in exchange the doctor, Dr. Rafael Gonzalez Pantaleon, who is a citizen of the Dominican Republic, signs his name to a number of documents, which of course then allow for the Medicare billing to go forward.

Incidentally, the good doctor was arrested in New York City by Federal agents on November 30, 1994, charged with 47 counts of Medicare fraud. There was a 7-week trial. He was convicted of defrauding the U.S. Government. He was sentenced to 78 months in prison, fined $3.5 million. However, between the time of his conviction and his sentencing, Dr. Gonzalez fled the United States to the Dominican Republic and he now practices medicine at the Clinica San Rafael in the Dominican Republic.

According to the Inspector General, the administration knows the exact address where he's practicing medicine today; and according to the State Department, the U.S. Embassy in the Dominican Republic and the Department of Justice's Office of Internal Affairs, no formal extradition request has ever been made that this fugitive return to the United States.

My concern is that the administration's lack of commitment in this case is particularly striking, given the fact that in article II of the bilateral treaty between the United States and the Dominican Republic, it clearly calls for extradition in cases of fraud and that

2 months ago the Dominican Republic agreed to extradite two Dominican nationals involved in drug trafficking, at the request of the President of the United States.

The administration has launched Operation Restore Trust in the area of Medicare waste, fraud, and abuse. I think perhaps they need to launch Operation Find and Bust when you have clearly convicted individuals.

Take a look at this tape for absolute gall.

[Videotape played.]

Chairman THOMAS. What you saw was the transfer of $1,100 prior to the doctor signing off on a number of requests for which Medicare was billed and promptly paid.

Today, I'm sending a letter to Attorney General Reno asking her to initiate a formal extradition process to return Rafael Gonzalez Pantaleon to the United States to serve his sentence for bilking the Medicare Program—and therefore the U.S. taxpayer—of over $3 million.

Unfortunately, the events shown on this tape are not as unusual as we would like to think. The Inspector General says that over 50 other cases involving kickback payments and durable medical equipment suppliers are currently under investigation.

We recognize that our work is not over. The Ranking Member in fact will highlight some alleged corporate fraud which will be another facet of our continued investigation of waste, fraud, and abuse. Additional legislative changes are going to need to be made and we need to stay vigilant, and that's one of the things that this hearing is designed to do; that is, to provide a report card on those areas where the 65 concrete steps in our antifraud plan have been most successful, where these reforms could be strengthened or better implemented, and where the most significant challenges lie in combatting waste, fraud, and abuse.

Chairman THOMAS. I look forward to today's testimony. I would recognize my colleague, the Ranking Member gentleman from California, Mr. Stark.

[The opening statement follows:]

Opening Statement of Chairman Bill Thomas

Welcome to today's hearing of the Health Subcommittee on waste, fraud, and abuse in the nation's health care system. Waste, fraud, and abuse are pervasive in our health care system. The General Accounting Office (GAO) estimates that waste, fraud, and abuse account for up to 10 percent of Medicare costs, and the Inspector General of the Department of Health and Human Services announced at a recent hearing of the Health Subcommittee that the Medicare program made improper payments totaling $23 billion in fiscal year 1996 alone.

It is important to point out that these problems have existed for a long time and that they have been exacerbated by escalating Medicare costs. The General Accounting Office (GAO) and the Office of Inspector General had highlighted weaknesses that made the Medicare vulnerable to waste, fraud, and abuse as early as 1986. Nevertheless, these reports were largely ignored until the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA) were passed ten years later, after total Medicare outlays had tripled from $71 billion to nearly $200 billion.

The Congress has responded forcefully by enacting legislation containing 65 concrete steps to stamp out waste, fraud and abuse. In the past two years, Congress has passed significant legislation developed by the Committee on Ways and Means, and other committees of jurisdiction, to address these growing concerns about waste, fraud, and abuse in the Medicare program and the health care system generally.

In HIPAA, Congress dedicated $5 billion dollars for law enforcement through fiscal year 2003, increased civil penalties five-fold for providers who commit health

care fraud, added new criminal penalties for false statements, theft, embezzlement, obstruction of justice, and money laundering, and established new programs to coordinate anti-fraud efforts among State, local, and federal officials, the private sector, and Medicare beneficiaries.

The recently-enacted Balanced Budget Act expands on the progress made under HIPAA. In addition to other reforms, the BBA requires the Secretary to expel providers from the Medicare program if they are convicted of three health care infractions, requires home health agencies, durable medical equipment suppliers and other providers to post surety bonds of at least $50,000, replaces fraud-ridden cost-based reimbursement with prospective payment systems, and requires the Inspector General to establish a new toll-free hotline and puts this number on every Medicare bill so that Medicare beneficiaries can directly report fraud and billing irregularities.

Together, these reforms have increased the number of federal fraud investigators on the streets by 31 percent over the last two years.

Despite our efforts, we know there are still examples of blatant waste, fraud, and abuse in the health care system. As we will hear today, over 90 percent of the American public still believes that health care fraud is widespread. Here are a few examples:

• Medicare beneficiary receives expensive, unnecessary orthotic body jacket. This picture shows a woman who stands 5 feet tall and weighs 86 pounds wearing an orthotic body jacket that is designed to be custom-fitted for a male size "extra large"—who stands about 6 feet tall and weighs at least 180 pounds.

Orthotic body jackets are designed to be rigid, form-fitting and customized. They are used to treat patients with muscular and spinal conditions by holding them immobile.

Just three months ago, this woman—who is a Medicare beneficiary with arthritis—was recruited at an adult recreation center by a durable medical equipment supplier, taken to a clinic for an examination and told she would shortly receive an orthotic body jacket.

This jacket was not medically indicated for her condition. Even if it had been, the extra-large size body jacket she received obviously was inappropriate for this beneficiary. Regardless, the supplier billed Medicare nearly $2,000 for this item and another $6,000 for other equipment the beneficiary never received.

The beneficiary did not know how to use the body jacket, or where to return it. She eventually turned it over to the Inspector General. And the case against the DME supplier is currently pending.

• Home health agency/pawn shop. This is a picture taken last year of a pawn shop in Van Nuys, California that also happens to be a home health agency. After responding to complaints, federal inspectors found that this home health agency was located in a building bearing little resemblance to what one would expect a home health agency to look like. Inspectors also found that the owner's previous health care experience consisted of his ownership and management of the pawn shop, a cab company, and a restaurant, and that the home health agency was out of compliance with 11 of 12 required conditions of participation in the Medicare program.

Based on this on-site review, the agency's provider number was revoked. If it would have continued billing Medicare, this one home health agency would have cost Medicare over $2 million in a single year.

• Kickback Videotape. In one of the most blatant examples of fraud that I have ever seen, we are about to witness a video taken by an undercover informer who was working with the Office of the Inspector General and the FBI in an effort to fight Medicare fraud.

The tape shows the informer bribing a doctor in return for the doctor's signature on Medicare Certificates of Medical Necessity. The doctor is seated on the left-hand side of the screen. These certificates, which bore the names of people who did not exist, would have allowed the informant to steal thousands of dollars from Medicare in phony claims.

Because the videotape is somewhat difficult to hear, the members of the Subcommittee and the press have been provided with transcripts. Let's follow along.

The doctor in this tape, Rafael Gonzalez—a citizen of the Dominican Republic—was arrested in New York City by federal agents on November 30, 1994.

On June 19, 1996, after a seven week trial, he was found guilty of a total of 45 counts of Medicare fraud conspiracy, making false statements, and conspiracy to defraud the United States government. He was sentenced to 78 months in prison and fined $3.5 million.

However, between the time of his conviction and his sentencing, Dr. Gonzalez fled the United States for his native country, the Dominican Republic, where he now practices medicine at the Clinica San Rafael.

I must also point out that this doctor, this fugitive of justice, was Ambassador to the United Nations from the Dominican Republic from 1989–1991 and that, despite his crimes, he is a free man and a prominent diplomat.

According to the Inspector General, the Administration knows the exact address where he is practicing medicine today in Santa Domingo.

And according to the State Department, the United States Embassy in the Dominican Republic, and the Department of Justice's Office of International Affairs, no formal extradition request was ever made to return this fugitive to justice in the United States. The Administration's lack of commitment in this case is particularly striking, given that Article II of a bilateral treaty between the United States and the Dominican Republic calls for extradition in cases of fraud and that just two months ago, the Dominican Republic agreed to extradite two Dominican nationals involved in drug trafficking at the request of the President of the United States.

Today, I am sending a letter to Attorney General Reno asking her to initiate a formal extradition process to return Rafael Gonzalez to the United States to serve his sentence for bilking the Medicare program and United States taxpayers of over $3 million dollars.

Let me point out that the events shown on this undercover tape are not unusual. The Inspector General says that over 50 other cases involving kickback payments and durable medical equipment suppliers are currently under investigation.

Finally, we recognize that additional legislative changes need to be made, and that we need to stay vigilant in our continuing battle against health care fraud. That is what this hearing is designed to do—to provide a report card on those areas where the 65 concrete steps in our anti-fraud plan have been most successful, where these reforms should be strengthened or better implemented, and where the most significant challenges lie ahead in combating waste, fraud, and abuse in the health care system.

We must also ensure that the new fraud-fighting tools and funds that Congress has provided through HIPAA and the BBA are used by the Administration to their full potential.

Conclusion. Congress must assure Medicare beneficiaries and the taxpayers that the Medicare is not squandering precious program dollars on waste, fraud, and abuse. Congress passed landmark anti-fraud and abuse legislation in both the 104th and 105th Congress. Now, we must ensure that these reforms are implemented and that the Administration follows the lead of Congress to make anti-fraud and abuse its top priority.

I look forward to today's testimony.

Mr. STARK. Thank you very much, Mr. Chairman.

I couldn't help but think that, on this question of leaving the country, and speculate as to a rumor that if the former chief executive officer of a major hospital chain were to be found guilty and happened to have gone to China to study, do we have an extradition treaty with China, and that may be an interesting thing for us to speculate on.

I'd also, with the Chair's indulgence, like to call attention today to the presence in the room of Scott Johnson. He arrived in Washington earlier this week and traveled by wheelchair all the way from Congressman Levin's district in Michigan, and he's come here to meet with us individually and give us some firsthand information about fraud and abuse in Medicare and the programs for the disabled. It's quite a journey for Mr. Johnson to have been here and I want to just recognize him and hope that he will have a chance to talk with all of us, but I want——

Chairman THOMAS. If the gentleman will yield, Mr. Johnson raise his hand, please.

Mr. STARK. There he is in the back.

Chairman THOMAS. Thank you very much.

Mr. STARK. Thank you. And thank you for this hearing.

We can all be proud of the recent legislative efforts to fight fraud, waste, and abuse and the recent acts made significant strides in combating. We're heading in the right direction. Massive fraud schemes continue, however, and we heard this week about corporate systems to systematically defraud the Medicare system. We don't know if that's the case, but those will be investigated. I guess what we'd all say is "enough is enough."

In an August 1997 statement, Mr. Anderson, the director of corporate financial investigations for Blue Cross and Blue Shield in Michigan, said it best, that "Despite increased enforcement in the publicity of million dollar settlements with large multistate health corporations, the rewards outweigh the risks," and that's what we've got to change.

I introduced a bill which I sent to all of you, with 35 individual provisions. Some you may like, some you may not, but they all aggressively increase the pressure against fraud, waste, and abuse in Medicare. The underlying message should be clear to all those who do business with Medicare and Medicaid, and that is, the fight against fraud is just beginning.

For me it's pretty simple. We have zero tolerance—we should have zero tolerance—for repeat offenders and we shouldn't hide behind free market language as an excuse for criminal behavior. If they do wrong, they should go to jail. I don't think there's much that we need to add to that.

I would like to commend my colleagues to begin to think about an additional or new format for auditing and reviewing, or whatever you choose to call it, and I just point out that in this investigation what the GAO did that turned up all the fraud, waste, and abuse, a new concept sort of appeared and that was comparing the medical records with the financial records. I think in the past you'll find that those have been done separately. There is a judgment call, as we're hearing, as we know, and I'm trying to encourage a new brand of examination.

Now, this comes out of my years of experience in banking, where we have examiners who are both competent to assess the medical record as well as the financial records, and, quite frankly, that the people being audited pay. This is done in the banking industry; the Controller of the Currency, its complete auditing staff is covered by the bank. Now, if you do a good job and your records are up to date, the examiners aren't there very long; it doesn't cost you much. If you're a bad actor and don't keep your records up, and you have to have extra examinations, you pay more. It sounds fair, and I'm going to try and work with my colleagues on the Subcommittee to see if we can, along with HCFA and the OIG, begin to increase the surveillance that is done among the providers and see if that won't help us save some money.

I commend the Chair and I look forward to hearing our witnesses this morning and working with you over the next year to see if we can begin to improve on this and work with the new administration and HCFA to see if we can't cut that fraud and abuse figure at least in half during our current tenancy. That'll be a wonderful goal for us to look forward to, and I'd like to work with you to do that, Mr. Chairman. Thank you very much.

[The opening statement follows:]

Opening Statement of Congressman Pete Stark

Mr. Chairman.

Thank you for holding this hearing.

We should be proud of recent legislative efforts to fight fraud, waste and abuse in the Medicare program. "The Health Insurance Portability and Accountability Act" and the "Balanced Budget Act of 1997" made significant strides in combating fraud, waste and abuse in the Medicare and Medicaid programs. With bi-partisan cooperation, we enacted unprecedented tools for fighting what has become one of the favorite crimes of the 90's—cheating the Government of billions of dollars through health care fraud.

Although we're heading in the right direction, massive fraud schemes to defraud the government continue. In addidavits unsealed this week, the FBI allege that they have "uncovered a systematic corporate scheme (by Columbia HCA)...to defraud Medicare and other government health insurance programs."

Enough is enough.

In a August 19, 1997 statement, Gregory Anderson, Director of Corporate and financial Investigations for Blue Cross and Blue Shield of Michigan said it best—despite increased enforcement and the publicity of million dollar settlements with large, multi-state health corporations, "the rewards outweigh the risks today."

While recent legislation is a good first step, we need to do more.

On Tuesday, I introduced another bill with over 35 new or improved provisions designed to aggressively continue the fight against fraud, waste and abuse. My message should be clear to those who do business with Medicare and Medicaid—the fight against health care fraud is just beginning.

It's simple for me—individuals found to intentionally, systematically and repeatedly defraud Medicare and Medicaid should go to jail. We should have a zero tolerance for repeat offenders. We should not hide behind "free market" language as an excuse for criminal behavior. The fight against health care fraud should be aggressive and on-going. Medicare beneficiaries deserve the best we can offer—quality care at an affordable price with strong protections against unscrupulous providers.

Chairman THOMAS. Thank the gentleman. We're always looking for new ways to deal with issues, but, frankly, the changes that were made in the Balanced Budget Act, moving away from the old cost-plus system, which frankly invited fraud with the inability to check, and moving as much as possible, as rapidly as possible, to a prospective payment system in which it is much more self-correcting will, I think, be a great advance once we can move forward, but any other tools that we might be able to come up with we'll certainly take a very careful look at.

Could I ask the first witness to come to the table. It's Esther "Tess" Canja. She has a personal story to tell, but she's also vice president of the American Association of Retired Persons. Ms. Canja, if you have a written testimony, it'll be made a part of the record. You may address the Subcommittee any way you see fit.

Normally, we have in front of us a typical stop light, which has a green light, a yellow caution—amber caution—and a red light. In California, when the yellow light comes on, California drivers brake. I found in this area when the yellow light comes on, these drivers speed up. So what we have done is simply eliminated the yellow, because of a malfunction. It will go green and then it'll go red. So, don't be concerned immediately, but it means that I would move toward the conclusion of your statement.

With that, if you'll speak directly into the microphone, because these aren't very good mikes, the Subcommittee would be interested in your testimony.

STATEMENT OF ESTHER "TESS" CANJA, VICE PRESIDENT AND MEMBER, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. CANJA. Thank you, Mr. Chairman, and good morning. I am Tess Canja of the American Association of Retired Persons, and I'm very glad to be here this morning. It is especially significant to me that I'm here today because of the personal story I have to share.

My mother, Linda Giovannone, suffered from Parkinson's disease. In 1994, she was placed in a nursing home, where she remained for 2½ years before she passed away. Although physically she was very disabled, mentally she was very, very alert. As her daughter, I was very involved in her care. There are three situations in particular that happened during her stay at the nursing home that I want to tell you about.

In the first case, my mother became the patient of the nursing home's new medical director. After receiving notice of three billings to Medicare, I asked my mother how she liked her new doctor. Much to my surprise, she said she had never seen him. I then decided to check her nursing home medical records, where I found there was a notation of notes on file. I wrote a letter to the doctor suggesting he had confused my mother with someone else, because she had never seen him. I also asked if he could please reimburse Medicare and her supplemental insurance carrier for the amount billed since a mistake obviously had been made. Soon afterward I received a reply by registered mail. The doctor stated he had indeed seen my mother and that notes from these visits were on file. I did not pursue the matter further.

A second situation involved care by a podiatrist. Not only did my mother not need podiatry care, but I regularly clipped my mother's nails myself. Yet, on two occasions that I particularly noted, a podiatrist came into the nursing home, clipped my mother's toenails, and then billed Medicare for another service that was reimbursable. The first time this happened, I left word with the nursing home staff that my mother did not need podiatry care. Yet, it happened again. Unfortunately, the second Medicare statement for this service came in after my mother died, and so I did not pursue the matter further.

The last incident began when I received a Medicare statement for my mother's participation in a psychotherapy discussion group. During the time that she was supposed to be benefiting from this discussion group, she was unable to speak and, therefore, unable to participate. I discussed the situation with the social services director and my mother was removed from the group.

Now, in all three of these situations, I believe the Medicare payments made were unwarranted. I can't help but wonder if some of these events may have been conscious acts to defraud the Medicare Program.

In discussing my story with the staff at AARP, they informed me that there were several new provisions in the Balanced Budget Act of 1997 that, had they been in place during my mother's stay, may have helped me and saved the Medicare Program money.

For instance, the budget act includes a provision that requires the inclusion of a toll-free number, 1–800–HHS–TIPS, on the explanation of Medicare benefits form to report suspected fraud and

abuse. Another provision that should be helpful is one that allows the beneficiary to request from a provider an itemized bill for Medicare services. While the budget act contains a number of other provisions that will reduce fraud and abuse, more, however, still needs to be done.

Enforcement authorities continue to need additional funding to detect, investigate, and prosecute unscrupulous providers, and consumers in particular could be of tremendous assistance if they only had more guidance. For instance, when I discovered irregularities in my mother's Medicare bills, I dealt directly with the providers. I did not notify Medicare of the suspicious billings for two reasons. First, I didn't know whom to call, and second, I did not know whether it would be worth it. The amount of the billings were so small compared to the millions I had read about in news reports, I believed at the time that my complaint would not matter. But I've begun to understand differently. With the limited financial resources enforcement authorities have, perhaps my phone call alone would not have made a difference. But my call, plus another's call, and yet another's call, may have shown a pattern of abuse by a particular provider, thus triggering an investigation.

One of the best ways, I believe, to keep Medicare beneficiaries informed is through the new Medicare summary notice, the MSN. I understand that production of this notice is currently limited to only a few States as a pilot project. I am lucky that my State of Florida is one of them. The new Medicare summary notice is a major improvement over the current EOMB form in that it encourages beneficiaries to help stop fraud by providing examples of the types of fraud we should be looking for and the number to call if we suspect fraud. What consumers need to know is what they should be suspicious about, such as double billing, charging for services not performed, or performing inappropriate or unnecessary services.

Moreover, consumers need to know how to avoid becoming unwitting participants in a scam. They need to understand that they should treat their Medicare or private insurance card like a VISA card—never giving out their beneficiary number over the phone unless they initiated the call and immediately reporting their card missing if it's lost or stolen.

It's a problem for consumers that providers have up to 1 year after providing a service to submit a claim to Medicare. After 1 year it can be very difficult for an individual to remember if the services billed were actually received or appropriate.

Despite the major drive by enforcement authorities in the past few years, a recent survey by AARP indicates that 80 percent of Americans are unaware of any efforts to combat health care fraud. Consumers do, however, believe that something can be done to reduce fraud and are eager to join in this fight themselves. The most positive findings in the survey pertain to the strong and nearly universal willingness of individuals to take personal responsibility for doing something themselves about health care fraud, as I tried to do in my mother's situations. But they still need to know what to do. AARP hopes to take the information learned in this survey and craft an education campaign to build on the positive attitudes that were revealed.

I thank you all for inviting me to speak before the Subcommittee today. If consumers were aware of the types of fraud being perpetrated, what to look for when reviewing their claims, and whom to call when they suspect fraud, they would become valuable partners in the fight to reduce health care fraud and abuse.

[The prepared statement and attachment follow:]

Statement of Esther "Tess" Canja, Vice President and Member, Board of Directors, American Association of Retired Persons

Good morning. I am Tess Canja from Port Charlotte, Florida. As Vice President and a member of the Board of Directors of the American Association of Retired Persons (AARP), I appreciate the opportunity to testify today about fraud and abuse in the health care system.

It is especially significant to me that I am here today not only because of my role as a representative of AARP but also because of the personal story I have to share.

MY PERSONAL EXPERIENCE WITH HEALTH CARE FRAUD

My mother, Linda Giovannone, suffered from Parkinson's Disease. In 1994, she was placed in a nursing home where she remained for two-and-a-half years before passing away. Although physically she was severely disabled, mentally she was very alert. As her daughter, I was very involved in her care. Not only did I oversee the providers who cared for her, but I also received her medical bills—including those from Medicare. I intervened on her behalf, when necessary, with both providers and insurance carriers.

None of her stay in the nursing home, with the exception of the physical therapy she received, resulted in Medicare payments to the facility. However, separate Medicare Part B payments were made to providers who came into the nursing home. It is some of their charges to Medicare that I found troubling.

There are three situations, in particular, that I want to tell you about.

In the first case, my mother's personal physician no longer serviced the nursing home, so she became the patient of the nursing home's new medical director. After receiving notice of three billings to Medicare of approximately $40 each, I asked my mother how she liked her new doctor. Much to my surprise, she had never seen him.

I then decided to check her nursing home medical records for the dates the physician apparently saw her. In the records, there was a notation of "notes on file." I wrote a letter to the doctor suggesting that he had confused my mother for another patient since she had never seen him. I also asked if he could please reimburse Medicare and her supplemental insurance carrier for the amount billed since a mistake had obviously been made.

Soon afterwards, I received a reply by registered mail. The doctor stated that he had indeed seen my mother and that his notes from these visits were on file. By now, I was sure that there would be notes on file and did not pursue the matter further. Shortly, thereafter, he resigned as medical director.

A second situation involved care by a podiatrist. Let me make it clear that my mother did not need podiatry care, nor was it ordered by her primary physician. In addition, I regularly clipped my mother's fingernails and toenails. Yet, on two occasions that I particularly noted, a podiatrist came into the nursing home, clipped my mother's toenails and then billed Medicare for another service that was reimbursable.

The first time this happened, I left word with the nursing home staff that my mother did not need podiatry care. Yet, it happened again. Unfortunately, the second Medicare statement for this service about $60—came in after my mother had died, so I did not pursue the matter further.

The last incident that I would like to share with you began when I received a Medicare statement for my mother's participation in a psychotherapy discussion group. During the time that she was allegedly benefiting from this discussion group, she was unable to speak, and therefore unable to participate. I discussed the situation with the social services director and my mother was removed from the group.

In all three of the situations I described, I believe the Medicare payments made were unwarranted. I can't help but wonder whether some of these may have been conscious acts to defraud the Medicare program.

THE BALANCED BUDGET ACT OF 1997

In discussing my story with the staff at AARP, they informed me that there were several new provisions in the Balanced Budget Act of 1997 that, had they been in

place during my mother's nursing home stay, may have helped me during this difficult time, and probably would have saved the Medicare program some money.

For instance, the Balanced Budget Act includes a provision that requires the inclusion of a toll-free number on the Explanation of Medicare Benefits (EOMB) form to report suspected fraud and abuse. AARP staff tell me that the hotline number 1–800–HHS–TIPS has actually been in place and operating for several years. Yet, many beneficiaries and caregivers, like myself, have been unaware of its existence. Had this number been printed on my mother's Medicare bills at the time, I would have realized that there was someone I could call to report my suspicions.

Another provision that should be helpful to beneficiaries is one that allows a beneficiary to request from a provider an itemized bill for Medicare services. The provider would have 30 days from the date of the request in which to furnish the beneficiary with an itemized statement. If the statement showed services not provided or other billing irregularities, the beneficiary would then be able to request a review of the statement by the Secretary of Health and Human Services. Requiring providers to furnish itemized statements upon request will not only help the beneficiary who, in some instances, may be making coinsurance payments for services not received but will benefit the Medicare program as well if beneficiaries can alert the program to billing irregularities.

The Budget Act also contains a provision that requires hospitals to include information on their discharge planning evaluations that would inform beneficiaries of the availability of Medicare home health services and whether or not the hospital has a financial interest in any such agencies. By informing beneficiaries of the options available to them and the hospital's financial interests, patients will be in a better position to make the best choice for their care.

While the Balanced Budget Act includes a number of provisions that will help consumers participate in the fight against fraud, it also includes a number of provisions that should make it more difficult for providers to scam the system.

For instance, requiring certain groups of providers such as durable medical equipment suppliers to post a $50,000 surety bond if they wish to do business with Medicare should help to weed out unscrupulous providers from the legitimate ones. Similarly, requiring providers and suppliers to provide HCFA with their Social Security numbers and employer identification numbers to check for past fraudulent activity should cause scam artists to think twice before setting up business. In addition, requiring providers who submit claims for services provided in nursing homes to list the identification number of the nursing home on their claim form should make it much easier to track—and hopefully deter—unscrupulous activities.

The budget bill gets tough with fraudulent providers by establishing a "three strikes and you're out" penalty. Any health care provider convicted of defrauding Medicare or any other federal health care program for the second time will be prohibited from participating in any federal health care program for 10 years. A provider who is convicted for a third time will be prohibited from participating in any federal health care program for life.

In addition, the Secretary of Health and Human Services will now have the option to deny participation in the Medicare program to any provider convicted of a felony medical or otherwise.

Other penalties include excluding from participation in the Medicare program entities controlled by a family member of a sanctioned individual, and imposing new civil monetary penalties on persons who contract with an excluded provider, as well as on health plans which fail to report information on adverse actions required under the health care fraud and abuse data collection program.

AARP is pleased with these new "get tough" penalties. They send a strong message to unscrupulous providers that Medicare will not tolerate those who commit fraud and abuse against the system.

One aspect of the budget bill, however, that may prove to have the greatest impact in reducing the "incentive" to commit fraud is the establishment of prospective payment systems (PPS) for home health care, skilled nursing facility care, ambulance services and rehabilitation services. In particular, the new PPS for skilled nursing facility care should eliminate the incentive to provide unnecessary therapy services, as occurred in my mother's case.

Up until now, it has simply been too easy for providers of these types of care to abuse the system. For instance, some home health care providers have their home offices in high-cost urban centers while maintaining branch offices in low-cost rural areas. Since, under current law, payment is based on where the service is billed and not where the service is provided, some providers have billed Medicare from their urban location where the cost is much higher to provide a service even if the service was actually provided in a rural area. In addition, the "reasonable cost basis" of pro-

viding the service varied greatly from provider to provider, as well as location to location.

The new payment systems should save the Medicare program millions by setting a fixed amount for each service regardless of location, with minor adjustments made for high cost areas. The new law also requires providers to submit claims based on the location of where the service is actually furnished, and not where the main office is located. AARP believes these new payment systems will be a major factor in reducing fraud and abuse.

THE NEED TO EDUCATE CONSUMERS

While the Balance Budget Act of 1997 provides significant legislative resources to aid both enforcement authorities and consumers in the fight against health care fraud, more still needs to be done.

Enforcement authorities e.g., the Department of Health and Human Services Office of Inspector General, the Department of Justice, the Federal Bureau of Investigation will continue to need additional financial resources to detect, investigate and prosecute unscrupulous providers.

Consumers, in particular, could be of tremendous assistance to the effort to reduce fraud and abuse if they only had more guidance. For instance, when I discovered irregularities in my mother's Medicare bills, I dealt directly with the providers. I did not notify Medicare of the suspicious billings for two reasons: 1) I didn't know who to call, and 2) I didn't know if it was worth going to the trouble to find out. The amount of the billings was so small compared to the millions I had read about in news reports, I believed at the time that no one would care. But I've begun to understand differently. With the limited financial resources enforcement authorities have, perhaps my phone call alone would not have made that big of a difference. However, my call plus another consumer's call and yet another call may have shown a pattern of abuse by a particular provider, thus triggering an investigation. Consumers need to know that their suspicions matter and that the government cares.

One of the best ways, I believe, to keep Medicare beneficiaries informed is through the new Medicare Summary Notice (MSN). I understand that production of this notice is currently limited to only a few states as a pilot project. Since Florida is one of these states, I am a lucky recipient of the MSN.

Let me begin by saying that the new Medicare Summary Notice is a major improvement over the current EOMB form. Though it is much easier to read and understand, the biggest difference is the information it contains. Not only does it encourage beneficiaries to help stop fraud, it provides examples of the types of fraud we should be looking for.

Consumers need to know how to properly audit their claims and what types of billing irregularities constitute fraud. Many beneficiaries consider the $5 aspirin to be fraud while it is an extraordinary charge, it's not where consumers' attention should be focused. Rather, what consumers really need to know is what they should be suspicious about such as double billing, charging for services not performed, or performing inappropriate or unnecessary services. Moreover, many do not know that waiving a Medicare patient's coinsurance is illegal.

Furthermore, consumers need to know how to avoid becoming unwitting participants in a scam. For example, many do not know that they should treat their Medicare or private insurance card like a VISA card. They don't know they should never give their beneficiary number out over the phone when they haven't initiated the call, or to someone who comes to their door, or in exchange for free medical services. They don't know to immediately report their card missing if it is lost or stolen.

If consumers were more aware of the types of fraud perpetrated they would be in a better position to avoid and report them. Yet many remain uninformed of the types of fraud that exist or whom to call if they suspect fraud.

The new summary notice not only helps educate consumers as to what types of fraud exist, but it also provides them in bold type with the HHS Inspector General's fraud hotline number: 1–800–HS–TIPS. One number they can count on to report their suspicions. AARP believes the Medicare Summary Notice should formally replace the EOMB form and be made available beyond the pilot project to all Medicare beneficiaries.

Another problem, from the consumer's standpoint, that I would like to alert you to is the current requirement that providers have up to one year after providing a service to submit a claim for payment from the Medicare program. While this may not be a problem for the provider, at times it can create a problem for the consumer. After a year, it can be difficult for an individual to remember if the services billed were actually received or appropriate. For family caregivers, like myself, it can be difficult to check if a loved one received the services actually billed if an entire year

has passed. It is especially difficult, as in my mother's case, if the patient died many months before the claims were received particularly since the claims reflected services performed the previous year.

One of the biggest problems in involving consumers in the fight against health care fraud is the lack of knowledge they have that anything is being done by the government to root out fraud. Despite the major drive by enforcement authorities in the past few years, a recent survey by AARP indicates that 80 percent of Americans are unaware of any efforts to combat health care fraud. Of those who are aware, nearly one-third believe that such efforts have had no effect.

Consumers do, however, believe that something can be done to reduce fraud and are eager to join in this fight themselves. In the survey, nearly 85 percent said they would be more inclined to report health care fraud if they only knew more about it. Interestingly, though, the survey showed that offering a reward or monetary incentive would do little to increase the likelihood that consumers would report suspected fraudulent behavior. Consumers believe reporting fraud is their personal responsibility.

The public also believes that reducing fraud and abuse will increase the quality of their care and lower their costs, and that more can and should be done to reduce fraud in the health care system. Yet they remain cynical about the government's ability to fight it. The most positive findings in the survey pertain to the strong and nearly universal willingness of individuals to take personal responsibility for doing something themselves about health care fraud, as I tried to do in my mother's situation.

AARP is taking the information learned in this survey and crafting an education campaign to build on the positive attitudes that were revealed and to dispel the myths and misperceptions about health care fraud.

AARP does not see itself as acting alone in designing and implementing such a campaign. The Association plans to work with both the public and private sectors in this effort. Educating Americans about the extent of fraud and about efforts already underway to combat it is one of many steps to reducing fraud and abuse. This, in itself, is one aspect to lowering health care costs and increasing the quality of our nation's health care.

CONCLUSION

Mr. Chairman, thank you for inviting me to speak before the Subcommittee today. Clearly, there is a need and a desire for greater public education on health care fraud and abuse. If consumers were aware of the types of fraud being perpetrated, what to look for when reviewing their claims, and whom to call when they suspect fraud, not only would they be able to avoid being unwitting participants in a scam, but they would also become valuable partners in the fight to reduce health care fraud and abuse.

America Speaks Out On Health Care Fraud

A Consumer Survey

Conducted for the
American Association of Retired Persons
(AARP)

by International Communications Research (ICR)
Survey Research Group

Updated-September, 1997

AARP

I. EXECUTIVE SUMMARY

Though there have been many efforts in recent years to stem the rising cost of health care, consumers continue to feel the pinch in their pocketbooks. Many consumers believe that fraud and abuse is a big contributor to the problem, that reducing fraud and abuse will increase the quality of their care and lower their costs, and that more can and should be done to reduce fraud in the health care system. In fact, nearly 70 percent of consumers believe the Medicare program would not go broke if fraud and abuse were eliminated.

The federal government, as well as private insurers, have spent hundreds of millions of dollars to improve claims auditing, beef up enforcement, and educate providers and the public in the fight against health care fraud.

Yet, AARP's Health Care Fraud Survey found that nearly 80 percent of consumers are unaware of any efforts to reduce health care fraud. **The idea that fraud is rampant and little is being done about it is very much alive in the public's mind.**

Despite the efforts of enforcement agencies, 87 percent of consumers believe health care fraud is increasing or staying the same. Even more — 93 percent — believe fraud is either extremely or somewhat widespread, and that it is extremely widespread in the Medicare and Medicaid programs, more so than in any other public or private health care program.

When asked what changes would give them greater confidence that their health care dollars were being better spent, the majority of respondents said greater control within the health care system — better monitoring, closer scrutiny of claims, better investigative techniques, catching the people who commit fraud (especially in the Medicare and Medicaid programs), stricter government regulations, and tougher qualifications for participation in Medicaid. It is clear that many Americans remain extremely concerned about the effects of fraud, not only on their health care costs, but also on the quality of their health care. And, most — 85 percent — say they stand ready to assist in the fight against fraud and abuse, if they only knew how. They simply do not know how to report it, whom to trust to do something about it, or where to get information about health care fraud.

The American public clearly sees health care fraud as a crime, but appears cynical about the government's ability to fight it. Their cynicism is counterbalanced, however, with a strong degree of optimism: eight in 10 Americans believe something can be done to reduce health care fraud, and two-thirds say they would like Congress to allot more funds to fight health care fraud (similar numbers call for more non-public anti-fraud funds, as well).

The most positive findings in the survey pertain to the strong and nearly universal willingness of individuals to take personal responsibility for doing something themselves about health care fraud, if only they were shown the way. The public perceives a clear self-interest in reducing health care fraud. They see fraud as costing them money, and the reduction of fraud as improving their own health care.

AARP hopes to take the information learned in this survey, craft an education campaign to build on the positive values expressed here, and to dispel the myths and misperceptions about health care fraud.

AARP does not see itself as acting alone in designing and implementing such a campaign. The Association plans to work with both the public and private sectors in this effort. Educating Americans about the extent of fraud — and of efforts already underway to combat it — is one of many steps to reducing fraud and abuse. This, in itself, is one aspect to lowering health care costs and increasing the quality of our nation's health care.

II. METHODOLOGY

In January, 1996, AARP established a task force to address the question of creating a public education campaign to focus on health care fraud. The goal is to educate members and the general public on health care fraud in an effort to involve them in the fight to reduce fraud and abuse in the Medicare and Medicaid programs, as well as in private health care plans. This survey is the first step in that effort.

To craft such an education campaign, AARP needed to explore the following aspects:

- Public understanding of fraud and abuse,
- Personal experience with fraud and abuse,
- Misunderstanding about fraud and abuse,
- Perceptions of the size of the problem,
- Public support for fighting fraud,
- Consumers' knowledge of how and where to file complaints, and
- Consumer experience with filing complaints.

To construct the survey itself, AARP conducted a series of four focus groups and consulted public and private sector agencies about key issues and specific questions to ask. These agencies included: the Department of Health and Human Services, Office of the Inspector General; the Health Care Financing Administration; the Federal Bureau of Investigation; the Department of Justice; the Federal Trade Commission; the National Association of Medicaid Fraud Control Units; the National Association of Attorneys General; the National Health Care Anti-Fraud Association, and the Health Insurance Association of America. Based on their insights, a survey instrument was drafted, reviewed, and tested.

The survey was conducted in November and December, 1996, by the ICR Survey Research Group. Two thousand adults aged 18 and older from around the country were interviewed by telephone using the random digit dialing (RDD) method. This sample was representative of the American adult population, with a sampling error for the entire survey of plus or minus two percent.

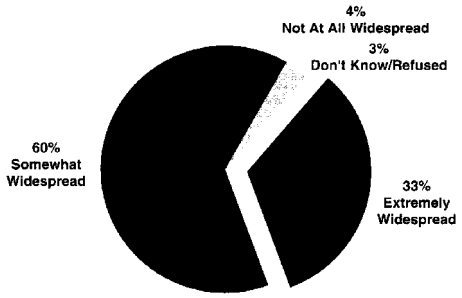
There were 500 respondents from each of four age groups: Generation X (18 - 29), Baby Boomers (30 - 49), Mid-Life Americans (50 - 64), and Seniors (65+). Sampling error for the age groups was plus or minus four percent.

III. FINDINGS

How Widespread Do We Think Fraud Is?

How many Americans are aware of health care fraud? According to the survey, an overwhelming majority of the population regards health care fraud as either extremely (33 percent) or somewhat (60 percent) widespread.

How Widespread Do You Think Health Care Fraud is in General?

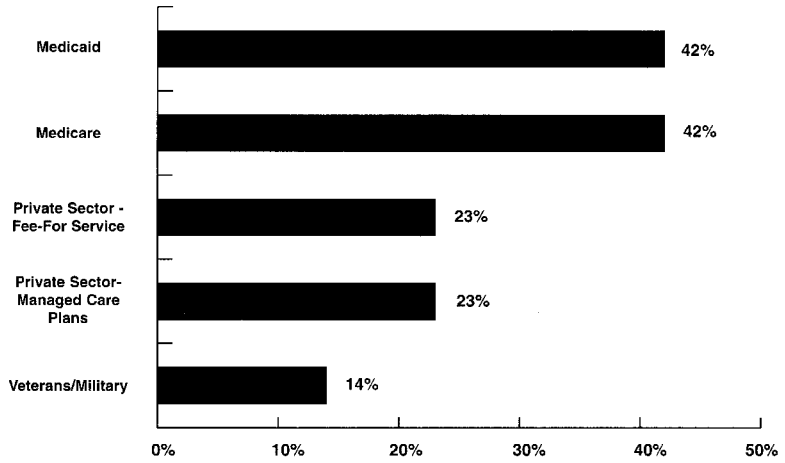


Belief that the problem is extremely widespread was highest among:

- those age 50-64 (42 percent);
- blacks (50 percent);
- those without high school diplomas (48 percent);
- those for whom health care fraud is a major issue (51 percent);
- those who have experienced health care fraud (47 percent);
- those who took no action about the health care fraud they had experienced (52 percent); and,
- those who think health care fraud is increasing (43 percent).

When asked in what areas they believe fraud is extremely widespread, over 40 percent believe that health care fraud is extremely widespread in the federal Medicare and Medicaid programs. Fewer respondents (23 percent) view fraud as extremely widespread in the private sector.

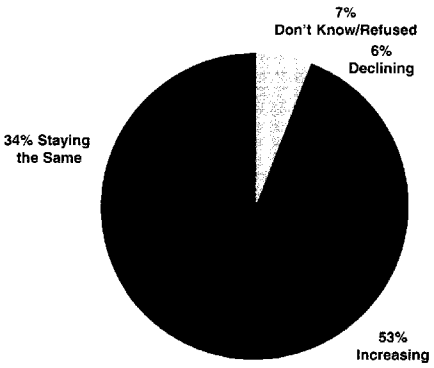
Percent Who Believe Fraud Is Extremely Widespread in the Following Specific Areas:



Is Fraud Increasing, Declining or Staying the Same?

More than half (53 percent) of the public believe that health care fraud is increasing, a third (34 percent) believe it is staying the same, while very few (6 percent) think it is declining.

Do Your Think the Amount of Health Care Fraud Is Increasing, Declining or Staying the Same?



This view is strongly related to the basic attitude about the extent of health care fraud:

- Seven in 10 who believe health care fraud is extremely widespread also believe that fraud is increasing, compared to only 48 percent of those who think the amount of fraud remains the same.
- The view that health care fraud is increasing is held more often by those who view health care fraud as an important issue to them personally (63 percent) and by those who have actually experienced fraud (62 percent), compared to those who have not (51 percent).

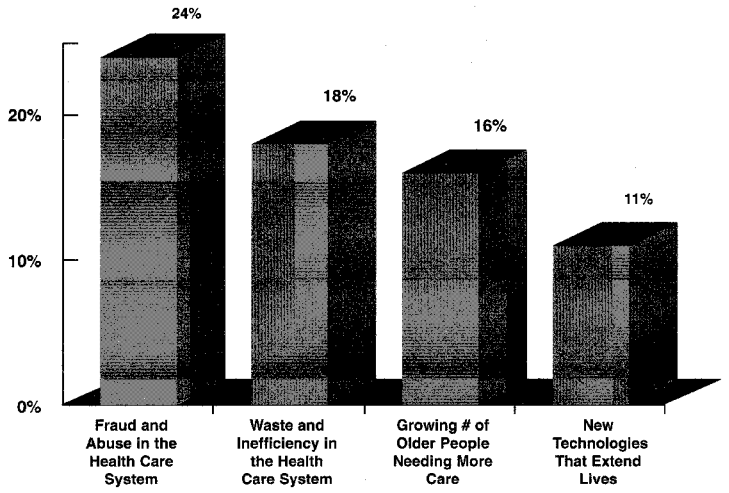
How Much Does Fraud Contribute to the Rising Costs of Health Care?

Four possible reasons for the rise in health care costs were presented to the respondents, who were asked how much weight they gave to each reason. **Health care fraud was more often viewed as a most important reason** (24 percent), compared with waste and inefficiency in the health care system (18 percent), the medical needs associated with aging (16 percent), and improved technology (11 percent).

There were few demographic differences, but this view is related strongly to the basic attitude about the prevalence of health care fraud: Those who believed health care fraud to be extremely widespread (36 percent) were much more likely to cite fraud as one of the most important reasons for the rise in health care costs, compared to those who thought fraud is somewhat widespread (18 percent), or not at all widespread (7 percent).

This view was also held more often by those who had experienced health care fraud (33 percent), compared to those who had not (22 percent).

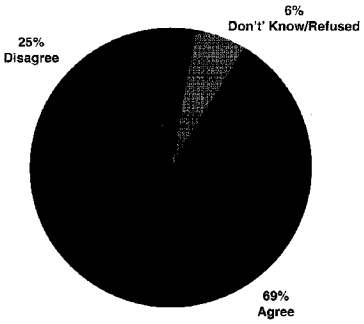
Percent Who Believe Each of the Following is One of the Most Important Reasons for the Rising Cost of Health Care



When asked who they thought paid the additional costs of fraud, **ninety-six percent of respondents responded that *individuals/consumers* are making up for the losses.** Respondents recognize, however, that they are not the only ones paying. They see employers (77 percent), the government (70 percent), and insurance companies (62 percent) as also paying for these costs. Fewer respondents (42 percent) see doctors and hospitals as bearing the costs of fraud.

Interestingly, 69 percent of respondents — more than two-thirds — believe the Medicare program would not go broke if fraud and abuse were eliminated.

"THE MEDICARE PROGRAM WOULD NOT GO BROKE IF FRAUD AND ABUSE WERE ELIMINATED"

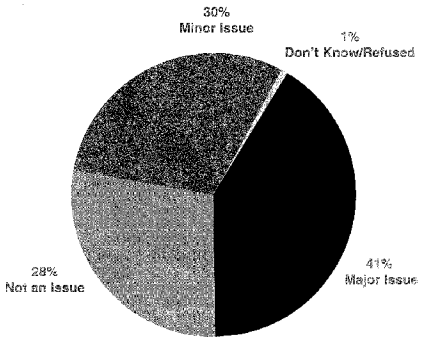


How Important Is Health Care Fraud to Us Personally?

Health care fraud was considered a *major issue* by 41 percent of respondents, a minor issue by 30 percent of respondents, and not an issue at all by 28 percent of the respondents. Fraud is less of an issue for Generation X-ers, 36 percent of whom said it was not an issue for them. More blacks (54 percent) than whites (38 percent) consider it a major issue for themselves.

Personal interest in the health care fraud issue was strongly related to the extent of health care fraud they perceive: Those who believed health care fraud to be extremely widespread were much more likely to say it was a major issue for them (64 percent), compared to those who thought fraud was somewhat widespread (31 percent) or those who took fraud to be not at all widespread (14 percent).

Is Health Care Fraud Currently a Major Issue, a Minor Issue, or Not an Issue for You?



Who's Responsible for Health Care Fraud and What's Being Done About It?

To respondents, health care fraud is not a matter of mistakes and inefficiencies. **Almost 70 percent view fraud as "intentional," the characteristic that makes it a crime.**

As far as health care providers are concerned, we get two different answers, depending on how the question is asked.

• An open-ended question about whom they thought **was most responsible for the level of health care fraud in this country** resulted in "top-of-mind" responses with which the respondents are most familiar, such as doctors (31 percent), consumers/patients (15 percent), and insurance companies (11 percent). *Interestingly, the respondents overlooked or gave very low numbers to certain providers where, according to enforcement officials, the potential for fraud is very high.* For example, nursing homes, durable medical equipment suppliers, medical laboratories, and home health agencies are not high on the respondents' list, while enforcement officials see these areas as "particularly susceptible to fraud."

• When asked *specifically* about various providers, leading the list of health care providers who are believed to commit a "great deal" of health care fraud are pharmaceutical companies (33 percent), insurance companies (29 percent), medical equipment companies (28 percent), and hospitals (28 percent). These are followed by doctors (22 percent), patients/consumers (21 percent), home health companies (18 percent), and pharmacists (11 percent).

A majority of Americans view public and private agencies overseeing expenditures to these providers with some cynicism. Nevertheless, there is also a large minority that disagrees. For example, a majority (51 percent) of the respondents is of the opinion that the "people you report health care fraud to don't really care enough to do anything about it." Yet, a large percentage (43 percent) disagrees with that statement.

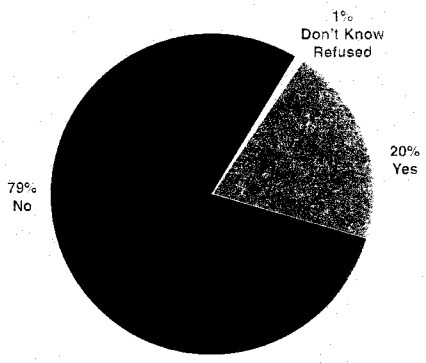
As to specific agencies, **42 percent of the respondents agree with the statement *"the Medicare Administration isn't really doing anything to detect and prosecute health care fraud."*** An equal number of respondents, however, disagrees with that statement. Forty-five percent of the respondents believe Medicaid administrators aren't "doing anything," while 39 percent disagree.

A majority of the respondents also question the efforts of private insurance companies to limit fraud. **Sixty-one percent agree with the statement that *"insurance companies have no incentive to detect health care fraud; they can always raise your premium."*** Again, however, a large percentage (37 percent) of respondents disagrees.

WHO IS FIGHTING HEALTH CARE FRAUD?

Public awareness of efforts to combat health care fraud is low for most of the population - 20 percent overall. Awareness is lowest among Generation X-ers (12 percent), the less educated (11 percent), and those with the lowest incomes (12 percent).

ARE YOU AWARE OF ANY OF THE EFFORTS TO REDUCE HEALTH CARE FRAUD?



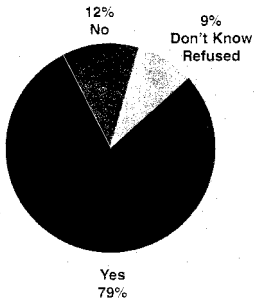
The 20 percent who were aware of efforts to reduce health care fraud were asked whether these efforts have increased, reduced, or had no effect on health care fraud. A majority (52 percent) of the "aware" respondents said that these efforts have reduced health care fraud, while 31 percent thought anti-fraud efforts have had no effect. One in 10 thought these efforts have actually increased fraud. Only the few who felt health care fraud is declining stood out in believing anti-fraud efforts have reduced health care fraud (66 percent).

All respondents were asked whether more public and nonpublic funds should be used to fight health care fraud. ***A solid two-thirds approved spending more public (66 percent) and nonpublic (69 percent) funds.***

WHAT CAN I DO ABOUT HEALTH CARE FRAUD?

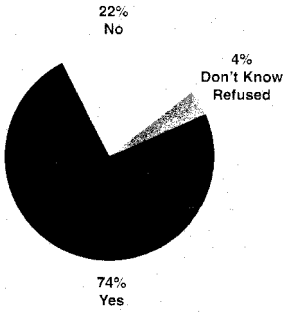
While they may disagree about the efficacy of current oversight, Americans are optimistic that something can be done about fraud. Almost eight in 10 agree that something "can be done to reduce health care fraud," and in a related question, nearly eight in 10 disagree with the statement that fraud is a natural part of the health care system and nothing can be done about it.

DO YOU THINK ANYTHING CAN BE DONE TO REDUCE HEALTH CARE FRAUD?



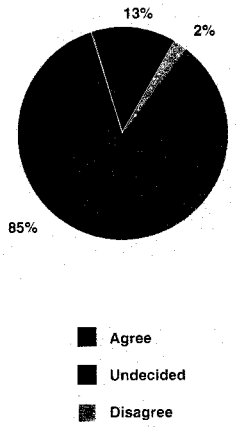
In addition, **74 percent of consumers conclude their own health care would improve if *"more was done to reduce health care fraud,"*** directly relating health care fraud to the quality of their care.

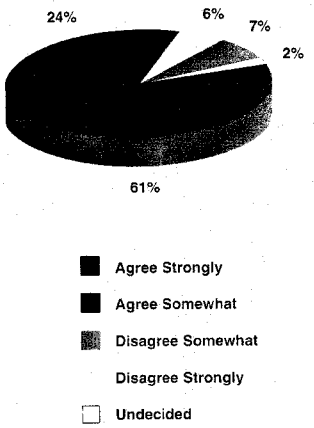
DO YOU THINK THAT YOUR HEALTH CARE WOULD IMPROVE IF MORE WAS DONE TO REDUCE HEALTH CARE FRAUD?



In the fight against health care fraud, consumers consider themselves to be partners alongside enforcement officials. **Almost *all* respondents (90 percent) agree that "it's my personal responsibility to report suspected health care fraud."** In fact, **85 percent indicate they would be *more inclined* to report fraud if they *"knew more about it."***

If I Knew More About Health Care Fraud, I Would be More Inclined to Report It





While patient-doctor relationships can be personal to many Americans, 90 percent of the respondents indicate they would "report my doctor if I thought he or she had committed fraud."

Notably, 18 percent of the survey respondents (representing nearly a fifth of all adult Americans) said they had personally experienced health care fraud. The types of health care fraud experienced included **billing for services not furnished** (28 percent), **overcharging for hospital services** (16 percent), **billing for medically unnecessary services** (16 percent), and **duplicate billings** (11 percent).

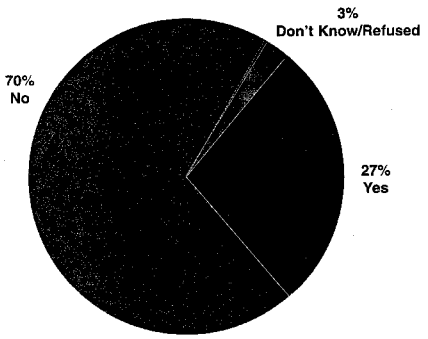
There were few demographic differences except for age (only nine percent of Generation X-ers said they had experienced health care fraud). Women (20 percent) were relatively more likely than men (15 percent) to have experienced fraud, as were those who think health care fraud is extremely widespread (25 percent) and those for whom the fraud issue is important (24 percent).

Half of those who said they had experienced health care fraud took some action about the suspected fraud (especially regarding billing for services not performed and in the case of duplicate billings).

Those who took some action contacted **their insurance company** (38 percent), **the hospital/clinic/nursing home** (22 percent), or their doctor (22 percent). Most (71 percent) said they got a response; in the majority of these cases (52 percent), the person they contacted did something about the suspected fraud.

Though most Americans believe they have never experienced health care fraud, they, nonetheless, indicated they do not need financial incentives to report fraud. Nine in ten believe that it's their "personal responsibility" to report suspected fraud.

WOULD YOU BE MORE LIKELY TO REPORT SUSPECTED FRAUDULENT BEHAVIOR IF A REWARD OR MONETARY INCENTIVE WAS OFFERED?



What Is the Role of Organizations in Fighting Health Care Fraud?

In the final grouping of questions, the survey asks consumers if they know who to complain to when fraud is suspected, whom they trust most to take the steps to reduce fraud, and where they would look for information about health care fraud.

When asked an open-ended question regarding **to whom they would report health care fraud**, respondents' answers were across the board with no clear pattern.

- The largest percentage of respondents (30 percent) indicated they didn't know or refused to answer.
- Next mentioned was insurance companies with 25 percent.
- The remaining responses consist of dozens of agencies and persons. However, no single agency received more than 13 percent of the responses. There appears to be a great difference of opinion among the public as to where to file complaints.

Similarly, more than 30 percent of respondents indicated **they didn't know whom they would trust the most to reduce health care fraud.**

- Fifteen percent answered insurance companies.
- Another 15 percent referred to their state government.
- Only 11 percent of respondents indicated the federal government.

Respondents were also asked where they would most likely look for information about this topic. **Again, 30 percent of respondents did not know or refused to answer.** No other answer garnered more than 16 percent of the respondents.

IV. CONCLUSIONS

The results of this survey have demonstrated that the American public believes there is a significant problem with fraud and abuse in our health care system, especially in the Medicare and Medicaid programs.

Despite the major drive by enforcement authorities in recent years, most Americans (eight in 10) are unaware of any efforts to combat health care fraud. Of those who are aware, nearly one-third believe that such efforts have had no effect. Furthermore, many do not know whom they would trust most to reduce health care fraud.

The American consumer does, however, believe that something can be done to reduce fraud and advocates spending more money by both the government and the private insurance sector to rid the health care system of unscrupulous providers.

Eager to join in this fight are American consumers themselves, believing that costs would decline and the quality of care would improve if fraud was reduced or eliminated. Nearly 85 percent said they would be more inclined to report health care fraud if they only knew more about it. Interestingly, though, offering a reward or monetary incentive does little to increase the likelihood that consumers would report suspected fraudulent behavior. Consumers believe reporting fraud is their personal responsibility.

Clearly, there is a need and a desire for greater public education on health care fraud and abuse. If consumers were aware of the types of fraud being perpetrated, what to look for when reviewing their claims, and who to call when they suspect fraud, not only would they be able to avoid being unwitting participants in a scam, but they would also become valuable partners in the fight to reduce health care fraud and abuse.

V. APPENDIX

ATTITUDINAL RESPONSES

RESPONDENTS WERE ASKED BY INTERVIEWERS TO AGREE OR DISAGREE WITH THE FOLLOWING SPECIFIC STATEMENTS ABOUT HEALTH CARE FRAUD:

"Most people, including doctors and hospitals, will just cheat when they think they can get away with it."

Slightly more than half (54 percent) agreed with this statement. Agreement was higher among Generation X-ers (63 percent), those with incomes of less than $15,000 (67 percent), those without high school education (65 percent), Southerners (60 percent), and blacks (78 percent). Disagreement was greatest among those at the highest income (50 percent) and education (52 percent) levels.

Cynicism is strongly related to the basic attitude about the prevalence of health care fraud. Seven in 10 of those who believe health care fraud is extremely widespread agree with this statement, compared to 49 percent of those who think fraud is somewhat widespread, and 28 percent of those who believe health care fraud is not at all widespread.

Cynicism is also related to issue salience and to experience with health care fraud (64 percent), as well as to the belief that nothing can be done about health care fraud (68 percent).

"Health care fraud is just built into the health care system: there's nothing that can be done about it."

Only one in five agree with this statement. Agreement is highest among those who don't think anything can be done about health care fraud (43 percent) and those who experienced health care fraud but did nothing about it (27 percent).

"People to whom you report suspected health care fraud don't really care enough to do something about it."

Roughly half (51 percent) agreed with this statement; 43 percent disagreed. Agreement was highest among blacks (62 percent), those who think health care fraud is extremely widespread (63 percent), those who have experienced fraud (59 percent), and those who do not believe anything can be done about health care fraud (57 percent), those ages 65 and over (56 percent), and those with less than a high school education (66 percent).

"Insurance companies have no incentive to detect health care fraud; they can always raise your premiums."

Six in 10 agree with the statement; 37 percent disagree. Agreement is strongly related to the basic attitude about the prevalence of health care fraud: extremely widespread (69 percent), somewhat widespread (59 percent), not at all widespread (36 percent). Agreement is also greater among those who experienced health care fraud (68 percent).

"Most health care fraud isn't really intentional: it's the result of mistakes and inefficiency."

Seven in 10 disagree with this statement: they see intent to commit fraud, just as the vast majority (9 in 10) considered health care fraud to be a crime. Agreement is relatively greater among those aged 65 and over (38 percent), those at the lowest educational and income levels (36 percent), those who believe nothing can be done about health care fraud (39 percent), those who

think fraud is not at all widespread (43 percent), and people who believe that health care fraud is declining (39 percent).

"Health care fraud may be wrong, but it isn't really a crime."

Nine in 10 respondents disagree with this statement. Almost everyone accepts the criminal nature of health care fraud, although relatively fewer seniors (81 percent) than respondents in other age groups reject this view. Rejection of this view is even greater among those who have experienced health care fraud (97 percent) and by those who think something can be done about health care fraud (92 percent).

"Insurance companies aren't really doing anything to detect and prosecute health care fraud."

"The Medicare administration isn't really doing anything to detect and prosecute health care fraud."

"State Medicaid administrations aren't really doing anything to detect and prosecute health care fraud."

On each of the above three statements, the survey respondents are approximately evenly split between agreement and disagreement. Agreement with each statement is greater among those who think health care fraud is extremely widespread , and among those who have experienced health care fraud. Agreement is also strongly and inversely related to education: highest among those who did not graduate from high school, and lowest among college graduates.

"It's my personal responsibility to report suspected cases of health care fraud."

Nine in 10 respondents agreed either strongly or somewhat with this statement. Strong agreement is greater among those who believe health care fraud is extremely widespread (75 percent), those who took some action about suspected health care fraud (84 percent), those who believe something can be done about health care fraud (72 percent), those for whom health care fraud is a major issue (76 percent), and people age 50-64 (76 percent).

"It's not worth the time and effort for me to report and pursue suspected health care fraud."

Eight in 10 respondents disagree with this companion statement about personal responsibility. There are few demographic differences other than seniors being slightly more likely to reject this statement (seven in 10). Disagreement is related to education and is greatest among college graduates (87 percent) and least among non-high school graduates (70 percent). It is also related to the belief that something can be done about health care fraud (84 percent) and is greater among those who took some action about suspected health care fraud (86 percent). Unlike the other statement about personal responsibility, this statement is not related to the basic attitude about the prevalence of health care fraud.

"I'm reluctant to report suspected health care fraud because I am afraid of the consequences of confronting my doctor or other health care provider."

Three-quarters reject this statement. Disagreement is greater among those who think something can be done about health care fraud (78 percent), those who took some action about suspected health care fraud (82 percent), college graduates (80 percent), Republicans (80 percent), and those with incomes of $50,000 or more (85 percent).

VI. QUESTIONNAIRE

AWARENESS

1. People have different ideas about what is causing health care costs to go up. For each of the following, please tell me if you think it is one of the most important reasons for rising costs, a major reason, a minor reason, or not a reason at all.

		a	b	c	d
4	One of the most important reasons	11	16	24	18
3	Major reason	41	49	42	43
2	Minor reason	33	25	26	31
1	Not a reason at all	12	8	6	5
D	(DO NOT READ) Don't Know	3	2	2	3
R	(DO NOT READ) Refused	-	-	-	-

a. New technologies that extend people's lives
b. A growing number of older people who need more health care
c. Fraud and abuse in health care - patients and doctors cheating or misusing the system
d. Waste and inefficiency in the health care system

2. Do you think more health care dollars are lost to "fraud" or to "waste and inefficiency"?

47 1 Fraud
46 2 Waste and inefficiency
7 D (DO NOT READ) Don't Know
- R (DO NOT READ) Refused

(IF ANSWERED "2" TO Q.2, ASK:)

2a. How does this differ from fraud?
(PROBE: In what other ways are waste and inefficiency not the same as fraud?)
(RECORD VERBATIM)

3. Is health care fraud currently a major issue, a minor issue, or not an issue for you?

41 1 Major issue
30 2 Minor issue
28 3 Not an issue
1 D (DO NOT READ) Don't Know
- R (DO NOT READ) Refused

4. Do you think the amount of health care fraud is increasing, declining, or staying the same?

53 1 Increasing
6 2 Declining
34 3 Staying the same
7 D (DO NOT READ) Don't Know
- R (DO NOT READ) Refused

5. Are you aware of any efforts to reduce health care fraud?

20	1 Yes	CONTINUE WITH Q.6
79	2 No	SKIP TO Q.7
1	D Don't Know	SKIP TO Q.7
-	R Refused	SKIP TO Q.7

6. Do you think these efforts have reduced, increased, or had no effect on health care fraud?

52	1 Reduced
10	2 Increased
31	3 Had no effect
7	D (DO NOT READ) Don't Know
-	R (DO NOT READ) Refused

7. Who do you think is most responsible for the level of health care fraud in this country:
(DO NOT READ LIST)

5	1 "White collar" criminals
31	2 Doctors
8	3 Hospitals
1	4 Nursing homes
11	5 Insurance companies
15	6 Patients/consumers
	7 Other (SPECIFY) _____
17	D Don't Know
-	R Refused

8. How widespread do you think health care fraud is in general?

33	1 Extremely widespread
60	2 Somewhat widespread
4	3 Not at all widespread
-	D (DO NOT READ) Don't Know
-	R (DO NOT READ) Refused

9. And how widespread do you think health care fraud is in each of the following specific sectors?
(READ LIST)

		a	b	c	d	e
1	Extremely widespread	23	23	42	42	14
2	Somewhat widespread	58	52	44	44	50
3	Not at all widespread	13	13	9	7	22
D	(DO NOT READ) Don't Know	5	12	5	7	15
R	(DO NOT READ) Refused	-	-	-	-	-

(ROTATE)

a. Private sector — traditional doctor and hospital arrangements
b. Private sector — managed care plans (Health Maintenance Organizations (HMOs) or PPOs)
c. Public sector — Medicare (health care for the elderly and disabled)
d. Public sector — Medicaid (health care for the poor)
e. Public sector — Veterans'/military health care

10. Who pays for the cost of health care fraud?
(READ LIST - RECORD ALL MENTIONS.)

1 Yes
2 No
D (DO NOT READ) Don't Know
R (DO NOT READ) Refused

% saying "yes"

96 a. Individuals/consumers
77 b. Employers
62 c. Insurance companies
70 d. The government (Medicare, Medicaid)
42 e. Doctors and hospitals

11. How much health care fraud do you think is committed by the following?

1 A great deal?
2 Some?
3 Very little, if any?
D (DO NOT READ) Don't Know
R (DO NOT READ) Refused

		Great Deal	Some	Very little, if any	DK	R
a.	Doctors	22	56	20	2	-
b.	Hospitals	28	50	20	2	-
c.	Medical labs	19	48	27	6	-
d.	Medical equipment companies	28	43	20	8	-
e.	Home health companies	18	49	22	12	-
f.	Nursing homes	35	45	15	5	-
g.	Hospices	8	34	44	14	-
h.	Patients/consumers	21	49	26	4	-
i.	Insurance companies	29	46	21	4	-
j.	Pharmaceutical companies	33	42	20	5	-
k.	Pharmacists	11	38	46	4	-

PERSONAL EXPERIENCE

12. Have you ever personally experienced health care fraud?
(READ LIST)

18	1 Yes	CONTINUE WITH Q.12
81	2 No	SKIP TO Q.16
1	D (DO NOT READ) Don't Know	SKIP TO Q.16
-	R (DO NOT READ) Refused	SKIP TO Q.16

(IF YES TO Q.12, ASK:)
13. Please describe your experience(s) with health care fraud.
(PROBE: What other types of health care fraud have you experienced?)
(DO NOT READ LIST. RECORD ALL MENTIONS.)

28	01 Billing for items of services that were not furnished as billed
6	02 Ordering medical tests that they knew were not needed
3	03 Falsifying a patient's medical condition to protect the patient from having to pay
3	04 Billing for medical equipment that was not needed
11	05 Billing twice for the same services
6	06 Misrepresenting the patient's medical condition in order to bill for more expensive services
16	07 Billing for medically unnecessary services
16	08 Overcharging for services in a hospital (such as $15 for an aspirin)
2	09 Insurance companies failing to check claims for fraud
1	10 Going to the doctor when you are not really sick
2	11 Misleading advertising for medical products or services
0	12 Failure to reveal potential side effects before medical treatment
1	13 Not charging patients co-payments
2	14 Obtaining your health insurance or Medicare number and submitting false claims in your name
	97 Other (SPECIFY) _____
6	DD Don't Know
4	RR Refused

(IF "YES" TO ANY OF Q.12, ASK:)
14. Did you take any action about this suspected fraud?
(NOTE: IF EXPERIENCED MULTIPLE TYPES OF FRAUD AND TOOK SOME TYPE OF ACTION ABOUT ANY TYPE, USE CODE 1 "YES".)

50	1 Yes
49	2 No
1	D (DO NOT READ) Don't Know
-	R (DO NOT READ) Refused

(IF "YES" TO Q.14, ASK:)
15. Whom did you contact about it?
(DO NOT READ LIST. RECORD ALL MENTIONS.)

38	01	My insurance company
2	02	My employer
3	03	The Medicare carrier/intermediary
3	04	The state attorney general
4	05	The state Medicaid Fraud Control Unit
1	06	State or local law enforcement agencies
0	07	FBI
3	08	Medicare program administration/Medicare fraud unit
1	09	Medicare or Health Care Financing Administration (HCFA) Hotline
1	10	Medicare Inspector General
0	11	Dept. of Health and Human Services Office of Inspector General: General
1	12	Dept. of Health and Human Services Office of Inspector General: Hotline
0	13	Better Business Bureau
0	14	Department of Aging
0	15	Consumer organizations (SPECIFY NAME) _____
0	16	Newspaper/media
0	17	Family/friends
22	18	My doctor
	97	Other (SPECIFY) _____
2	DD	Don't Know
-	RR	Refused
22		Hospital/Nursing home/Clinic

(IF "YES" TO Q.14, ASK:)
16. Were they responsive to your complaint(s)? of those who contacted someone

71	1	Yes
29	2	No
-	D	(DO NOT READ) Don't Know
-	R	(DO NOT READ) Refused

(IF "YES" TO Q.14, ASK:)
[2]17. Did they DO anything about your complaint(s)?
of those who contacted someone

52	1	Yes
42	2	No
6	D	(DO NOT READ) Don't Know
-	R	(DO NOT READ) Refused

18. Do you think that anything CAN be done to reduce health care fraud?

79	1	Yes
12	2	No
9	D	(DO NOT READ) Don't Know
-	R	(DO NOT READ) Refused

(IF NO TO Q.18)

18a. Why not?
(PROBE: What else stands in the way of reducing health care fraud?)
(RECORD VERBATIM)

19. If you register a complaint about suspected health care fraud....

	a	b
1 Yes	50	46
2 No	44	48
D (DO NOT READ) Don't Know	5	6
R (DO NOT READ) Refused	-	-

a. Do you believe that you will have an effect?
b. Do you believe that the government or insurance company will do anything in your behalf?

20. Should Congress allot more money for health care fraud detection?

66	1 Yes
28	2 No
6	D (DO NOT READ) Don't Know
-	R (DO NOT READ) Refused

21. Should more non-public funds be used to fight health care fraud?

69	1 Yes
23	2 No
8	D (DO NOT READ) Don't Know
-	R (DO NOT READ) Refused

22. Do you think that YOUR health care would improve if more was done to reduce health care fraud?

74	1 Yes
22	2 No
4	D (DO NOT READ) Don't Know
-	R (DO NOT READ) Refused

23. What changes would give you greater confidence that your health care dollars are being better spent?
(RECORD VERBATIM)

24. I'm going to read you some statements about possible health care fraud. Please tell me whether you agree or disagree with each statement.
do you agree or disagree
(PROBE: Is that strongly or somewhat?)

4 Agree strongly
3 Agree somewhat
2 Disagree somewhat
1 Disagree strongly
D (DO NOT READ) Don't Know
R (DO NOT READ) Refused

(ROTATE)
% agree

69 a. The Medicare program would not go broke if fraud and abuse were eliminated.
90 b. I would report my doctor if I thought he or she had committed fraud.
61 c. Insurance companies have no incentive to detect health care fraud; they can always raise your premiums.
90 d. It's my personal responsibility to report suspected cases of health care fraud.
19 e. Health care fraud is just built-in to the health care system: there's nothing that can be done about it.
28 f. Most health care fraud isn't really intentional: it's the result of mistakes and inefficiency.
54 g. Most people, including doctors and hospitals, will just cheat when they think they can get away with it.
51 h. People you report suspected health care fraud to don't really care enough to do anything about it.

25. I have just a few more statements I'd like to get your reaction to.
do you agree or disagree
(PROBE: Is that strongly or somewhat?)

% agree

17 a. It's not worth the time and effort for me to report and pursue suspected health care fraud.
85 b. If I knew more about health care fraud, I would be more inclined to report it.
22 c. I'm reluctant to report suspected health care fraud because I am afraid of the consequences of confronting my doctor or other health care provider.

42 d. The Medicare administration isn't really doing anything to detect and prosecute health care fraud.
44 e. State Medicaid administrations aren't really doing anything to detect and prosecute health care fraud.
44 f. Insurance companies aren't really doing anything to detect and prosecute health care fraud.
8 g. Health care fraud may be wrong, but it isn't really a crime.

ORGANIZATIONAL ROLES

26. If you thought you had experienced an instance of health care fraud, who would you report it to?
(DO NOT READ LIST, RECORD ALL MENTIONS.)

8 01 The federal government: General response (ASK WHO?)
4 02 The federal government: Medicare Program/Health Care Financing Admin.
1 03 The federal government: HHS Office of Inspector General
1 04 The federal government: HHS Office or Inspector General Hotline
13 05 State governments
1 06 Medicaid program
6 07 State attorney general
1 08 FBI
25 09 Insurance companies
5 10 The American Medical Association

1	11 The American Hospital Association
6	12 Your Doctor
4	13 Hospital billing office
0	14 Nursing home operators
1	15 Medical labs
0	16 Home health companies
1	17 Home health companies
1	18 Consumer organizations (WHICH?)
1	19 Newspapers/media
	97 Other (SPECIFY) _____
1	NN Would probably not report it
29	DD Don't Know
1	RR Refused

27. Who would you trust most to reduce health care fraud?
(DO NOT READ LIST. RECORD ALL MENTIONS.)

11	01 The federal government: General response (ASK WHO?)
3	02 The federal government: Medicare Program/Health Care Financing Admin.
2	03 The federal government: HHS Office of Inspector General
1	04 The federal government: HHS Office of Inspector General Hotline
15	05 State governments
1	06 Medicaid program
3	07 State attorney general
1	08 FBI
15	09 Insurance companies
1	10 The American Medical Association
0	11 The American Hospital Association
6	12 Your Doctor
1	13 Hospital billing office
-	14 Nursing home operators
-	15 Medical labs
-	16 Medical Equipment suppliers
1	17 Home health companies
1	18 Consumer organizations (WHICH?).....
1	19 Newspapers/media
	97 Other (WHICH?)
6	NN Would probably not report it
31	DD Don't Know
-	RR Refused

28. Where would you be most inclined to look for information about health care fraud?
(DO NOT READ LIST. RECORD ALL MENTIONS.)

10	01 Newspapers
3	02 Pamphlets and brochures
-	03 Radio public service ads
-	04 Radio talk shows
2	05 Television public service ads
3	06 TV news
1	07 TV news magazines (such as 60 Minutes, Prime Time, 20/20)
0	08 Community forums

16	09 Programs at the library, senior center or civic club
-	10 Inserts in newspaper or magazines
1	11 Newsletters
4	12 Magazines
5	13 Internet or World Wide Web
3	14 Medical claims statements
10	15 Insurance companies
2	16 Consumer organizations
10	17 Government agencies
	97 Other sources (SPECIFY) _____
30	DD Don't Know
1	RR Refused

29. Would you be more likely to report suspected fraudulent behavior if a reward or monetary incentive was offered?

27	1 Yes
70	2 No
2	D (DO NOT READ) Don't Know
1	R (DO NOT READ) Refused

(ASK AGE 50+ ONLY)

30. Are you or anyone else in your household a member of AARP, the American Association of Retired Persons?

of those age 50+

55	1 Yes
43	2 No
1	D (DO NOT READ) Don't Know
1	R (DO NOT READ) Refused

Mrs. JOHNSON of Connecticut [presiding]. Thank you very much for your excellent testimony. It is very helpful to hear specific examples and share people's experiences. I know one of the most frustrating experiences for me as a Member is to have constituents come to you with very specific examples and then get the reaction

from the fiscal intermediary that we just can't look at that; we can't get into that; we can't judge whether the care was actually delivered or whether it was necessary, as long as it was generally appropriate. I mean it is scandalous in a sense the way we pay bills through our intermediaries and the system not only rewards fraud, but encourages it.

There are a couple of things that you didn't mention in terms of the recent legislation that will address a lot of your concerns. The first is that we are bundling the reimbursement for ancillary services to nursing homes so that there will be a disincentive to provide inappropriate ancillary services. We're also requiring that doctors, on their bill, put the number of the nursing home on it, so that we can see the pattern of physician action in nursing homes and be sure that it relates to patient need. So, those are two examples.

We did, however, include 65 different concrete steps to fight Medicare waste, fraud, and abuse, and with the enormous experience of the AARP, I wondered if you would want to enlarge on which of those specific tools you think are most important or get back to us at a future date.

Ms. CANJA. Let us take a look at that and get back to you. We'd be very happy to do that.

[The following was subsequently received:]

This information can be found on pages 3–7 of our written testimony.

Mrs. JOHNSON of Connecticut. Thank you very much.

Mr. Stark.

Mr. STARK. Thank you, Madam Chair.

I want to thank Ms. Canja for her testimony and I hope that her testimony will encourage others who have similar experiences to come forward. It's often suggested that we're dealing with anecdotes here, but it is these anecdotes which call to our attention many of the abuses that we eventually have to correct. I appreciate your taking the time and the effort to come here.

We passed some antifraud bills recently, and as I said, I think we need to do more. Senator Kyl of Arizona and Chairman Archer of our Committee have introduced bills to let doctors privately contract with Medicare anytime they want and, in effect, force the patients to give up their Medicare benefits and pay privately on the side. Last week the AARP released a paper pointing out that this would contribute to fraud, waste, and abuse of the Medicare system, because there's no way that Medicare could keep track of these side deals and, what we call, unbundling of services in the private contracts that doctors in managed care plans could then enter into. I want to ask you if you agree with the AARP's position.

And, second, in the press yesterday, Mr. Salido, a spokesman for Senator Kyl, indicated that we're denying senior citizens the right to choose any doctor in Medicare, and it's my understanding—and I wonder if you and AARP would agree—that under Medicare, currently, a Medicare beneficiary can see any doctor they want for any Medicare-approved procedure and that there is currently no restriction on seeing a doctor or indeed choosing a hospital? Are you in accordance with the AARP's position in opposition to the Kyl

amendment and do you think it would have an affect on increased fraud and abuse? And, second, is it your understanding that there is no need for it because we have the broadest possible choice now under Medicare?

Ms. CANJA. To answer your first question, yes, I do agree with AARP's concerns about the private contracting bill. There are opportunities in this measure, we believe, to defraud the system, because it opens the door to double billing. Whether it's the physician receiving payment from the beneficiary and then receiving payment from Medicare or in a managed care situation, where Medicare would pay the managed care plan and then the physician would receive a separate payment. So that does concern us.

For your second question, you asked can beneficiaries now see doctors of their choice? Under fee-for-service they can. You're aware that they pay a copayment, a 20-percent copayment, but under any of the services that Medicare covers, they could go and be covered by Medicare for those services. For other services that Medicare doesn't cover, they can still go to the physician and pay.

Mr. STARK. Thank you.

Ms. CANJA. Out of pocket.

Mr. STARK. Thank you very much.

Chairman THOMAS [presiding]. Ms. Canja, I apologize, I had to deal with another issue, but I had read your testimony.

And from personal experience, my parents were in an automobile accident. My mother was killed instantly, but my father was in intensive care and then moved into a skilled nursing facility. I have three sisters and we attended our parent, as did you, and did a number of personal grooming routines, just out of kindness and love, and it was a constant amazement to us the number of professionals who would come by, and notwithstanding the condition of my father, would, nevertheless, argue to perform a service and then, of course, to bill.

One of the reasons I've worked so hard to try to create a prospective structure which would remove these individual billing capabilities was because of the firsthand experience. I guess you can watch things that happen and try to appreciate it, but until you go through it——

Ms. CANJA. Exactly.

Chairman THOMAS [continuing]. As you did, you just can't appreciate, under the old system, how many opportunities there were to make money in a fraudulent way.

Ms. CANJA. Yes, isn't it true, and I'm sorry to hear of your personal experience.

Chairman THOMAS. Well, that's always the best teacher.

Ms. CANJA. It is.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. Thank you, Mr. Chairman, and thank you, Ms. Canja, for your testimony.

Just to follow up on my friend from California's line of question about the Kyl bill. While I appreciate AARP's position, I gather that the reason that AARP and you are concerned about fraud and abuse is that the fraud and abuse increases the costs to Medicare and the taxpayers, thereby, diluting the services perhaps, or with the potential to dilute the services to seniors in the future, if the

fraud and abuse gets so large and takes so much of the available money that we have to cut back on the services. Is that a fair statement?

Ms. CANJA. I think that's a fair statement, yes.

Mr. MCCRERY. So, if you're concerned about a dilution of services, one way the services could be diluted is by more and more providers refusing to take Medicare patients. Isn't that correct?

Ms. CANJA. Yes, if that we're to happen.

Mr. MCCRERY. And it could happen, couldn't it, if, say, the reimbursement rates had to be ratcheted down so low that many providers felt like it wasn't worth their time to see Medicare patients for the remuneration that they were going to get from Medicare?

Ms. CANJA. AARP has always been concerned that we have fair reimbursement rates, but also, I see it, and I'm talking personally here, as a disincentive for physician's to take Medicare if there's an opportunity to get any kind of money that the doctor may want to charge.

Mr. MCCRERY. Well, I, too, am concerned about the dilution of services and I'm very concerned about the long-term viability of the Medicare Program under its current structure. We've done some good things, as you helped us point out, and Mr. Thomas has pointed out here today, in the last couple of years in terms of identifying fraud and fighting fraud. Still, with a program this large and with so many points of contact between the consumer of services and the provider of services, there's a huge potential for fraud in this program. I hope that you will work with us to look at some different ways of providing this service to seniors in this country and not simply reject ideas like Mr. Kyl's and Chairman Archer's out of hand, because I think those ideas, potentially, are the very building blocks that we will need to put in place to save this program over the long term and to prevent wholesale rationing of services, because of the widespread abuse that will always be in this program in my view, under its current structure.

We can spend billions and billions more on more and more investigators, but as long as you have a program this big and a pot of money this big and handled the way it's handled, your going to have abuse. So, I would just ask you to work with Mr. Kyl and Chairman Archer and me and others who want to preserve this program, but want to do it in a fiscally responsible way and in a way that will continue to provide a high level of services to the elderly in this country.

Ms. CANJA. You know, I think you have all received this fact sheet that we have that detailed our concerns, and really I think that you could consider that as the beginning of our cooperation with you, because it details the things that we are concerned about, asking you to please look at those things and see how they might be addressed.

Mr. MCCRERY. And we appreciate that and I want to thank you for doing that. Once again, thank you for your testimony here today and, also, thank you for AARP helping us to advertise some of the changes that have been made to help consumers fight fraud and abuse in the system. Thank you.

Ms. CANJA. Thank you. We appreciate that.

Chairman THOMAS. Does the gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman. Just very briefly, following on Mr. McCrery's comments.

Let me, first, thank you and AARP for your presence here today and your willingness to work with this Subcommittee to deal with fraud and abuse within the Medicare system. I agree with the underlying point that, to the extent that we can reduce fraud and abuse—we'll never get rid of it—we will make more resources available to deal with the problems that Mr. McCrery was talking about—access to care and a proper reimbursement rate for the providers that work within the Medicare system.

I just really want to at least put on the record a statement regarding the Kyl amendment. If you wish to comment, fine. I know neither the Kyl amendment in the Balanced Budget Act or the new Kyl bill are before us and I understand that. But, I am concerned that I don't know of any private insurance company in a managed care environment that would allow its doctors to receive payment under the managed care program and then go out and bill the subscriber whatever the subscriber could pay for services. It seems to me that's a condition of participating in the program.

Medicare is the largest insurance program in the country, and why would we be setting a standard different for our beneficiaries than private health care plans? To me, that would make little sense. But today we are discussing fraud and abuse. I think the underlying point here is that if we were to permit a system where a doctor could participate in Medicare and get Medicare reimbursements and then for certain services go out and bill privately whatever the doctor wished to charge, whatever that doctor could collect from the Medicare beneficiary, it would seem to me that we could be opening up a more difficult enviornment in which to battle fraud and abuse.

Ms. CANJA. You know, we have that same concern in our statement.

Mr. CARDIN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. Does the gentleman from Nevada wish to inquire?

Mr. ENSIGN. Thank you, Mr. Chairman. I really enjoyed your testimony although it's not that I enjoyed your testimony on what happened with your Mom's situation, but I've had a lot of townhall meetings around southern Nevada, and your testimony has been repeated so many times, and as Mrs. Johnson talked about before, it is incredibly frustrating for a Member of Congress.

First of all, in the last couple of years, finding out where some of the confusion lies, like you said, you didn't even know whether it was fraud, whether it was just the way that the system was set up it was confusing, or did somebody's orders get taken wrong. It's such an incredibly complex bureaucracy now that has been set up and the system is so large that it seems to invite mistakes. Even if they aren't actual out-and-out fraud, it seems to invite a lot of abuses of the system simply because of clerical errors, or whatever.

In your membership, how many letters do you get, and when you get those letters on fraud and abuse, what do you do with them,

because I know you probably get some of the same things from your membership that we get here in Congress?

Ms. CANJA. Obviously, I can't pick out of the air right now the number of letters that we get, but we did do this survey that showed that people are enormously concerned about health care fraud and abuse; they believe that it is tremendously widespread and if we just did something about fraud and abuse, we could take care of Medicare. So that gives you some idea of the dimensions of the educational effort that really is going to be needed to help people understand what is fraud, what is abuse, what they can do about it, how they can report it.

You know, I come to you today, as a pretty informed consumer, and yet, I still had those problems when I saw these situations: Is this fraud and what do I do about it? I did the best I could.

This is what we found out in our survey and our focus groups: People want to do something about it; they want to be active participants and they will do what they think they can do, but, you know, you've really done a tremendous job with the budget bill and the provisions you've put in it, because you're going to give a lot more guidance to consumers. These examples of fraud and abuse that I talked to you about, each one of them is small, but I think that taken in the aggregate, they probably add up to a great deal of money.

Mr. ENSIGN. One of the things I would like to encourage your organization, because your organization does touch so many seniors and you communicate with them all the time, and that is to help us educate, because most Members of Congress aren't even aware of what the new provisions of Medicare are to be able to answer those questions for their constituents. I would very much encourage your organization in its communication with its members, because you touch so many of the seniors in the country, and that is first of all, to educate them that there is a 1–800 number to call.

Ms. CANJA. Exactly.

Mr. ENSIGN. And all of the other things that now maybe that empower seniors, but also will maybe give them a little more sense that Congress really is doing something up here, because it does seem that very seldom do we get credit for some of the good things that we're trying to do to cut out waste, fraud, and abuse in Medicare. Certainly, some of the things that we've done: Increasing penalties, whether it's preventing transfer of illicit businesses to family members or increasing civil penalties or the help lines that we've set up or whatever, I think that Congress really has taken the step in the right direction. We have a long way to go, but we'd certainly like your help in communicating some of the things that we've done.

Ms. CANJA. You know, we are continuing to do a major educational campaign on health care fraud and abuse. We have a fact sheet on it; we're now training volunteers on what are some of the scams and what they can do about it, and we're going to send them out as a gray patrol to educate others at senior centers and at other place where seniors congregate. So, we're really into that. We're working with our members; we're working with you—that's why I'm here today—we're working with the law enforcement agencies. We will do whatever we can to help in this effort.

Mr. ENSIGN. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. Does the gentleman from California wish to inquire?

Mr. BECERRA. Thank you, Mr. Chairman. I noted in your written testimony you mentioned that a survey had been done in which it showed that even if you provided the consumer with the monetary incentive or some type of reward for reporting waste, fraud, or abuse, that doesn't really do much to get people to act.

Ms. CANJA. That seems to be what the survey showed. That incentive really wasn't that necessary.

Mr. BECERRA. And you mention in your testimony that it was your opinion that people consider it their personal responsibility to try to report that type of activity.

Ms. CANJA. Right.

Mr. BECERRA. Is there something that we could do that would be more personal in scope, that would help consumers become more engaged in trying to report these activities?

Ms. CANJA. I think they just need to have some education about—I mean this is a major thing; they need to know about fraud and abuse and what it is, because right now, you know, their example of fraud is the $5 aspirin. They have to have a better idea of exactly what to look for. So, we all need to do a good job of trying to get that kind of information out.

Mr. BECERRA. Do you or do you know if any of the individuals you know who receive Medicare have a personal relationship with anyone who works with the Department of Health and Human Services that administers the Medicare Program?

Ms. CANJA. I didn't hear the first part of your question, sir, I'm sorry.

Mr. BECERRA. I'm trying to figure out if Medicare recipients have a personal relationship with the administrative authority for Medicare. Certainly, you have a relationship——

Ms. CANJA. No, I don't believe so. It's pretty far removed from them probably.

Mr. BECERRA. So when it comes to trying to report abuse by a provider or fraud by a provider, there's no one that you can naturally turn to within the government or the administrative office that helps administer Medicare in order to try to report that abuse?

Ms. CANJA. Well, an 800 hotline is a very good help if they have it in front of them.

Mr. BECERRA. I understand the 800 hotline is there, but you, as a Medicare recipient, don't happen to know anyone that answers that hotline, for example?

Ms. CANJA. No.

Mr. BECERRA. Did you ever make use—I believe you said that you did not make use of the hotline when you found these problems occurring with your mother?

Ms. CANJA. No, and on those earlier Medicare statements there wasn't even a hotline, I mean, there was not a hotline; there was no number to call.

Mr. BECERRA. OK. Do you believe that consumers of Medicare services are making use of the hotline well?

Ms. CANJA. Well, I think the hotline, I don't think they know about it, and this is one of the things that's going to come out of the Balanced Budget Act—that they will know, they will, that hotline now. I don't think it's been that available to them.

Mr. BECERRA. Do you think the notice that recipients will be receiving now will be sufficient to give them a sense that there is a hotline to call if there is abuse or fraud occurring?

Ms. CANJA. Two things are needed: Not just the hotline, but what to look for so they know what to report. When I was looking at the form, there is something they could do. They could make it much more explicit in the back of the form when they give you some guidance on what kinds of calls to make. It would be tremendously helpful.

Mr. BECERRA. Does the Medicare card itself have the hotline number on it?

Ms. CANJA. Does Medicare?

Mr. BECERRA. The Medicare card, your beneficiary card?

Ms. CANJA. I have no idea. I never looked at it to see that.

Mr. BECERRA. It might be a good place to put it. It sure would be handy if you keep the card.

Ms. CANJA. It may be there.

Mr. BECERRA. What of the issue of individuals not realizing that they should treat, as you say in your testimony, they should treat their Medicare card and their beneficiary number as they would treat any credit card and credit card number, not to give it to anyone who happens to call them by phone, or someone who happens to drop by and offer them free medical services?

Ms. CANJA. Well, that number can be used just as a VISA card number can be used for fraudulent claims, but I don't think people understand that, so that's going to be a part of the educational campaign.

Mr. BECERRA. Is it your belief that people are actually using or giving out that card number very liberally?

Ms. CANJA. Oh, I couldn't say that; I have no idea. I would doubt it. I think that there a lot of ways to get a number, though.

Mr. BECERRA. Right. So there——

Ms. CANJA. I can't answer that.

Mr. BECERRA [continuing]. Probably needs to be a better way to try to protect that number as well.

Thank you for the time, and thank you very much for coming and providing testimony.

Ms. CANJA. You're welcome.

Chairman THOMAS. Ms. Canja, thank you very much. It's clear that informed patients and informed loved ones know what was and was not done, and that if you were provided specific billing records, which we now do, and a phone line to contact people—oftentimes, there was a phone number on the billing information, but that was the particular contract agency to deal with——

Ms. CANJA. Exactly.

Chairman THOMAS [continuing]. The billing problems. But what we have assigned is a clear statement that there is fraud and abuse and that this is the number to call if you suspect it. It's a 1–800 number tied directly to the Office of Inspector General, and it will be a centralized collection structure. That is, I think, a far

cry over the real, I won't say unwillingness, but clear failure to take what I think is a key frontline of defense—those people who are receiving or not receiving particular procedures to report their suspicions. We think over time this will be a useful tool, and I'm pleased you're willing to support it.

Thank you very much for your testimony.

Ms. CANJA. Thank you.

Chairman THOMAS. The Subcommittee will stand in recess before we begin the next panel, so we don't start and then disrupt us, and will convene again at 11:30 a.m.

[Recess.]

Chairman THOMAS. Eleven-thirty having arrived, the Subcommittee reconvenes and thank you.

The panel in front of us will be Michael Mangano, whose name tag I cannot see. He's the Principal Deputy, Office of Inspector General, Department of Health and Human Services; Linda Ruiz, who is Director, Program Integrity Group, Office of Financial Management at HCFA; Charles Owens, who is the Chief of Financial Crimes Section, Federal Bureau of Investigation; and Dr. William Scanlon, who's been with us a number of times, Director, Health Financing and System Issues, U.S. General Accounting Office.

Your written testimony will be made a part of the record. I would ask that you summarize your testimony in any way that you see fit within the timeframe that's available to us, and I look forward to the information you'll provide us on this midterm report card.

Mr. Mangano.

STATEMENT OF MICHAEL F. MANGANO, PRINCIPAL DEPUTY INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. MANGANO. Thank you very much, Mr. Chairman. I'm very pleased to be here this morning to report to you on the efforts that we've made to combat fraud, waste, and abuse in the Medicare Program. The impact of the Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act, and also some areas that we think still warrant some concern.

With the budget exceeding $200 billion this year, it's no wonder why Medicare is an inviting target for scam artists and those who want to steal from the Medicare Program and its beneficiaries. A recently issued report before this Subcommittee that the Chairman mentioned this morning indicated that about $23 billion last year was inappropriately spent from the Medicare Program. Now, while that's not all fraud, it is a problem that causes us great concern and ought to consume the attention of the Health Care Financing Administration, as well as our office and other law enforcement organizations. That is why we are so delighted with the provisions of both of these two acts. I want to specially thank this Subcommittee and the leadership that the Chairman and the Ranking Minority Member have had in forging these pieces of legislation.

HIPAA provides us with a number of new enforcement tools, reliable funding, and a management structure in which we can coordinate the various fraud-fighting units across government. I want to assure this Subcommittee that we're working with the Department of Justice, the FBI, and the Health Care Financing Administration

to address a number of these programs, as well as to conduct a series of investigations, audits and evaluations.

The question you may ask is, How are we doing? I'm very pleased to report this morning that we've been successful in this first year and we anticipate receiving $1.2 billion in estimated fines, penalties, and restitutions to the program; this is about five times higher than last year. We've doubled the number of criminal and civil actions that have come out of the reviews that we've been doing to over 1,300 this year, and the number of exclusions exceeds 2,600.

The Balanced Budget Act gives us even more weapons we can use in this fight, but I think what's most important are the program reforms that we think will make the Medicare Program a far more prudent purchaser of goods and services. The chart attached to my testimony indicates about $58 billion that these two pieces of legislation will save for the Medicare Program on the basis of program changes to be made. Scored by the Congressional Budget Office, we supported a number of these recommendations and offered them over the years.

Very briefly, I'd just like to mention a couple of the issues that we still believe warrant close scrutiny. As the gatekeeper for home health services, we believe that the role of the physician needs to be strengthened. For example, Medicare does not require at the current time that a physician actually examine a patient before ordering home health services. We think that's a mistake. We also think that the certification form that the physician signs ought to be more explicit in terms of what the eligibility requirements are. In our reviews of home health agencies, we found doctors that didn't know what the term "homebound" meant. We think that leads to a number of problems.

Second, we're looking at whether or not hospitals are prematurely releasing patients to reduce their costs and receive additional reimbursement from the Medicare Program for nursing homes and home health agencies that they refer those patients to. In our analysis, we found that patients released from hospitals to nursing homes that they owned had 2 day shorter hospital stays and 8 day longer nursing home stays. We found similar situations, although less pronounced, with home health.

While the Balanced Budget Act establishes a fee schedule for ambulance——

Chairman THOMAS. Just for the record, Michael, what you meant to say was the center that cost more got longer days than the center that costs less. Is that what you we're saying?

Mr. MANGANO. Yes.

Chairman THOMAS. OK.

Mr. MANGANO. Yes, yes.

Chairman THOMAS. Surprise, surprise.

Mr. MANGANO. With regard to ambulance services, we think that this was the right approach to take to put that on a fee schedule, but we think that we may have locked in rates at far too high a level, and we think that further reductions should be considered.

Finally, we think for prescription drugs that the provision establishing a cut of 5 percent below average wholesale price is a good first start, but once again, I think the reimbursement levels are

going to be far too high. We took a look at the 22 most prominent drugs that Medicare pays for in prescriptions and Medicare paid higher than any other provider that bought those drugs, and in fact, for about one-third, paid twice as high as anybody else. The AWP, average wholesale price, is easily manipulated and greatly inflated.

So let me conclude, then, by saying that we pledge our assistance to watch after potential scams that may be perpetrated against the Medicare Program in the near future.

Thank you.

[The prepared statement and attachment follow:]

Statement of Michael F. Mangano, Principal Deputy, Office of Inspector General, Department of Health and Human Services

Good morning Mr. Chairman. My name is Michael F. Mangano. I am Principal Deputy Inspector General for the Department of Health and Human Services (HHS). It is my pleasure today to share with you my assessment of where we stand in our continuing fight against waste, fraud, and abuse in the Medicare program.

In summary, we are fully engaged and making good progress. We have exposed and measured the problem more completely and accurately than ever before. It is bigger, more complex, and more formidable than many may have imagined. But we are more fully armed, have better tools, and are better organized than in the past. As a result, we have recently had some notable successes and are confident of favorable outcomes on several fronts. And we feel fully supported by allies in every branch and unit of government.

This positive assessment, even in the face of staggering affronts, is the result of an unparalleled coordinated and cooperative response to the problem by the Administration and the Congress, particularly through the passage of two landmark pieces of legislation—the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997.

This new legislation has so greatly strengthened our hand that most of our efforts now are directed to proving that implied trust in us is well founded. Thus, we are now focused on implementing the new laws. As a result, at this time we only have a few potential proposals to call to your attention, while assessing new ideas being presented from several sources.

While treating ourselves to a brief moment of self re-assurance, we remain on guard, watching certain facets of the Medicare program which we believe remain particularly vulnerable to waste, fraud, or abuse—especially home health, durable medical equipment, and ambulance services. And while we see advantages to the evolving integration of the health care industry at large, we are wary of some inappropriate incentives this may create in service referrals, especially to nursing homes and home health agencies. Managed care programs of all kinds present new risks in both the Medicare and Medicaid programs. We also remain generally concerned about upcoding of all kinds, and are analyzing new technologies now available both to automate billings and to detect inappropriate manipulation of the billing system.

I will now describe in greater detail the basis for our simultaneous confidence and wariness.

NEW WAYS TO FIGHT FRAUD

Since 1993, the Department has been emphasizing the need to stem losses to the Medicare program by preventing fraud and prosecuting unscrupulous fraud perpetrators. Operation Restore Trust, initiated by the Administration in 1995, laid a stronger foundation by promoting the development of new techniques to ferret out and combat fraud and abuse and to cultivate effective partnerships of fraud fighting organizations within the Department of Health and Human Services, the Department of Justice, and the States. It demonstrated the effectiveness of these new approaches in three programmatic areas—home health, nursing homes, and durable medical equipment—in New York, Texas, Florida, Illinois, and California. On an experimental basis it provided steady, reliable funding for fraud fighting, anticipating a fair return on investment through reduced spending and recoveries of lost trust fund dollars. This planning assumption proved to be correct. The demonstration program identified $183 million dollars in overpayments, fines, and penalties.

STRONGER ANTI-FRAUD AUTHORITIES

Meanwhile, both the Congress and the Administration were developing far more sweeping and fundamental reforms to address waste, fraud, and abuse in the Medicare program. As noted above, these are embodied in the Health Insurance Portability and Accountability Act and the Balanced Budget Act. This Subcommittee, under both the Chairman and the Ranking Minority Member, played a crucial role in encouraging the bipartisan support and responsible public policy-making that brought both pieces of legislation to passage.

In this effort, the Congress and Administration did more than just pass laws. The legislative process brought about an attitudinal change—not only within the branches of Government, but in the quality of consciousness with which taxpayers, the media, and the health care industry are viewing Medicare. Beginning with the momentum of HIPAA in 1996 and continuing through the debates on the Balanced Budget Act in the current Congress, much needed attention has been drawn to the purpose and management of the Medicare program and how to make it more effective, efficient, and less vulnerable to waste, fraud, and abuse. Much has been accomplished.

Many specific, positive changes have been made to shore up the $200 billion Medicare program and its payment methods; and, thanks to increased resources provided through the new legislation, our Department, the Department of Justice, and related agencies at the State and Federal levels now have better authority and capacity to fight fraud and to reduce waste in all federally-funded health care programs.

Health Insurance Portability and Accountability Act of 1996

Last year we got a major boost in our efforts through the Health Care Fraud and Abuse Control Program, a key part of the Health Insurance Portability and Accountability Act. This program provides much needed resources, stronger enforcement tools, and a management structure to coordinate the efforts of numerous fraud fighting units of Federal, State, and local governments. The Health Care Fraud and Abuse Control Program is a creative and far-reaching program to root out fraud and abuse in the nation's health care system.

The program is under the joint direction of the Attorney General and the Secretary of Health and Human Services, working through the Inspector General. It is designed to provide the framework and resources to coordinate Federal, State, and local law enforcement efforts. It mandates a comprehensive program of investigations, audits, and evaluations of health care delivery; authorizes new criminal, civil, and administrative remedies; requires guidance to the health care industry about potentially fraudulent health care practices; and establishes a national data bank to receive and report final adverse actions imposed against health care providers. The Act also provides an innovative mechanism to fund these new anti-fraud efforts, thereby assuring that needed resources are always available for the effort.

We are already reaping the benefits of the additional resources and authorities from this new legislation. Based on projected usage of 1022 FTE for fiscal year 1997, OIG on-board staffing increased from a little over 900 to 1143 by the end of the fiscal year. In addition, we are opening 6 new investigative offices, bringing from 26 to 31 the number of States in which we will have an investigative presence. We plan to open 6 more in fiscal year 1998. Three new audit offices are also being opened. We have generally intensified and expanded all our activities in the health care field and are now able to coordinate a more effective effort to curb those who exploit the Nation's health care systems, particularly Medicare.

The total of fines, restitutions and settlements accruing from judicial and administrative processes that resulted from OIG civil and criminal actions totaled $1.2 billion in 1997. This is five times higher than the recoveries for fiscal year 1996 and over three times higher than the previous best year for recoveries. Many of the larger settlements were related to improper marketing and billing of laboratory services. Criminal and civil prosecutions totaled 1,340 cases in fiscal year 1997. This was double the number for fiscal year 1996 and more than five times the total number in fiscal year 1995. Over 2,600 individuals and entities were excluded from doing business with Medicare, Medicaid and other Federal and State health care programs because of violations of the law—an 86 percent increase from the 1,400 exclusions in fiscal year 1996.

Balanced Budget Act of 1997

The Balanced Budget Act provides a number of provisions to help prevent Medicare fraud and abuse and to promote responsible program enforcement. For example, it authorizes the Secretary to collect social security numbers and employer identification numbers from entities paid under Medicare (Part B), Medicaid, and Child

Services Block Grants. The OIG, the Health Care Financing Administration (HCFA), and the General Accounting Office (GAO) have been in general agreement in recent years that this authority is critical to monitor provider billing activities effectively and to keep excluded or other problematic providers from coming back into the program under the cloak of new business arrangements. These numbers are required from the entity, persons with ownership or control interest (5 percent or more), its managing employees, and subcontractors.

The Act provides several enhanced penalty authorities; for example a $50,000 civil money penalty for kickback violations; a penalty for institutional providers who employ or contract with excluded providers; and a penalty to be imposed when a health plan or other designated entity fails to report required information to the Adverse Action Data Bank established under the Health Insurance Portability and Accountability Act.

Included too are general improvements to the Medicare payment system. For example, the Act streamlines the process for adjusting by up to 15 percent the amount paid by Medicare for unreasonably priced Part B services (except physician services); it authorizes up to 5 projects, including one for oxygen, to demonstrate the efficacy of competitive bidding as a way to procure Medicare services and supplies. All of these are consistent with broad policies which the OIG has been advocating and strongly supporting for several years, and we are grateful to see legislation enacted along these lines.

Related to the payment system is a general pros from the definition of "reasonable cost" payments for costs not related to patient care including entertainment, gifts, and donations, education expenses, personal use of automobiles, and costs for fines and penalties. This new provision addresses problems encountered repeatedly in OIG audits and investigations.

The Act also addresses serious vulnerabilities in the process whereby Medicare enrolls health care professionals or agencies to provide services to Medicare beneficiaries. Quite fundamentally, the new law authorizes HCFA to refuse to enter into contracts with felons. The Secretary could stipulate, for example, that individuals convicted of embezzlement not be allowed to enroll as a Medicare provider even if the conviction did not occur in connection with a health care business. HCFA will also be able to exclude from the Medicare program entities owned or controlled by the family or household members of excluded individuals. This latter provision prevents an excluded individual from continuing to do business with Medicare through a company allegedly owned by a family or household member. Some excluded providers have been able to escape the impact of their sanctions by expediting transfers on paper of their ownership and control interests in health care entities to family or household members while retaining true, silent control of the businesses.

In addition, we were pleased to see the new "Three Strikes, You're Out" provision that mandates a lifelong exclusion from participation in any Federal health care program for any provider who is found guilty of health care fraud for the third time. We thank you for your leadership on that.

PROGRAMMATIC REFORMS

Broad Sweep of the Balanced Budget Act

The Balanced Budget Act went a lot further in reducing fraud and abuse than is reflected in the specific section of the Act dealing with fraud. It reformed underlying Medicare program areas to reduce their vulnerability to fraud, abuse, or waste. Included in this category are provisions to: reform Medicare payments systems for home health and skilled nursing care; eliminate payment for losses upon the sale of a hospital or nursing home (by ignoring accounting adjustments that misrepresented the profit or loss of the entities engaged in the sale); reduce excessive payments for oxygen, prescription drugs, capital expenses, laboratory tests, and outpatient medical services; more frequently recertify eligibility for hospice care (which will improve quality of care while also eliminating a vulnerability in the hospice eligibility determination system); permanently authorize systems and protocols to ensure that Medicare pays as secondary payer when other insurance provides first payer coverage for Medicare beneficiaries; restructure Medicare payments for bad debt, disproportionate share allowances, and indirect medical education; reform Medicare payment methods for ambulance services; establish better controls and improved policy making procedures for laboratory services.

The attached table shows the 5 year savings as scored by the Congressional Budget Office for these provisions. All of them are items which have been highlighted through the years in the OIG's Cost Saver Book (also known as the Red Book), audits and inspection reports, and testimony, and in various publications of the General Accounting Office, and other organizations as being vulnerable to fraud or

abuse or as embodying unnecessary, excessive, or wasteful spending. As the table indicates, the total savings for these provisions over 5 years exceeds $58 billion.

Home Health and Skilled Nursing Facilities

Of these programmatic reforms, two stand out as outstanding examples of coonalism of numerous organizations desiring to deal with complex but important policies and where reforms were sorely needed to prevent waste, abuse, and fraud while improving the quality of care of Medicare beneficiaries. These are the provisions relating to home health and skilled nursing facilities. The savings from these two areas alone amount to almost $26 billion. The OIG testified before this Subcommittee on these subjects and worked with the subcommittee's staff to iron out crucial sections of the prospective payment systems, interim cost and utilization control systems, and accounting provisions which were eventually passed into law. These two reforms are the "successes" which truly have many parents—especially the Health Care Financing Administration and many professional organizations who had come to support the concepts embodied in the final law. I must say that we were particularly impressed by and appreciative of the work of the subcommittee staff in working through the many details of these reforms.

In both cases, the fundamental approach was to establish a prospective payment system. In the case of home health, speed is of the essence. The new law recognized the difficulties inherent in implementing such a system, and so provides for interim price and utilization controls. It also begins to address the problem of unscrupulous individuals and companies who exploit or cheat the program through sham companies and irresponsible business practices. It requires home health agencies and others to post a surety bond of a minimum of $50,000 as a condition of participation. We have recommended this in the past as one method for reducing the number of "providers. Other general fraud provisions mentioned previously especially apply in this case.

The Balanced Budget Act simplifies Medicare payments for services provided to nursing home residents. It phases in a prospective payment system for skilled nursing facility care covered by Medicare Part A. Covered services not only include all payments previously made to the facility under Part A but also all services for which payment may be made under Part B (except physician and certain other professional services) during the period when the beneficiary is provided covered Skilled Nursing Facility (SNF) care. The Act also requires consolidated billing of Part B items and services when a beneficiary is in a nursing home but is not covered under a skilled nursing facility stay paid for by Medicare Part A. These provisions related to Part B services are responsive to recommendations the OIG has frequently made with regard to things like incontinence supplies, wound care, enteral nutrition, durable medical equipment and supplies, and orthotic body jackets. Not only will these new provisions make Medicare less vulnerable to improper marketing, excessively high prices, unnecessary use, and over utilization, but they will be more conducive to a higher quality of care for nursing home residents. This is because the nursing home administrators will now be more responsible for monitoring, approving, and justifying the services that are provided for individuals under their care. This will also bring about a greater protection of privacy of the medical records of the nursing home residents. The records were sometimes reviewed by providers of equipment and supplies who wished to market their goods to these patients.

FUTURE CONCERNS

We in the Office of Inspector General are heartened by the support we have received from the Administration and the Congress in our fight against fraud, waste, and abuse in the Medicare program. At the same time, our new authorities and resources have enabled us to see more clearly just how pervasive and overwhelming these problems are. Our audit of the financial statements of the Medicare program as required by the Chief Financial Officers Act of 1990 as amended by the Government Management Reform Act of 1994 was released at a hearing before this Subcommittee on July 17. We reported that the estimated range of Medicare fee for service payments that were made incorrectly was $17.8 billion to $28.6 billion, or about 11 percent to 17 percent. This estimate is at the 95 percent confidence level. We do not know how much of these payments were due to fraud or abuse or just common errors. All the money improperly paid is wasteful, though. And these audits would not detect well known forms of fraud such as kickbacks or deliberate forgery of bills or supporting documents. Whatever the audits reveal or fail to reveal, we know from our investigations and from complaints that we receive that fraud and cheating are still pervasive in the health care sector.

Nor would the audits reveal wasteful spending due to high prices, which are properly billed and legally paid even if excessive. For example, none of the savings that Medicare will achieve through reduced prices for oxygen, which were mandated by the Balanced Budget Act, would have been classified as improper payments under the audit protocols we used for the financial statement audit.

All of this is to say that we cannot take much time out of our fight against fraud, waste, and abuse. We are still watching all areas of Medicare through our audits, inspections, and investigations. And we are continuing to encourage and receive support from industry and beneficiary groups in our efforts. However, as you requested for this hearing, I would like to single out some areas where we continue to have special concerns. Some of them are follow-ups to matters addressed in the recent legislation—areas where we want to watch closely the implementation of the new provisions.

Home Health

As you know, the President has recently announced a major initiative to crack down on abuse in the home health program. A recent audit of Medicare home health services in four large States found that 40 percent of them were incorrectly paid. A related study identified weaknesses in the system used to enroll providers and demonstrated how vulnerable the home health program is to cheating.

The initiative places a temporary moratorium on enrollment of new providers while HCFA strengthens the process to keep untrustworthy agencies out of the program. The moratorium is an approach we had suggested. We have been advising HCFA about a number of the procedures that could be used to screen out unworthy providers. These include criteria related to recent bankruptcies, Federal program debt, and bad credit ratings. Many of the procedures they will use are the ones which were so carefully included in the Balanced Budget Act for this very purpose. The enactment of the new legislation combined with the strong administrative action is a dual effort that should go a long way to address the problems in this crucial area.

One additional aspect of the home health program that requires attention is the role of physicians in approving the plans of care for homebound patients. Our studies show that physicians are sometimes not familiar with the patients whose plans of care they approve, are not aware of Medicare's home health eligibility requirements, or rely too much on the home health agencies which provide the care and get reimbursed for it to prepare detailed plans which they sign. We have recommended in the past that physicians be required to physically examine all patients whose home health care plans they certify before they do so. We still believe this is a good idea. Other ideas we are now considering are to modify the certification forms which physicians sign to spell out more clearly what Medicare requirements are and provide an attestation by the physician that they are aware of these requirements and of the patient's condition, and possibly to include on the form the amount of money that Medicare will pay for the patient if the plan of care which the physician certifies is implemented. We are beginning to solicit other ideas from physician groups on how to strengthen the physician's role. We believe that everyone will gain from that—patients, physicians, and taxpayers—through better quality of care and less waste.

We also previously recommended that a fee be charged to new provider applicants to help defray some of the cost of conducting background checks and conducting on-site reviews of their operations before enrolling them into the program. We continue to support this proposal.

Integration of Health Care Businesses

We have become increasingly concerned about the effect of financial incentives on care and billings made in connection with services owned by a health care entity that has authority and opportunity to refer patients for services to another entity, especially one in which it has a financial stake. One area in particular is the case of a hospital which owns or has some other financial interest in a nursing home or home health agency to which it can refer patients when they are discharged from the hospital. We have prepared a draft report on this subject, which was provided to members and staff of this Subcommittee at their request prior to the enactment of the Balanced Budget Act. We hope to release the final as soon as we complete our internal reviews.

The study addresses several issues, including: whether or not hospitals prematurely release patients from the hospital to reduce costs and receive additional cost-based reimbursement under Medicare's skilled nursing facility or home health programs; whether hospitals restrict freedom of choice for patients by explicitly or

subtly steering them to their own nursing facilities and home health agencies; and whether the continuity and quality of care is affected by such referrals.

The study does indeed provide a basis for concern. The premature release of patients to nursing homes seems to be in evidence, with patients referred to a hospital's nursing home being released 2 days sooner than those referred to a nursing home not owned by the hospital. A similar phenomenon seems to affect home health agency referrals too, but only by one day. And this result for home health agencies is not conclusive because of the small sample size. In the case of steering, there is clear evidence that hospitals do steer patients to their home health agencies; the evidence is less clear about steering discharged patients to the hospital's own nursing homes.

On the positive side, home health patients believe that their continuity of care is better when discharged to the hospital owned home health agency. Patient satisfaction and perceived quality of care seem to be unaffected.

The Balanced Budget Act addressed the problems which our report raised. It requires that a hospital notify beneficiaries of all available home health agencies during the discharge planning process and identify those entities in which hospitals have an ownership interest. Further, the statute requires that hospitals report information to the Secretary on referrals to post-hospital facilities in which the hospital has a financial interest. It also allows the Secretary to specify certain diagnostic review groups for which discharges to nursing homes and home health agencies will be treated like hospital transfers for billing purposes.

These new requirements and procedures should help to reduce abuses. But this is an evolving field, part of the larger phenomenon of medical care integration. We will watch it closely and are conducting additional studies to determine how serious and pervasive it is. We are wary as well of the possibility of shifting costs among owned entities. This was revealed by a problem in an investigation of at least one home health agency whose owner was convicted of Medicare fraud.

These problems with home health illustrate issues that can arise in the evolving environment of services integration in the health care industry. We are also watching other spects of this such as hospital purchasing of physician practices. We have concerns about possible increases in Medicare expenditures that might result from the application of different accounting rules under these circumstances. We are now beginning to study this.

Ambulance Services

We recently issued a draft report on Medicare ambulance services, the results of which we shared with this subcommittee before enactment of the Balanced Budget Act. It shows that Medicare payments for ambulance services appear to lack common sense. In 26 States, Medicare pays more for routine, non-emergency basic life support transportation than it does for advance life support emergency transportation. Ambulance payment policies are vulnerable to fraud and abuse. Medicare contractors report wide-spread abusive situations involving unnecessary transports, oxygen, EKGs and other services. In the last five years, the OIG has had more than 100 convictions involving ambulance providers. Problems result from the extremely complex payment methods and inconsistent policies. We recommended establishment of a fee schedule for ambulance services to correct these problems.

The report supported the work of the congressional staff who had also concluded that a fee schedule was needed. The Balanced Budget Act makes interim reductions in ambulance payments by limiting the allowed rate of increase and mandates the establishment of a fee schedule by January 1, 2000. The fee schedule is to be set so that aggregate payments are reduced by 1 percent.

We are concerned that even with the one percent reduction the new fee schedule will lock in unreasonably high payment rates in some cases. For example, our study shows that some base rates and mileage payment levels could be reduced significantly. We were able to reach this conclusion by examining only some of the illogical payment variations which our study uncovered. No doubt others could be reduced as well. We hope to provide more information on this subject.

Previous studies by our office also showed that payments for routine, scheduled ambulance trips, easily identifiable for dialysis trips, for example, could be reimbursed much more cheaply than the rate for on-call trips now being charged. We also found that many trips for these dialysis patients were not medically necessary. The patients could have been transported by car, for example. All this leads us to believe that even with the new fee schedule mandated by the Balanced Budget Act Medicare costs for ambulance services will be excessive. We intend to continue our reviews of this area.

Prescription Drugs

The Balanced Budget Act reduces Medicare payments for prescription drugs, which are paid based on the average wholesale price, by 5 percent. Our work supports taking this step. We issued two reports in 1996 recommending that HCFA reexamine its Medicare drug reimbursement methodologies, with a goal of reducing payments as appropriate. In a recent review, we found that Medicare allowances for prescription drugs increased 25 percent from $1.8 billion in 1995 to $2.3 billion in 1996. However, the number of services allowed increased only 9 percent between the two years. While Medicare pays for only a narrow range of prescription drugs, it is a cost that is increasing rapidly and needs to be controlled.

The newly enacted reduction is a good first step. We have found, however, that the published wholesale prices that are currently being used by Medicare-contracted carriers to determine reimbursement bear little or no resemblance to actual wholesale prices that are available to the physician and supplier communities that bill for these drugs. For more than one-third of the 22 drugs we reviewed, Medicare paid more than double the average price available to physicians and suppliers. Not only did Medicare pay more than the average price, the program reimbursed more than even the highest wholesale price for every drug. We also found there is no consistency among Medicare contractors in establishing and updating Medicare drug reimbursement amounts. We believe this variance is not appropriate.

It is likely that new regulations to be issued by HCFA to implement the provisions of the Balanced Budget Act will correct the problems we have found. But some of the problems will not be within HCFA's control if the industry publications upon which the prices are based are inaccurate or misleading. We intend to watch this closely and will recommend additional legislative remedies if we find problems in this regard.

Additional Authorities

As mentioned earlier, the Congress enacted most of the legislative proposals that the President requested in his anti-fraud bill, the "Medicare Fraud, Abuse, and Waste Prevention Amendments of 1997," and, in some cases, went further. We are grateful for the additional support this has provided to us. Some provisions were not accepted, however, and we would like to reiterate our support for them.

One deals with the bankruptcy code. It is still possible for wrong doers to use bankruptcy protection as a way to avoid responsibility for repayment of overpayments, fines, or penalties. Many of the cases we deal with are not those where a legitimate business declares bankruptcy because of unfavorable economic or business conditions. Rather, the bankruptcy is used on the heals of a fine or penalty to avoid completely any responsibility for wrong doing. We are also concerned about using the bankruptcy law to prevent the Secretary from suspending Medicare payments to a provider under investigation for fraud. We hope the Congress will reconsider these proposals soon.

We also continue to support our proposal to authorize the Secretary to exclude from Federal health care programs anyone who furnishes medical items or services ordered or prescribed by an excluded individual or entity if the person furnishing the services knows or should have known of the exclusion.

Planning New Work

We are continuing to set our priorities and develop our work plans for the coming year. We look forward to consulting with the Subcommittee and its staff about our planned activities. We welcome your ideas and will gladly consider new projects of interest to you.

CONCLUSION

Again Mr. Chairman, we would like to thank you and the Ranking Minority Member for the role this subcommittee played in working with the Administration to steer Medicare's payment and enforcement activities in a positive direction. The many provisions targeted at more realistic reimbursements and the increased authorities and enforcement resources found in the Health Insurance Portability and Accountability Act and the Balanced Budget Act of 1997 have put the program back on course. Medicare can now begin to move forward to serve the Nation's retired and disabled at a price we can afford. We will continue to remain vigilant to current abuses and any future fraud schemes that emerge. I welcome your questions.

SAVINGS FROM REDUCING HEALTH CARE FRAUD, WASTE AND ABUSE

Balanced Budget Act
FY 1998 - FY 2002
(in millions of dollars)

	1998	1999	2000	2001	2002	FY 98-02 Total
Home Health	1100	2050	4130	4170	4750	16200
Skilled Nursing Facilities	90	1250	2150	2730	3310	9530
Oxygen	200	400	400	500	600	2100
Bad Debt	40	90	120	140	140	530
Pharmaceuticals	80	110	110	40	30	370
Rural Health Clinics	30	30	40	40	50	190
Hospital Sales	30	50	50	50	60	240
Hospice	10	30	40	60	70	210
Outpatient Hospital Policy	1270	1890	1690	1260	1110	7220
Secondary Payer	140	1700	1790	1890	2000	7520
Indirect Medical Education	380	750	1140	1570	1780	5620
Hospital Capital	750	1100	1140	1140	1160	5290
Lab Services	100	300	400	500	600	1900
Medical Equipment	0	100	200	200	300	800
Disproportionate Share	30	70	120	160	210	590
Ambulance Payments	0	10	10	10	10	40
Fraud & Abuse Provisions	40	50	50	60	60	260
TOTAL SAVINGS	4290	9980	13580	14520	16240	58610

Source: Savings estimates based on Congressional Budget Office Estimated Budgetary Impact of Subtitles A-G of P.L. 105-33

Chairman THOMAS. Thank you very much, Michael. We adopted a number of your suggestions and this exactly what we want as we take a look at what we've done. Kind of like the Sears list of items: Good, better, best. We're moving in the right direction.

Mr. MANGANO. Absolutely.

Chairman THOMAS. But we could move some more.

Ms. Ruiz.

STATEMENT OF LINDA A. RUIZ, DIRECTOR, PROGRAM INTEGRITY GROUP, OFFICE OF FINANCIAL MANAGEMENT, HEALTH CARE FINANCING ADMINISTRATION

Ms. RUIZ. Good—I guess I was going to say, "Good morning," but it's now good afternoon, Mr. Chairman and Members of the Subcommittee. My name is Linda Ruiz and I'm the Director of Program Integrity for the Health Care Financing Administration. I appreciate the opportunity to be here today to describe our program integrity initiatives.

Program integrity is very important to HCFA. It is taken into account throughout the agency as we make policy, seek legislation, and implement new operational procedures in both fee-for-service and managed care. One of the jobs I have is to make sure that program integrity is considered by all parts of the agency. We recognize that we need to be a prudent purchaser of services for beneficiaries, and program integrity is one of the ways in which we can

do that. I'd like to spend a few minutes on the progress we've made in combating fraud and abuse.

I'd also like to extend my thanks to you, Mr. Chairman, and to the other Subcommittee Members for your efforts in helping us improve Medicare and Medicaid Program integrity. Both HIPAA and the BBA have given us an unprecedented amount of Medicare legislation that will be very helpful to us in our fight against fraud and abuse. The passage of these two pieces of legislation is a milestone for health care, and we look forward to working with you in the future to implement them.

One of the most important HIPAA provisions is the fraud and abuse control program which provides resources and tools primarily to our law enforcement partners. We already see a major improvement in the programs ability to get cases brought against bad providers. The Medicare Integrity Program, which is also part of HIPAA, provides increased resources over a 5-year period and stabilizes funding for the Medicare contractor payment safeguard activities. We expect to have a notice of proposed rulemaking out on the street later this fall which would out the rule for competing these contracts and more clearly define what we consider to be a conflict of interest.

The Balanced Budget Act of 1997 really strengthens our antifraud and abuse capabilities to implement the program integrity strategy. Our program integrity strategy uses four basic approaches: Prevention, early detection, coordination, and enforcement. These may seem like buzzwords or campaign phrases, but they really mean a great deal to HCFA and we have taken a number of concrete actions to implement them.

We agree with you, Mr. Chairman, that postpayment enforcement efforts alone will not do the job. This is why a key part of our effort is prevention. The BBA contains several helpful preventive actions, including barring felons from getting into the program, improving our provider enrollment, the PPS and other payment reforms, and having definitions for home health.

We have also completed some activities in HCFA that we'd like you to know about. We've completed a national revision of our provider enrollment form and procedures, and as the President's recent announcement on home health demonstrated, we're continuing to reform our provider enrollment requirements to maximize the likelihood that those billing Medicare are legitimate and are offering value to our beneficiaries.

Starting in 1996, we implemented the correct coding initiative, which has resulted in approximately $200 million in savings in fiscal year 1996 and another $128 million for the first half of fiscal year 1997. We're also evaluating the GMIS product group from the field of commercial off-the-shelf software to test software applications.

Also, for early detection, we have databases both at the national level and at the contractor level, and we have a statistical analysis contractor for durable medical equipment that has saved us a great deal of money and to start some important fraud investigations.

I guess the last thing I'd like to mention is Operation Restore Trust, which is our finest example of coordination with the people who sit with me at the table today and with others. I'd like to men-

tion that one of the things that we are doing in terms of cooperation is working with our beneficiaries. Part of Operation Restore Trust is partnering with the Administration on Aging and getting the word out to beneficiaries. We are now working on some of the projects that AARP is participating in with the Office of Inspector General and the Administration on Aging. We look forward to working with a more knowledgeable and aware beneficiary population who can continue to help us find fraud and abuse.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of Linda A. Ruiz, Director, Program Integrity Group, Health Care Financing Administration

INTRODUCTION

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Linda Ruiz and I am the Director of Program Integrity in the Health Care Financing Administration (HCFA). I appreciate the opportunity to be here today to describe HCFA's program integrity initiatives. The location of the Program Integrity Group, which is housed in the Office of Financial Management, reflects our stewardship responsibility for the Medicare and Medicaid programs. Program integrity efforts permeate every corner of HCFA and are the result of a conscious decision to extend our mission's focus throughout the organization. In our newly reorganized HCFA, program integrity is no longer viewed as the responsibility of one department, one office, or one individual. It is a vital element of every policy decision.

This Administration can be proud of its success in combating waste, fraud, and abuse. Because health care has become a target for unscrupulous individuals, both private industry and government are employing a variety of tools to combat fraud and abuse. Since 1992, we have made tremendous progress in protecting the fiscal integrity of the Medicare program. An example is the HCFA-initiated partnership with the enforcement agencies targeting fraud and abuse in the five States that account for nearly 40 percent of all Medicare and Medicaid beneficiaries. This two-year project, Operation Restore Trust, encompassed a wide range of projects aimed at eliminating fraud schemes and identifying vulnerabilities in the Medicare programs. The reforms enacted in the Balanced Budget Act of 1997 and the Health Insurance Portability and Accountability Act of 1996 provide significant new tools to further assist us, but I think we all know that equally tremendous challenges lie ahead. Our goal is to ensure that the Medicare and Medicaid programs have the necessary arsenal to combat fraud and abuse.

I want to highlight the substantial progress we have made in combating fraud and abuse and discuss some recent events affecting our anti-fraud and abuse efforts, including the reforms enacted in the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, and the home health agency moratorium announced earlier this month by President Clinton. I would also like to extend my thanks to you, Mr. Chairman and the other Members of this Subcommittee, for your efforts in helping us improve Medicare and Medicaid program integrity.

LEGISLATIVE ACHIEVEMENTS

Both 1996 and 1997 have been key legislative years, with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997. The impact of these two Acts is dramatic. In particular, the changes generated by the BBA, are the most significant in the history of Medicare. It is our hope that implementation of the provisions contained in this legislation will take us a step further toward eliminating fraud, waste, and abuse in Medicare and preserving the Medicare Trust Fund for future generations.

HIPAA—KEY FRAUD AND ABUSE PROVISIONS

Fraud and Abuse Control Program—The program integrity activities of the Medicare contractors initiate many of the cases subsequently developed by the Office of Inspector General and Federal Bureau of Investigation, and support their prosecution by the Department of Justice. Using monies made available through the Fraud and Abuse Control Fund, established in HIPAA, we expanded our successful two-year Operation Restore Trust (ORT) demonstration using the State survey agencies to be our "eyes and ears" in the field and to report back to the contractors whether

providers are meeting Medicare billing as well as quality requirements. As you know, ORT was designed to demonstrate new partnerships and new approaches in finding and minimizing fraud in Medicare and Medicaid. We have used this model successfully with our expanded home health surveys in the five Operation Restore Trust (ORT) States.

Approximately $1.8 million was allocated to HCFA for "Project ORT" through HIPAA's Fraud and Abuse Control Program, to enhance the program integrity activities that involve collaboration with State certification agencies. Eighteen States are participating in a total of 26 HIPAA funded projects, allowing us to survey approximately 300 providers for both certification and reimbursement issues. These enhanced surveys will be made of providers of home health services, skilled nursing services, outpatient physical therapy services, and laboratory services, as well as psychiatric services in both hospitals and community mental health centers. Many of these surveys are modeled after the home health agency and skilled nursing facility surveys conducted during ORT.

Medicare Integrity Program (MIP)—This program, enacted in the Health Insurance Portability and Accountability Act of 1996, authorizes the Secretary to promote the integrity of the Medicare program by entering into contracts with eligible entities to carry out activities such as audits of cost reports, medical and utilization review, and payment determinations. MIP provides a stable source of funding for HCFA's program integrity activities, and gives us authority to contract for these activities with any qualified entity, not just those insurance companies who are currently our fiscal intermediaries or carriers.

The Medicare Integrity Program strengthens the Secretary's ability to deter fraud and abuse in the Medicare program in a number of ways. First, it creates a separate and stable long-term funding mechanism for program integrity activities. Historically, Medicare contractor budgets had been subject to fluctuations of funding levels from year to year. Such variations in funding did not have anything to do with the underlying requirements for program integrity activities. This instability made it difficult for HCFA to invest in innovative strategies to control fraud and abuse. Our contractors also found it difficult to attract, train, and retain qualified professional staff, including clinicians, auditors, and fraud investigators. A dependable funding source allows HCFA the flexibility to invest in new and innovative strategies to combat fraud and abuse. It helps HCFA shift emphasis from post-payment recoveries on fraudulent claims to pre-payment strategies designed to ensure that more claims are paid correctly the first time.

Second, by permitting the Secretary to use full and open competition rather than requiring that HCFA contract only with the existing intermediaries and carriers to perform MIP functions, the government can seek to obtain the best value for its contracted services. Because prior law limited the pool of contractors that could compete for contracts, we were not always able to negotiate the best deal for the taxpayers or take advantage of new ways to deter fraud and abuse. Using competitive procedures as established in the Federal Acquisition Regulations System (FARS), we expect to attract a variety of offerors who will propose innovative approaches to implement MIP.

Third, MIP permits HCFA to address potential conflict of interest situations. We will require our contractors to report situations which may constitute conflicts of interest, thus minimizing the number of instances where there is either an actual, or an apparent, conflict of interest. By invoking the FAR in establishing multi-year contracts with an expanded pool of contractors, we will be able to avoid potential conflicts of interest and obtain the best value. Also, by permitting us to develop methods to identify, evaluate and resolve conflicts of interest, we can create a process to ensure objectivity and impartiality when dealing with our contractors. This is a concern particularly when intermediaries and carriers are also private health insurance companies processing Medicare claims.

We are currently developing regulations to implement MIP and we are also working on a statement of work for competitive contracts. As we transition work from one of our contractors, Aetna (which is terminating its Medicare work), we are testing a new contracting relationship in several Western States that will separate out (and consolidate) payment integrity activities from claims processing. This will give us valuable experience as we prepare to implement MIP.

Beneficiary Notification—An equally important program integrity priority for HCFA is beneficiary information. As a product of our claims payment system, HIPAA requires that HCFA send each beneficiary an Explanation of Medicare Benefits (EOMB) statement. These statements detail actions that Medicare has taken on claims filed on their behalf. We have learned that better-informed customers can actually help fight fraud and abuse, and we currently receive and investigate an overwhelming number of inquiries from beneficiaries alerting us to questionable services

on their statements. All of our carriers have 1–800 numbers which appear at the bottom of the EOMB, encouraging beneficiaries to call with questions about their claims. By expanding our consumer information programs, we are ensuring that Medicare beneficiaries receive current, easy-to-understand, and unambiguous information in a timely manner, so that they may assist us in identifying improper claims and erroneous bills. A well-informed beneficiary can save us Medicare and Medicaid funds by alerting our investigators and claims reviewers to potential fraud, waste, and abuse of taxpayers' dollars. HCFA is in the process of formulating a proposed rule for the program to encourage beneficiaries to report fraud and abuse. EOMBs were sent for select items and services beginning in June 1997.

The National Provider Identifier (NPI) is another key initiative which will help in the prevention of fraud and abuse. NPI is an industry wide unique identifier for providers and suppliers created under the authority of the Health Insurance Portability and Accountability Act of 1996. This identifier will be used to create databases that will contain a record of all providers and suppliers who bill Medicare. This database will be available to the Medicare contractors processing claims so they can automatically deny or give greater scrutiny to claims associated with abusive billers. We plan to publish a proposed regulation defining the NPI as the national standard later this fall. We will then begin issuing NPIs to providers in late 1998 or early 1999 and phase in national implementation over the next few years.

Sanction of Providers for Fraud and Abuse—HIPAA also requires the Secretary to exclude from Medicare and Medicaid providers with felony convictions related to health care fraud or controlled substances, and gives the Secretary greater flexibility to exclude providers convicted of misdemeanors or who violate Medicare quality rules. The DHHS Inspector General has the lead on implementation of this provision.

Adverse Action Data Base—To ensure that our computer capabilities are commensurate with our program integrity goals, HIPAA establishes a data base, the Adverse Action Data Base, which coordinates with but does not duplicate the National Practitioner Data Bank. The data base will include providers, suppliers and practitioners against which final adverse actions have been taken.

The Health Resources and Services Administration (HRSA) is taking action to coordinate this data base.

Transfer of Assets to Obtain Medicaid Eligibility—HIPAA makes knowing and willful transfer of assets to gain eligibility for Medicaid subject to criminal penalties—including civil monetary penalties or prison—if the transfer resulted in a period of ineligibility. This was amended by BBA to clarify that the penalties apply to the advisor, not the beneficiary. Implementation of this initiative rests with the Department of Justice.

The Balanced Budget Act of 1997

The recently enacted Balanced Budget Act of 1997 builds on the anti-fraud and abuse provisions of HIPAA and gives HCFA more authority through its anti-fraud and pro-efficiency measures. Planning and implementation are already under way for these anti-fraud and abuse provisions. It is a very ambitious schedule and one we are committed to achieving. We will keep you informed of our progress and will alert you if we encounter any barriers to meeting a particular deadline.

Surety Bond Requirements for DME and Other Suppliers—This provision gives HCFA the authority to require durable medical equipment (DME) suppliers, home health agencies and other types of provider facilities to post a surety bond of at least $50,000 before they are certified for both Medicare and Medicaid. We hope to publish a supplier standard regulation, requiring a $50,000 surety bond for DME suppliers soon in the Federal Register. We are contemplating a graduated sliding scale based on the amount of Medicare billings, either a $50,000 minimum or 15 percent of the amount shown on the IRS 1099 for each supplier. We are also developing a regulation, which should be published in the next six months, to implement the surety bond requirement for home health agencies and provide important programmatic protections. The home health agency moratorium will remain in effect until we strengthen these requirements. HCFA is also preparing a regulation to require a $50,000 minimum bond for comprehensive outpatient rehabilitation facilities as required by the BBA. We may adopt a surety bond requirement for other types of providers as deemed necessary.

Barring Felons and Improvement of the Provider Enrollment Process—The BBA provides the ability to bar convicted health care felons from ever receiving Medicare and Medicaid payments again, and to exclude the family members of sanctioned providers so that such providers can't simply transfer the business to a relative and continue operation. The Office of the Inspector General has the lead on implementing this provision through regulation. HCFA will then modify its provider enroll-

ment application and contractor manual instructions to ensure that convicted health care felons no longer bill and receive payment from the Medicare program.

The authority granted by the BBA to require providers and suppliers to report their Social Security and Employer Identification Numbers is a significant factor in identifying fraudulent providers. First, the Secretary must report to the Congress on the privacy and protection of Social Security numbers. HCFA will be working closely with SSA to define the privacy and protection guidelines, which the Secretary will present to the Congress. Continued cooperation with SSA and assistance from the IRS will also be needed for successful implementation.

The BBA gives HCFA the authority to require providers and suppliers to report their Social Security and Employer Identification Numbers in order to verify the information on the provider enrollment form and evaluate whether or not a provider number should be awarded. The exact mechanism for verifying Social Security numbers is now being worked out with the Social Sen. This provision gives the Secretary authority to deny Medicare entry for provider applicants who have been convicted of a felony. If an application is denied, a 6-month waiting period must be completed before the provider may reapply.

Home Health Prospective Payment System—This provision provides the ability to establish a prospective payment system that will pay providers a flat rate, in advance, for a patient's care, eliminating incentives for providing unnecessary care. It also will end "periodic interim payments" that are made in advance and not justified until the end of each year. The law establishes October 1, 1999 as the date by which the prospective payment system must begin, and we are working hard to meet that date with the necessary research and infrastructure development. Meanwhile, the interim system established in the Balanced Budget Act went into effect on October 1 of this year.

Clarification of Home Health Care Definition—This provision provides a clear definition specifying the hours and days that home care must be needed or provided in order to be covered by Medicare. We have just issued an instruction that announces the new requirements for this provision. Regulations and additional instructions will follow.

Clarification of the Definition of Skilled Service for the Purposes of Home Health Eligibility—Previously, venipuncture qualified as skilled nursing care and enabled a beneficiary to meet the eligibility criterion for intermittent skilled nursing services under the home health benefit. Thus, if the other criteria were met (homebound, etc.), then a beneficiary who only required venipuncture would have been entitled to all of the other covered home health services including home health aide services. Now, if venipuncture for the purpose of obtaining a blood sample is the only skilled service that is needed by the beneficiary, that individual will not qualify for home health. This provision is self-implementing and is effective for services furnished 6 months after August 5, 1997.

Home Health Agency/Hospice Billing Based on Location of Services—This provision will require billing to be based on the location of service delivered rather than the location of the agency, so providers will no longer get high urban reimbursement rates for care delivered in low-cost areas. Programs are being developed to implement and administer this provision. We expect to pay claims under the current system and adjust payments when the system is completed in January to assure that agency reviews are not interrupted by the programming effort.

Development of Payment Standards—This provision gives HCFA the authority to develop normative utilization standards and deny payment to agencies that bill for services in excess of these standards. We are currently considering how most effectively to implement this critical provision.

Home Health Moratorium—The steadily increasing volume of investigations, indictments, and convictions against home health agencies has led to a great deal of publicity and concern about home health care fraud. In response to this concern, earlier this month President Clinton and Secretary Shalala announced an unprecedented moratorium on the entry of any new home health agencies into Medicare. The current moratorium on entry of new home health agencies is designed to reduce the likelihood of "fly-by-night" operators entering the program while HCFA strengthens its requirements, thus preventing fraud, waste and abuse.

While the temporary moratorium is in effect, the Department of Health and Human Services will implement program safeguards included in the Balanced Budget Act, and work on important changes in requirements for home health agencies. For example, DHHS will implement the statutory requirement that home health agencies post at least a $50,000 surety bond before they are certified. Additionally, a related rule will require new agencies to have enough funds on hand to operate for the first three to six months. These requirements will establish the financial stability of home health providers.

During this six-month moratorium, the Department will also develop more stringent standards against fraud. New regulations will include requirements for more business information from home health agencies; recertification every three years with independent audits each time; and, experience based on serving a minimum number of patients prior to Medicare certification. We are in the process of completing a final regulation to require home health agencies to conduct criminal background checks of the aides they hire, and to be more accountable for the care they provide. In conjunction with this regulation, new videos and brochures will be designed to teach beneficiaries how to detect and report fraud and abuse.

These changes will not only strengthen the payment safeguards we already have in place, but will expand and enhance them. There will always be unscrupulous providers and questionable billing practices—but with the tools provided to us in the BBA and our new, stricter standards, we will have the ability to be one step ahead of them.

HCFA'S PROGRAM INTEGRITY STRATEGY

The Administration is pursuing a strategy intended to deter fraud and abuse on every front—prevention, early detection, collaboration and enforcement. Prevention is the best means we have to guarantee the initial accuracy of both claims and payments, and to avoid having to "pay and chase," a lengthy, uncertain and expensive process. Early detection is a second key ingredient of our approach. We can identify patterns of fraudulent activity early by using data to monitor the billing patterns and other indicators of the financial status of providers, promptly identifying and collecting overpayments, and making appropriate referrals to law enforcement.

Close collaboration with our partners in the law enforcement arena is one way we can maximize our success. A lesson learned through Operation Restore Trust is the importance of working closely with the States, the Department of Justice, including the FBI, the Inspector General and the private sector to share information and tactics about fighting fraud and abuse.

Finally, when we find "bad apples" among our many good providers, we must take enforcement action against them, including suspension of payment, exclusion from the program, disenrollment, collection of overpayments, and imposition of civil money penalties. Investing in prevention, early detection and enforcement has a proven record of returns to the Medicare Trust Fund. In FY 1995, every dollar spent by our Medicare contractors using these methods yielded $14 in return.

Our prevention, early detection and enforcement strategies are aided by using the best technology available. In combating fraud and abuse in Medicare, HCFA needs to rely on the best technology available to detect fraudulent providers and deter them from abusing the Medicare Trust Funds.

Prevention, detection, coordination, and enforcement—these terms are more than just buzzwords or campaign phrases. They are the actual cornerstones for the variety of anti-fraud mechanisms that HCFA currently has at its disposal. I would like to highlight some of these.

PREVENTION means paying right the first time through such measures as:

- Conducting prepayment medical review and on-site reviews;
- Developing local medical review policies that articulate when we will pay for services;
- Evaluating our national policy for vulnerabilities and loopholes;
- Changing Medicare payment methodologies and billing procedures to make it harder for fraud to occur;
- Keeping convicted criminals out of the program;
- Requiring surety bonds; and,
- Collecting identifying information on providers.

Currently, HCFA has a variety of concrete actions underway to facilitate the prevention piece of our vision. Our contractors currently have state-of-the-art systems that enable us to make proper payments and prevent fraudulent claims from being paid. We are constantly searching for ways to update and improve our claims processing technologies.

Extensive Use of Edits—Our contractors process over 800 million claims a year. Using our standard systems, these claims are subjected to a rigorous prepayment electronic screening process to verify beneficiary information, provider information, utilization history, procedure and diagnosis, and coordination of benefits. Each computer instruction which verifies information on a claim is called an edit.

These edits are performed to determine beneficiary information, such as whether the patient is enrolled in Medicare and if all co-payments and deductibles have been met. Our contractors also perform a series of edits to determine if the provider is eligible and is in good standing with the Medicare program. Claims are then edited

for utilization history. For example, our contractor's systems will only pay one claim in a patient's lifetime for an appendectomy. Many claims are also checked to verify if the procedure being billed is appropriate for the diagnosis. Finally, our contractors coordinate benefits to determine if a beneficiary has other coverage that is primary to Medicare. In total our contractors have thousands of these edits in place which perform a comprehensive review of each claim before Medicare payment is made for a service.

Correct Coding Initiative—Implemented in 1996, the Correct Coding Initiative began with a contract to evaluate all physician coding and recommend policy for how codes should be billed, including which codes should be bundled prior to payment when separately billed. Unbundling occurs when physicians incorrectly use multiple procedure codes when describing individual components of a service instead of a single, comprehensive procedure code which describes the entire service. Our carriers have installed approximately 93,000 computerized coding edits which check each claim for "unbundled" services and prevent a payment from being made. The project has resulted in approximately $200 million in savings in the first year of implementation.

Commercial Off-the-Shelf Software (COTS)—We are currently studying COTS to do some of this editing and it may become a part of our arsenal. In 1996, HCFA selected GPG (GMIS Products Group) to test a commercially available software application know as "Claims Check" which is designed to evaluate physician claims and reduce erroneous or abusive billing on a prepayment basis.

We are currently testing this software at one of our contractors to evaluate the underlying policy of edits, the customization needs, savings, and the installation and integration issues. Our goal when we began this evaluation was to achieve maximum savings by integrating the COTS claims editing software into the Medicare claims processing system. When our final evaluation is completed later this fall, we will make a decision about how we can best use claims editing technology to ensure that claims are paid correctly and cost-effectively.

Los Alamos National Laboratory—Those who prey on the Medicare Trust Funds are ever-resourceful. As a result, HCFA must seek out new ways of detecting fraudulent claims and preventing their payment. One effort on this front is the 2-year interagency agreement that HCFA established with the Department of Energy in 1995 to use the expertise of Los Alamos National Laboratory. The purpose of this research agreement is to develop a ground-breaking new claims review approach that differs from existing methodologies. The ultimate goal of this new technology is to know on a prepayment basis the likelihood that a claim is suspect. This kind of research is bold and promising, but like all basic research, one whose "payoff" is not certain. Our hope is that the product of this project will be a prototype system of dynamic algorithms and features, that has been tested and refined to detect fraud, waste, and abuse in prepayment environments.

Prospective Data Sharing—This is an initiative involving agreements with major insurance companies to exchange enrollment information that permits us to identify Medicare Secondary Payor situations before we pay. Our preliminary analysis indicates that this initiative will save Medicare approximately $720 million in fiscal year 1997. Later in my testimony, I will address how HCFA is seeking to make data sharing mandatory by law.

National Medicaid Fraud and Abuse Initiative—This past summer, HCFA's Southern Consortium of regional offices has assumed the leadership role for the National Medicaid Fraud and Abuse Initiative. This project is unique in HCFA and I believe that it illustrates the flexibility of our new organization and a willingness to do business in a more efficient and responsive way.

One of the primary goals of this initiative is prevention of fraud and abuse. Administering this initiative at the Federal level and assisting the States in implementing proper program safeguards, will prevent fraud and abuse. Under this initiative we will continue to assist the Office of the Inspector General, the Medicaid Fraud Control Units and Program Integrity Units in their role of prosecuting fraudulent providers. We will also ensure all States are aware of fraudulent activities and scams occurring nationwide and promote consistency by developing national standards.

Some of the primary functional areas the team will be focusing on are formation of a National Fraud and Abuse Technical Advisory Group (TAG) composed of HCFA and State agencies; the development of a model legislative fraud and abuse package that takes the best of legislation from States that already have it and shares it for consideration with States that don't; the encouragement of greater State involvement in Project Operation Restore Trust (ORT); and a general strengthening of our partnerships with the States, OIG and other entities. This initiative is a pilot

project which will run for approximately one year, at which time we will evaluate the results and reassess our approach if indicated.

EARLY DETECTION is the second part of our program integrity strategy—

HCFA is constantly seeking means to assure that we avoid paying for improper claims. Early detection includes using data to monitor the billing patterns and other indicators of the financial status of providers and promptly identify and collect overpayments. For example, we are continuing to promote efficiency in overpayment collection through the review of a statistically valid sample of claims where overpayments are then projected to the universe. Also, we are supporting several other initiatives to assist in our detection efforts—

Enhanced HCFA Customer Information System (HCIS)—The HCIS has been used in one of our most successful anti-fraud programs, Operation Restore Trust, which began as a collaborative demonstration project with the Department of Justice and State Medicaid Anti-Fraud Units. The HCIS enables HCFA and its contractors to view provider or service utilization data at several levels including the national, the state, contractor, provider type, or individual provider. For example, if I were trying to find out how many times a certain service had been billed in a state, I could obtain that information through the HCIS database immediately. This capability allows the rapid identification and analysis of factors contributing to aberrant data. As a result, audits or reviews can be focused, rapidly and inexpensively, on a particular level.

HCFA first used HCIS last year to identify a number of skilled nursing facilities with potential problems in Miami, Florida. The project identified over $2 million in overpayments and mandated corrective action plans from the problem providers. To date, over $24 million in overpayments have been identified in these reviews. The OIG and the DOJ also both routinely request information from HCIS to assist them with their cases.

Statistical Analysis Contractors—Since 1993, HCFA has supported a dedicated statistical analysis contractor, Palmetto Government Benefits Administrator, Inc., to support our four Durable Medical Equipment Regional Contractors (DMERCs). The contractor produces ongoing analysis of trends, utilization rates, billing patterns, referral patterns and related information at the national and regional levels. As an example, through their analysis the contractor has identified fraudulent billing practices for nebulizers and related drugs, and many abusive practices for incontinence supplies, surgical dressings, parenteral & enteral nutrition and urological supplies. The DMERCs have made changes in their payment policies that have saved the Medicare program in excess of $200 million.

HCFA Contractor Tools—HCFA's development of early detection tools at the national level has been complemented by continuing investment in analytic tools used by HCFA contractors. The Service Tracking, Analysis and Reporting System (STARS) and the Super Operator are two other software packages which are used by a number of contractors. These programs compile and analyze claims data and use statistical analysis to identify aberrant utilization profiles.

COORDINATION is the third key part of our strategy—

Coordination includes inter-agency collaboration and cooperation, case support for enforcement, development of fraud alerts and fraud databases, and working with beneficiaries and providers who make complaints. The importance of coordination cannot be overemphasized. The complexity of the Medicare and Medicaid systems requires information sharing and partnership among all segments of the health care environment in order for the fight against fraudulent providers to be successful.

Operation Restore Trust (ORT)—This project, which I mentioned earlier in the testimony, is probably the best example of coordination where HCFA and its contractors worked hand in hand with the Office of Inspector General, the Department of Justice and State agencies to attack fraud. As you know, in 1997 these efforts have been expanded into additional states and we look forward to the results of this combined effort. ORT has given us a new way to accomplish our work, one that takes advantage of the expertise and common goals that we share with our partners.

Fraud Investigation Database—Since 1996, the Fraud Investigation Database has provided a comprehensive nationwide system devoted to accumulating fraud and abuse information. It represents all cases Medicare contractors have referred to law enforcement, chronology of events for each case, and disposition of each case. The database also contains the Office of the Inspector General excluded provider list. Currently this database is available to HCFA, the Office of the Inspector General, Department of Justice, including the FBI, U.S. Postal Inspector, and Medicaid Fraud Control Units.

The effectiveness of FID is illustrated by two cases that became national investigations, one involving a provider of diagnostic services and the other involving am-

bulance services. Local Medicare contractors queried the FID and noticed that diagnostic and ambulance services were under investigation in several jurisdictions across the country. The contractors were able to consolidate their investigative efforts and pursue these two national cases. The FID has also served as a valuable resource to investigators and attorneys as they begin new cases. Through the FID, they can search for past, similar cases, and gather information about the investigation, prosecution and disposition of similar cases. HCFA will use this database as another tool for analyzing patterns to help in prevention and detection activities.

CFO Audit—Another example of how HCFA is working with its partners is reflected in the Chief Financial Officer's Act audit, which was released to Congress in July. The audit, conducted by the DHHS OIG, provides HCFA with an opportunity to identify areas needing work. The audit showed that Medicare contractors' claims processing systems work well. The actions taken, based on the information submitted on the claim, were accurate 99 percent of the time.

The audit also identified some key areas where we must work harder to ensure program integrity. When the OIG did a "look-behind" review of those claims, which were accurate on the surface, errors were identified. When the OIG reviewed supporting documentation not originally submitted with the claim, they found cases of no documentation or insufficient documentation to support the claim, instances where services provided were not medically necessary, billings for non-covered services, incorrect coding, and services billed but not performed. These findings led to the projected error rate of 14 percent or an estimated $23 billion in improper payments in fiscal year 1996.

Although some of these instances could be fraudulent, this error rate does NOT reflect a rate of fraud and/or abuse in the Medicare program. it did identify some key areas where we must work harder to ensure program integrity. We are currently implementing a Corrective Action Plan to reduce the claims payment error rate through more comprehensive review of the underlying documentation.

ENFORCEMENT is the final link in HCFA's strategy—

These enforcement activities include suspension, verification of program exclusions, disenrollment, collection of overpayment, and civil monetary penalties. Clearly, enforcement is an area in which HCFA will continue to work closely with its partners. New provisions in the Balanced Budget Act of 1997, as well as those provided for in HIPAA, will strengthen our enforcement capabilities.

In the chain of activities that comprise fraud detection and prevention, enforcement is the final link. It is the tangible result of a series of collaborative actions taken by HCFA and its interagency partners, Medicare contractors, and ultimately, beneficiaries. This is why cooperation and collaboration among HCFA and its partners is so critical to protecting Medicare—it takes the efforts of all of our partners to successfully thwart potential fraud, waste, and abuse.

REMAINING TASKS AND FUTURE CHALLENGES

Some of the anti-fraud proposals in the President's Bill were not included in the Balanced Budget Act of 1997, and we believe it is important to identify them and explain why they are critical to the overall success of our program integrity efforts. We would especially like to acknowledge Mr. Stark's efforts in introducing proposed legislation which would include some of these proposals.

Civil Monetary Penalties—We think it is of the utmost importance to have the appropriate penalties for providers found guilty of defrauding Medicare. Without appropriate sanctions, anti-fraud laws will have little effect. There a several proposals that would create new civil monetary penalties for: false certification of Medicare eligibility, prior knowledge of claims submitted by excluded providers; and acceptance of requests from excluded providers (i.e. pharmacy services). In addition, specific dollar amounts would be specified for cases of repetitive overbilling and unallowed charges.

Kickback Penalties—Subsequent to the 1995 Hanlester Network v. Shalala decision, a very high burden of proof was put on the government in proving the existence of kickbacks. To ensure that our fraud detection efforts are not in vain, legislation is needed to establish the same burden of proof under the anti-kickback laws as with other criminal statutes. In addition, there is a proposal to expand the criminal penalties by extending Federal anti-kickback criminal sanctions to all public and private health care programs and plans.

Medicare Provider and Supplier Agreement Fee—This proposal would authorize the Secretary to collect a fee for enrollment or re-enrollment of Medicare providers or suppliers. The fee would cover administrative costs and generate considerable savings for the Medicare and Medicaid programs.

Extension of Subpoena and Injunction Authority—This proposal would extend the testimonial subpoena power and injunctive authority that the Secretary has for civil money penalties to other administrative sanctions such as exclusions against Federal health care program providers. These investigative tools are needed in the complex investigations of fraud, kickbacks and other prohibited activities.

Liability of Physicians in Speciality Hospitals—Under the anti-dumping statute, this proposal would clarify that physicians who are "on call" to specialty hospitals must respond to a call from the hospital to come in to the specialty unit (e.g. a burn center) in order to examine and stabilize the emergency medical condition of an individual who is proposed to be transferred to that unit. This proposal would close a loophole in the coverage of the anti-dumping statute.

Prospective Payment System for Rural Health Center Services (RHCs)—The Secretary would develop a prospective payment system for RHCs no later than December 31, 2000. A prospective payment system would remove the incentives for providers to inflate their charges and would work to ensure that Medicare was only paying appropriate costs.

Decreased Beneficiary Cost Sharing for Rural Health Center Services—Under a prospective payment system, beneficiary cost sharing would be based on 20 percent of the PPS amount. Beneficiary cost sharing (prior to the development of a PPS system) could not exceed 20 percent Medicare's payment limit. A 20 percent cost-sharing limit would be consistent with current Administration policy to ensure that beneficiaries do not pay more than 20 percent of the amount that the provider receives from Medicare.

Partial Hospitalization Services Not to be Furnished in Residential Settings—This proposal would preclude providers from furnishing partial hospitalization services in a beneficiary's home or in an inpatient or nursing home. This proposal would discourage development of partial hospitalization programs targeted to patients in their homes or in settings where there is a residential population, such as nursing facilities and assisted living facilities.

Additional Requirements for Community Mental Health Centers (CMHCs)—This proposal would provide authority for the Secretary to establish through regulation Medicare participation requirements for CMHCs (health and safety requirements, provider eligibility standards). Additionally, it would provide authority for CMHCs to be surveyed by state agencies to determine compliance with Federal requirements or investigate complaints upon request. This proposal will be accompanied by a user fee or specific appropriation for survey money. It would also prohibit Medicare-only CMHCs. Currently, a CMHC is defined as an entity that provides certain mental health services that are listed in the Public Health Service Act and meets applicable state licensing or certification requirements. Since 2/3 of the states do not license or certify CMHCs, this definition is insufficient to ensure that appropriate organizations become Medicare providers. Prohibiting Medicare—only CMHCs would discourage establishment of programs targeted to Medicare beneficiaries.

CMHC Prospective Payment System—It would also provide the Secretary broad authority to establish through regulation a prospective payment system for partial hospitalization services that reflects appropriate payment levels for efficient providers of service and payment levels for similar services in other delivery systems. (The current cost reimbursement system would stay in place until the Secretary exercises this payment authority.) The partial hospitalization benefit was intended to be a less-costly alternative to inpatient psychiatric care. The current reasonable cost reimbursement methodology has resulted in excessive payment and inappropriate payment for items and services that are excluded from the definition of partial hospitalization services.

Bankruptcy Provisions—These proposals would protect Medicare and Medicaid interests in bankruptcy cases. A provider would still be liable to refund overpayments and pay penalties and fines even if he filed for bankruptcy. Quality of care penalties could be imposed and collected even if a provider was in bankruptcy. Medicare suspensions and exclusions (including for not re-paying scholarships) would still be in force even if a provider files for bankruptcy. If Medicare law and bankruptcy law conflict, Medicare law would prevail. Bankruptcy courts would not be able to readjudicate our coverage and/or payment decisions.

Insurer Information Reporting—This proposal would build on HCFA's prospective data sharing initiative to clarify that Medicare can require information from all group health plans in order to ensure that Medicare is paying the appropriate amount for beneficiaries who may be covered by private insurance. The problem of Medicare's initially paying and then attempting to recover payment (or not having enough time to recover payment) from a group health plan could largely be eliminated if all group health plans were required to report to us information about the insurance coverage of Medicare beneficiaries. We would then know from the start

what our payment obligations are (i.e., if Medicare is responsible for paying most of a claim or whether Medicare is responsible only for the co-payment and deductible). The appropriate payments could be made in a timely fashion and resources would not need to be spent to recoup mistaken payments.

Conditions for Double Damages—This proposal would provide that when a third party payer is required to reimburse Medicare, double damages are payable unless the third party payer can demonstrate that it did not know, and could not have known, of its responsibility to pay first. This would reduce gaming of the system by third party payers.

Clarification of Time and Filing Limitations—This proposal would clarify that Medicare can recover mistaken payments from all entities that make insurance payments, without a time limit upon when Medicare can file a claim. Unfortunately, because we must utilize information from tax returns, which is then matched against information from the Social Security Administration (in the HCFA/IRS/SSA Data Match), by the time we receive data it is already one and a half, and sometimes two years old. We must then match this information against Medicare files before a questionnaire can be sent to identified employers to determine if a Medicare beneficiary (or their spouse) had coverage through the group health plan of an employer. Thus, the current three-year limit for recovery of erroneous Medicare payments effectively means that no erroneous primary payments are collected. Consequently, private insurance companies (whose obligation it is to pay before Medicare when the beneficiary has a primary policy) receive substantial windfalls at the expense of the Medicare Trust Fund.

Technical Changes Concerning Minimum Sizes of Group Health Plans—This proposal would make technical changes concerning the minimum sizes of group health plans so that the Social Security Act and the IRS Code would not be contradictory.

Eliminate Exception to Anti-kickback Statute for Certain Managed Care Plans—The term "substantial financial risk" is undefined and somewhat broad. This proposal would eliminate the broad new exception (created in HIPAA) to the anti-kickback statute when providers are at "substantial financial risk." The Congressional Budget Office assigned a considerable cost to this provision precisely because it could be easily abused by those wishing to profit from referrals.

Repeal of Clarification Concerning Levels of Knowledge Required for Imposition of CMPs: This proposal would reinstate the reasonable diligence standard that the OIG used to levy civil money penalties on Federal health care program providers who violated the law. HIPAA eliminated the standard for use of reasonable diligence and made providers subject to civil money penalties only if they acted with deliberate ignorance or reckless disregard.

We believe that these provisions are needed to address areas of vulnerability that are not covered by existing legislation, and that they will provide us with additional valuable weapons in the war against fraud and abuse. We need the support of Congress in order to add these important tools to our current efforts.

CONCLUSION

As the nation's largest purchaser of health care services and as the health care insurer for one in four Americans, we know that it is the most vulnerable—the oldest, the frailest, the least able—who are the first to be victimized. Program integrity measures not only protect these individuals; they build a strong base for Medicare, as we know it today, and as it will evolve to meet HCFA's program needs as we face the next century.

Building on the principles of our program integrity vision—Prevention, Early Detection, Coordination, and Enforcement—it is our intention to strengthen the fight against waste, fraud and abuse in the Medicare and Medicaid programs. We are gaining on the agents of fraud. Now is the time to increase the pressure, not reduce it. I look forward to working with all of you in this endeavor.

Chairman THOMAS. Thank you, Ms. Ruiz.

Mr. Owens.

STATEMENT OF CHARLES L. "CHUCK" OWENS, CHIEF, FINANCIAL CRIMES SECTION, FEDERAL BUREAU OF INVESTIGATION

Mr. OWENS. Thank you, Mr. Chairman, for inviting me to testify at this hearing today.

Mr. Chairman, the FBI has conducted health care investigations for several years now, but it was only in 1991 that we first designated health care fraud as a national priority. Since that time we've continued to increase the commitment of resources to these investigations and frankly, the HIPAA legislation and the resulting funding that came from that to the FBI was a real shot in the arm.

I brought some charts with us today I'd like to show you. I think some points of interest which will clearly indicate what the FBI's doing in health care fraud investigations. The first chart reflects that, prior to enactment of the HIPAA legislation, we had designated and dedicated health care fraud squads in a number of our field offices around the country, but with the legislation and the additional agents we were able to allocate to our field offices, we were able to add about seven new dedicated squads throughout the country, including adding one-third squad, one-third full dedicated health care squad in Miami, and a second full dedicated squad in New York.

The second chart reflects our resource utilization again—special agents dedicated to this area. It clearly shows from 1992 through, on the chart, the second quarter of 1997, how we've continuously increased our commitment there. Through the third quarter, which is the latest figures I have, it's up now to about 365 agent positions.

The next chart reflects the pending caseload. Again, you see a continual increase in the number of investigations that we're conducting there, and frankly, I expect that that will now start to level off as we've continued to do more and more cases here. We've gotten involved in more complex cases, many times cases that are national in scope, and the very difficult cases, so we wouldn't expect to see an increase in this area. We do think we'll work the cases that will make more impact.

The next chart reflects a breakdown of the cost of health care in the country. As you know, the FBI has jurisdiction to investigate both fraud against the private payor plans as well as the government-sponsored plans. The inset in the left corner indicates that in 60 percent of the investigations we conduct, they're in the federally sponsored programs with the remaining 40 in the private sector. However, what we've seen in most instances, if the providers are defrauding the Medicare Program and Medicaid, their also defrauding the private payors as well.

The last chart I have shows the convictions, and I want to point out, as Mike did, that many of these are joint investigations that we've conducted with the Inspector General's Office, IRS, other Federal agencies, and State and locals as well. Again, through the third quarter we were up to about 400, so I would expect this year we will exceed what we did last year.

In the interest of time, I'll be brief. I just wanted to make a couple of points. In my statement, I indicated a number of successful investigations that we've conducted, but I just want to highlight

one very briefly. That's a recent home health care investigation that we conducted in the Miami division. In that instance, we actually established a home health care agency ourselves and operated it and we went overt just a few weeks ago and arrested the first two individuals. We anticipate numerous additional arrests in that case. But we were able to make those arrests, we focused not only on the health care fraud that was apparent there, but also the money laundering activity that was associated. I think this case is particularly important because of the high incidence of home health care fraud that we're seeing and this shows our efforts to attack it. Also, because of the techniques used—we think by using these type of techniques we can really get on the inside of some of these operations and develop evidence of the broad nature of the frauds that are occurring.

Mr. Chairman, I believe that economic losses to the American public are now greater from health care fraud than from any other form of white-collar crime and that is why we are placing such an important emphasis in this area. We're working closely with several other agencies to conduct these matters; there are numerous task forces and working groups established throughout the country with the prosecutors and investigators, and we think we are beginning to make some real impact. We're using, as I've indicated, undercover operations and proactive techniques to address this. We're being encouraged to do more and more civil investigations as well as criminal, and we've done that. We've applied the RICO statute in some instances, and we're certainly willing to do that if the circumstances warrant. We're also, as I indicated, investigating more and more cases that are national in scope.

With that, at the appropriate time, I'd be happy to answer any questions.

[The prepared statement follows:]

Statement of Charles L. "Chuck" Owens, Chief, Financial Crimes Section, Federal Bureau of Investigation

Good Morning Mr. Chairman and Members of the Subcommittee on Health.

The FBI places a high priority on investigating Health Care Fraud and is committed to working with this Committee and all of Congress to ensure that law enforcement has the necessary tools to combat the health care crime crisis. I testified several months ago on this issue to the Senate Permanent Subcommittee on Investigations. I would be delighted to furnish this Committee with similar statistics relating to the FBI's enforcement efforts as well as to update you on some very recent developments. Another FBI representative recently participated in a hearing held by the Senate Special Committee on Aging. At this hearing the FBI representative played a video obtained by use of a closed circuit television, installed under court order, located in the billing area of a doctor's office. The doctor was captured in the act of altering billing records to facilitate his fraud scheme. Inasmuch as it was previously shown and was the subject of widespread publicity, I chose not to play this tape today but I can certainly make it available to the Committee.

As the Committee is aware, in addition to providing new statutory tools to combat health care fraud, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which was passed by the last session of Congress, specified mandatory funding to the FBI for Health Care Fraud Enforcement. The last chart accompanying my written statement depicts the incremental increases in FBI appropriations. The law provided the FBI with $47 million in fiscal year 1997 for its health care fraud efforts, up from $38 million in fiscal year 1996. The FBI used this enhancement, in large part, to fund an additional 46 agent and 31 support positions for health care fraud and to create several new dedicated Health Care Fraud Squads. (see chart 1 attached). This increase in personnel resources brought the number of FBI agents addressing health care fraud in the 2nd quarter of FYER fiscal year 1997) as compared to 112 in 1992. (see chart 2 attached). Funding is slated to in-

crease incrementally until the year 2003, when it will reach $114 million and remain at that level each year thereafter. With this additional funding, the FBI will be in a position to continue to increase the number of agents committed to Health Care Fraud investigations.

As the FBI has increased the number of agents assigned to health care fraud investigations, the caseload has increased dramatically from 591 cases in 1992, to over 2,300 cases in the first half of 1997 (2,428 3rd quarter fiscal year 1997). (see chart 3 attached). The FBI caseload is divided between those health plans receiving government funds and those that are privately funded (see chart 4 attached). Criminal health care fraud convictions resulting from FBI investigations have risen from 116 in 1992, to 475 in 1996. (see chart 5 attached). As the complexity and long-term nature of our health care fraud investigations increase we anticipate that the number of investigations and convictions will begin to level off.

A considerable portion of this funding increase was utilized to support major health care fraud investigations such as the federal probe of Columbia Healthcare Corporation, reportedly the nation's largest for-profit health care provider. This investigation has been widely reported in the media and I am sure the Committee is aware of the allegations. The coordinated execution of multiple search warrants at Columbia related facilities required the services of hundreds of FBI agents and representatives of other cooperating agencies. The expenses associated with the searches, as well as post search document storage and review expenses, were funded in large part through the appropriations made possible through HIPAA. The committee can be assured that HIPAA funding is being used to enhance the staffing level of FBI field offices involved in ongoing investigations of national importance.

The funding made available through HIPAA also made possible four regional training conferences for FBI agents assigned to Health Care Fraud Investigations. These one week training sessions sponsored by the Health Care Financing Administration provided in-depth training on the Medicare Program to almost 300 agents. Other training sessions, to include a session for the Bureau's Financial Analysts and an FBI, Defense Criminal Investigative Service (DCIS), and Office of Inspector General-Health and Human Services (OIG–HHS) Managers' Conference, were also made possible by HIPAA.

As the Committee is aware, Health Care Fraud Investigations are document intensive. Each of the Bureau's Health Care Fraud Squads are being provided with newly purchased computer hardware and software and other technical equipment to aid in their investigations. These purchases were made possible through HIPAA funding.

Our investigations to date have shown that no segment of the Health Care System is immune from fraud. This morning i would like to discuss briefly three areas of the Health Care Delivery System which FBI investigations have shown to be particularly susceptible to fraud: Laboratory billings; Home Health Care; and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

Eight months ago, Damon Clinical Laboratories Inc. agreed to pay the Federal government $119 million in civil and criminal penalties for submitting false claims to various Federal Health Care Programs, including the Medicare Program and a number of Medicaid Programs. In November of last year, the Laboratory Corporation of America agreed to pay the Federal government $182 million in civil penalties associated with submitting false claims for medically unnecessary tests. As part of this agreement, Allied Clinical Laboratories, a labcorp subsidiary, pled guilty to a criminal charge and will pay a $5 million criminal fine. In February of this year, Smithkline Beecham Clinical Laboratories Inc. agreed to pay $325 million to settle fraud charges.

These multi-agency investigations and settlements were the result of the cooperative efforts of a number of agencies and resulted in significant restorations to the hospital insurance trust fund—which funds the Medicare and Medicaid Programs—as well as other Federal Health Care Programs. The fraud schemes include bundling certain lab tests with blood panels, causing physicians to order tests that were not medically necessary; billing for hemogram indices each time a complete blood count was ordered; "Code Jamming" on screening tests to ensure Medicare payment; and providing inducements to physicians to obtain their Medicare business. Investigations into other allegations involving the laboratory industry are continuing.

The home health industry has grown tremendously during the last few years. In 1993, Home Health Agencies were reimbursed by Medicare in the amount of $9.7 billion for services provided to 2.8 million Medicare beneficiaries. By 1996, Medicare paid $17.2 billion to providers of Home Health Care for services rendered to 3.8 million beneficiaries. The number of Home Health Agencies billing Medicare has grown from just over 7,000 in 1993, to an estimated 9,500 in 1996.

Investigations conducted by the FBI and OIG–HHS have uncovered fraud schemes in the Home Health Area involving cost reporting fraud; billing for services not rendered; up-coding visits to a higher reimbursement code, such as a skilled nursing visit; and billing for services rendered to persons not "Home Bound" as required by medicare. A number of factors may contribute to the high rate of fraud detected in the Home Health Industry. Less than 4 percent of the agencies receive on-site audits by Medicare contractors and the beneficiaries are not required to make a co-payment, making it less likely that a beneficiary will complain about the extent of service or what's being billed to Medicare. As the committee is aware, the President recently announced that the Government will be doubling its audits of Home Health Agencies. It can be expected that more audits will result in the predication of more criminal investigations and the FBI applauds this effort.

Just last month a Federal grand jury in Miami returned a 102 count indictment of twelve defendants, including two administrators and five physicians, from one of the Nation's largest Home Health Care Agencies. allegedly, this is a $15 million fraud and one of the Nation's largest Home Health Care Fraud indictments ever. Two of the defendants are charged with creating a large network of bogus nursing groups and then using these groups to fraudulently bill the Medicare System for Home Health Care Services that were not provided or for persons they knew were not qualified to receive the service. They also allegedly instructed employees to fabricate the records necessary to support these billings and then "Laundered" the proceeds through accounts set up through the secret owners of the bogus nursing groups, who were either family members or friends of the defendants. The money laundering charges carry a maximum of twenty years in prison and a fine of twice the amount laundered. The conspiracy, false claims and wire fraud counts are punishable by up to five years imprisonment each and a $250,000 fine, per count. This indictment was a culmination of a four and one half year investigation by the FBI, IRS, and United States Attorney's Office.

Another area of Health Care that has been shown to be particularly vulnerable to fraud is durable medical equipment. Recently, five midwest residents pled guilty to racketeering charges in connection with more than $25 million in fraudulent billings to Medicare through the marketing of durable medical equipment to Medicare reimbursement for products they did not provide, receiving payment for non-reimbursable supplies, providing unnecessary items to patients, misrepresenting the quantities of supplies actually provided, and engaging in billing activities to avoid detection by the Medicare contractor. Part of the scheme included adding unnecessary items in urinary incontinence kits and marketing those items to nursing homes for reimbursement from Medicare. The two principle subjects were each sentenced to 57 months in prison and agreed to the forfeiture of $12 million.

In a highly unusual case, just last week two individuals were arrested and charged in connection with a two-year fbi sting operation addressing Medicare fraud and money laundering. The FBI set up its own Home Health Care Agency and participated with the subjects in laundering $1.2 million in what the subjects thought was drug money through the subjects Home Health Agency. The investigation is still ongoing and efforts are underway to freeze the subjects assets and prevent further Medicare billings. The subjects Home Health Agency received over $8 million in Medicare payments over the last two years.

The HIPAA of 1996 (The Act) established the Health Care Fraud and Abuse Control Account which provided funding to HHS as well as the Department of Justice. This funding increase for the Department of Justice provides great support for the Department's decision, from approximately five years ago, to make Health Care fraud Prosecution one of its top priorities. Through the funding provisions of this Act, the Department was able to hire an additional 90 Assistant United States Attorneys (AUSAS), 60 criminal and 30 civil, to support Health Care Fraud Prosecutions. The assignment of these AUSAS To various districts was closely coordinated with the Bureau's staffing increases in an effort to ensure adequate prosecutive support for the anticipated increase in criminal matters under investigation.

The Act also created a Federal health care fraud offense, which covers any Health Care Plan, whether Government or privately funded, and empowers the Attorney General or her designee to issue investigative demands to obtain records pertaining to Federal criminal health care offenses. Records obtained pursuant to this method are not subject to the same constraints applicable to records obtained through the use of a Grand Jury subpoena. A number of investigative demands have already been issued in connection with ongoing criminal investigations.

As the committee is well aware, the Balanced Budget Act of 1997 goes even further than HIPAA'S efforts to combat Health Care additional anti-fraud measures continues to exist. The Bureau strongly supports provisions requiring the permanent exclusion of individuals with multiple convictions of program related offenses

and the posting of surety bonds. The Bureau also supports efforts to require providers to furnish social security and employer identification numbers of all owners and managing employees prior to certification.

Despite the great strides made by the last session of Congress, additional legal tools are still needed if law enforcement is to make even more of an impact on this estimated $100 billion a year crime problem.

The FBI concurs with the Department of Justice that there should be a liberalization of F.R.CR.P. 6(E) to facilitate the sharing of information among criminal and civil attorneys in health care cases. Often, investigations which are initiated on complaints of criminal allegations fall short of the burden of proof required to sustain criminal convictions and the appropriate remedy becomes civil enforcement. Information currently obtained through the Grand Jury cannot be routinely used by civil attorneys, absent a court order.

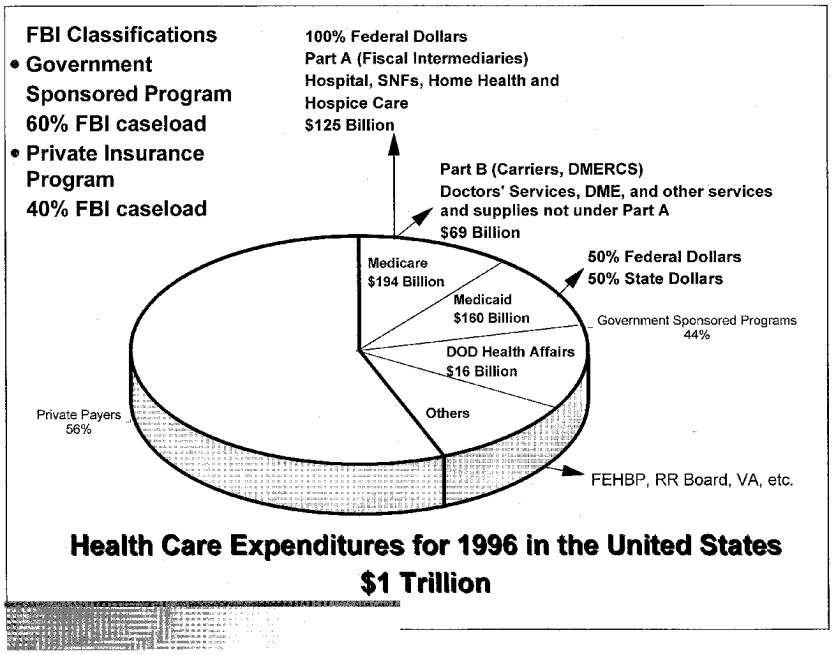
Secondly, while Section 204 of the Act extends Title 42 criminal provisions relating to kickbacks in all health plans receiving Federal funds, except the Federal Employees Health Benefit Plan (FEHBP), it does not apply illegal remuneration prohibitions to the private health care industry. Congress has also not included violation of the anti-kickback statute in the definition of Federal Health Care Offense. Thus, in an investigation based solely on illegal kickbacks, the new health care violations and new procedural tools, such as investigative demand authority and injunctive relief, will not be applicable.

Statistical analysis of billing data typically reflects high usage peaks during certain time periods for various procedure codes. Reimbursement for these procedures or tests require certification from a medical provider stating the procedure or test was medically necessary. Typically, after law enforcement activity is initiated based partly on the statistically aberrant usage of a particular code, usage decreases and another procedure exhibits higher than normal usage. One cannot help but assume that these aberrant billing patterns are due in part to monetary incentives paid to providers to certify that the tests or procedures were medically necessary. When the medical judgement of providers becomes obscured by the motive for profit, all americans seeking medical care become potential victims. The FBI and other Department of Justice components would support an amendment to the Federal criminal code to create a new generalized offense against kickbacks paid in connection with a "Health Care Benefit Program" as defined in 18 U.S.C. Sec. 24 (B). This provision would fill the gap in the law by extending Federal anti-kickback criminal sanctions to all Health Care Benefit Programs, public and private.

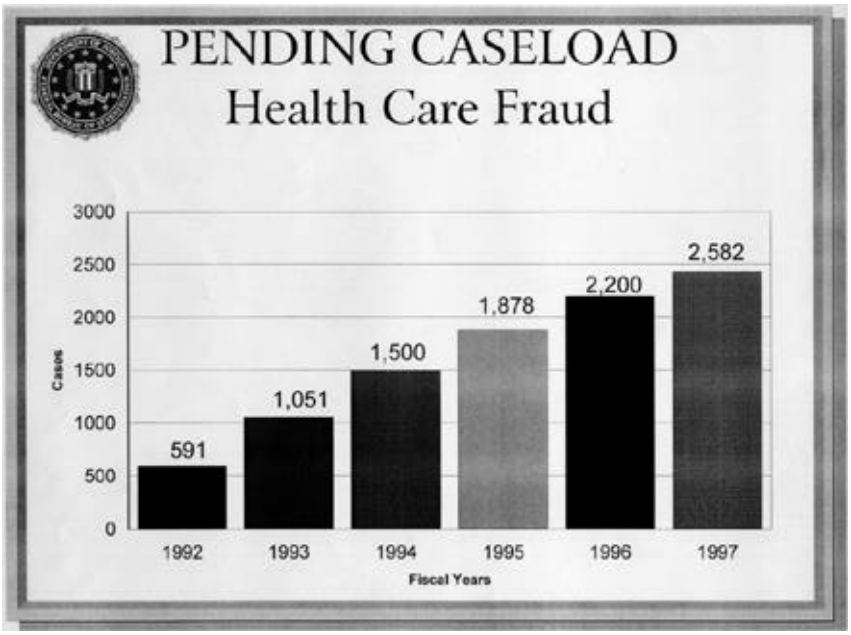
An ongoing FBI undercover investigation has determined that the payment of illegal kickbacks for referral of Medicare business is a widespread and accepted practice in the segment of health care under investigation. At this time I am unable to share with the Subcommittee audio and visual confirmation of this assertion but I would be happy to share these tapes with the Subcommittee when this investigation is concluded. These recorded Acts will serve as a compelling argument for further expansion of the anti-kickback statute.

This ongoing undercover investigation now involves investigators from, in addition to the FBI, agents from the OIG–HHS, IRS, and DCIS and is but one example of the cooperative Federal effort to combat health care fraud.

That concludes my prepared remarks and at this time I would be pleased to answers any questions that you may have.


FBI Classifications
• Government Sponsored Program 60% FBI caseload
• Private Insurance Program 40% FBI caseload
100% Federal Dollars
Part A (Fiscal Intermediaries)
Hospital, SNFs, Home Health and Hospice Care
$125 Billion
Part B (Carriers, DMERCS)
Doctors' Services, DME, and other services and supplies not under Part A
$69 Billion
50% Federal Dollars
50% State Dollars
Medicare
$194 Billion
Medicaid
$160 Billion
Government Sponsored Programs
44%
DOD Health Affairs
$16 Billion
Others
Private Payers
56%
FEHBP, RR Board, VA, etc.
Health Care Expenditures for 1996 in the United States
$1 Trillion

Federal Bureau of Investigation
Designated Health Care Squads
Existing
Boston
Chicago
Dallas
Miami
Newark
New Haven
New York
WFO
To be established
Cleveland
Los Angeles
Miami(+)
New Orleans
New York (+)
Phoenix
Tampa


PENDING CASELOAD
Health Care Fraud
3000
2500
2000
1500
1000
500
0
Cases
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1,051
1,500
1,878
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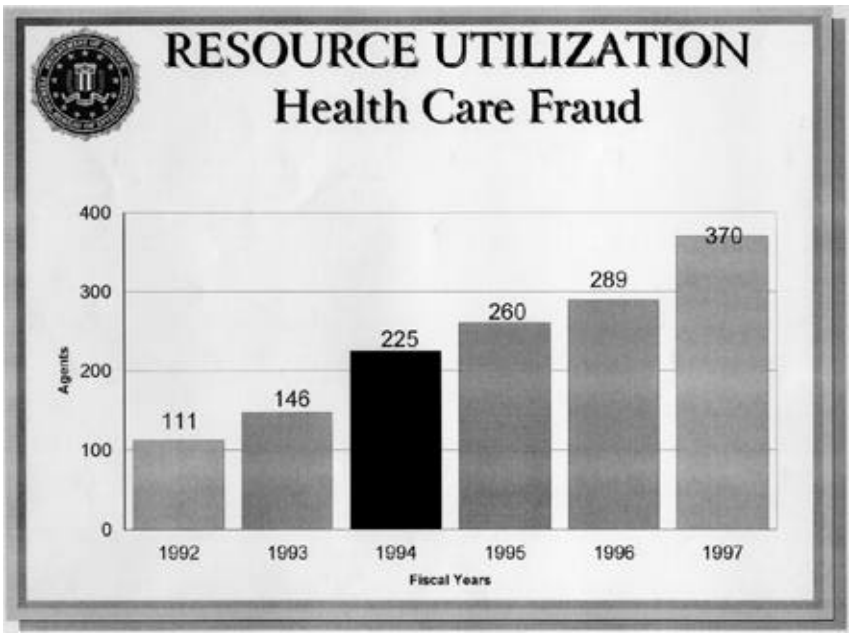
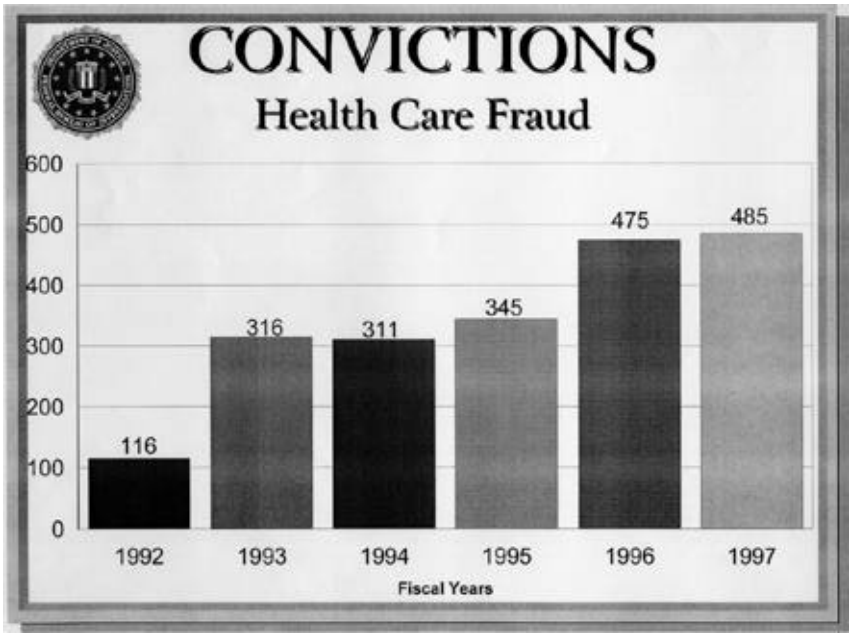
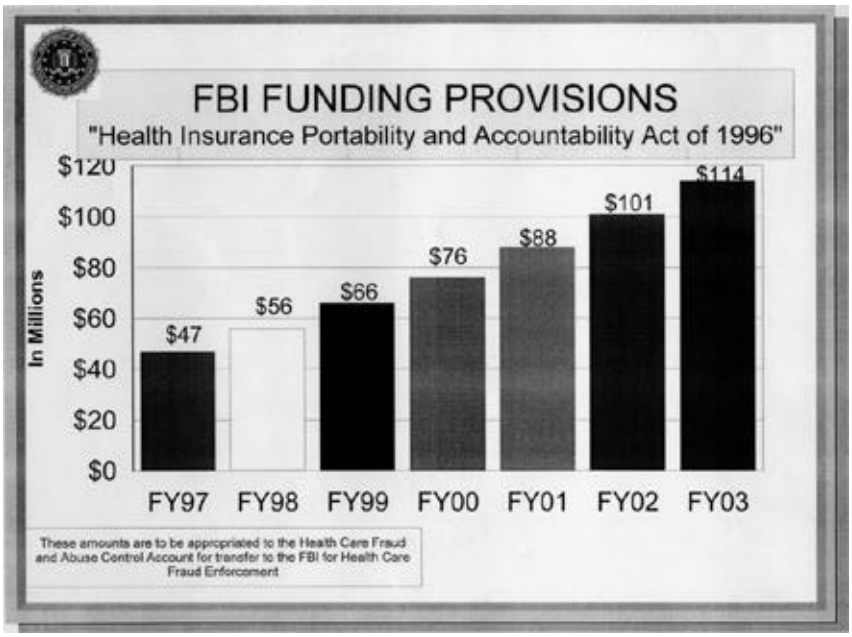
2,582
1992
1993
1994
1995
1996
1997
Fiscal Years


RESOURCE UTILIZATION
Health Care Fraud
400
300
200
100
0
Agents
111
146
225
260
289
370
1992
1993
1994
1995
1996
1997
Fiscal Years





Chairman THOMAS. Thank you, Mr. Owens. My assumption is you didn't operate your home health care agency through a pawnshop front arrangement. Did it look more like a home health care?

Mr. OWENS. Actually, it wasn't too different than the one you showed. It just shows the——

Chairman THOMAS. Careful.

Mr. OWENS [continuing]. Egregious nature of this activity, I think.

Chairman THOMAS. And still they came.

Mr. Mangano, to begin the discussion. What we did was, again, to give people an idea of how—I'm sorry, Dr. Scanlon.

Mr. SCANLON. That's OK.

Chairman THOMAS. You're here so often.

Mr. SCANLON. Beg your pardon?

Chairman THOMAS. You're here so often.

Mr. SCANLON. Right. [Laughter.]

Chairman THOMAS. But I do want to hear from you.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. SCANLON. Thank you very much. It's a pleasure to be back again. In particular, I'm pleased to be here as you discuss the recent legislative efforts to address fraud and abuse in the Medicare Program.

As you indicated at the start, as well as what you've heard from my fellow panelists, the Congress has squarely faced the mounting concerns that exist about Medicare fraud and abuse and has responded very decisively in HIPAA and the Balanced Budget Act. Indeed, the broad scope of this response is demonstrated by the fact that these acts address the bulk of the waste, fraud, and abuse recommendations that have been made by the Inspector General and ourselves over the years. At your request, we have issued correspondence to the Subcommittee today elaborating on how well you have addressed those recommendations.

Today, I would like to focus in my statement on the work that lies ahead to realize the potential benefits of these pieces of legislation. As you know, the success of any reform legislation is contingent upon its implementation. This new Medicare legislation is no exception. Take, for example, the mandates under BBA to replace cost-based reimbursement with prospective payment systems to eliminate the financial incentives for providers to deliver more services than necessary. HCFA will have to bring to a speedy conclusion years of data-intensive research to develop prospective payment methods and settle on methods that, first of all, avoid building excessive payments of the past into future rates.

Second, they will have to compensate providers fairly for their sicker or healthier-than-average patients, and finally, they will have to avoid creating incentives for underservice that could put beneficiaries at risk. Then, under the standard regulatory process, HCFA will need to develop implementing regulations, seek public comments, and ultimately issue final regulations.

For the expectations of BBA to be realized, this process is going to have to be accelerated significantly. Under the Balanced Budget Act, HCFA will have to develop concurrently separate prospective payment methods for inpatient rehabilitation facilities, home

health agencies, skilled nursing facilities, and hospital outpatient departments.

Medicare's new Choice plans also present implementation challenges. For example, in setting standards for planned participation, HCFA will need to strike a judicious balance between encouraging plan growth and adequately protecting beneficiaries quality of and access to care. In addition, HCFA may face extraordinary challenges in overseeing compliance with participation standards. The newly authorized higher HMO rates for rural areas, plus the options for preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans may well increase substantially the total number of participating plans. If that anticipated growth occurs, HCFA may not be equipped to make the site visits at the current rate of once every other year or to give adequate scrutiny to the marketing material that plans are submitting for HHS approval.

Another implementation concern is related to HCFA's information management systems. As you know, HCFA's major project to modernize its information system, the Medicare Transaction System, was terminated about 2 months ago. This is a significant setback for HCFA's efforts to intercept fraud and abuse. MTS was expected to provide an online database that could integrate data on part A and part B services and payments. This information is currently stored separately, limiting contractors' efforts to detect double billing for the same service or supply or other patterns of suspicious billing. HCFA's other antifraud and abuse software development projects are also years away from implementation nationwide.

I'd like to conclude by reiterating that these acts, the Balanced Budget Act and HIPAA, offer HCFA great potential to combat Medicare fraud and abuse. Some provisions, however, will require extensive time and resources to implement effectively. Additional congressional oversight, encouragement, and possibly action will be needed to achieve timely and effective implementation and to realize the potential of this legislation. At the same time, HCFA's management information difficulties undermine the agency's abilities to perform the high-tech investigative work needed to scrutinize Medicare bills effectively. Medicare's program managers and their Federal law enforcement partners will certainly have to work diligently to keep pace with the persistent attempts to defraud the program.

Thank you, Mr. Chairman. I'd be happy to answer any questions you or other Members of the Subcommittee have.

[The prepared statement follows:]

Statement of William J. Scanlon, Director, Health Financing and Systems Issues, Health, Education, and Human Services Division, U.S. General Accounting Office

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here as you discuss recent legislative efforts to address fraud and abuse in the Medicare program. In response to heightened concern about the exploitation of Medicare, the Congress enacted as part of the Balanced Budget Act of 1997 (BBA) (P.L. 105–33) a number of provisions designed to control fraud and abuse. At your request, we have sent correspondence to the Subcommittee today that discusses the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104–191) and BBA that address anti-fraud-and-abuse recommendations that we and the Inspector General of the Department of Health and

Human Services (HHS) have made.[1] We also included in the correspondence our remaining open recommendations and those from the Inspector General.

In noting the comprehensive legislation that the Congress enacted, in part, to grapple with program fraud and abuse, my statement today focuses on the work it will likely take to realize the potential benefits of HIPAA and BBA in three areas—in traditional fee-for-service Medicare, the new Medicare+Choice plans, and information management systems. My remarks are based on the work we have done to prepare today's correspondence and relevant GAO studies. (See the list of related products at the end of this statement.)

In summary, both HIPAA and BBA directly address Medicare fraud and abuse and provide opportunities to improve program management. Both acts offer civil and criminal penalties. They also introduce opportunities to deploy new program safeguards. For example, on the fee-for-service side of the program, BBA introduces prospective payment methods for skilled nursing facility and home health services, in part to halt opportunists from overbilling Medicare. These are among Medicare's fastest-growing components: From 1989 to 1996, spending for home health care and skilled nursing facility care averaged, respectively, a 33-percent and 22-percent annual rise. HIPAA also ensures a stable source of funding for anti-fraud-and-abuse activities, authorizes HCFA to contract for improved claims reviews, enhances law enforcement coordination, and calls for data collection improvements. On the managed care side, BBA's Medicare+Choice program, which broadens beyond health maintenance organizations (HMO) the private health plans available to Medicare beneficiaries, includes several provisions addressing the marketing, enrollment, and quality of care issues raised in our reports and those of the Inspector General.

As always, however, the success of any reform legislation is contingent on its implementation. The Congress has provided HHS and the Health Care Financing Administration (HCFA), the Department's administrator of the Medicare program, with many new statutory requirements governing traditional fee-for-service Medicare; some require little effort to carry out, whereas others, such as prospective payment system development, will require extensive time and resources to implement effectively. In addition, the Medicare+Choice program will add considerably to HCFA's private plan monitoring workload. Finally, the project to modernize Medicare's claims processing systems, which are at the core of many fraud and abuse detection efforts, has recently been halted. This brings into question the ability of HCFA and its contractors to perform expeditiously the data-intensive analyses needed to spot and counteract abusive billing schemes. HCFA agrees that the tasks associated with implementing HIPAA and BBA mandates are considerable and plans to report routinely to HHS officials and to the Congress on HCFA's progress implementing the legislation.

As we stated in our 1997 High-Risk Series report on Medicare, fraudulent and abusive schemes are inherently dynamic, as unprincipled entrepreneurs continually seek ways to dodge program safeguards.[2] As a result, fortifying Medicare against fraud and abuse will require a concerted and ongoing effort by Medicare program managers and federal law enforcement agencies to keep pace with new attempts to exploit the program. It will also likely require additional congressional oversight to encourage timely and effective program management.

BACKGROUND

Established under the Social Security Amendments of 1965, Medicare is a two-part program: (1) "hospital insurance," or part A, which covers inpatient hospital services and skilled nursing facility, hospice, and home health care services, and (2) "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, diagnostic tests, and ambulance and other medical services and supplies. In fiscal year 1997, part A will have covered an estimated 38.1 million aged and disabled beneficiaries, including those with chronic kidney disease. Total outlays for parts A and B are estimated at $212 billion for fiscal year 1997.

In Medicare's fee-for-service program, which is used by almost 90 percent of the program's beneficiaries, physicians, hospitals, and other providers submit claims for services rendered to Medicare beneficiaries. HCFA administers the fee-for-service program largely through claims processing contractors. Insurance companies—like Blue Cross and Blue Shield plans, Mutual of Omaha, and CIGNA—process and pay Medicare claims, which totaled an estimated 900 million in fiscal year 1997. As

[1] Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 (GAO/HEHS–98–18R, Oct. 9, 1997).

[2] High-Risk Series: Medicare (GAO/HR–97–10, Feb. 1997).

Medicare contractors, these companies use federal funds to pay health care providers and beneficiaries and are reimbursed for the administrative expenses incurred in performing the Medicare work. Over the years, HCFA has consolidated some of Medicare's operations, and the number of contractors has fallen from a peak of about 130 to about 65 in 1997.

Generally, intermediaries are the contractors that handle claims submitted by "institutional providers" (hospitals, skilled nursing facilities, hospices, and home health agencies); carriers generally handle claims submitted by physicians, laboratories, equipment suppliers, and other practitioners. HCFA has guarded against inappropriate payments largely through contractor-managed operations, leaving the intermediaries and carriers broad discretion over how to protect Medicare program dollars. As a result, contractors' implementation of Medicare payment safeguard policies varies significantly.

Medicare's managed care program covers a growing number of beneficiaries—more than 5 million as of September 1997—who have chosen to enroll in a prepaid health plan rather than purchase medical services from individual providers. The managed care program, which is funded from both the part A and part B trust funds, consists mostly of risk contract HMOs that enrolled nearly 5 million Medicare beneficiaries as of September 1997.[3] Medicare pays these HMOs a monthly amount, fixed in advance, for each beneficiary enrolled. In this sense, the HMO has a "risk" contract because regardless of what it spends for each enrollee's care, the HMO assumes the financial risk of providing health care in return for the payments received. An HMO profits if its cost of providing services is lower than the predetermined payment but lose if its cost is higher than the payment.

IMPLEMENTING NEW LAWS AFFECTING FEE-FOR-SERVICE MEDICARE WILL REQUIRE SUSTAINED EFFORT TO REALIZE BENEFITS

The Congress provided important new resources and tools to fight health care fraud and abuse when it enacted HIPAA and BBA. To address problems in traditional fee-for-service Medicare, various provisions require HCFA to change outmoded payment methods, largely by establishing new prospective payment systems and by imposing fee caps, reductions, and updates to contain unnecessary expenditures. Certain provisions offer the potential to improve claims reviews—mandating specific increases in reviews and providing HCFA new contracting authority to acquire technical expertise.

Enactment of the legislation represents an important first step toward the realization of program integrity goals. As we have noted in previous testimony, the legislation process sets forth the broad concepts while the administering agencies implement the legislation through planning, design, and execution.[4] In the case of HIPAA, now more than a year old, HCFA and the HHS Inspector General have been developing plans on many fronts, but actual implementation is just beginning. In the case of BBA, less than 3 months old, the "to-do" list is long. Three examples relating to both acts illustrate the situation.

First, HIPAA, enacted over a year ago, grants HCFA the authority to use contractors other than the insurers serving as Medicare intermediaries and carriers to conduct medical and utilization review, audit cost reports, and carry out other program safeguard activities. The purpose is to enhance HCFA's oversight of claims payment operations by increasing contractor accountability, enhancing data analysis capabilities, and avoiding potential contractor conflicts of interest.

HCFA's target date for awarding the first program safeguard contract is in fiscal year 1999, more than a year from now. HCFA officials are preparing for public comment a notice of proposed rulemaking that would ultimately govern the selection of contractors to perform safeguard functions, but they are not able to specify when the contract award rules will be final.

Second, to allow greater information-sharing among federal and state government agencies and health plans, HIPAA mandates the creation of a national data collection program under which information on final adverse actions against health care providers will be maintained. Officials from the Office of the Inspector General are working with the Health Resources and Services Administration to develop the

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[3] The Medicare managed care program also includes cost contract HMOs and health care prepayment plans. Cost contract HMOs allow beneficiaries to choose health services from their HMO network or outside providers. Health care prepayment plans may cover only part B services. Together, both types of plans enroll fewer than 2 percent of the Medicare population.

[4] "Administration's Proposed Budget Cuts Affecting the Medicare Program," hearing before the House Subcommittee on Health, Committee on Ways and Means, March 2 and June 15, 1982, serial 97–53, pp. 331–38.

database. On the basis of past experiences with database development, it could be several years before the system can be fully operational.

Distinct from its predecessor system, the National Provider Data Bank, this data collection program is expected to maintain information on civil judgments, criminal convictions, licensing and certification actions on suppliers and providers, exclusions, and other adjudicated adverse actions—involving the collection of data from state and local governments. The program must also be self-supporting, requiring market research to assess the needs and preferences of potential users. Finally, because existing federal and state statutes and regulations may impede the collection and dissemination of the information required, new federal regulations may be necessary, requiring the publication of proposed rules, a 60-day period for receipt of public comments, and an indeterminate period for making the regulations final.

Third, BBA requires the implementation of several prospective payment systems to replace cost-based reimbursement methods. Depending on their design, prospective payment systems can remove the incentive to provide services unnecessarily. For example, prospective payment for skilled nursing facilities (SNF) should make it more difficult to increase payments by manipulating Medicare's billing rules for ancillary services provided to beneficiaries in these facilities, an issue often raised in our reports and testimonies. However, a considerable amount of work will be involved. Establishing rates that will enable efficient providers to furnish adequate services without overcompensating them will require (1) accounting for the varying needs of patients for routine and ancillary services and (2) collecting reliable cost and utilization data to compute the rates and the needed health status adjustment factors. Earlier this year in testimony before this Committee on prospective payment proposals, we suggested that HCFA use the results of audits of a projectable sample of SNF cost reports when setting base rates to avoid incorporating the inflated costs found in the HHS Inspector General's reviews of SNF cost reports. We also discussed the need for systems to adequately monitor prospective payments to help ensure that providers do not skimp on services to increase profits at the expense of quality care.[5]

In general, reforming payment methods entails developing payment methodology components that require data-intensive studies, developing the implementing regulations, publishing the proposed regulations for public comment, and issuing final regulations. For example, it took HCFA 4 years—from the time a task force was established in 1993—to issue proposed salary guideline regulations for rehabilitation therapy services. To meet the requirements of BBA, HCFA will have to develop, concurrently, separate prospective payment systems for services delivered through inpatient rehabilitation facilities, home health agencies, skilled nursing facilities, and hospital outpatient departments.

Developing prospective payment systems, moreover, represents only a fraction of the design and implementation work that HIPAA and BBA require. Conducting demonstration projects and reporting to the Congress constitute another portion of work mandated by the legislation.

MEDICARE'S NEW CHOICE PLANS PRESENT UNKNOWN CHALLENGES FOR PROGRAM MANAGERS

Among the more challenging of BBA's provisions to implement are those establishing the Medicare+Choice program, which expands beneficiaries' private plan options to include preferred provider organizations (PPO), provider sponsored organizations (PSO), and private fee-for-service plans. It also makes medical savings accounts (MSA) available to a limited number of beneficiaries under a demonstration program. The reforms the Congress embodied in these provisions are major, helping Medicare adapt to and capitalize on changes in the health care market.

However, each of these options will have to be carefully monitored to identify and correct vulnerabilities. Our observations of HCFA's oversight of Medicare's risk contract HMOs, which have been the chief alternative to traditional fee-for-service Medicare, raise concerns. In our 1997 High-Risk Series report, we noted that HCFA's monitoring of HMOs has been historically weak. HCFA has allowed some plans with a history of abusive sales practices, delays in processing beneficiaries' appeals of HMO decisions to deny coverage, and patterns of poor-quality care to receive little more than a slap on the wrist. We also noted that HCFA had done little to inform beneficiaries of HMO performance and did not publish available data on

[5] Medicare Post-Acute Care: Cost Growth and Proposals to Manage It Through Prospective Payment and Other Controls (GAO/T–HEHS–97–106, Apr. 9, 1997).

such satisfaction indicators as rapid disenrollment rates compared across Medicare HMOs within a given market.[6]

BBA addresses many of these problems. For example, the legislation calls for all Medicare+Choice plans to, among other things, obtain external review from an independent quality assurance organization, such as a peer review organization, that would assess such factors as the quality of the plan's inpatient and outpatient services and the adequacy of the plan's response to written complaints about poor-quality care. These and other mandates should help improve oversight. The act also requires HHS to disseminate to all beneficiaries within a market area consumer information on the area's Medicare+Choice plans, including, for example, disenrollment rates, health outcomes, and compliance with program requirements. Collectively, these consumer information requirements enlist market forces to help improve HMO performance.

We remain concerned that HCFA will have to be attentive to new issues raised by expanded choice for beneficiaries. The implementation challenge for HCFA will be to strike a judicious balance between encouraging plan growth and development and adequately protecting beneficiaries' quality of care. For example, under BBA, requirements for minimum enrollment levels—aimed at achieving an adequate spreading of risk to ensure a plan's financial solvency—can be waived for new Choice plans in their first 3 years of operation. In addition, the recent authorization of higher HMO rates in rural areas may well increase the total number of risk contract HMOs. If the number of Medicare managed care organization grows, HCFA may not be equipped to make site visits at the current rate of every other year. Finally, all the Medicare+Choice plans, including PPOs, PSOs, and private fee-for-service plans, will have to submit new marketing materials for HHS approval; with an escalating workload, however, these materials could be approved without adequate scrutiny. Under the law, marketing materials are approved automatically if HHS does not disapprove them within 45 days of their submission to the Department.

DELAYS IN MODERNIZING MEDICARE'S CLAIMS PROCESSING SYSTEMS COULD HAMPER PROGRAM INTEGRITY EFFORTS

Another implementation concern is related to HCFA's information management systems. As you know, HCFA's major project to modernize its information systems—the Medicare Transaction System (MTS)—all but collapsed as of August 15, 1997.[7] This is a significant setback for HCFA's efforts to prevent and detect fraud and abuse. For example, HCFA intended MTS to replace nine separate automated information systems with a single, unified system. It was expected to provide an on-line database that could integrate data on part A and part B services and payments that are currently stored separately. Ideally, such a system would enable the comparison of claims against other claims already submitted on behalf of the beneficiary, other claims submitted by the provider, and other claims for the same procedure or item. Work is still underway to develop a new system for collecting payment and other information related to risk contract HMOs, but the MTS contract has been terminated.

HCFA is in the process of consolidating its nine separate systems into one part A claims system and one part B claims system. While having a single system for each part should allow better claims editing, it would not provide all the benefits that had been expected from MTS, including the ability to ensure routinely, before payments are made, that an item or service billed to part A has not also been billed to part B and vice versa. Other anti-fraud-and-abuse software development discussed in our High-Risk report—namely, algorithms under development by the Los Alamos National Laboratory for generating prepayment claims screens and commercial off-the-shelf software controls being tested at one contractor—are years away from implementation nationwide.[8]

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[6] Our in-depth study on this subject is entitled Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS–97–23, Oct. 22, 1996).

[7] On that day, an internal HCFA memo was issued stating, "Today, HCFA formally notified GTE of our decision to close down the contract by January 1998. This contract action results from the stop work order that we issued to GTE on April 4, 1997."

[8] For a more detailed discussion of this work, see Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse (GAO/T–AIMD–97–176, Sept. 29, 1997).

HCFA Dedicates Staff to Implement BBA Mandates

Aware of the need for agencywide coordination and planning to implement BBA's multiple provisions, HCFA has established an infrastructure to track and monitor the tasks associated with BBA mandates. Staff organized into functional teams will be led by a project management team tasked with reporting to agency executives, including the HCFA Administrator. According to a HCFA official, the agency has plans to keep Department officials and the Congress routinely informed of the agency's progress.

Conclusions

With the enactment of HIPAA and BBA, the Congress has provided significant opportunities to strengthen several of Medicare's areas of vulnerability. How HHS and HCFA will use the authority of HIPAA and BBA to improve its vigilance over Medicare benefit dollars remains to be seen. The outcome largely depends on how promptly and effectively HCFA implements the various provisions. HCFA's past efforts to implement regulations, oversee Medicare managed care plans, and acquire a major information system have often been slow or ineffective. Now that many more requirements have been placed on HCFA, we are concerned that the promise of the new legislation to combat health care fraud and abuse could at best be delayed or not be realized at all without sustained efforts at implementation.

Mr. Chairman, this concludes my statement. I will be happy to answer your questions.

Related GAO Products

Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse (GAO/T–AIMD–97–176, Sept. 29, 1997).

Medicare Home Health Agencies: Certification Process Is Ineffective in Excluding Problem Agencies (GAO/T–HEHS–97–180, July 28, 1997).

Medicare: Control Over Fraud and Abuse Remains Elusive (GAO/T–HEHS–97–165, June 26, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS–97–108, June 13, 1997).

Medicare Transaction System: Success Depends Upon Correcting Critical Managerial and Technical Weaknesses (GAO/AIMD–97–78, May 16, 1997).

Nursing Homes: Too Early to Assess New Efforts to Control Fraud and Abuse (GAO/T–HEHS–97–114, Apr. 16, 1997).

Medicare Post-Acute Care: Cost Growth and Proposals to Manage It Through Prospective Payment and Other Controls (GAO/T–HEHS–97–106, Apr. 9, 1997).

Medicaid Fraud and Abuse: Stronger Action Needed to Remove Excluded Providers From Federal Health Programs (GAO/HEHS–97–63, Mar. 31, 1997).

High-Risk Series: Medicare (GAO/HR–97–10, Feb. 1997).

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS–97–23, Oct. 22, 1996).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS–96–16, Mar. 27, 1996).

Medicare Transaction System: Strengthened Management and Sound Development Approach Critical to Success (GAO/T–AIMD–96–12, Nov. 16, 1995).

Medicare: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD–95–135, May 5, 1995).

Chairman THOMAS. Thank you, Dr. Scanlon. Normally, we refer to economics as the dismal science, but your outline of the job of trying to get HCFA to do its job sounds fairly dismal as well, and I hope you're painting a darker picture than is necessary. When the agent from the FBI makes a statement that he believes that Medicare waste, fraud, and abuse is the number one white-collar crime in the United States, I would have to think that $23 billion-and-growing is more than a sufficient incentive to make sure that people are as creative as possible in doing the job. If they can't do it, one of the things I can assure you is that we will provide you with more tools and we will investigate who's doing it and we'll find somebody who will do it, and we've appreciated your work.

Before I go to other questions, I'd like to ask Mr. Mangano to come up front and talk about some of the devices that we have here because perhaps some people are not as fully appreciative of the creativeness that went on in the system, and, unfortunately, may be still more pervasive that we would like.

In dealing with the very thing you talked about, Dr. Scanlon, prior to the prospective payment—and we're quite sure that there will be some creative folk under prospective payment who will continue to try to figure out how to scam the system—Mr. Owens' comment that apparently these crooks are not scam-specific; once they understand that it is high reward and little risk, they move clear across the taxpayer-supported health care and prey on individuals with their own money as well.

So would you please come up, Mr. Mangano?

Mr. MANGANO. Mr. Chairman, if it's OK, I could have my assistant hold some of these items while I talk about it.

Chairman THOMAS. Sure. Just explain to us what it is and how Medicare got billed, and if possible, why maybe there's less the chance of it occurring now than there was prior to the passage of HIPAA or the BBA.

Mr. MANGANO. Great. I'd be happy to do that. I'd like to just give a little bit of the background and just say that most of the time some of these scams come to our attention, they come to us largely in two formats. One, allegations of fraud that come either directly to our office or through the Health Care Financing Administration carriers, or through other sources. The other is through reviews that we do to analyze some of the reimbursements that are coming into Medicare for billing. The first thing I want to talk about——

Chairman THOMAS. Do you think the new hotline and the more specific billing given to the patients themselves will provide you with another resource that was always there but not tapped as adequately as it should be?

Mr. MANGANO. We think that will help. We're working with the AARP to go out and do public education across the country. The Administration on Aging is sending their ombudspersons out to nursing homes as well as the senior centers to get the message out and we're going to be using other forms to get the message out. So, I think the hotline will be a help.

Chairman THOMAS. Well, just let me underscore that as a public agency responsible for getting the information out, I would certainly think the AARP would be a useful group, but they are not exclusive, and I would be concerned that, if there was too close a working relationship there, there might be some assumptions made that weren't warranted.

Mr. MANGANO. Yes, we're also going to other groups in the industry to talk with them about assisting us as well.

Chairman THOMAS. Thank you.

Mr. MANGANO. But the first item I would mention is the orthotic body jacket. You had the poster up this morning and actually the device that the woman was wearing actually was a legitimate device and that was a device that would run about $1,300 in Medicare reimbursement. When we began to look at this, we found that there was a meteoric rise in Medicare reimbursements over 3 years. It went up 8,200 percent. The first year Medicare reimburse-

ments were $217,000; it went up to $18 million in 3 years. That's what caused us to take a look at it. What we found is that 95 percent of the cases that we reviewed were fraudulent. They were billing for things that we're not covered. That $1,300——

Chairman THOMAS. Would you repeat that?

Mr. MANGANO. Sure. We found that in our sample, 95 percent of the claims were for fraudulent items. They were nonreimbursable items.

Chairman THOMAS. So, if you denied 100 percent of the claims, you'd only have a 5-percent error rate?

Mr. MANGANO. That's correct. Yes.

Chairman THOMAS. Do you ever think about approaching it that way?

Mr. MANGANO. Yes, that's true, that's true. Well, for this device it was. Instead of that $1,300 device which was billed, the providers were supplying any one of these three items on display or other devices like it. Two of them look like wheelchair pads and another one looks like a bib, to be honest with you. None of those items at the time we first started this would have cost more than $50. The good news is that the Medicare Program got onto this very quickly and actually right now the reimbursements have dropped from $18 million to about $5 million. We still have more work to do, and we're working on it.

The second issue is a glucose monitor which most people know a diabetic would use to monitor their blood sugar. When we first took a look at this, the Medicare fee schedule was allowing $114 to $211 for these. We sent our investigators into pharmacies across the country and found out we could buy them for about $50. A number of them even had rebates that would drive the price down further. The Medicare Program jumped on this, and the only method they had at that time was to change the rules for the fee schedule, and they did change it. It took about 2 years and reduced the Medicare reimbursement rate to $58.

Chairman THOMAS. Mr. Mangano, on that point, because you do have some products that are being identified by name, this in no way is to imply that any of these products are not capable of performing the service that their indicated, except perhaps for the bib and it may have some use, but it was the misbilling that is the problem, and the overbilling. So, I don't want anyone to assume that these products are not capable of doing what they claim to do. It is the billing process and the amount that's being paid for them that is of primary concern.

Mr. MANGANO. Absolutely correct. Any one of these devices could be useful. The rulemaking occurred and it was——

Chairman THOMAS. For something.

Mr. MANGANO. Yes. The rulemaking changed it to a $58 reimbursement, and we think that will help a great deal. The Balanced Budget Act does give the Secretary authority now to reduce things that are inherently unreasonable. So, that authority could be used in the future to reduce some of these costs.

The third item was incontinence supplies. This is another one of these meteoric rises in reimbursements for Medicare. It almost tripled in 4 years, up to $230 million. So, that captured our interest, and we wanted to go out and find out what was going on. These

are devices for persons who have bladder or bowel control problems. This was the scam of all scams. Durable medical equipment suppliers would go largely to nursing homes and tell the nursing homeowners, we can take care of your patients' incontinence problems, and by the way, it isn't going to cost you anything, because we're going to bill Medicare directly. So, one of the schemes that they were doing was to bill for covered items not provided. They were supplying the adult diapers at about 35 cents a diaper and billing Medicare for what was called a female urinary collection pouch which costs about $7.38; so you can see the profit margin here was enormous.

A diaper is never reimbursable in the Medicare Program. Medicare got their durable medical equipment regional carriers, working on this, and in 1 year, reduced the incontinence reimbursement by $100 million. It's absolutely fascinating.

Let me mention one other thing, a lymphedema pump. This is for persons who have lymph nodes removed, and their arms and legs are swelling. In some cases, a lymphedema pump will help a great deal. I will give you some examples:

In 1990, Medicare was reimbursing $6.3 million for these; by 1995 it was up to $118 million. What we found were two schemes. One, these pumps were being supplied when people really didn't need them, but even more important than that, lower-level $500 to $600 pumps were being supplied to the persons, but they were billing Medicare for $4,600—a tremendous scam. Since then, Medicare has taken care of that. The reimbursements in 1996 were under $20 million.

I think the Balanced Budget Act helps a great deal with nursing homes, because now we have this consolidated billing. The durable medical equipment companies can't come in and individually work with patients and bill Medicare directly.

Chairman THOMAS. Any other comments?

Mr. MANGANO. There are other items up there—a TENS unit, that is, a transcutaneous nerve stimulator. This is a nonnarcotic, pain-relieving device. Once again, it has good reliability for certain people. Medicare required beneficiaries, though, to try it out for a trial period to see if it works, and then if it does, they would then purchase the item. Medicare was getting billed $450 for this. With our investigators going to Radio Shack, we were able to put together another one that resembled that for about $50. One-third of the people that we looked at in our sample did not have that trial period, so we thought there was a gross number of TENS units being sold inappropriately.

There are some other items there—wound care kits that were being provided to patients in their homes. There we found about two-thirds of the reimbursements were inappropriate. For example, Medicare was billed $5,800 for 1 inch tape over 6 months for one patient. This tape, if you put it end to end, would have stretched 12.5 miles. Clearly, it was a fraudulent example of the way they wanted to do business.

Chairman THOMAS. Might have been an appropriate bill for an NFL football team.

Mr. MANGANO. Maybe, for the whole team.

Chairman THOMAS. Certainly, not a single individual at home. Well, and, of course, the problem is that the old system simply invited this, but the one statistic that I find just absolutely incredible is 95 percent false billing—just amazing.

Mr. Owens indicated that the number of cases that they're going to initiate probably is going to drop because they're getting into more complex cases. My assumption is that the more complex cases perhaps would bring larger dollar amounts if they're more sophisticated, but it just seems to me that there's a whole lot of stuff that can be done that's normally under the heading of common sense and ordinary followup that could save enormous amounts of money as well. With $23 billion at stake, there are a whole lot of ways to get at it.

What we did do is provide you, as you indicated, with a more stable funding source, which means if you're going to have a piece of that $5-plus billion between now and 2003, it might lend itself to more long-range planning. Could you just give us a flavor over where you think you might be looking in going over the next 2 to 5 years?

Mr. MANGANO. Well, you're absolutely right. This reliable funding source helps us a great deal. The health care industry itself is one that is going to occupy our time for a considerable number of years. We've been working together with the Health Care Financing Administration and the FBI to plan a number of investigations, audits and evaluations. We're doing more work this year in the hospital arena; we think there are a number of areas that need to be paid attention to there.

Prior to about a year ago, the work that we were doing in hospitals had pretty much languished for a number of years and we're getting back into that area and quite heavily. We're going to be doing much more work in the managed care area as well, and physician services. So those will be the three areas I'd say were most involved.

Chairman THOMAS. Thank you very much.

Ms. Ruiz, you mentioned Operation Restore Trust. I'd indicated earlier before we recessed on the votes that I'm hopeful we can initiate "Operation Find and Bust" of criminals who have been convicted but we aren't willing to go get them. I was looking at the flowchart and I do note that you are director of the program integrity group, but according to the HCFA chart, the program integrity group is under the Chief Finance Office, Office of Financial Management. Wouldn't you, if you were doing your job, and you discovered a number of these items as an integrity program, partially reflect on the performance of your chief financial officer and the department of financial management? I found oftentimes when people are out looking for problems, if they have a degree of independence to report to the actual head of the operation, for example, the administrator, that you sometimes get better results. This is a difficult question and so I don't want to put it on any kind of a personal basis, but do you think that now we've given you some new tools, that perhaps a degree of independence in some agencies might produce better results than the current structure?

Ms. RUIZ. I think we actually have provided for that under the reorganization. What doesn't show up on that flowchart is a dotted

line between my position and the Administrator of HCFA. I have the ability, and regularly exercise it, to talk directly with the Administrator and make known the problems that are identified and the issues that are going on. For a person in my position, it presents a challenge because there are a lot of people to keep in the loop in terms of communication. However, at the moment, it seems to be working.

Chairman THOMAS. I prefer solid lines to dotted lines. In the legislation that we passed, Congress asked for, by October 1, an estimate from the Secretary of expected Medicare outlays for fiscal years 1998 through 2002 in terms of the home health services and of course the administration has suspended the creation of new home health care agencies. When are we going to get the work product?

Ms. RUIZ. Yes, sir. I was just made aware this morning that this report has not yet arrived on your desk. It's my understanding that it has been prepared and we're in the stages of finalizing it. We expect to get it to you very shortly.

Chairman THOMAS. Dr. Scanlon outlined his concerns about HCFA's ability to perform. Given all the responsibility that you've been given, I'm disappointed to find out that some of the earlier hurdles that were placed in front of you for information that will allow us to make some at least monitoring, if not decisions, haven't been met. So, I hope we can take a look at what we asked for and that you set up some timeliness that allow us to get what we asked for——

Ms. RUIZ. Yes, sir.

Chairman THOMAS [continuing]. In the timeframe that we asked for it.

Let me stop there and turn to the gentleman from Louisiana if he has any—

Mr. MCCRERY. Thank you, Mr. Chairman.

Let me begin by saying how much I appreciate Mr. Mangano bringing to us today the hammers and toilet seats of HCFA. I hope the media will spend as much time highlighting the abuses of Medicare spending as they did Defense spending, and I hope the public is as outraged as I am, and you are, at the abuses that have taken place in this program.

Mr. Owens, in your testimony, you state that the following health care industries are particularly susceptible to fraud and we've seen examples of some of this today: Laboratory billings, home health care, and durable medical equipment, prosthetics, orthotics, and supplies. How will the reforms addressing waste, fraud, and abuse included in both the HIPAA and the Balanced Budget Act, enhance the FBI's ability to combat the most egregious health care fraud in these particular industries?

Mr. OWENS. I think in two ways, Congressman. One, certainly the additional funding that was provided has enabled us to add a lot more agents on the street investigating these types of crimes, and as I indicated, we're attempting to go into the higher levels now and address the more egregious type of frauds. The other certainly is the new statutes that were provided to us to give us a particular health care statute which we can begin to employ, and I

think that's going to be helpful to us. So, we should be able to benefit tremendously from that.

Mr. MCCRERY. Good. I understand that the FBI and the OIG worked well together on the Gonzalez case and that this kind of collaboration is not uncommon. Can you elaborate, Mr. Owens, on the extent to which the FBI coordinates their investigations with other agencies, such as the OIG and HCFA, to ensure consistent interpretation of the law?

Mr. OWENS. Yes, at the headquarters level, we actually have an exchange program where we have a supervisory special agent from the FBI detailed to the Inspector General's Office, and conversely, they have one of their Deputy Assistant Inspector Generals detailed to the FBI, so that we can coordinate virtually any issue that arises. Throughout our field offices, there's a tremendously good working relationship. I'm not sure of the numbers, but I want to say, something like 41 of our 56 field offices, we have either task forces or working groups established that include Inspector General representation, as well as U.S. Attorney's Office representatives, and in many instances, local investigators, people from Medicaid fraud control units, and so forth. This is a highly complex area and again, as we particularly get into the complex activities that are occurring, so we are committed to this type of a cooperative effort and we think it's essential.

Mr. MCCRERY. Do you have any thoughts or suggestions on how coordination could be improved among the various agencies? Anything that we can do to help you with that?

Mr. OWENS. I think it's very good we're doing joint training now. For instance, we do rely on the expertise, the technical expertise, even of the HCFA representatives as well as people from HHS. We constantly look at that sort of thing and certainly we have the type of relationship, if new things develop, that we think can improve our efforts we attempt to work on it, and I think it's very good.

Mr. MCCRERY. Dr. Scanlon, your agency's been making recommendations to the Congress for quite some time on fraud and abuse in the Medicare system; is that right?

Mr. SCANLON. That's correct.

Mr. MCCRERY. Were a lot of the recommendations that you've been making over the years finally included in the HIPAA legislation and in the Balanced Budget Act?

Mr. SCANLON. They definitely were. The vast bulk of the recommendations that we've made are reflected in one part or another of either act. In addition, the Congress went somewhat further in terms of recommendations that we had made over the years to HCFA and to the department in terms of including them in the act, as well as certain of the act's unique provisions indicating both the priority and importance that you attach to using those tools and those mechanisms to attack fraud and abuse.

Mr. MCCRERY. Were there any major areas of your recommendations that were not addressed in the legislation that we could look at?

Mr. SCANLON. The recommendations that were either in the IG's Red Book of open recommendations or our open recommendation report that were not addressed directly involved Medicare as a secondary payor program, both reports on the effectiveness of those

programs as well as the use of the State Medicaid Programs actions to try to recover funds from other third-party payors, and then another recommendation related to home health care. But relative to the recommendations we've been making, these are very small compared to sort of what you've accomplished. But we think, though, that what you've done is laid out a clear path that you would like for HCFA and the Medicare Program to follow to eliminate waste, fraud, and abuse, but the agency may need your assistance in the future as we discover sort of how well we can navigate that path to try to accomplish that task.

Mr. MCCRERY [presiding]. Thank you, Dr. Scanlon.

Mr. Ensign.

Mr. ENSIGN. Thank you. I would like—I only have a couple minutes before we adjourn—one quick question and that is for Mr. Owens and Dr. Scanlon. That is, Medicaid and Medicare, two separate programs, but yet Federal dollars going to both of them. The example is on ambulances and there are abuses that happen and fraud that happens in Medicare with ambulances and the one thing that happens on Medicaid, from what I understand, is with ambulance transports a lot of Medicaid patients, a tremendous percentage at least what have been told to me anecdotal in my State, a lot of ambulance rides are taken to the hospital by Medicaid patients to get these prescriptions filled; that it's cheaper than a cab ride and Medicaid patients get, I think, three hospital rides a year, or whatever, and many of them take advantage of these hospital rides. You can talk to people just generally in the emergency rooms, the people who work there, and everyone that I've ever talked to confirms that the same thing happens. I've talked to ambulance drivers; I've talked to emergency room people, and they've confirmed this.

FBI, GAO, do you get into the combination of Medicare/Medicaid abuses together, because it's not just happening in one of the systems?

Mr. OWENS. I think from my perspective in the past that we worked several of the ambulance cases, and I can't give you specific details on that, but throughout the programs what we've seen is providers, or service providers or medical providers, when they're defrauding one program, they're defrauding others, even private insurance companies. So my suspicion is that those ambulance service are doing that sort of thing, but I could certainly check and get back to you if you'd like.

Mr. ENSIGN. OK, please.

[The following was subsequently received:]

Reply from Mr. Owens.

It is the rule rather than the exception that those engaged in committing health care fraud do not discriminate against any particular health care plan. Most FBI investigations have multiple health care plans, such as Medicare and Medicaid, as victims of the fraud scheme.

In the area of medical transportation fraud the schemes include billing for a higher reimbursement code, such as advanced life support vs. basic life support, inflated mileage, billing round-trip vs. one way, paying kickbacks for patient referrals, billing for supplies not used and billing for trips not made or for trips which were not medically necessary. Medicare will only cover medically necessary ambulance transportation from the residence to a hospital or skilled nursing facility when the use of other methods of transportation would endanger the patient's health. Medicaid

will reimburse for a variety of reasons for transportation by taxi or other means of conveyance.

ABC World News Tonight aired a segment on 3/6/95 regarding ambulance fraud in the San Diego, CA area. (Tape available upon request) The targeted ambulance company was defrauding all insurance carriers, including Medicare, Medicaid and the private insurance companies.

The Medicare reimbursement system is very complex which only encourages fraud and abuse. The Medicaid reimbursement systems very with each state. In most instances, when an ambulance company is defrauding one, they are defrauding both. In those instances the FBI has been known to work jointly with the State Medicaid Fraud Control Units. With the new Health Insurance Portability and Accountability Act (HIPAA) regulations regarding coordination of Federal, State and local law enforcement programs to combat fraud and abuse, working together is becoming even more common.

Reply from Mr. Scanlon.

We have not done any recent work regarding that.

Mr. SCANLON. We're also very concerned about the fraud and abuse that occurs within the Medicaid Program as well as Medicare and are looking into especially the issues of dual eligibles. We haven't looked specifically at the question of ambulance services, but to the extent that Medicaid is operating fee-for-service programs within each State, similar to Medicare, it faces some of the same difficulties. We're talking about large populations of beneficiaries and large numbers of providers who can bill directly, and as a result, have many opportunities to take advantage of it.

Mr. ENSIGN. This today may have been more focused on the providers, but we also have to look at the beneficiaries sometimes. Sometimes somebody is taking advantage of something that they can do under the system that's given to them, and that should not be allowed. So, I think we have to look for every way that we can cut out, and that's why I always like to call it waste, fraud, and abuse of the system because they all go together, and sometimes it's fraud, sometimes it's just abuse, or sometimes it's just waste from a bureaucracy.

I just want to thank all of you, and give that some thought when you're looking into these type programs.

Mr. MCCRERY. Thank you all very much for your testimony.

[The following was subsequently received:]

The following questions were submitted to the four Government witnesses by Rep. Pete Stark.

The HHS OIG has responded in writing to the first 12 questions. The remaining questions were sent too late for the OIG to respond.

The other agencies will respond in writing for the Record on all those questions in their jurisdiction.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

The Honorable Fortney Pete Stark
House of Representatives
Washington, D.C. 20515

Dear Mr. Stark:

I am writing in response to your letter dated September 22, 1997 in which you asked for written responses to a number of questions prior to my upcoming appearance before the Ways and Means Health Subcommittee. Enclosed are responses to your questions. I hope that they adequately address your concerns.

I look forward to discussing these and other issues with you at the October 9th hearing. If you have any questions prior to the hearing, please do not hesitate to call me.

Sincerely,

Michael Mangano

Michael F. Mangano
Principal Deputy Inspector General

Enclosure

QUESTIONS AND ANSWERS

1. Provider-funded audits of compliance.

Question

I have introduced legislation to require institutional providers to fund both a compliance and financial audit. This is similar to the OIG's settlement with several teaching hospitals, and a growing number of providers are reportedly undertaking these audits on their own.

Given the budget constraints on Federal agency audits, would you support this type of legislation?

Answer

There are both advantages and disadvantages to this approach. One the one hand, there are precedents for this type of requirement. Most hospitals have independent auditors review their financial statements and Head Start grantees are required to perform self-audits. We recently recommended that Rural Health Clinics be required to provide certified financial statements and this type of requirement is a possibility for all institutional providers.

On the other hand, I would suggest that we need to be sensitive to imposing undue burdens (including costs) on providers that participate in Medicare. Further, there is a great difference in the amount of resources required to conduct a compliance audit rather than a review of a financial statement.

HCFA's budget for audits includes substantial funds for its provider audit function to perform audits of hospital cost reports. To the extent that hospitals could have cost report audits performed at a reasonable fee, these independent audits could replace part of HCFA's budgeted dollars for the provider audit function. This could be accomplished by extending the engagement of a CPA firm's audit of hospital financial statements to also cover certification of the cost report.

2. Abuse of Hospital Outpatient Department designation.

Question

Increasingly, hospitals are buying physician practices off the campus of the hospital and designating them as HOPDs. This process allows the hospital to load overhead costs onto the doctor practices, thus increasing costs to Medicare; it allows the doctors to charge much more than the Medicare fee schedule, thus increasing costs to beneficiaries.

I have introduced legislation to require that future HOPDs be limited to the campus of the hospital with which they are affiliated. Would you support this type of legislation?

Answer

We are very concerned about possible adverse affects resulting from hospital purchases of physician practices.

One issue is the potential increased costs to Medicare and beneficiaries from designating physician offices as provider based. We are specifically addressing this issue in a review. We are also currently conducting a study which will look at how HCFA designates physician offices as "provider based." These two projects are just starting and two additional projects related to utilization and quality are planned.

It is our understanding that HCFA currently requires physician offices to be in "close proximity" to the hospital in order to be designated as a hospital outpatient department. The problem is that there are not consistent definitions of "close proximity." We have heard that some fiscal intermediaries interpret this to mean that the physician office can be located 80 miles away.

It is true that the definition can be narrowed to include only physician offices located on the "campus" or some other term. However, we really haven't looked closely enough at this issue to determine if such a restriction may have implications for reimbursement, quality oversight, access in medically underserved areas, etc. We hope to address these issues in our ongoing work and then be able to make some recommendations which will improve the situation.

3. Partial hospitalization.

Question

There are reports of serious abuse of the Medicare partial hospitalization mental health benefit, particularly in Florida. Several of us have introduced legislation to require quality standards in these programs, a review of all new and existing programs, and a prospective payment system for this benefit. Would you support this type of legislation?

Answer

We have done some work which indicates that there are abusive practices occurring with this benefit.

While we have not made specific recommendations in this area or reviewed the legislation you mentioned, we would support corrective action along the lines that you outlined. Additionally, the President's most recent anti-fraud and abuse bill contained proposals to prohibit payment for services provided in the patient's home; to require that not all services of

a community health center be covered by Medicare; establish standards; and to switch to a prospective payment system.

4. Discharge Abuse.

Question

The Balanced Budget Act proposes some reform of the hospital discharge-to-downstream-facilities problem, but the reform is limited to 10 DRGs over the next several years. The Administration's initial proposal was a total reform. The hospital industry has indicated it will seek to repeal even the limited, 10-DRG reform. The OIG has a draft report which indicates that

> "Some hospitals which own nursing homes discharge patients sooner to their own facilities and those patients stay in the facilities longer, increasing Medicare reimbursement. We found significantly shorter hospital stays combined with longer nursing home stays for patients who went to the hospital-owned nursing home."
>
> On hospital referrals to home health agencies, "beneficiaries that received services from the hospital home health agency did get services for a longer period of time."

Do you oppose weakening the 10 DRG reform included in the Balanced Budget Act? Do you support expanding the reform to included more DRGs?

Answer

We believe that the 10 DRG reform pertaining to post hospital home health and skilled nursing facility use which is included in the Balanced Budget Act is a good start and should be implemented as written.

In a follow-up to our work on discharge planning, we are currently planning on looking at hospital ownership and discharge issues related to home health agencies and specific DRGs.

We intend to continue to follow this issue and, in the future, we may have to revisit it to see if any additional program modifications have to be made.

5. Overpayment of HMOs.

Question

There are press reports that the week after he retired, Dr. Vladeck said that HCFA had received 4 bids in the now-aborted Denver demonstration project, in which the plans maintained their current level of extra benefits, but offered to cut reimbursement 10 to 12? Is that correct?

On August 18, the GAO reported that HMOs substantially avoid the chronically ill. These two reports indicate that we are easily overpaying HMOs about $2 billion a year. I have introduced legislation to speed up the date that we begin to risk adjust these plans, so as to avoid overpaying them for their enrollment of largely healthier individuals.

Would you support this type of legislation?

Answer

We share your concern that Medicare may be overpaying HMOs for the treatment of Medicare beneficiaries.

Our work related to profit margins of Medicaid managed care plans is consistent with the GAO work you cited.

I do not have any knowledge about when it is going to be administratively feasible for HCFA to implement risk adjustment changes. I am also unsure whether Dr. Vladeck was quoted correctly.

6. Excessive Medicare payment for drugs; inaccuracy of the average wholesale price system.

Question

The Administration had proposed reimbursing Medicare drugs on the basis of acquisition cost. The Congress in the Balanced Budget Act changed the provision to reimbursement of the Average Wholesale Price minus 5%. Is that likely to be as effective in saving money as the Administration's original proposal?

Is it accurate to say that providers are often able to actually acquire drugs for prices far below the AWP? I have re-introduced the Administration acquisition price proposal. I assume you continue to support that approach?

The OIG reported in a letter of July 11, 1996, fourteen months ago, about drug overpayment. The Justice Department has been looking at some of the reasons for the inaccuracy of the AWP figures. What is the status of these reviews and when will the savings described in the OIG letter (attached) be achieved?

Answer

We continue to be concerned about excessive payments for Medicare prescription drugs. We believe that the problem with using the average wholesale price (AWP) is that it does not actually reflect the price at which the product can be purchased. The Balanced Budget Act approach still relies on the AWP, discounting it by only 5 percent. We are concerned that the

5 percent reduction can be easily gamed by the manufacturers by just raising the published AWP by 5 percent.

Our ongoing work indicates that the published AWPs that are currently being used by Medicare-contracted carriers to determine reimbursement bear little or no resemblance to actual wholesale prices that are available to the physicians and suppliers that bill for these drugs. For example, we found that Medicare would have saved about $440 million (of $1.5 billion) in 1996 by basing reimbursement on actual wholesale prices for 22 drugs with large Medicare expenditures.

We also found a differential of 18.3 percent between acquisition costs and AWP for Medicaid covered drugs. For just the top 100 brand name drugs with the greatest amount of Medicaid reimbursement in 1994, savings could have totaled as much as $225 million through the use of this higher discount.

Thus, while the 5 percent reduction is a good start, we believe that the resulting payment levels will still be too high.

We understand the Department of Justice work in this area is continuing.

7. Excessive payments for generic drugs.

Question

For several years, I've been writing the OIG and HCFA about excessive payments for generic drugs, and about a HCFA regulation that allows generic drugs which come on the market at a higher price than the brand name drug to drive up the average Medicare payment for drugs (Letters attached). When will this abuse be stopped?

Answer

Our work to date involving prescription drugs has found examples of where the average wholesale price for generic drugs were considerably higher than the brand name drug. Since Medicare reimbursement is based on the median average wholesale price of generic products and the Medicaid program usually pays a percent of the average wholesale price this has caused both the Medicare and Medicaid program expenditures for these drugs to be higher than they should be. In addition, the problem is compounded in the Medicaid program when the rebate is taken into account. In most cases the rebate for the brand is higher than the generic. This causes the net cost to the Medicaid program to be even more for generic, with a higher average wholesale price, than the brand.

We are currently looking into concerns about specific brand and generic drugs that were raised by you. We hope to report back this month with the results of our work.

8. Parenteral nutrition therapy.

Question

The OIG has found that parenteral nutrition therapy is often performed on kidney disease (ESRD) patients who do not need it, and that payments for this therapy can be excessive.

What are you doing to stop abuses in ESRD usage of this therapy and in developing a fair price for the purchase of PEN and for the services necessary for the administration of these nutrients?

Answer

We reported in 1993 that 43 percent of Medicare expenditures for total parenteral nutrition was improperly paid in 1991. As you stated, most of these improper payments were made to ESRD patients.

In response to our report, the Durable Medical Equipment Regional Carriers developed guidelines that went into effect July 1, 1996. These guidelines stipulated that providers must clearly prove that ESRD beneficiaries receiving parenteral nutrition suffer from a permanently impaired gastrointestinal tract. While we believe that this corrective action is sufficient, we have not conducted any follow-up work in this area.

Our recent work on the pricing of parental nutrition therapy found that Medicare's reimbursement was higher than Medicaid agencies and lower paying Medicare risk contracted HMOs. Additionally, we found that Medicare reimbursement for some parental nutrition codes were between 9 and 12 times higher than the contracted price charged by three manufacturers to low volume supplier of parental nutrition.

While the Balanced Budget Act made some pricing reductions in this area, we believe that Medicare payments will continue to be excessive. We have recommended a number of options to properly price parental nutrition. The options include using inherent reasonableness principles, acquisition cost, and competitive bidding.

9. EPO.

Question

I understand that there is a draft OIG report indicating that we are overpaying ESRD facilities by at least $[redacted] per 1000 units of the drug EPO used in dialysis centers.

What is the status of this report and will HCFA make the price adjustment to save Medicare at least $100 million per year?

Answer

As you know, EPOGEN is an important compound for dialysis patients.

Our work regarding EPOGEN reimbursement is underway. We anticipate receiving HCFA's formal comments shortly, and we will issue the report very quickly after receiving their formal comments. However, we have had informal indications that HCFA will act upon our recommendation to reduce the Medicare reimbursement rate by $1 per 1000 units.

If implemented, the reduction will save $88 million for the program and another $24 million for ESRD beneficiaries.

10. Home Health Agency Overpayments.

Question

The President has just announced that the Government will be doubling its audit of home health agencies. Will the adjustments made by those audits be used in calculating the PPS system for home health agencies, so that we do not build into that system inflated and abusive costs?

Answer

We believe that the legislative language in the Balanced Budget Act directs HCFA to base payments on the "most current" audited cost report.

Because of the time needed to schedule and conduct audits it can take 2 or more years to reach final settlement, PPS payments may not reflect the full effect of the increase in audits.

Therefore, we will look closely at the results of these audits and determine whether additional recommendations to Congress for price reductions are appropriate.

11. Abuse by For-Profit Home Health Agencies.

Question

Studies by the GAO and others have repeatedly found that for-profit home health agencies are making almost twice as many visits as not-for-profits make to patients with similar illnesses. No one is able to explain this difference, other than as an example of fraud and abuse (See GAO letter to Stark, June 2, 1997 (B-277090)).

One way to hold down home health agency costs is to hold the interim payment limits for newly-established HHAs (which tend to have built in higher costs and to be among the more

abusive agencies) to a national median rather than regional medians. The balanced Budget Act permits you to interpret the median limits as national limits. Will you?

Would you support modifying the Balanced Budget Act's home health language to require a 50% national/50% regional median blend (instead of 75% regional)?

Answer

The Balanced Budget Act contains a number of provisions to constrain home health costs and utilization. For example, for cost reports filed on or after October 1, 1997, the cost per visit is limited to105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies. The Act does not specify whether these rates are national or any blend of regional and national. While it is HCFA's responsibility to implement this provision, we support national limits whenever possible and believe that only legitimate local variations should be allowed.

Another provision in the Act attempts to deal with excessive utilization by placing limits on the cost per beneficiary. This provision calls for a 75 percent blended agency specific rate blended with 25 percent of the national limit you mentioned. As in the case of per visit cost limits, we support using the lower of national, regional and agency specific limits for per beneficiary cost limits.

12. Self-referral.

Question

We have been hearing that manufacturers are perhaps paying physicians for referrals to their products. One example involves two similar prostate cancer drugs. One of the competing companies allegedly pays physicians $150 per patient referral which angers hospitals that want to use the cheaper drug.

I have heard similar stories involving complaints with certain medical devices.

Would you support greater protections in this area?

Answer

The example you cited appears to be unlawful under current law as it violates the Federal anti-kickback statute. If you hear of particular instances such as this, please encourage people to make referrals to our Office of Investigation.

Hospitals shifting costs to ancillary facilities:

I have introduced legislation to require that Hospital Outpatient Departments actually be on the campus of the hospital facility. Since that legislation was introduced, I received the attached memo from a Southern medical college which was approached by "entrepreneurs developing assisted living facilities and seeking to incorporate Senior Health Centers with local hospitals...to maximize cost based reimbursement."

It appears to me that the idea of affiliating every imaginable kind of care center with hospitals and letting everyone shift costs is spreading rapidly. Do you need legislation to close this "off campus" loophole, or can you act administratively?

University Medical Center

..or Practice Management

September 11, 1997

TO: Don Young MD - Executive Director,
Prospective Payment Assessment Commission

FROM:

Recently, I met with a company initiating the development of Senior Health Centers. These new entrepreneurs are developing assisted living facilities and are seeking to incorporate Senior Health Centers with local hospitals using the guidelines developed by HCFA to maximize cost based reimbursement.

Our discussion involved the establishment of centers within 10 miles of a hospital where the developers will have joint venture relationships in which they would share in the ownership of the center and be responsible for their management. The management focus includes how to structure the centers and maximize the hospital based Medicare cost report. In essence due to the perceived requirements (10 miles from a hospital) of Medicare, these centers are generally not being developed physically within assisted living facilities. Presentations by these groups of developers indicate the center's focus is to provide a broad spectrum of services such as chronic disease management, patient education, case management and preventative services. In some cases, M.D.'s; office's/clinics will be converted for this purpose.

Setting Standards for Entry:

Anyone can get a provider number to provide home health, medical equipment, oxygen, nutrition therapy, etc. A number of people in the equipment and home health trade associations have talked about setting standards for those able to enter the field and get a provider number. There is always the danger of anti-competitive practices in setting entry standards too high, but given the problems in these sectors, why not set entry standards that have to be met before a provider number is given? Surety bonds will address some of this problem, but additional standards would weed out the non-professionals and the fly-by-nights. [See for example, the Supplier Standards Consensus Conference: Recommendations for Standards for Medicare Part B Suppliers, developed 12/16/96 and sponsored by HIDA or the Certified Home Care Executive developed by the National Association for Home Care.]

Overpayment of Managed Care:

HMOs are paid 95% of the average of Medicare costs in a region. Yet we have determined that fraud, waste, and abuse in traditional Medicare is somewhere between 10 and 14%. Therefore, on its face, are we not overpaying HMOs? If they are really managing their providers and avoiding fraud, waste, and abuse, we should be able to pay them between 86% and 90% of average Medicare costs in a region, no?

To OIG:

Excessive Executive Compensation Allocation:

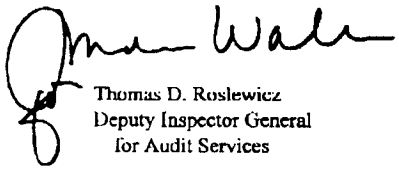
Earlier this year, I asked you to audit a large rehab hospital chain to see if they were assigning extraordinary CEO compensation and other overhead costs to Medicare. Because of resource limitations, you turned the request over to the local BCBS. They did, I understand a limited audit and during the course of it, the company voluntarily reduced its corporate aircraft charges by $903,655. But in general, BCBS did not detect problems. Are you satisfied that the local intermediaries and carriers have a good definition of what is reasonable overhead to allocate to Medicare, and will you be doing more work in this area?

Portion of a response to Stark's question from the HHS OIG

Future Office of Inspector General Work

We have concerns with the lack of reasonableness standards for determining an adequate level of executive compensation and are always looking at appropriate charges in overhead accounts. In 1993 we issued a report on executive compensation and general and administrative costs and hope to do a follow-up in Fiscal Year 1998, resources permitting. We plan to focus attention on determining what could be used as a reasonableness standard.

Sincerely,



Thomas D. Roslewicz
Deputy Inspector General
for Audit Services

Enclosures

Tripscript/Medicare Medication Evaluation Dispensing Information System:

I've introduced legislation, HR 1201, to provide for a computerized system of checking prescriptions for Medicare patients to improve health by preventing contra-indicated drugs and over-dosing, and to prevent fraud and abuse by detecting unusual patterns of prescription. This is a computerized version of the old tripscript proposals used by a number of States and Medicaid agencies and which have been very successful in improving health and cutting fraud.

Would you be supportive of this type of legislation?

HCFA: Surety Bonds and Home Health Moratorium:

The BBA calls for $50,000 surety bonds to weed out bad apples from the home health and other fields. The Administration then announced a moratorium for 6 months-- until about next March-- on new home health agencies while HCFA develops new guidelines. Some Home Health Agencies are reporting difficulties in getting surety bonds for January 1, because the bondsmen don't know what the new standards will be. You need to address the uncertainty of the standards immediately or delay the bond date. What is the status of coordinating these two dates?

In a related area, the BBA in section 4312 says that the "Secretary may waive the requirement of a [surety] bond in the case of a supplier that provides a comparable surety bond under State law." How is HCFA going to implement this section? Will you waive in the cases where there is a comparable State law?

Hemophilia clotting factor:

I have received reports that hemophilia clotting factor that is being sold at a discount under the Public Health Service Act to various providers is being resold to patients at a very high mark-up. Have you heard such reports, and if so, what should be done about it?

List of Pending Anti-fraud, waste and abuse bills submitted by Rep. Pete Stark

HR 443, Medicare Non-Profit Hospital Protection Act, introduced January 9, 1997 (Congressional Record E83) requires hospital conversions are carried out in the sunshine of public information and debate, that the conversion price is fair, and that there are no sweetheart deals.

HR 800, Accreditation Accountability Act, introduced Feb. 13, 1997, (Congressional Record E250), requires all Medicare accrediting organizations to hold public meetings and to ensure that at a least a third of the governing board consists of members of the public.

HR 1201, Medicare Medication Evaluation and Dispensing Information System, introduced March 20, 1997, designed to prevent fraud and abuse and poor quality in prescription dispensing.

HR 1769, Reduction in Medicare Overpayment Costs, introduced June 3, 1997, identical to Sen. McCain legislation to recoup funds with interest from providers who consistently overbill.

HR 2466, Bankruptcy Reform provisions, requested by Administration (Congressional Record of September 11, 1997, E1739).

HR 2482, Speed risk adjustment requirement by 1 year, from 2000 to 1999 in view of GAO reports on serious adverse selection against traditional Medicare (Congressional Record of September 16, E1766).

HR 2543, Medicare & Medicaid Provider Review Act of 1997, requires various institutional providers to pay for comprehensive compliance audits (Congressional Record September 24, E1845).

HR 2558, Medicare Hospital Outpatient Payment Fairness Act, would end higher payments for services in HOPDs and apply the RB-RVS fee schedule to services in an HOPD and require the Secretary to ensure that hospital costs for ER services are fully covered.

Mr. McCrery. The hearing's adjourned.

[Whereupon, at 12:41 p.m., the hearing adjourned subject to the call of the Chair.]

[Submissions for the record follow:]

Statement of Douglas R. Wilwerding, Chief Operating Officer, Accent Insurance Recovery Solutions, Omaha, Nebraska

Mr. Chairman, I want to thank you and the Members of the Committee for the opportunity to testify today.

My name is Doug Wilwerding. I am Chief Operating Officer of Accent Insurance Recovery Solutions headquartered in Omaha, Nebraska. Accent was founded in 1986

as a cost containment recovery firm. Accent recovers overpaid insurance claims on behalf of healthcare payors and administrators of healthcare insurance.

First, I would like to praise this Committee for addressing the issues of waste, fraud and abuse in the Medicare program. Today, I will specifically address overpayments and the lethal condition in which it is placing the healthcare program for our senior citizens. Medicare overpayments represent a diversion of resources that are badly needed by aging beneficiaries who require quality care; they also lead to higher taxes and increased insurance premiums.

"$23 Billion Overpaid By Medicare" read the headline of virtually every newspaper in the country earlier this summer as the Inspector General of HHS announced that the "records of the Medicare agency and its contractors were in such disarray that they could not be thoroughly audited." The $23 billion is only for Fiscal Year 1996 and does not account for the additional billions unrecovered going back to the boundary of the federal statute of limitations. Nor will the figure stay at the same level going forward as demographics inexorably increase the load on Medicare.

HCFA officials acknowledged that a substantial number of erroneous payments had been made. Contractors have mixed up Medicare's two trust funds; other contractors have confused amounts owed to the federal government with amounts owed by the federal government, and serious coding errors accounted for billions of dollars in overpaid claims. What is more, nearly everyone involved agrees that Medicare documentation requirements are confusing and convoluted.

As "fraud and abuse" become everyday words to those of us in the healthcare indat is estimated as being responsible for a third of the $23 billion overpaid—the waste of unrecovered claims that have been overpaid through error.

Overpayment recovery is no secret to healthcare—nor is it a newfound concept. It is an entire industry. Commercial healthcare payors have been either utilizing internal recovery units or contractors like my company, Accent, to recover their overpaid claims for years.

The overpayment recovery industry is capable of returning between 50 and 85 cents on the dollar. Imagine what that would do for increased care for our seniors, as well as tax and premium relief based on an annual overpayment loss of at least $7 billion per year.

What is the difference between private group health claims and Medicare claims? Virtually nothing. In fact, the similarities are startling. The same administrators that are paying Medicare claims are paying the rest of the country's claims. Those same companies are contracting with overpayment recovery vendors like Accent, to recover hundreds of millions of dollars in overpayments to return to the private sector employers. Leaders responsible for health benefits for private groups would never ignore the savings found in overpayment recovery. Neither should Medicare.

HCFA currently provides no incentive for Medicare contractors to recover overpaid claims. Further, the current Medicare system lacks the expert systems, trained personnel and years of nationwide experience to systematically address this problem. Now, safeguards, criminal investigations and audits are being created to attempt to put a dent in fraud. Meanwhile, obvious cost savings are being ignored—those claims being paid in error. They are not fraudulent, just recoverable.

HCFA and Medicare policymakers need to acknowledge and adopt the cost containment techniques used by the private sector. These techniques should not only be investigated, but also administered to assuage the continuing drainage of federal funds because of simple, yet recoverable, errors. We in the health insurance recovery industry stand ready and eager to assist this Committee in accomplishing this task.

Thank you.

AMERICAN COLLEGE FOR
ADVANCEMENT IN MEDICINE
October 10, 1997

For consideration by the Committee and for inclusion in the printed record of the hearing.

As President of a rapidly growing medical society that is dedicated to research and teaching about innovative therapies, I am greatly concerned about the huge burden threatened by current legislation on those physicians who want to provide non-covered services to their patients.

Either to require them not to treat any patients under Medicare or to impose wasteful, useless reporting requirement for services not covered is unacceptable.

We as a country need to encourage innovative approaches to find dramatically improved, cost-effective treatments for chronic degenerative diseases. Otherwise, we will never escape from the medical quagmire that is sucking our health care system into bankruptcy.

Further, the rights to choose the type of medical care one desires and to make contracts should be freedoms that are diligently preserved in our country. Loosing these would be a severe blow to American Society.

Requiring that physicians who provide noncovered services to be excluded from Medicare will stifle innovation and substantially impede medical progress. Such restrictions would be a serious blow to medical freedom and the right to make contracts.

Sincerely,

L. TERRY CHAPPELL, M.D.
President

LTC/jla

Statement by the American Hospital Association

On behalf of the American Hospital Association (AHA) and its 5,000 member hospitals, health care systems, networks and other providers of care, and the patients we serve, we are pleased to submit this statement regarding health care waste, fraud, and abuse. In recent years, and particularly these past several months, the federal government has dramatically stepped up its efforts to crack down on what it calls health care fraud and abuse.

Ridding the health care system of fraudulent operators should be applauded and a high priority for all. But we should not paint as fraud every billing error or misinterpretation of what are often vague and complicated regulations—regulations so ambiguous that they are often misunderstood by Medicare's own bureaucracy. The vast majority of health care services are provided ethically and appropriately. Those who intend to defraud the system are a small segment of the health care community. Our goal is to develop a system which prevents fraud in the first place, separates real fraud from mismanagement or error, and finally imposes penalties to deter those who might consider cheating the system from doing so.

Hospitals and health systems are rooted in a tradition of ethics and caring. We are strongly opposed to fraud and abuse and we support efforts to prosecute those who knowingly and willfully take illegal actions. We deeply regret that the health care industry is tainted by a minority of bad apples. As a result, the people who Americans rely on to provide emergency and often life-saving health care are also being compelled to keep voluminous records that explain, defend and validate their actions. Both hospitals and health care professionals are being forced to divert valuable resources from patient care.

As our institutions face unprecedented scrutiny from all segments of society—government, media, business community, and the public in general—it is vital that we continue to act in ways that strengthen both public confidence and the bonds we have forged with our patients and communities. This is particularly important as hospitals and health systems face challenges of complying with the many conflicting and ambiguous rules governing Medicare, Medicaid, and other federal programs. The challenge is made even more difficult for us when the government characterizes unintentional errors in billing as intentional fraud.

Prevention:

The AHA board recently endorsed voluntary adoption of regulatory compliance programs by hospitals and health systems as a way to minimize errors in conforming to highly technical and complicated rules. The AHA urges all hospitals and health systems to develop and implement a strong, formal compliance program to ensure that regulations are accurately followed.

The Department of Health and Human Services (HHS) Office of Inspector General (OIG) is in the process of developing model compliance plans for the health care field. The AHA submitted a draft hospital model compliance plan for the OIG's consideration last April. The OIG circulated its first draft in July. Hospitals expected to see the OIG issue a final compliance plan this fall. Unfortunately, it appears that

they will not release a revised draft until 1998. Hospitals wanting to establish a compliance plan are anxiously awaiting its release.

Nevertheless, responding to our members' strong desire to adopt compliance plans, the AHA is developing a Health Care Compliance Service. It will be available in early November. This service will help health care organizations develop a system that achieves the best possible compliance with government payment policies. We anticipate that compliance programs will move toward universalizing best practices and help enforcement agencies distinguish between error and true fraud. The law should recognize and provide incentives for institutions to adopt effective compliance plans. Hospitals who take the measures to implement compliance programs should be deemed protected from qui tam (whistle blower) challenges and have damages limited.

However, even the most comprehensive compliance plan will not enable providers to fully comply with the letter of the law, if providers cannot obtain more timely and clear regulations from the Health Care Financing Administration (HCFA) and instructions from government contractors. Further payment system refot against fraud and abuse. The Balanced Budget Act of 1997 mandated the implementation of four new prospective payment systems by 2002. These reforms modify incentives making the system more efficient.

Enforcement:

Congress vastly increased the number of tools enforcers may use to attack health care fraud and funding for investigations and other enforcement activities. In the largest-ever investigation of Medicare and Medicaid billing practices, the HHS has allocated more than $1 billion through 2002 to target every type of provider. The Federal Bureau of Investigation (FBI) has tripled the number of investigators dedicated to health care fraud enforcement since 1992, and the OIG has increased its staff by about 250 in one year's time. Indeed, the OIG and FBI indicated that they have yet to meet their staffing capacity as already funded by Congress. Additionally, these agencies can tap into approximately 55 new enforcement tools and 53 new payment safeguards under the Balanced Budget Act of 1997 and Health Insurance Protection and Affordability Act of 1996 to detect fraud. Before new remedies are considered by Congress, the current arsenal of laws should be tested.

We do agree with some of the witnesses that the laws used to enforce health care fraud and abuse need to be reformed to reflect the current health care market. For example, we believe that the HHS should be required to use a materiality standard—based on American Institute of Certified Public Accountants guidelines—when referring Medicare overpayment cases to the Department of Justice (DOJ) for prosecution.

Many of the settlements arise from claim disputes involving less than one percent of an institution's total claims. In determining whether a pattern of incorrect claims submission exists, or if the hospital intended to defraud the government, the HHS secretary should be required to consider whether the total amount of the incorrect submissions by a health care provider is material to the total claims submitted by that provider. If the number of disputed claims is less than a certain percentage, then the issue should be resolved through direct repayment—with interest—to HHS. If the disputed claims exceed an acceptable number, the secretary would be free to refer the case to the DOJ for further investigation.

The AHA is also looking at ways in which to address the use of the False Claims Act. The False Claims Act was first passed in the 1860s to outlaw certain practices in the trade of horses and manufacture of weapons for the government during the Civil War. Although it was revised in 1986, it remains a very broad law which allows the federal government to file suit against anyone submitting a false claim to the government for payment of goods and services. The statute does not require proof that the defendant actually intended to defraud the government or that the government actually suffered any loss.

The DOJ, using the False Claims Act, is targeting 4,700 hospitals nationwide for fraud and abuse. That means that virtually every hospital paid under the Medicare prospective payment system will be the target of a federal investigation. It simply defies logic to assume that every one of these institutions should be a Medicare fraud suspect. But, until the law differentiates between fraud and error, every institution will be liable for honest mistakes and misunderstandings.

Fraud vs. Error:

It is commonly understood that there is waste in the health care system. But, waste—albeit unacceptable—is not, by definition, the intent to defraud. The OIG estimates that about $17.8 billion to $28.6 billion is inappropriately paid by Medicare each year. But, the OIG admits that, "We do not know how much of these payments

were due to fraud and abuse or just common errors." Billing errors are unacceptable, but they do not constitute intentional fraud.

Medicare itself is a massive federal program that grows larger every year. The number of claims increases by about 3 million each year. In 1995, hospitals and health systems submitted on average nearly 200,000 claims a day and provided care to a total 38.2 million individuals in the inpatient setting and 483.2 million outpatient visits. Hospitals have to comply with 3,000 pages of statutes and regulations with 14,277 instructions to interpret the regulations. At the same time, hospitals, health systems, and other care givers are expected to comply with rules from 43 different Medicare Part A fiscal intermediaries, and 28 Medicare Part B carriers. Given the number of claims generated under so many different systems, it is not surprising that honest errors will be made.

All components of the reimbursement stream—providers, patients, and intermediaries—should be responsible for controlling fraud and abuse in the system. Fiscal intermediaries (private organizations, usually an insurance company, that serves as an agent for HCFA) are on the front line of the Medicare reimbursement stream. Intermediaries make initial coverage determinations and handle the early stages of beneficiary appeals. The federal government pays fiscal intermediaries approximately $1.5 billion each year to process Medicare claims.

In the FY 1996 Chief Financial Office Audit, the OIG estimated that $11.6 billion in claims payments, or about half of all "fraud and abuse" is actually billing error or incomplete claims. If all of these claims have been billed incorrectly by providers, they have been paid incorrectly by fiscal intermediaries. We believe more attention should be directed to HCFA and the performance of its contracted fiscal intermediaries who fail to instruct hospitals in a clear manner.

Hospitals receive incomplete, inadequate, and often, conflicting information from their fiscal intermediaries. We found in the hospital lab unbundling case that fiscal intermediaries instructed hospitals to bill laboratory tests separately, because their computer system had the ability to group (or bundle) the payments together as required by HCFA. However, the Justice Department is now holding hospitals liable for not bundling tests and threatening penalties equal to triple the cost of each test plus $10,000 per claim in accordance with the False Claims Act. Here is a clear example of inconsistent standards and lack of accountability on the part of the intermediaries. Hospitals in several states are the subject of similar Catch-22 situations.

The AHA, together with the Ohio Hospital Association, brought suit against the secretary for improperly and retroactively enforcing new coding and billing standards in connection with Medicare reimbursement for certain medical laboratory tests. In the opinion issued by U.S. District Court Judge Kathleen M. O'Malley in Ohio Hospital Association v. Shalala, she expressed the "understandable concern over the secretary's and attorney general's investigative tactics [of hospitals]." She stated that "despite the very real possibility that the secretary's position regarding the hospitals" billing practices is wrong, the practical barriers of challenging the secretary leave the hospitals with little choice and no bargaining room." She further criticized the government for its 'heavy-handed tactics.' The case was dismissed on jurisdictional grounds and will be appealed.

An example of retroactive application of reimbursement rules, inadequate notice by the government and their fiscal intermediaries and lack of instruction by the HHS is the physicians at teaching hospital (PATH) audits. In 1996, HCFA revised and clarified its guidelines on billing for teaching physician services. Teaching hospitals are now being audited as far back as 10 years and are held responsible for claims made while the reimbursement rules covered by the PATH audits were in many instances highly ambiguous. The HHS General Counsel acknowledged that such ambiguity existed and halted audits in several states after receiving letters of inquiry from members of Congress. However, the Department of Justice continues to issue subpoenas to teaching hospitals demanding years of records, raising questions of fundamental fairness.

We must all share responsibility for reducing waste and billing errors in the system. The rules must be clear, and all parties involved in rulemaking, implementation, interpretation, and claims processing must be held accountable—not just providers, but regulators and fiscal intermediaries too.

Summary:

Government resources should be used to attack true fraud. However, a continuous stream of investigations and recoveries using the False Claims Act ignores the underlying complexity and confusion of the Medicare payment system, defers important time and dollars away from patient care and erodes public confidence in their public institutions. We will do our part to improve provider compliance, but that's not enough. We must all share the responsibility of preventing errors from occurring

in the first place through clear regulations and guidelines and their consistent application. We also need to make sure the laws enforcing these provisions do not label hospital billing error as fraud.

Thank you for considering these comments and we are eager to work with the Committee toward eliminating fraud and abuse in the American health care system.

Statement of American Preventive Medical Association

Thank you for this opportunity to present our sentiments regarding the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and, what we believe to be the precarious and potentially detrimental effects it may have on those medical practitioners who engage in alternative or complementary medical techniques. As the law stands now, there is the possibility that HIPAA could be employed by those who are ignorant of alternative medicine; and further, certain elements of HIPAA may actually encourage so-called "quack busters" to instigate a "witch hunt" of alternative medicine, one of the growing branches of medicine. This testimonial attempts to address the most threatening effects which HIPAA has prompted.

The most important and controversial aspect of this new law is that concerning the federalization of health care crimes. This area is important because of the number of persons affected by it and the radical changes which it makes; it is controversial because the intentions behind its inception are dubious, and the effects of its imposition have the potential to seriously impact the practices and lives of every alternative medicine practitioner in the country. It is not reactionary or inciting to say that alternative medicine practitioners have much to fear from HIPAA. HIPAA portends serious legal implications for those physicians practicing alternative medicine; namely, federal criminalization for what is loosely defined as "health care fraud."

The relevant portion of the newly enacted HIPAA is Title II, entitled "Preventing Health Care Fraud and Abuse; Administrative Simplification." Title II of HIPAA is therein broken down into numerous sections; some of which have legitimate purposes, many of which are suspect.

The first important area is section 201: "Fraud and Abuse Control Program." This section provides for the establishment of a program to coordinate Federal, State and local law enforcement programs to control "fraud and abuse with respect to health plans," and thereby any and all measures needed to reach that end, including "investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States."[1] The important point to take from this section is that hereafter all types of supposed "fraud" or "abuse" are now under the microscope of federal investigators. This impliedly suggests that both staff and physicians themselves are at risk of FBI agents appearing at their homes to "investigate" federal crimes; this investigation may include rummaging through personal property to look for diagnoses and then comparing them with CPT codes, as well as other billing and insurance information. Whereas before the state would most likely make inquiries and arrange for hearings, the federal government now has authority to coordinate with state governments in the investigation; and since federal matters inevitably preempt state or local matters, the federal government will ultimately be the driving force behind these "investigations," and their modus operandi may take an ominous manner.

Another way in which HIPAA may be used in the alternative medicine hunt is through the expansion of the health care fraud and abuse data collection program. This program will expand the "data bank" to include the reporting of final adverse actions against health care providers, suppliers, or practitioners.[2] For the purposes of this section, a final adverse judgment includes criminal convictions, civil judgments, licensing and certification decisions, or "any other negative action or finding by [a] Federal or State agency," including "[a]ny other adjudicated actions or decisions the Secretary may establish by regulation."[3] This leaves quite a bit of uncertainty in the determination of what type of information is entered into the data bank; for instance—an adverse Medicare audit might be includable. Furthermore, though HIPAA uses the term "final," actions which may still be on appeal are also includable. This means that even though a physician may still be awaiting appeal

[1] Health Insurance Portability and Accountability Act of 1996, Public Law 104–191 (H.R. 3103), Title II, Subtitle A, sections 201(1)(A),(B).

[2] Title II, Subtitle C, section 221(a).

[3] Title II, Subtitle C, sections 221(g)(1)(A)(i)–(v).

of an action against him, the action is nonetheless entered into the data bank. It is unjust to penalize those who are still awaiting a further determination on an issue of this type. Also, the reporting of "negative findings" leaves far too much discretion to the government; only those negative findings that are part of a final, unappealable action should be reportable. To do otherwise allows for abuse and prejudice to run rampant; those who may harbor ill-will toward a physician can permanently scar their record by the reporting of "negative findings" which may or may not be legitimate.

The question then becomes, who is it that is responsible to give this information to the data bank? Certainly, government agencies should be responsible for this type of reporting. In fact, in the past, government plans such as Medicare and Medicaid were under affirmative duties to do so. However, it is now also the duty of all "health plans," meaning private companies, to also report such information.[4] That is, whenever any health plan learns of any "adverse action" against a health care provider, it is its duty to report that to the government. This implies that anybody associated with a health plan can report a physician's actions to the government; and, in fact, has a duty to do so. While an alternative medicine physician may be doing nothing wrong, this provision allows for a much greater amount of discretion on the part of the reporting entity. For example, suppose a traditional medicine HMO decides to report that an alternative medicine practitioner is practicing an allegedly non-approved treatment— though that physician may have done nothing illegal, that information will put up red flags as to that physician's practice, and the subject physician may be exposed to investigations or audits by federal agents, as well as have a State inquiry into that physician's legitimate practice.

In addition to being at risk of reporting from health plan entities, HIPAA actually gives monetary incentives for individuals to report to the government "information on individuals and entities who are engaging in or who have engaged in acts or omissions which constitute grounds for the imposition of sanctions. . .or who have otherwise engaged in fraud or abuse against the Medicare program."[5] This provision now allows any member of the general public to receive compensation for whistleblowing. Again, while alternative medicine practitioners are not doing anything illegal, this provision permits further exposure to an investigation; and the government now has a statutory duty to "look into" the reports of individuals who, for all we know, may be traditional medicine doctors, or so-called "quack-busters." This additional attention will further complicate the lives of alternative medicine physicians, who will now have to use precious time and money defending and explaining their actions against a governmental investigation brought on because of individual reports, elicited for dually recognizable gains—money and vengeance. Inevitably, a new market will emerge, filled with complainants who have nothing to lose; if, in fact, their complaint is successful, they are awarded a pecuniary gain, yet they have expended no expense in making the complaint since the one who files the complaint does not have to investigate or prosecute. Why not make as many complaints as possible, with the hope that even if a few are successful they may present some monetary gain, without having to put out any expense in return? This type of reward system needs some measure of regulation to curb the potential for abuse.

Additionally, those who will be investigating and auditing these complaints are funded, in part, by a new Health Care Fraud and Abuse Account program. Its goal is to collect as much money from alleged violators of HIPAA. In fact, it is through the collection of fines and forfeitures which provide sustenance to the program. The organizational expenditures and salaries are dictated by the amount of collections. This plan creates a precarious conflict of interest. The program administration's objectivity will be greatly obscured through the lure of easy money. The cycle is vicious: the more prosecution, the more money made—the more money made, the more prosecution. All of this with no procedural safeguards against potential abuse.

Furthermore, HIPAA has now "federalized" all health care program violations.[6] This means that if in fact a violation took place against a state health program, it is now a federal violation, and the federal government can now become involved in the investigation.

The issues examined above only detail what the possible effects are of the underlying mechanism for identifying violators—that is, how problems will be created for

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[4] Title II, Subtitle C, section 221(b)(1). ("Health plans" is defined by Title II, Subtitle A, sections 201(c)(1)–(3) as "a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—(1) a policy of health insurance; (2) a contract of a service benefit organization; and (3) a membership agreement with a health maintenance organization or other prepaid health plan.").

[5] Title II, Subtitle A, section 203(b)(1).

[6] Title II, Subtitle A, section 204(a).

alternative medicine from only the procedures which have been implemented to catch "fraud and abuse" perpetrators. However, the actual substantive laws which are newly created under HIPAA have as many potential problems as the infrastructure implemented to effectuate them. These new violations, and the corresponding penalties, drive a chill through all alternative medicine practitioners.

The most prominent of the new federal health care offenses is that of health care fraud, defined as "knowingly and wilfully" executing or attempting to execute a plan or scheme:

(1) to defraud any health care benefit program; or

(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program, in connection with the delivery of or payment for health care benefits, items, or services.[7]

These crimes are punishable by fines and up to ten (10) years in prison.

The reason alternative medicine practitioners worry is derived from an examination of another statute which defines what courts may attempt to use to determine what a new type of fraud is.

Under HIPAA, civil penalties may be assessed against any person who:

[E]ngages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a [CPT] code that the person knows or should know will result in greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided[.][8]

Furthermore, penalties may be assessed against any person who submits a claim which is for "a pattern of medical or other items or services that a person knows or should know are not medically necessary" (emphasis added).

This one line addition which HIPAA mandates may unleash a flood of litigation. Alternative medicine practitioners may have immediate fines and penalties assessed against them because, under HIPAA, many will state that their treatments are not "medically necessary"—a term which is not defined in HIPAA, and which even the Social Security Act has never specifically outlined. Until the government puts into place some scheme of approved and medically necessary treatments verses those that are non-medically necessary, there is no standard with which to apply equally. This in turn hurts both physicians and patients. Physicians will have to guess at what treatments they may use, in the hope that they do not violate HIPAA. Meanwhile, those patients who may wish novel or experimental treatments are at a loss because physicians will be unlikely to treat them for fear of inducing liability. Furthermore, the price that physicians will have to pay, both in time and expense, hurts their patients. The cost of defending potential numerous actions will be passed on to their patients; either through higher costs or fewer treating physicians.

Further, if this standard is accepted by courts as a "fraudulent" activity, it would immediately subject practitioners to criminal penalties for health care fraud. That is, if courts were to conclude that this type of activity, that is—submitting claims for non-"medically necessary" treatments, is fraudulent, then the practitioner could be fined, have his personal property forfeited[9], and could go to jail for ten (10) years.

The idea that courts could adopt the civil penalty standard to the criminal definition of "fraud" is not just a paranoid delusion; especially if there are hundreds of traditional medicine "quack busters" jamming the government's phone lines with reports of the fraudulent activity of alternative medicine practitioners who are submitting claims for non-"medically necessary" treatments.

There are numerous problems which HIPAA creates for those medical practitioners that specialize in alternative medicine. It is necessary for action to be taken in order to clarify and delineate specific language which may be employed in the activation of HIPAA, so that this new law is not abused by those with anti-alternative agendas, who may attempt to gain personal reward from the destruction of legitimate alternative medical practitioners.

Apart from inducing fear in the alternative medicine community, HIPAA recreates George Orwell's "1984." Everyone is against fraud but you cannot find it under every rock. This bill creates a negative atmosphere for all physicians.

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[7] Title II, Subtitle E, sections 242(a)(1).

[8] Title II, Subtitle D, section 231(e)(1).

[9] Title II, Subtitle E, section 249(a).

Statement of Citizens Against Government Waste

Medicare Fraud: The Symptoms and the Cure

EXECUTIVE SUMMARY

Citizens Against Government Waste's (CAGW) 1995 Medicare Fraud: Tales From the Gypped exposed and detailed many avenues of Medicare fraud. Since then, numerous hearings have been held, and legislation, the Health Insurance Portability and Accountability Act (HIPAA), was passed in 1996 to further expose and punish those responsible for gaming the system by giving the Department of Health and Human Services (HHS) Inspector General's (IG) office additional resources to aggressively combat Medicare fraud. CAGW's new report, Medicare Fraud: The Symptoms and the Cure, not only documents new and unsavory examples of fraud and abuse, but offers long-term solutions to improve the Medicare system itself.

The report addresses major questions surrounding Medicare, including: Who's at fault for the waste, fraud, and abuse—the system itself, those who use it, or both? Who are the real victims—the taxpayers, the seniors who rely on Medicare, or those who are expecting to draw down benefits in the future? What is the best way to cure Medicare's afflictions in the long run? Should the current course of treatment be continued; i.e., attacking fraud, reducing payments to hospitals and doctors, and marginally increasing choices for seniors in Medicare services? Or, is the country ready to embrace more innovative approaches that will allow seniors to regain control of their healthcare choices, rather than deferring to third parties and the federal government?

This report identifies dozens of examples of waste, fraud, and abuse, which can be characterized as: civil penalties, criminal penalties, kickbacks, home healthcare, nursing home fraud, laboratory fraud, durable medical equipment fraud, hospital fraud, and program exclusions. These examples are further graphic proof that, as long as funds flow generously and indiscriminately from this impersonal and nebulous source called the government, Medicare will continue to be plagued by scam artists and crooks, as well as garden variety bureaucratic snafus and misunderstandings.

In 1995, HHS IG June Gibbs Brown estimated that up to $17 billion, or 10 percent of Medicare funds, were lost each year because of waste, fraud, abuse and mismanagement.[1] In 1996, following the first comprehensive audit of Medicare since its inception 32 years ago, the IG was forced to revise that staggering figure upward, estimating that the true losses due to fraud, waste, and abuse were closer to $23.2 billion a year. That is $63 million per day, or about 14 percent of total program costs, in net overpayments by Medicare in fiscal year 1996.[2] Almost half (46 percent) of the $23 billion was the result of insufficient or absent documentation. The IG admitted that her staff was unable to determine exactly how many of the improper payments occurred as a result of outright fraud and how many were simply honest human errors.[3]

Recent high-profile Medicare investigations indicate that the system may be as much, if not more, to blame as healthcare providers. While there are certainly plenty of unscrupulous individuals bilking Medicare—and the examples offered in this report will rightly outrage the public—there are genuine disagreements between the Health Care Financing Administration (HCFA) and providers, and a significant number of these discrepancies grow directly out of misinterpretation of vague and sometimes conflicting HCFA guidelines.

HCFA has admitted that "the best hospitals can do is to be paid for their costs of furnishing services; they can also be paid less than costs, but they cannot make a profit even if they are extremely efficient."[4] This no-win situation naturally drives Medicare providers to seek the highest possible reimbursements and encourages even the most law-abiding among them to stretch the rules as far as possible. Some

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[1] Congressional Quarterly, Congressional Monitor, August 1, 1995, p. 7.

[2] Department of Health and Human Services (HHS), Office of the Inspector General (OIG), Report on the Financial Audit of Health Care Financing Administration for fiscal year 1996 (HCFA Financial Audit), July 1997, p. 5.

[3] June Gibbs Brown, Inspector General, Department of HHS, Audit of HCFA Financial Statements—Testimony before House Committee on Ways and Means, Subcommittee on Health, June 17, 1997.

[4] Susan Horn and Robert Goldberg, "A Sickly Approach to Medicare," The Washington Post, July 1994.

providers conjure up ever more creative techniques to fraudulently squeeze out additional dollars. Further, Medicare's price control system is ineffective and may reduce the quality of healthcare services available to beneficiaries. In fact, the Balanced Budget Act of 1997, with its short-term "fix" of further lowering reimbursement rates for providers, will only exacerbate this problem.

This helps explain why attacking fraud alone, although a laudable goal and the government's only bulwark against the appalling abuses of the system, will never solve Medicare's problems entirely. Medicare needs much more than a vigilant IG to ensure its long-term viability.

Seniors are not the only players in the Medicare debate. Legislators, law enforcement officials, lawyers, healthcare providers, healthcare consultants, accountants, and bureaucrats all have a stake in the outcome. Ironically, two groups—members of Congress and HCFA employees—wield a disproportionate percentage of power over which healthcare procedures will be covered by Medicare and at what cost, despite the fact that few of them are healthcare professionals.

Their decisions are heavily influenced by the well-organized and well-financed lobbying efforts of hundreds of special interest groups. Members of Congress are under a constant barrage from groups demanding changes to the Medicare laws that address their special causes, diseases, or constituencies. Expensive legal advisors must, in turn, be retained by hospitals, healthcare professional associations, trade groups and other organizations to interpret the impact of these new laws on their ability to deliver quality healthcare to their patients. And finally, accountants, consultants and healthcare insurers must also pore over the 45,000 pages of convoluted Medicare regulations to determine which medical procedures they can bill for and for how much.

Medicare not only encourages providers to stretch the limits of reimbursement to recapture as many of their costs as possible, it also offers patients little incentive to question excessive costs or report overpayments. Because there are no rewards for delivering high quality healthcare or improving efficiency, there are no "up front" incentives for providers to control costs. Instead, there are "back-end" investigations and billing disputes, well after the money has disappeared, and lack of attention to the root causes of the problems. In this insidious cycle, more dollars are reprogrammed and committed to investigations, and regulations are constantly made more complex and vulnerable to misinterpretation, abuse, and litigation. This, in turn, leads to still more insistent calls for crackdowns and investigations.

These problems will multiply as technology and advances in medicine continue to outpace the government's ability to write and enforce new rules and regulations. Many of the newest and most innovative medical techniques are not even recognized or covered by Medicare, which means that seniors do not have access to all of the same high quality treatments under Medicare as patients under the age of 65. Medicare trails the private sector in using both managed care and healthcare outcomes to control unnecessary medical spending. The only way to control expenditures in this type of entitlement program is to specify in advance exactly what price the government will pay for each and every service rendered. A lumbering, monopolistic bureaucracy like Medicare is simply not nimble enough to keep up with a rapidly evolving industry that offers many different types of services, products, and treatments.

Real change in Medicare will only come about when the power to make healthcare decisions is taken away from politicians, bureaucrats, lawyers, consultants, and accountants, and placed into the hands of those who depend upon the program. The Balanced Budget Act of 1997 was a good start in providing seniors with more choices and more control. But it does not address the core problem: Medicare will begin to slide into bankruptcy in 10 years, as the baby boomers begin flooding the program. The commission created by the Balanced Budget Act must confront this immediate crisis head-on by taking bold steps. CAGW concurs with U.S. Rep. Pete Stark (D–Calif.), who recently wrote "Medicare beneficiaries deserve the best we can offer—quality care at an affordable price with strong protections against unscrupulous providers."[5]

WASTE, FRAUD AND ABUSE—THE CONTINUING SAGA

Medicare was created in 1965 to provide healthcare insurance benefits to the aged and other eligible populations who might not otherwise be able to afford decent health insurance coverage in the event of injury or illness.

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[5] Congressman Pete Stark, "Letter to the Editor," The Wall Street Journal, September 11, 1997.

Medicare Part A provides hospital and other institutional coverage for eligible disabled persons and persons 65 or older. This coverage is premium-free and is financed through mandatory payroll taxes. Part A is commonly referred to as the hospital insurance program.

Medicare Part B, Supplementary Medical Insurance (SMI), is an optional program that covers most of the costs of medically necessary physician and other services. All persons 65 years or older can choose to enroll in the SMI program by paying a monthly premium. Even though this is a voluntary program, non-participating taxpayers finance approximately 75 percent of the spending.

HCFA administers Medicare through more than 70 private claims processing contractors (who are really in control of the system). Healthcare providers and beneficiaries are paid by these companies, which also receive tax dollars to cover administrative expenses (approximately $1.2 billion in 1996). According to the General Accounting Office (GAO), HCFA processed more than 800 million claims in 1996.[6] The sheer volume of the claims processed allows incidents like the following to occur:

• After unsuccessfully pleading insanity (claiming psychotic delusions caused him to overbill), a Boston, Massachusetts, psychiatrist was sentenced to 46 months imprisonment and fined $1 million for Medicare and private insurer fraud, obstructing justice, and intimidating a witness. The psychiatrist attempted to get patients to lie for him and even threatened to make public the medical records of a family member of one of the patients if she didn't lie to the government. The witness refused to be intimidated and testified against him.[7]

In 1995, the GAO warned that, "Medicare pays more claims with less scrutiny than at any other time over the past five years."[8] Two years later the situation is not much better:

[P]roblems in funding program safeguards and HCFA's limited oversight of contractors continue to contribute to fee-for-service program losses. While HCFA expects a major system acquisition project to reduce certain weaknesses, the project itself has several risks that may keep HCFA from attaining its goals. In addition, the managed care program suffers from excessive payment rates to HMOs and weak HCFA oversight of the HMOs it contracts with.[9]

The 1996 HHS audit identified HCFA's four internal control weaknesses that hinder Medicare from tracking its money: there is no process to estimate a national error rate for improper payments; no acceptable method for estimating Medicare accounts payable; no integrated financial reporting system to properly account for Medicare accounts receivable or other financial management and reporting issues; and deficient electronic data processing and controls relating to security access, system application development, and service continuity.[10]

The anti-fraud provisions passed by Congress in fiscal year 1996 made significant changes in the oversight of Medicare fraud. HIPAA (also referred to as Kassebaum-Kennedy, after its Senate co-sponsors) contained increased funding for IG activities, along with provisions that will enable the government to recoup more of its losses. The Balanced Budget Act also contained measures to stave off Medicare's financial failure until 2007. Congress chose to carve out the bulk of the savings over the next five years, $115 billion, by once again reducing payments to doctors, hospitals, and other healthcare providers.

COMBATING HEALTH CARE FRAUD

Since 1995, the HHS IG's office has stepped up its attacks on Medicare fraud. That year, the department established Operation Restore Trust in California, Florida, Illinois, New York, and Texas, to target areas of waste, fraud, and abuse. HHS joined forces with multiple federal and state agencies to examine the activities of home healthcare agencies, nursing homes, and durable medical equipment suppliers. According to Michael Mangano, HHS's principal deputy inspector general, the IG eventually expects to recover about $1.1 billion through criminal cases and civil settlements.[11] This is an enormous increase over last year's collections, which totaled $205 million (the IG collected $69.8 million five years ago). That figure does

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[6] GAO, High Risk Series: Medicare (GAO/HR–97–10), February, 1997, p. 15.

[7] Department of Health and Human Services (HHS), Office of Inspector General (OIG), Semiannual Report, April 1, 1996–September 30, 1996, p. 15.

[8] GAO, High Risk Series: Medicare Claims, February, 1995, p. 7.

[9] GAO, High Risk Series: Medicare, February, 1997, p. 8.

[10] Department of HHS, OIG, HCFA Financial Audit 1996, July 1997, p. 2.

[11] David S. Hilzenrath, "Bold Scams Bilk Medicare of Billions," The Washington Post, August 8, 1997.

not include any collections that may accrue as a result of the IG's ongoing investigation of Columbia/HCA, the largest tax-paying hospital chain in the country.[12]

In May 1997, the IG's office reported that for every dollar spent on Operation Restore Trust, $23 was recovered. It identified more than $187.5 million in fines, recoveries, settlements, audit disallowances, and civil monetary penalties. There are still hundreds of pending cases. Because of the program's success, HIPAA will double the IG's appropriation over the next seven years and the operation will be expanded to include specific targets in all 50 states. Eventually, it will be applied in all 50 states and throughout all Medicare program areas.

Tracking and punishing fraud, of course, are vital parts of administering any government program. And, as a result of some of new laws governing Medicare, they have also become more lucrative. But there are risks. Recent congressional hearings on the Internal Revenue Service (IRS) should serve as a cautionary tale about what can happen when federal law enforcement officials exceed their authority in response to financial or other incentives.

According to The Wall Street Journal, almost all 187 hospitals in Ohio recently received letters from federal officials accusing them of overbilling Medicare for blood and urinalysis tests. The letters then offered settlements in lieu of prosecution.[13] Investigations and audits must not become institutionalized government shakedowns.

CIVIL PENALTIES FOR FALSE CLAIMS

Congress enacted the Civil Monetary Penalties Act to empower the IG to impose penalties and assessments against healthcare providers who submit false or improper claims to Medicare and state healthcare programs. The law allows the government to try to recover money lost through illegitimate claims and to impose additional penalties, if necessary. The IG may now also direct companies found to have engaged in improper billing or other transgressions to enter a corporate integrity program and submit to increased scrutiny in order to remain in Medicare.

The IG is currently monitoring 70 such corporate integrity programs, from small physician offices to large laboratory corporations. Most supervision lasts for 5 years and compels active participation by the provider to certify that it is operating within HCFA regulations and the parameters established by the plan. Failure to comply may result in lengthy, or permanent, exclusion from participation in Medicare.

The following are recent examples of civil cases and their settlements:

- A Massachusetts laboratory agreed to pay $6.67 million to settle charges that it overbilled Medicare. According to the IG, the laboratory routinely billed Medicare for a serum iron test whenever a physician requested a standard panel of tests, even though the iron test was not specifically requested. The laboratory improperly collected more than $3.35 million from Medicare for the unnecessary tests.[14]
- A New Jersey corporation performing X-ray and electrocardiographic services used subsidiaries in Massachusetts and Pennsylvania to illegally bill in regions where reimbursement rates were higher. The corporation agreed to pay $2.1 million to settle the case, and the president and vice president of one subsidiary pled guilty for their involvement in the scheme.[15]
- After submitting false claims to the Medicare and Medicaid programs for experimental cardiac devices that were not FDA-approved, a California hospital paid nearly $1.3 million to resolve its civil liability.[16]
- In early 1997, four Georgia healthcare providers agreed to pay $2 million to settle allegations of Medicare fraud. According to the Justice Department, California-based Apria Healthcare Group Inc. used sham consulting contracts to give kickbacks to physicians in exchange for referrals of Medicare patients. Apria, one of the nation's largest suppliers of medical equipment and oxygen, agreed to pay $1.65 million. The other companies involved were Georgia Lung Associates, which agreed to pay $346,000; Pasa del Norte Health Foundation of El Paso, Texas, which agreed to pay $20,000; and Physicians Pharmacy Inc. of Georgia, which agreed to pay $4,000.[17]
- Between 1991 and 1993, a Philadelphia psychiatrist and his wife filed numerous false Medicare and Medicaid claims by billing for therapy that was not provided,

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[12] Greg Jaffe and Eva Rodriguez, "In Hospital Probes, a New Focus on Bottom Line," The Wall Street Journal, September 12, 1997.

[13] Idem.

[14] HHS, OIG, Semiannual Report, April 1, 1996–September 30, 1996, p. 12.

[15] HHS, OIG, Semiannual Report, October 1, 1995–March 31, 1996, p. 14.

[16] Idem.

[17] Bill Rankin, "Medicare Fraud Case Settled for $2 million," Atlanta Journal-Constitution, February 6, 1997.

for unsupervised treatments, and for more therapy units than were provided. The psychiatrist attempted to destroy records when federal investigators searched his office. The couple agreed to pay a $500,000 settlement and entered a corporate integrity program.[18]

• A New Jersey medical supply company paid $330,000 to settle charges that it billed Medicare for expensive, custom-fitted "spinal body jackets" that were actually little more than seat cushions provided to nursing home residents.[19]

• Pennsylvania-based Mediq Inc. and its subsidiary, ATS Inc., agreed to a settlement in which ATS and its president pled guilty to concealing a felony and ATS agreed to pay $2.1 million in fines. The settlement was the result of a whistleblower lawsuit, which exposed illegal cross-billing of portable EKGs and portable X-rays. ATS billed services performed in one carrier's jurisdiction to a carrier in another jurisdiction where reimbursement rates were higher.[20]

CRIMINAL PENALTIES

Medicare fraud is often tried as a criminal offense, and a conviction can lead to jail time for the perpetrators. Recent criminal convictions for Medicare fraud include the following cases:

• A former Colorado heart surgeon was convicted of Medicare and Medicaid fraud for billing for heart bypasses he never performed. The surgeon was sentenced to 30 days' incarceration, 3 years' probation, and 200 hours of community service. Total restitution, fines, and damages recovered totaled $30,000.[21]

• An Oregon opthamologist pled guilty and was sentenced to 2 years' probation and fined $10,370 for submitting false claims for medically unnecessary cataract surgeries. Though his patients had near-perfect vision prior to surgery, the opthamologist gave the hospital false information about the patients' true visual abilities. He subsequently surrendered his medical license and declared bankruptcy.[22]

The owner and chief executive officer of Georgia's largest home healthcare agency pled guilty to charging Medicare and Medicaid for campaign contributions, phantom employees, and personal vacations. She was sentenced to 33 months in prison, followed by 3 years' supervised work release, including 200 hours of community service. She was fined $25 million and ordered to pay $11.5 million in restitution. The company's former vice president was fined $75,000, had to repay $710,000, and was sentenced to 151 months incarceration followed by 3 years' probation. The agency's former risk manager was ordered to repay $710,000 and received 97 months' incarceration and 3 subsequent years of probation.[23]

• A joint audit and investigation revealed that a California nursing home owner had billed Medicare for nonexistent medical supplies and filed false cost reports. The former owner was sentenced to more than 11 years in prison and was ordered to pay more than $3.5 million in fines, restitution, and special assessments. Two former Medicare carriers and two former employees also pled guilty and were sentenced after they testified against the owner.[24]

• A laboratory clerk and her husband (the president of the laboratory) used a fraudulent passport to set up a laboratory. The clerk and her husband submitted more than 700 claims for 416 beneficiaries (many of whom were already dead) and collected $330,000 over a 60-day period. One of the "referring physicians" had been dead for 2 years. The wife was sentenced in Florida to 9 months in prison, 2 years' supervised release, and ordered to pay a $50 special assessment. The husband was arrested after trying to withdraw $200,000 from the corporate account and was sentenced to 10 months in prison, 3 years probation, and ordered to make restitution of $115,800.[25]

• After pleading guilty to submitting false claims for complex procedures that he did not perform, a California urologist was sentenced to 24 months in prison. Before the sentencing, he agreed to pay $440,000 in damages and penalties. The urologist will be barred from participation in Medicare for 10 years due to the egregious na-

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[18] HHS, OIG, Semiannual Report, October 1, 1995–March 31, 1996, p. 15.

[19] Alice Ann Love, "Medicare Crackdown to Target 12 New States," The Orange County Register, May 21, 1997.

[20] U.S. Department of Justice, Department of Justice Health Care Fraud Report: Fiscal Years 1995–1996, p. 25.

[21] HHS, OIG, Semiannual Report, April 1, 1996–September 30, 1996, p. 16.

[22] Idem.

[23] HHS, OIG, Semiannual Report, October 1, 1995–March 31, 1996, p. 19.

[24] Ibid., pp. 19–20.

[25] Ibid., p. 21.

ture of his crimes. For example, he performed invasive procedures that he admitted were not medically necessary. He has also surrendered his medical license.[26]

• While employed by a doctor as an office manager, a Texas woman submitted false claims for a personal friend, even though no services were performed. The two split the proceeds when the checks came in. The office manager was sentenced to a year and a day in prison and ordered to make restitution of $41,500. The friend was sentenced to one year probation and fined $2,550.[27]

• A former IRS mail clerk was sentenced to five months in prison and five months' home confinement with electronic monitoring, followed by one year supervised release, for impersonating a federal officer, intimidating a witness, and obstructing a Medicare fraud investigation. Before becoming an IRS employee, he had worked for an ambulance company that was being investigated for fraudulent Medicare billing. During that investigation, several company employees revealed that the man had claimed to be an IRS agent and had threatened at least one of them with a tax audit if he cooperated with authorities.[28]

• A psychologist in Pennsylvania was sentenced to 6 months' home detention, 12 months' probation, and 300 hours of community service for mail fraud. Over a 4-year period, she billed Medicare for more than 700 services that were never provided. The Medicare loss was estimated at $113,000.[29]

• Blake Alan Wimpee was sentenced to 18 months in prison for submitting false claims to Medicare. Between 1994 and 1996, Mr. Wimpee billed Medicare for 28 power wheelchairs when he actually provided electric scooters instead. As a result, Medicare overpaid the San Angelo, Texas businessman by more than $82,000.[30]

• In 1996, Ronald W. Nemeroff pled guilty in U.S. District Court in Newark, New Jersey, to paying kickbacks of $36,000 to get $145,000 worth of Medicare-funded orders for equipment.[31]

KICKBACKS

Many businesses use referrals as an integral part of their day-to-day operations to meet customer needs and provide specialized medical services that are not part of their expertise. The healthcare system is especially dependent on referrals because there are so many medical specialty areas. A referral becomes a kickback when patients are referred in exchange for anything of value. Both parties, the giver and the receiver, share culpability under the law. Medicare requires that referrals be made in the best interest of the patient and without financial gain by either party.

Medicare's anti-kickback statute "penalizes anyone who knowingly and willfully solicits, receives, offers or pays remuneration in cash or in kind to induce or in return for:

• referring an individual to a person or entity for the furnishing, or arranging for the furnishing, of any item or service payable under the Medicare or Medicaid programs; or

• purchasing, leasing or ordering, or arranging for or recommending the purchasing, leasing, or ordering of any good, facility, service or item payable under the Medicare or Medicaid programs."[32]

The following are recent examples of Medicare kickback schemes:

• In the first case initiated under the anti-kickback law, a group of cardiologists in a Massachusetts hospital, who are not permitted to bill Medicare for interpreting coronary angiograms and ventriculograms, gained the illicit cooperation of a group of radiologists, who agreed to pass the bills through to Medicare. The hospital paid agreed to pay $177,000 in restitution.[33]

• Tony Abad, a 43-year-old Florida X-ray and ultrasound technician who owned and operated Physicians Choice Diagnostic Service Inc., was charged with 24 counts of paying illegal kickbacks for Medicare business.[34]

• Two brothers were found guilty by a New York jury for conspiracy related to fraudulent Medicare claims. The brothers visited senior citizen highrises and conducted health fairs where they coaxed Medicare beneficiaries into revealing their

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[26] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, pp. 21–22.
[27] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, p. 23.
[28] Idem.
[29] Idem.
[30] Associated Press, "Medicare Supplier Gets Prison Time for Fraud," San Antonio Express-News, June 8, 1997.
[31] Jerry DeMarco, "Guilty Plea in Kickback Scheme," The Record, September 25, 1996.
[32] HHS, OIG, Semiannual Report, April 1, 1996–September 30, 1996, p. 17.
[33] Idem.
[34] Mark Albright, "Medicare Fraud Inquiry Spreads," St. Petersburg Times, August 1, 1997.

Medicare identification numbers. The brothers then used the numbers to forge certificates of medical necessity to two durable medical equipment (DME) companies. The companies then billed for equipment, much of which was never supplied, costing Medicare $750,000. The brothers received "commissions" based upon the cost of each piece of equipment.[35]

• Five owners of licensed branches of the Florida Impotence Clinic Inc. were indicted for receiving kickbacks for referring Medicare patients to medical equipment manufacturers and service providers.[36]

• A former salesman for a New York DME company was sentenced to four months in prison, followed by 2 years' probation, and $13,500 in restitution fines for Medicare fraud conspiracy. The salesman recruited patients for his father, a semi-retired podiatrist, in return for the patients' Medicare identification numbers and signed certificates of medical necessity. The salesman then turned around and sold the certificates to his employer. The father was sentenced to three years probation and four months home confinement for billing Medicare and private health insurance for treatments not done and visits not made.[37]

• Physicians First Choice and Somed Company, both owned by Frank J. Lopez of Clearwater, Florida, are accused of paying clinics for Medicare patient referrals and then including the payments in their charges to Medicare. The government is seeking triple damages on 17,000 false claims that Lopez's companies submitted, for a total of $170 million in punitive damages.[38]

HOME HEALTHCARE

Home healthcare is a rapidly growing industry that allows seniors to receive care in their own homes for less than the cost of hospitalization or nursing home care. Unfortunately, it has become rife with fraud and abuse. A recent government audit found that 40 percent of home healthcare visits reimbursed by Medicare in California, Illinois, New York, and Texas do not qualify for reimbursement. Another IG report uncovered the fact that 25 percent of home healthcare agencies certified to participate in Medicare have defrauded or exploited the program at one time or another. Medicare spends $17 billion per year on home healthcare services.[39]

Ironically, it was Medicare's policies that helped spawn the huge explosion into home healthcare spending. Much of the technology that has been developed in recent years allows many medical procedures to be performed at home, often by patients themselves. Medicare deliberately offered generous payments for home healthcare, based upon the fact that caring for someone at home is less expensive and more desirable for seniors than admitting them to a hospital. But in the process, Medicare allowed for unlimited payments for a wide variety of home healthcare services instead of capping prices as it has for in-hospital care.

The Balanced Budget Act passed this year by Congress will require home healthcare agencies and other post-acute healthcare providers to move from Medicare's current cost-based reimbursement system to the prospective payment system (PPS) by 1999. It is believed that under PPS, hospitals will no longer have the incentive to shift acute-care costs to home healthcare operations.[40]

After years of promoting the expansion of home health care agencies and then failing to exercise oversight, the Clinton Administration has finally taken steps to address the problem by announcing a moratorium on the acceptance of new home healthcare agencies and by a doubling of the number of investigators assigned to examine agencies' activities. This is the first time since Medicare was implemented that a whole section of the healthcare industry has been barred from admission to the program. The moratorium will put the brakes on what has been one of the fastest growing segments of the healthcare industry—Medicare was accepting an average of 100 new home healthcare companies each month. Furthermore, currently certified home healthcare companies will be required to reapply for admittance to remain eligible to receive Medicare reimbursements.[41]

In Florida alone, the IG found that:

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[35] HHS, OIG, Semiannual Report, October 1, 1995–March 31, 1996, p. 22.

[36] Mark Albright, "Medicare Fraud Inquiry Spreads," St. Petersburg Times, August 1, 1997.

[37] HHS, OIG, Semiannual Report, October 1, 1995–March 31, 1996, p. 23.

[38] Mark Albright, "Medicare Fraud Inquiry Spreads," St. Petersburg Times, August 1, 1997.

[39] Testimony of George F. Grob, Deputy Inspector General for Evaluation and Inspections HHS Office of Inspector General, Hearing before the Senate Special Committee on Aging, July 28, 1997, p. 1.

[40] Charlotte Snow, "Home Health Heats Up," Modern Healthcare, August 18, 1997, p. 30.

[41] Amy Goldstein, "President Acts to Curb Home Health Care Fraud," The Washington Post, September 16, 1997.

• In Miami Lakes, 24 percent of claims did not meet guidelines: 11 percent were for 145 services that were not reasonable or necessary, 9 percent were for 177 services that physicians either denied authorizing or authorized improperly, and 4 percent were for 24 services that were not provided.[42]

• In Miami, 40 percent of claims did not meet Medicare guidelines: 25 percent of the claims were for 466 services made to individuals who were not homebound; 8 percent of the claims were for 200 services that were not reasonable or necessary; 5 percent of the claims were for 127 services that were not provided; and 2 percent of the claims were for 53 services that physicians denied authorizing.[43]

• In Dade County, 32 percent of claims did not meet Medicare guidelines: 16 percent were for 208 services that were not reasonable or necessary; 9 percent of the claims for 129 services were provided to beneficiaries who were not homebound; 4 percent were for 18 services that were not provided; and 3 percent were for 48 services that physicians either denied authorizing or authorized improperly.[44]

• In one Florida home healthcare agency (HHA), 32 percent of claims did not meet Medicare guidelines: 23 percent were for 262 services that were not reasonable or necessary; 5 percent were for 69 services provided to beneficiaries who were not homebound; 3 percent were for 17 services that physicians did not authorize; and 1 percent were for 5 services that were not provided. During this fiscal year period, the HHA claimed $12 million in 8,700 claims representing 151,015 services.[45]

Other examples of home healthcare fraud include:

• Some people in the home healthcare business are very generous to their relatives. One HHA hired the owner's nephew to maintain its computer system. The nephew was a full-time college student and was paid $250,000 for the work.[46]

• The former owner of a Michigan HHA was sentenced to 5 months house arrest and ordered to pay $18,000 for his participation in Medicare fraud. He sold his agency in December 1994 to a Georgia agency but backdated the sale to November 12, 1994. This sleight-of-hand allowed the corporation to bill Medicare for all the services provided by the former owner's HHA, thereby covering nearly all of the corporation's acquisition costs. Although the former owner provided no services, he received a $5,000 a month salary from December 1994 to June 1995.[47]

• The former owner of a Texas HHA was handed a sentence of 27 months after he pled guilty to filing false Medicare claims totaling more than $49,000 in only 6 months. The harsh sentence was partly due to a previous state conviction for embezzlement.[48]

• Two brothers in Texas conspired to include phony expenses for medical supplies, office supplies, and automobile leases on Medicare claims forms. One brother was the president of a medical supply company, which sold equipment to the other brother's agency at a 100 percent markup. The two then altered invoices for supplies not purchased and fabricated automobile lease contracts from vendors who never leased vehicles. They agreed to pay $30,000 to resolve their civil liabilities.[49]

• In 1996, John Watts, Jr. pled guilty to defrauding Medicare of at least $1.5 million. He started his company, United Care Home Health Services Inc., just 13 months after finishing a prison term for dealing cocaine. Watts paid kickbacks to local doctors to get his first patients, but later decided it was easier just to bill for services never provided, in some cases using the names of dead people. Watts sent his claims via computer. When investigators asked for documentation of the services, Watts and his partner forged the documents, hoodwinking investigators for several months. Watts made so much money with the scam that he was able to put a $1.2 million cash down payment on a $2.5 million house.[50]

• In less than one year, Urgent Home Health Care of Washington, D.C., billed for 1,450 visits its nurses never made, often leaving patients waiting for needed care. The owners of the company, Pauline Bapack and Pierre Yopa, collected about $100,000 for those fraudulent billings. Bapack was sentenced to three years in jail. Yopa is wanted for failing to show up for sentencing.[51]

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[42] HHS, OIG, Semiannual Report, April 1, 1996–September 30, 1996, p. 18.
[43] Idem.
[44] Idem.
[45] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, pp. 24–25.
[46] HHS, OIG, Home Health: Problems and Their Impact on Medicare, July 1997, p.9.
[47] HHS, OIG, Semiannual Report, April 1, 1996–September 30, 1996, p. 19.
[48] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, pp. 26–27.
[49] Ibid., p. 27.
[50] Peter Eisler, "Fraud On the Rise," USA Today, November 12, 1996.
[51] Brooke A. Masters, "Investigators Try to Keep up with Growing Problem of Health Care Fraud," The Washington Post, April 6, 1997.

NURSING HOME FRAUD

Most nursing home staffs are trustworthy providers of care and comfort for seniors who are unable to care for themselves. When nursing home doctors, nurses, suppliers, or staffs defraud the Medicare system for personal gain, they break that trust. The GAO identified two reasons why nursing homes are so vulnerable to fraud:

First, because a nursing facility locates individual Medicare beneficiaries under one roof, unscrupulous billers of services can operate their schemes in volume. Second, in some instances, nursing facilities make patient records available to outside providers who are not responsible for direct care of the patient, contrary to federal regulations that prohibit such inappropriate access.[52]

As the baby-boom generation matures and more seniors enter the nursing home system, the potential for fraud will explode. The following cases are recent examples of fraudulent schemes involving nursing home facilities:

- An Ohio hospital agreed to pay the federal government $1.45 million to settle charges of defrauding the Medicare and Medicaid programs. False claims for geriatric psychiatric services that were non-therapeutic or unnecessary were submitted while the hospital was operating an outpatient clinic for nursing home patients. Many of the patients suffered organic brain disorders that did not call for psychiatric treatments, resulting in an overpayment to the hospital of more than $600,000. The hospital agreed to enter a corporate integrity program.[53]
- A company in New Jersey that employed psychologists to provide services to nursing home residents agreed to pay $700,000 to settle allegations it submitted false Medicare claims. The company billed for 45 to 50 minutes of psychotherapy to nursing home residents when only 20 to 30 minute sessions were held. Some of the company's psychologists billed for more than 14 hours of therapy a day, and one billed for the equivalent of more than 24 hours in one day. The company has entered a corporate integrity program.[54]
- An Illinois ambulance company owner and one of his employees pled guilty to Medicare and Medicaid fraud for filing false and inflated claims for same-day, round-trip transfers of nursing home patients, many of whom were in fact bed-confined. The company owner was sentenced to 5 months' incarceration, ordered to sell his business, and fined $10,000. He had previously agreed to a $367,000 civil settlement. The employee was given two years probation and fined $500.[55]
- A podiatrist received $143,580 for performing unneeded surgical procedures on at least 4,400 nursing home patients during a six-month period. A doctor would have to operate on at least 34 patients per day, five days a week in order to perform surgery at that volume.[56]
- A Florida therapy company provided free services to nursing homes, then billed group activities such as sing-alongs and arts-and-crafts classes as individual therapy for each patient. The sing-alongs were billed as speech therapy. The arts-and-crafts classes were billed as occupational therapy. The company offered the services to the nursing homes in exchange for information from the patients' charts, which they then used to bill Medicare.[57]

LABORATORY FRAUD

HHS determined in 1993 that many independent clinical laboratories were billing Medicare for millions of tests that were medically unnecessary. Many individual lab tests are included in a routine screen, or panel, of tests. Some laboratories, however, were leading physicians to believe that the tests were free of charge and then billed Medicare for them anyway. The government ordered a national investigation involving the HHS IG auditors, HCFA staff, U.S. attorneys, and federal law enforcement agencies to examine clinical laboratories.[58] What follows are some examples of fraud uncovered during those investigations:

- In one of the biggest financial settlements involving healthcare fraud in the history of the False Claims Act, one laboratory agreed to a $325 million settlement and

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[52] GAO, Fraud and Abuse: Providers Target Medicare Patients in Nursing Homes (GAO/HEHS–96–18), January, 1996, p. 2.
[53] HHS, OIG, Semiannual Report, April 1, 1996–September 30, 1996, pp. 22–23.
[54] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, pp. 29–30.
[55] Ibid., pp. 30–31.
[56] GAO, Fraud and Abuse in Nursing Homes, p. 4.
[57] Lindsay Peterson, "Medicare Swindlers Exposed," The Tampa Tribune, June 23, 1996.
[58] U.S. Department of Justice, Health Care Fraud Report, Fiscal Years 1995–1996, p. 7.

entered a corporate integrity agreement to ensure stringent compliance in its future billing practices.[59]

• A laboratory owned by SmithKline Beecham allegedly programmed computers to fabricate information for Medicare claims when missing or incomplete data would have delayed payment and, in some cases, substituted a false diagnosis that would assure payment instead of submitting one that would be rejected. The company has also been accused of unbundling tests, charging for tests that doctors never ordered, and offering physicians kickbacks for patient referrals.[60]

• Another major clinical laboratory agreed to pay $187 million to resolve its civil liabilities and to enter a corporate integrity program with comprehensive training and monitoring. One of its constituent laboratories also pled guilty to fraud, paid a $5 million criminal fine, and was excluded from participation in federal and state healthcare programs.[61]

• A fourth major independent laboratory fell victim to "successor liability" for the conduct of laboratory companies that it had purchased during its growth in the early 1990s. Two settlements were reached amounting to $130 million, bringing the total amount recouped in this case thus far to $185 million.[62]

• In early 1997, Medicalab Inc. and its owners agreed to pay $1.3 million to settle allegations that it defrauded Medicare by overbilling for mileage traveled by workers and charging for duplicate radiology services.[63]

DURABLE MEDICAL EQUIPMENT

DME is one of the more prevalent and long-standing areas of fraud. Medicare is often billed for higher-cost equipment than that which is actually delivered, equipment that never arrives at all, medically unnecessary equipment and supplies, or equipment delivered in one state but billed in a state where the reimbursement rates are more generous. The HHS IG's office has made investigating DME scams one of its highest priorities. There are a number of ingenious scams used by unscrupulous companies and individuals in order to squeeze more money out of Medicare, including the following cases:

• A New York physician, who was sentenced to 12 months' imprisonment and ordered to pay $87,000 in restitution, was one of 19 people participating in a scam involving a medical supply company which ended up costing Medicare more than $13 million over an 18-month period. Without ever seeing patients, the physician signed medical necessity forms, then falsified medical charts to indicate treatment.[64]

• Ben Carroll, owner of Bulldog Medical of Kissimmee Inc. and MLC–Geriatric Health Services, was sentenced to 10 years in prison for overbilling Medicare by $71 million. Mr. Carroll billed Medicare for urinary-collection pouches costing $8.45 each, when what he actually supplied were adult diapers costing only 35 cents each. He also pled guilty to defrauding Medicare of $2.3 million in Kansas City, Kansas.[65]

• Alfredo Lazaro Borges of Miami set up two phony DME supply companies and, using the Medicare identification numbers of patients and the names and identification numbers of several licensed physicians, filed falsified Medicare claims between August 1993 and June 1994. He stole $2.6 million in the course of one year. He never saw a patient, nor did he ever provide anyone with any medical equipment.[66]

The FBI is investigating complaints that several companies in the Tampa Bay area offered free motorized wheelchairs to residents of a seniors' housing complex, but delivered motor scooters instead. The scooters sell for around $1,700 each; Medicare was billed and paid nearly $5,000 each for what it thought were wheelchairs.[67]

• In Charlotte, North Carolina, federal prosecutors have charged five men and one woman with filing more than 11,000 fraudulent Medicare claims for medical supplies and equipment.[68]

• On December 13, 1996, Arthur Schinitsky, a supplier of medical equipment based in Bradenton, Florida, pled guilty to charges that he defrauded Medicare by

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[59] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, p. 32.

[60] David S. Hilzenrath, "Medicare Scams Easy, Officials Say," The Florida Times Union, August 10, 1997.

[61] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, p. 32.

[62] Idem.

[63] Associated Press, "Lab Settles Medicare Fraud Allegations with Feds for $1.3 Million," The Boston Globe, July 1, 1997.

[64] HHS, OIG, Semiannual Report, April 1, 1996–September 30, 1996, pp. 24–25.

[65] Maya Bell, "Medicare Easy Target for Thieves," Orlando Sentinel, June 15, 1997; and Associated Press, "$71 Million Medicare Overbilling Alleged Against Medical Supplier," The Washington Post, October 13, 1996.

[66] "Man Sentenced for Fraud," Fort Lauderdale Sun-Sentinel, March 22, 1997.

[67] Lindsey Peterson, "Scooter Bills Spur Probe," Tampa Tribune, July 27, 1997.

[68] Harvey Burgess, "Fraud Suspect Strikes Deal," The Herald Rock Hill, April 25, 1997.

submitting claims for services he never delivered. On some of the claim forms, he used the Social Security numbers of dead people. His network of transactions involved at least 15 real or fictitious businesses in three states, and relied heavily on mail services, which helped delay his capture. Two of his employees have also been charged with complicity in the scams. In all, Mr. Schinitsky is accused of stealing $9 million from the government.[69]

• As part of a plea bargain agreement, a Texas DME company paid restitution of $450,000 and was sentenced to one year probation for supplying wheel chair pads to nursing home patients and then fraudulently billing Medicare for a more expensive lumbar sacral support system.[70]

• A physician fled to the Dominican Republic and his cohort in crime fled to Sierra Leone for preparing and signing fraudulent certificates of medical necessity for DME. A New York judge sentenced the Dominican refugee in absentia to 78 months in prison and ordered him to pay $3.5 million. His partner waived extradition to return to the United States.[71]

• A New York DME company used a sham subsidiary to submit claims in Pennsylvania for equipment sold in Western New York. In addition to a criminal fine of $300,000, the subsidiary also pled guilty and agreed to make full restitution of $1.1 million and to pay a civil penalty of $2.5 million.[72]

• A Pennsylvania DME company agreed to pay $110,000 to settle criminal and civil liabilities for submitting false claims to Medicare for marketing and distributing lower-quality body jackets to long-term care facilities than those actually delivered. The company and its president were barred for life from participation in any HHS programs.[73]

LYMPHEDEMA PUMPS—A SPECIAL LOOK

A significant area of abuse in DME has been the purchase of lymphedema pumps. Lymphedema is the swelling of an arm, leg, or other part of the body, a condition that can occur when lymph nodes and vessels in the armpit or the groin have been removed or damaged by surgery, radiotherapy, or blocked by a tumor. This condition is most common in cancer patients whose lymph nodes have been removed. Although there is no cure for lymphedema, several treatments are available to control swelling, including pumps. These pumps vary in complexity and range in price from $600 to $6,000 each. HCFA recognizes the pumps as a treatment of last resort.[74]

Several medical supply companies have settled charges that they defrauded Medicare for marketing and selling lymphedema pumps for $500 while billing Medicare $5,000 each. The allegations of fraud were first made by Ron Wells, the owner of a medical supply company. In 1991, Wells was approached by Huntleigh Technology Inc., an American subsidiary of Huntleigh Technology of Great Britain, and asked to participate in a network of retailers offering the pumps for the marked-up price. Wells realized that the pumps were identical to a version that cost only $600 and reported the company's improprieties to authorities. The government's investigation led to a settlement with Huntleigh in which the company agreed to repay $4.9 million.[75]

Many of the medical supply companies that purchased the pumps from Huntleigh have also reached settlements with the government. The latest settlement came in May 1997, when Mediserv Inc. of Texas agreed to pay $1.35 million and Medico International Inc. of New Jersey agreed to pay $150,000. In all, the federal government has garnered $15 million from settlements of such charges. None of the companies were required to admit wrongdoing, however. Between 1990 and 1992, Medicare claims for the pumps jumped from $4.8 million to $49.1 million.[76] A few specific examples:

• The former owner of New Jersey's largest Medicare supplier of lymphedema pumps was sentenced to 35 months in prison followed by 3 years supervised release, fined $7,500, and ordered to pay a total of $220,100 in restitution for a scheme involving beneficiaries in Florida and New Jersey. The owner billed Medicare for pumps reimbursable at $4,000 per pump when cheaper quality pumps were actually

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[69] Sara Langenberg, "Medicare Fraud Charges Spread," Sarasota Herald-Tribune, April 16, 1997.
[70] HHS, OIG, Semiannual Report, October 1, 1995–March 31, 1996, p. 26.
[71] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, p. 34.
[72] Ibid., p. 35.
[73] Ibid., p. 36.
[74] Idem.
[75] Robert Rudolph, "U.S. To Reward Whistleblower for Diagnosing Medi-Fraud," The Star-Ledger, May 24, 1997, p. 1.
[76] Idem.

delivered. In addition, many of the pumps were medically unnecessary, and overpayments totaled more than $200,000.[77]

• A Maryland DME company agreed to pay $1.5 million and enter a corporate integrity program to prevent future incorrect billing after submitting claims for lymphedema pumps under an improper code. The company was overpaid approximately $690,000.[78]

• Bernice Tambascia, owner of MedFast Inc., forged physicians' signatures for prescriptions of lymphedema pumps and billed Medicare in New Jersey and Florida for the equipment. She was sentenced to 2 years and 11 months in jail, and ordered to make immediate restitution of nearly $200,000 to Medicare carriers and to a private insurance company.[79]

• In October 1995, National Medical Systems agreed to a $1.5 million settlement for billing the government for 200 top-of-the-line lymphedema pumps when it provided much cheaper equipment. Public Integrity Inc., a watchdog group for the medical equipment industry, received $225,000 for bringing the qui tam suit that led to the settlement.[80]

• The former owner/operator of a DME company in the state of Washington was sentenced to a year and a day in prison, 3 years' supervised release, and ordered to pay $294,860 in restitution, fines, and penalties. He billed Medicare and private insurance companies for lymphedema pumps at $4,500 each, but delivered pumps that were only worth $600 and pocketed the difference.[81]

HOSPITAL FRAUD

Recent headlines demonstrate that Medicare fraud is also occurring in some of the nation's most prestigious hospitals. The chief executive officer of the largest investor-owned hospital chain in the U.S., Columbia/HCA, was forced to resign after three employees at a Columbia hospital in Florida were indicted for Medicare fraud. Now, the government has expanded its investigations and says the entire company has become a target of the probe. Investigators want to know whether Columbia illegally passed on to Medicare the costs it incurred during the acquisition of hospitals and other healthcare facilities. The government is also investigating Columbia's home healthcare division to determine if the company engaged in cost-shifting of non-reimbursable items such as gift shop merchandise and cafeteria expenses. The investigation could ultimately cost Columbia a record $1 billion.[82]

HHS officials are also examining the billing practices of many of the nation's 125 teaching hospitals. These audits, commonly referred to as PATH audits (Physicians at Teaching Hospitals), aim to find out if some hospitals billed Medicare for the treatment of patients by senior doctors when medical records show the work was actually performed by residents. Not surprisingly, politics are seeping into the act. Several members of Congress, under heavy pressure from teaching hospital lobbyists, are trying to persuade HHS to suspend the audits pending the release of a congressional study that will try to determine whether the complexity and vagueness of HCFA's regulations contribute to the problem.

While many of Medicare's billing foul-ups certainly occur as a direct result of confusion, it is also clear that some teaching hospitals have erroneously billed for a senior physician's services even when the physician was not physically in the hospital at the time. HHS IG June Gibbs Brown recently explained in a letter to CAGW that:

In order to claim reimbursement from Medicare Part B for a service rendered to a patient, the teaching physician must have personally provided the service or have been present when the intern or resident furnished the care. Physicians claiming reimbursement for services only provided by the intern or the resident are making a duplicate claim—since that service has already been paid for under Part A through the Graduate Medical Education Program.

The following recent incidents are only the tip of the iceberg. More are sure to be uncovered as HHS auditors go forward.

• A former controller and vice president of finance at a New Jersey medical center was ordered to make restitution of more than $1 million to the hospital and $24,870 to Medicare after he was sentenced to 25 months in prison for tax evasion,

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[77] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, p. 37.

[78] HHS, OIG, Semiannual Report, October 1, 1995–March 31, 1996, p. 25.

[79] Joseph D. McCaffrey, "Cherry Hill Woman Gets Prison in Med-Fraud," The Star-Ledger, September 20, 1996.

[80] John Rivera, "Health Care Fraud Cases on the Rise," The Baltimore Sun, August 19, 1996.

[81] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, p. 37.

[82] Greg Jaffe and Eva Rodriguez, "In Hospital Probes, a New Focus on Bottom Line," The Wall Street Journal, September 12, 1997.

embezzlement, and fraud. The official agreed to aid in the investigation of other hospital officials accused of kickbacks and false billing schemes that cost the hospital nearly $3.8 million. The executive vice president was also sentenced to 55 months in prison and ordered to repay $21,000. Three others executives who pled guilty await sentencing.[83]

• Part of a Pennsylvania university healthcare system agreed to pay $30 million to settle charges of defrauding Medicare. An audit and investigation revealed that false Medicare bills (totaling approximately $10 million) were submitted for physician services, and that many of the claims improperly reported the level of care provided or falsely reported the involvement of attending physicians.[84]

• The FBI and the Justice Department are currently investigating whether 4,600 hospitals have been routinely billing twice for blood tests, X-rays, and other outpatient services performed during pre-admission workups. Those services are supposed to be included in the fee Medicare pays for a related inpatient stay.[85]

PROGRAM EXCLUSIONS

One method of deterring fraud is to bar perpetrators from participation in the Medicare program, temporarily or permanently.

According to the IG, such program exclusions can be imposed for "conviction of fraud against a private health insurer, obstruction of an investigation, distribution of a controlled substance, revocation or surrender of a healthcare license, or failure to repay health education assistance loans." The following are only a few of the thousands of program exclusions issued by HHS over the past several years:

• The owner and operator of eight Florida DME companies was excluded from Medicare for 30 years after being convicted of conspiracy to defraud, filing false and fraudulent claims, and paying kickbacks for the referral of Medicare patients. One employee was also convicted of conspiracy and excluded from Medicare for 10 years.[86]

• Two officers in two different Florida DME companies were excluded from Medicare for 20 years each after selling liquid nutritional supplements to beneficiaries who didn't need them. The companies paid fees to several doctors to sign certificates of medical necessity authorizing the supplements, even though the doctors never examined the patients. Once the companies had the certificates, they billed Medicare about $400 each month for the supplements and an additional $250 each month for tubal feedings.[87]

• After convictions for defrauding Medicare of more than $108,000, a Florida DME company owner and its sales manager were both barred from the program for 10 years. The two had submitted false claims for X-ray tests that had not been ordered or were determined to be medically unnecessary, and for equipment that had never been provided.[88]

TIME FOR REAL CHANGE

The current crusade against Medicare fraud is long overdue. Unscrupulous providers who game the system must be punished. However, it is striking to note that the $23 billion in losses identified by the IG are referred to as "improper payments" rather than "fraud," and that more than half of that estimate is based on insufficient or total lack of documentation. Criminalizing and exacting restitution for paperwork snafus and honest misunderstandings will certainly replenish government coffers. The real question is: Will it improve the quality of healthcare for Medicare beneficiaries?

Under the current system, greedy providers motivated to prey on Medicare's inherent vulnerabilities have shown almost limitless creativity in ripping off the system, sometimes repeatedly and for long periods of time. At the same time, law-abiding healthcare providers must engage in expensive anti-fraud education and retain professionals to help them constantly retool their billing systems, as well as to figure out how to recoup some of their costs. As Congress reflexively returns again and again to providers, squeezing them as a short-term fix for Medicare's financial problems, it is almost inevitable that they will, at times, skirt the bounds of "proper" reimbursements.

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[83] HHS, OIG, Semiannual Report, October 1, 1996–March 31, 1997, pp. 7–8.
[84] HHS, OIG, Semiannual Report, October 1, 1995–March 31, 1996, p. 13.
[85] David S. Hilzenrath, "Medicare Scams Easy, Officials Say," The Florida Times Union, August 10, 1997.
[86] HHS, OIG, Semiannual Report, October 1, 1995–March 31, 1996, p. 12–13.
[87] HHS, OIG, Semiannual Report, April 1, 1996–September 30, 1996, p. 10.
[88] HHS, OIG, Semiannual Report, October 1, 1997–March 31, 1997, p. 16.

The Clinton Administration recently suspended a contract for the design of an advanced computer system that would have accelerated payments, improved service, and reduced fraud. The idea was to create a single national database, which would pay all doctors and healthcare facilities that serve Medicare beneficiaries. Government officials finally concluded that Medicare's payment system was far more anachronistic and impenetrable than they had anticipated. They were unable to even reconcile the current system. Estimates on how much this fiasco cost taxpayers vary between $30 to $43 million.[89]

Medicare teems with perverse incentives that drive both providers and beneficiaries to spend money that contributes nothing to individual health. Many of the features designed to control costs actually compromise well-being, force seniors to spend billions out-of-pocket, and encourage wasteful spending. The new wave of price controls included in the Balanced Budget Act passed by Congress is yet another politically facile, stop-gap measure that will simply compound Medicare's problems.

MEDICARE'S PRICE CONTROLS

Medicare was initially an open-ended entitlement program that promised to pay for every medical service and procedure for every eligible beneficiary on a reasonable cost basis. By 1982, the explosive costs of this approach became politically and financially unsustainable. So Congress and President Reagan agreed to squeeze the "fat" out of Medicare by instituting strict price controls, known today as the prospective payment system (PPS).

The PPS established fixed prices for hospitals for treatment of different types of illnesses. In 1989, Congress went a step further and created the Resource-Based Relative Value Scale (RBRVS) for doctors serving Medicare patients. Supporters at the time, including CAGW, argued that price controls would force hospitals and doctors to be more efficient. But, instead, price controls in Medicare actually increased costs and barriers to healthcare.

In the 1980s, healthcare costs in the private sector rates exceeded Medicare's rates. For example, in 1996 Medicare costs grew at a rate of 8.5 percent per year, while private sector costs increased at an annual rate of only 3.2 percent. According to the January 1997 Congressional Budget Office (CBO) baseline budget estimates, Medicare is projected to continue to grow at 8.5 percent per year over the next 5 years, while federal budget outlays will grow at an average annual rate of 5.2 percent and the gross domestic product at an average of 4.8 percent.[90]

Indeed, rather than promoting efficiency, price controls have only led to rationing of healthcare services as a way of reducing costs. As health analyst J.D. Kleinke points out, "Medicare's prospective payment system effectively rewards the rapid discharge of patients, many of whom are not well enough, relapse, are re-admitted—and the meter starts running all over again."[91] In other words, Medicare gets people out of hospitals quicker, but sicker.

HOW PRICE CONTROLS PROMOTE WASTE, FRAUD, AND ABUSE

The causes of fraud and waste in Medicare are deeply rooted in the program's structure itself. The absence of any incentives to deliver high-quality, low-cost healthcare greatly contributes to the problem. First, price controls have encouraged doctors and hospitals to "cost shift," or recoup their losses by increasing their prices to unregulated, or privately insured, patients. Second, providers have resorted to "unbundling" medical procedures, separating a course of treatment into individual, more expensive elements. Third, they will often "upcode" a diagnosis to maximize reimbursement. Fourth, even though Medicare caps the price it will pay for a medical procedure, it will also pay for any procedure for which a claim is filed. It is common to hear seniors complain about their Medicare bills being loaded up with lots of unnecessary procedures. Fifth, a whole new industry has sprung up to educate physicians and other healthcare providers on how to understand, and work around, Medicare's labyrinthine payment systems.[92] Of the $23 billion in improper payments uncovered by the HHS IG, 36 percent were for services deemed medically un-

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[89] Robert Pear, "Modernization for Medicare Grinds to a Halt," The New York Times, September 16, 1997.

[90] Gail Wilensky, Ph.D., Testimony before Senate Finance Subcommittee on Health Care, February 12, 1997, p. 3.

[91] Susan Horn and Robert Goldberg, "A Sickly Approach to Medicare," The Washington Post, September 17, 1995.

[92] Edmund Haislmaier, "Why Global Budgets and Price Controls Will Not Curb Health Costs," Heritage Foundation Backgrounder, No. 929, March 8, 1993, pp. 18–19.

necessary after the fact. This steady increase in losses attributable to improper billing is not surprising when the system is set up to reward quantity of care, rather than quality of care.

ENFORCEMENT ALONE WILL NEVER ELIMINATE FRAUD AND WASTE

Will more aggressive oversight make a difference? Yes, but it will come at a tremendous cost, both in dollars and in further corrosion of the doctor-patient relationship. Every action taken by a doctor or hospital will increasingly be subject to second-guessing and third-party monitoring. Medical judgments made and services rendered will become, in retrospect, grounds for civil and criminal action. Even today, doctors and hospitals practice the art of medicine with the knowledge that even an honest billing error could set off chain of events that could threaten their livelihoods and even land them in prison. It remains to be seen, for example, how much of this is true and the government's unprecedented investigation of Columbia/HCA. These unfavorable trends will only continue and grow under the current system.

This post hoc criminalization of medicine is a direct outgrowth of Medicare's archaic system. Because it is an entitlement, the Medicare bureaucracy in Washington, D.C., has only the most tenuous control over the program as a whole. Hence, no amount of enforcement will have an impact on the real reason providers inflate medical bills. Medicare cannot capture quality-based savings, because it cannot measure quality, and it will pay for any healthcare, regardless of whether it is good, bad, or indifferent.

Even now, despite a push to improve the quality of the healthcare purchased through Medicare, the program lacks accurate information on how the treatments it pays for relate to the patient's true medical needs or the patient's ultimate well-being. Until recently, even private insurers did not demand, and did not receive, up-to-date medical information. However, under the lash of market competition, private healthcare providers have begun to recognize the value of fresh, accurate data and are spending more money to capture, store, and analyze the information needed to generate quality healthcare. Medicare has no such market forces to reward quality.

In fact, Medicare lags so far behind the private sector in the inevitable rush toward the information age that a recent GAO report stated:

HCFA's efforts in distributing comparative performance data lag behind those of state agencies and many employers in the private sector. Furthermore, GAO's analysis of HCFA's previous implementation efforts raises concerns about how well HCFA will implement comprehensive programs to deal effectively with poorly performing providers and improve all providers' performance.[93]

Even if Medicare tried to improve quality, spending money on anything other than Medicare's benefits package must first be approved by HCFA, a process that takes years. As a result, Medicare is also unable to compete with the private sector in using both managed care and healthcare outcomes to measure and control unnecessary medical spending.

Similarly, Medicare has been notoriously slow to recognize and adopt new medical treatments and innovative technologies that provide better healthcare. For example, cochlear implants, which are widely accepted as a superior treatment for hearing loss, are not reimbursed under Medicare. Consequently, patients must pay between $3,000 and $5,000 out-of-pocket for this state-of-the-art technology, and physicians may be reluctant to recommend the treatment to low-income patients. Overall, the Medicare bureaucracy conducted only 10 assessments of new technologies and innovations for coverage under Medicare in 1991, and only eight in 1992. Some ongoing assessments have been under consideration for over three years.[94]

THE IMPACT ON THE ELDERLY

Medicare's antiquated approach to medicine does more than compromise patient care. Seniors tend to spend more on healthcare than the general population and they also spend more on co-payments and deductibles. But studies show that seniors who purchase Medigap insurance (in addition to Parts A and B) to cover these costs spend 70 percent more on healthcare than those who do not, with little measurable increase in their well-being.[95]

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[93] GAO, Medicare: Federal Efforts to Enhance Patient Quality of Care, April 10, 1996.

[94] Peter Ferrara, "A Proposal for Reform: Resolving the Medicare Crisis," United Seniors Association, Fairfax, Virginia, 1996.

[95] Michael Morrisey, "Retiree Health Benefits," Annual Review of Public Health, 1993, Volume 14, pp. 271–292.

THE IMPACT ON FUTURE BENEFICIARIES

In spite of the reforms made to Medicare in the 1997 Balanced Budget Act, Medicare will only remain solvent for 10 years. The program will begin to accrue losses just as the baby boomers begin to retire.

For the last 15 years, Medicare has grown faster than any other federal program. The Medicare tax has increased from 0.7 percent of the first $6,000 in wages to 2.9 percent of every dollar in wages. In 1965, there were 5.5 workers for every beneficiary. Today, there are 3.9 workers for the current number of beneficiaries. The number of retirees will increase by 800 percent in the next 15 years, leaving only 2.2 workers to support every beneficiary.[96] The system foments intergenerational competition for resources and will, if left unchecked, rob future workers—along with their children and grandchildren—of their livelihoods.

REDUCING FRAUD BY REFORMING MEDICARE

To paraphrase Friedrich Hayek, the Nobel Prize-winning economist, there are only two ways of holding men accountable: prices and prisons. Enforcing price controls requires throwing people in jail. Unfortunately, some of the people who get thrown in jail may have honestly misunderstood the regulation they needed to follow. But, when prices are set by free-market forces, overcharging for a product is simply punished by the loss of market share.

Eliminating fraud in Medicare calls for reducing the incentives and opportunities to profiteer. Medicare is currently rife with such enticements. Only the discipline of the free market and the creation of a patient-centered healthcare market will allow Medicare patients to choose care based on cost and quality. Providers will then have to compete for patients based upon their ability to provide a variety of quality medical outcomes.

The following changes would go a long way toward establishing such a system:

1. Medicare would be changed from a government-run, fee-for-service health insurance plan to a system in which Medicare beneficiaries would choose among publicly available private health insurance plans. The government would subsidize insurance purchases through individual premium allowances, at an amount set by the average price of competing plans, keyed to a benchmark benefit package.

2. Healthcare plans, physician groups, and health insurers would have to provide consumers with information on the quality of their care. Recent studies show that beneficiaries value such information because they want to be informed, cost-conscious consumers of healthcare services, rather than passive recipients.

3. Direct competition between provider systems would be based on quality and cost. Providers would no longer go to Medicare for their payments. How much money to spend and what to spend it on would be the responsibility of Medicare program participants. The Medicare bureaucracy would simply serve to collect and disseminate up-to-date, patient-friendly healthcare information and stimulate the universal adoption of the best available medical practices. Rooting out and eradicating fraud would be the responsibility of the private sector.

Leaders in healthcare policy from all sides of the political spectrum are now providing sound ideas and solutions for transforming Medicare into a program that responds to the needs of the elderly by providing the best possible healthcare at a reasonable price. Many of these ideas have originated in think tanks and public policy organizations.[97] The Medicare commission, which will be established pursuant to the Balanced Budget Act, should give careful consideration to these proposals, and be bold in its final recommendations. The future health of Medicare, our economy, and our people depends upon true reform.

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[96] Senator Phil Gramm, "How to Avoid Medicare's Implosion," The Wall Street Journal, February 4, 1997.

[97] Senator Phil Gramm, "How to Avoid Medicare's Implosion," The Wall Street Journal, February 4, 1997; Dowd, Feldman, and Christianson, "Competitive Pricing for Medicare," American Enterprise Institute, July 1996; Butler and Moffit, "Congress's Own Health Plan as a Model for Medicare Reform," Heritage Foundation Backgrounder, June 1997; Dave Kendall, "The Phony Medicare Debate," The Progressive Policy Institute, April 1996.