KEEPING FRAUDULENT PROVIDERS OUT OF MEDICARE AND MEDICAID

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

HOUSE OF REPRESENTATIVES

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KEEPING FRAUDULENT PROVIDERS OUT OF MEDICARE AND MEDICAID

THURSDAY, JUNE 15, 1995

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:23 a.m., in room 2247, Rayburn House Office Building, Hon. Christopher Shays (chairman of the subcommittee) presiding.

Present: Representatives Shays, Souder, Schiff, Chrysler, Martini, Clinger (ex officio), Towns, Barrett, Green, and Fattah.

Staff present: Lawrence J. Halloran, staff director and counsel; Doris F. Jacobs, associate counsel; Kate Hickey, Robert Newman, professional staff, Thomas M. Costa, clerk; Liz Campbell, minority staff assistant; and Cheryl Phelps, minority professional staff.

Mr. SHAYS. I would like to call this hearing to order and to welcome our witnesses. We are going to have a very important session today, and I appreciate you all for coming. I also welcome our guests and apologize that we don't have enough chairs.

The purpose of today's oversight hearing is to examine current efforts to fight fraud and abuse in the Medicare and Medicaid programs. In particular, we will focus on what can be done to keep fraudulent providers out of those important Government programs.

This is the third hearing this subcommittee has had on these issues. On March 22, we asked the HHS Inspector General, the GAO, and others to comment on the management of Federal health spending. On May 23, we heard from authors and commentators about waste in HHS programs, including the testimony of a young reporter from the New York Post who, at great risk, went undercover for 2 months on the streets of New York to expose a Medicaid scam costing more than $150 million a year in prescription drug diversion.

More than anything else, it was his testimony that prompted me and my ranking member to hold this hearing today, to answer the question, "How can it be so easy to steal so much?"

How much? Federal health care programs will cost $262 billion this year. According to the GAO, up to 10 percent of health care spending is lost to fraud and abuse. That means for Medicare and Medicaid losses of perhaps as much as $26 billion, or $71 million each day.

Losses of this magnitude pose a real threat to the solvency of Federal health care programs. Therefore, reducing fraud is an es-

sential part of the effort to control the growth of Medicare and Medicaid spending. It is also an effort which has broad, bipartisan support.

Yet we are not winning the fight. Today, there is little assurance that individuals and organizations known to have committed fraudulent activities will be kept out of the system. The financial incentives for abuse are great. The chances of getting caught are small. Penalties are mild. There are procedural delays. Enforcement resources are short, and there is a limited exchange of information among program administrators, insurers, and law enforcement officials.

Even when a wrongdoer is caught, the Government often settles the case for monetary fines and nominal restitution. This is called "pay and chase." In too many cases, we appear to be paying and chasing the same people over and over because the settlements allow wrongdoers right back into the system, and exclusion is used primarily against low-dollar fraud.

Those entrusted with the management of Medicare and Medicaid have the authority to screen providers seeking billing numbers, to suspend payments, revoke billing numbers, and exclude those providers who don't follow the rules. Yet the losses to fraud grow. So we must ask how current enforcement sanctions can be used more effectively, and what new authority might be needed to stem this tremendous drain on our health care system.

The threat of a more readily applied exclusion penalty could be a powerful deterrent force and could save taxpayers billions of dollars each year.

We have three panels of witnesses today. On our first panel, we have Bruce Vladeck, Administrator of HCFA; second, we have June Gibbs Brown, Inspector General, and Gerald Stern, Special Counsel, Health Care Fraud, Department of Justice; and on our third panel, we have Jonathan Ratner, Associate Director, Health Finance Issues, GAO, William Mahon, executive director, National Health Care Anti-Fraud Association, and Rufus Noble, inspector general, Health Care Administration, from Florida.

At this time I would like to thank my ranking member, and to say that he has really been a pleasure to work with. Much of what we are doing is an extension of what he did in his time as chairman, and we are going to try to come to some conclusions. I would like to ask Mr. Towns if he has a statement?

Mr. TOWNS. Mr. Chairman, I would be delighted to yield to the full committee Chair.

Mr. CLINGER. No.

Mr. SHAYS. I asked him first if he wanted to go ahead of me, in fact. I made sure I covered my bases.

Mr. TOWNS. I was trying to get those points.

Mr. CLINGER. You got them anyway.

Mr. TOWNS. First of all, Mr. Chairman, let me thank you for holding these hearings. As you have indicated in a very eloquent fashion, fraud and abuse are very, very serious. When you talk about 10 percent of the overall budget going to fraud and abuse, I think that is something that needs to be addressed, and now.

As you indicated in the last Congress, of course, we dealt with it. I wanted to let you know that yesterday I dropped a bill in, H.R.

1850, which deals with fraud and abuse, and I am hoping that at some point in time we will be able to have a hearing on that. I hope to be able to move it forward. Because if we look at fraud and abuse as we think about cutting Medicare and Medicaid, if we are able to eliminate it, there is a strong possibility that we would not have to cut too much from Medicaid or Medicare.

Then there is another issue that keeps popping up when I talk to people in the medical profession. They mention defensive medicine, which is also a form of abuse—saying they are required to do a lot of different things as a result of the fact that we have not been able to move in terms of real legislation. I am hoping that as a result of what we have heard today, if HCFA needs additional legislation, or if we need to do some things to make it possible for them to carry out their duties and responsibilities, we need to do that right away, because if we are losing 10 percent to fraud and abuse, we need to address it.

In another hearing we had, Mr. Kennedy from the New York Post indicated that he had gone underground and of course it was just so easy for him to defraud the Government. He made some very simple kinds of suggestions. He said an I.D. picture would help eliminate fraud. That seems to be very doable, and the fact that we have not moved to do some of these kind of things is really mind-blowing. I am hoping that as a result of what we hear today we will be able to take this information and address some of these issues, because if we are going to cut Medicare and Medicaid, and then of course on top of that we have this kind of fraud and abuse, that is something that needs to be dealt with.

The other thing, Mr. Chairman, that I was very concerned about, even when we try and go after fraud and abuse, it seems we waste manpower and womanpower hours with various agencies stumbling over each other. When an investigation took place, you would have three or four agencies investigating the same problem; and I think that somewhere along the line there needs to be better communication.

So I am happy to know that you are moving forward to take a very serious look at fraud, and I look forward to working with you in terms of trying to bring this problem under control.

I yield back the balance of my time.

[The prepared statement of Hon. Edolphus Towns follows:]

PREPARED STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman, thank you for convening today's hearing to examine fraud and abuse in the Federal health care system, the effectiveness of current enforcement efforts, and opportunities to improve enforcement of fraud and abuse violations.

This hearing continues the subcommittee's work initiated during my chairmanship in the 103rd Congress. I am confident that our continued efforts will bring us closer to identifying measures needed to decrease the billions of dollars the Federal Government spends unnecessarily in the financing and delivery of health care.

In fact, Mr. Chairman, I have before me H.R. 1850, which I introduced yesterday as a comprehensive anti-health care fraud measure. This bill was a component of the bipartisan legislation that the committee reported last year as part of health care reform. I hope that you and other members of the subcommittee will join me again in supporting H.R. 1850.

The general accounting office estimates that as much as 10 percent of U.S. health care spending, or $100 billion, is lost annually to health care fraud and abuse. Of

that amount, $25 billion can be attributed to fraudulent and abusive practices in the Medicare and Medicaid programs.

Several factors make the Medicare and Medicaid programs vulnerable to fraud: higher than market rates for certain services, equipment, and pharmaceuticals that encourage provider exploitation; weak and superficial fraud and abuse controls to detect questionable practices; and ineffective enforcement tools.

I am reminded of the recent testimony of Douglas Kennedy, who exposed the lax controls in the medicaid system, and demonstrated how, with no great difficulty, someone could cheat the system. Mr. Kennedy easily "rented" a number of Medicaid identification cards, and with the complicity of doctors, pharmacists, black marketeers, and the intended Medicaid beneficiaries, Mr. Kennedy defrauded the Medicaid program. One of his recommendations for corrective action? Simply putting a picture on the I.D. Card. Obviously, while it will not put an end to this type of fraud, we have to admit that it is a do-able step in the right direction.

Eliminating, or in the very least, controlling these opportunities for fraud and abuse can save billions of program dollars. More importantly, Mr. Chairman, the failure to curb these losses can no longer be sustained in the face of major cuts in Medicare and Medicaid that are being considered in both the Congress and in the White House.

The committee's oversight of this issue is critical; not only to the fiscal well-being of these programs, and the Federal Government as a whole—but in view of the fact that these fraudulent practices also undermine the quality of care available to Medicare and Medicaid beneficiaries—our oversight is critical to the health of the most vulnerable of America's citizens.

Chairman Shays, I join you in welcoming today's witnesses, and look forward to hearing their perspective on the serious concerns I hope to see addressed here today:

For example, fragmentation of health care fraud enforcement is a significant contributor to the prevalence of fraud and abuse in the system. How can we address the problems of overlapping and unclear jurisdiction of Federal health care law enforcement agencies? Is "Operation: Restore Trust" the answer?

Second, I am concerned that HCFA may not be exercising sufficient authority to exclude fraudulent or abusive providers from participation in Medicare and Medicaid programs. Does HCFA need additional statutory authority? Do they need to make more aggressive use of current authority? Are there aspects of HCFA administrative practices or management controls that contribute to health care fraud and abuse?

Finally, I am deeply concerned about the repeated opportunities we allow criminal providers to defraud the Federal Government. GAO found that although Federal laws are in place to exclude convicted providers from program participation, no one with authority and adequate resources monitors those charged or convicted. What needs to be done to correct this problem? Are there changes that must be made to current criminal and civil statutes to improve their effectiveness in sanctioning and deterring health care fraud?

This committee has the responsibility and the authority to ensure the accountability, the integrity, and the effectiveness of the Federal health care system. Mr. Chairman, I look forward to working cooperatively with you in pursuing solutions, including legislative remedies, to these seemingly intractable problems with fraud and abuse control.

Mr. SHAYS. I thank the gentleman. At this time, I would like to recognize the chairman of the full Government Reform Committee. I would also like to suggest that anytime you attend a hearing that we meet in the full hearing room so we have a little more space. It is wonderful to have you here. I welcome any statement you might have.

Mr. CLINGER. I am sure my presence is not the reason for the good attendance here.

The issue is a very important one, and I want to commend you for bringing this very critical subject of Medicare and Medicaid fraud and abuse before the subcommittee, and I certainly want to associate myself with your opening remarks, and those of Mr. Towns as well.

The problem before us is certainly clear. The General Accounting Office estimates that fraud and abuse consume nearly 10 percent

of all U.S. health care spending. The massive Medicare and Medicaid programs have become attractive, very attractive targets for unscrupulous providers because there is little chance under the present regime for being caught in a system that has really no effective, coordinated antifraud efforts.

It is estimated that Medicare and Medicaid will lose approximately $26 billion this year alone to fraudulent activities. Despite this alarming fact, the Government has not taken full advantage of antifraud statutes which allow the Government to "exclude" fraudulent providers from participating in the Medicare program.

Health care contractors who knowingly submit false, duplicate, or unnecessary reimbursement claims not only defraud the Government, they also defraud every senior citizen who relies on these essential programs for medical care and every other working American whose taxes help support the program. Fraudulent activity not only drives up the cost of the Medicare program, but also makes it more expensive for all individuals to afford quality health care.

God only knows for sure how many fraudulent providers are really out there. But when the Health Care Financing Administration and the Department of Justice do catch somebody, they ought to kick them out of the program permanently.

Does it make any sense to continue doing business with somebody who has ripped you off? Not to me, and I suspect not to anybody. I would love to hear why it makes sense to somebody in the Government to keep allowing people who have defrauded the Government to be able to continue to be a part of the program.

I say that because many of the bad actors in the program view penalties and fines as, frankly, a cost of doing business. Once they pay their fine, they move to a new location and restart the original scheme, and continue to scam the Government. When we demonstrate to these habitual offenders that exclusion and jail time are real possibilities, then I suspect we might have more success fighting fraud. To me, the exclusion provisions could serve as a valuable deterrent if used effectively and regularly. I hope the witnesses today will give the subcommittee some facts that give us an idea of how frequently or infrequently the exclusion authority has been used on the Federal level. If the witnesses have suggestions for making the exclusion provisions more attractive, then I suggest that they develop recommendations and present them to this committee for our consideration.

Cracking down on fraud is especially crucial considering the Medicare board of trustees' recent report warning that the Medicare trust fund will go bankrupt by the year 2002. If we are serious about reducing the rate of growth in Medicare and preserving Medicare for current and future beneficiaries—and that clearly is going to be one of the principal issues debated during this Congress—then antifraud efforts have to be included and any efforts to save the Medicare system should be a principal part of that effort.

Obviously, we don't want to get in a position of cutting services or reducing services to any extent, but we may have to if we are not able to find the kinds of savings we are going to have to to make it fiscally viable.

So, again, I want to thank you, Mr. Chairman, for conducting this hearing today, and I look forward to reviewing the testimony of the witnesses.

Mr. SHAYS. I thank the gentleman and appreciate his statement.

Mr. Chrysler, do you have a statement you would like to make?

Mr. CHRYSLER. Sure. Obviously, this is a very important issue, and we need to protect and preserve and strengthen the Medicare and Medicaid systems, and we are looking at ideas to do that. An idea that I heard at a town hall meeting last week was to give every person that receives Medicare or Medicaid treatment a copy of their bill. If they alert authorities that they were charged for something erroneously, we will let them keep 25 percent of what they save in order to root out the fraud and abuse and waste in these systems.

I think, second, and Mr. Towns mentioned, that we need the legal reforms which passed in the House and are being considered in the Senate right now.

Third, we need to pass medical savings accounts, which I am happy to say were introduced this week; and I think medical savings accounts could literally replace the Medicaid system and on the long term, over the long haul, replace 90 percent of Medicare.

But we do need your ideas, and the testimony we are going to hear today is extremely important because we need to hear from the people that are on the front lines of this system; their ideas are what can shape this debate and make the difference in the solutions that we come up with to preserve and protect and strengthen the Medicaid and Medicare systems.

Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

Mr. Souder, do you have a statement? We are about to begin and would be happy to hear any statement you might have.

Mr. SOUDER. No, I am here to listen.

Mr. SHAYS. Let me ask both our witnesses to stand up so they can be sworn, as we swear in all witnesses who come before the committee. Raise your right hand please.

[Witnesses sworn.]

Mr. SHAYS. Thank you. For the record, both have responded in the affirmative. And let me say that beside the Administrator of HCFA, Bruce Vladeck, we are also joined by Ms. Judy Berek, who is the Senior Advisor to the Administrator for Intraoffice Coordination. Do I have it correct? I didn't get it right?

Ms. BEREK. That is OK. I never use it. It is too long.

Mr. SHAYS. Well, it is nice to have you here.

Mr. Vladeck, we got your testimony at 9:30 last night. We ask all witnesses to summarize their testimony, but we are going to give you a little more leeway, to pay special attention to your testimony since we received it so late. I apologize that you have been here for 40 minutes already, but I guess you are used to that. It is nice to have you here, both of you.

STATEMENT OF BRUCE C. VLADECK, Ph.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY JUDY BEREK, SENIOR ADVISER TO THE ADMINISTRATOR FOR INTRAOFFICE COORDINATION

Mr. VLADECK. Thank you much, Mr. Chairman, members of the subcommittee. I really am very pleased to be here this morning. There is no area of the administration of the Medicare and Medicaid programs to which we attach more importance than our efforts to restore and improve public program integrity, and we are very mindful and appreciative of the work of this subcommittee in this very important area.

I do apologize for the lateness with which our testimony arrived. As I think you may understand, some of the folks involved in health care financing in the administration were busy the last week or two on other matters as well, and we will try not to make anything like a pattern of that in the future.

It was one reflection of the importance to me personally of our efforts to address issues of program integrity that for the first time in the history of our agency I created a special position within the Office of the Administrator to coordinate and lead fraud and abuse efforts and to address payment integrity throughout all of HCFA's programs and activities. We were fortunate to entice Judy Berek to take that responsibility and take on that role. I am pleased that she is with me this morning.

Our strategy toward addressing problems of fraud and abuse in Medicare and Medicaid has essentially three parts. Prevention is a centrally important part. To the extent we were unsuccessful with prevention and deterrence, we need to substantially strengthen our efforts and our success at early detection; and then not least, although third, given the division of labor provided under law, and in reference to a comment you made earlier, Mr. Chairman, it is especially important that we find better ways to work more effectively and more systematically with those organizations that have formal law enforcement responsibilities in this area.

Let me begin by saying a few words about prevention. Over time, the most effective fraud and abuse strategy is to pay the right claims for the right services at the right time in the first place, thus minimizing opportunities for fraud and abuse and limiting the extent to which we have to engage in so-called "pay and chase" activities in which we seek to identify problems after the fact, and particularly from a financial point of view, have to attempt to recover payments that should not have been made in the first place, which is necessarily an uncertain, lengthy and expensive process.

Prevention has a number of parts to it. One of the most effective ways to improve prevention is to better educate providers of service, beneficiaries as well as our contractors and the general public, about patterns or problems with fraud in the program, about ways in which they can help and be enlisted to identify particular problems and identify potential areas of fraud and abuse.

In the tradition that an executive agency needs to have at least one prop to present at a hearing of this kind, we did bring samples of pamphlets that we have distributed—over 3 million copies—to beneficiaries and to senior organizations on how to identify potential fraud in Medicare, in the medical and home medical equipment

part of the program, how to deal with problems of fraud and abuse more generally, both in English and in Spanish.

We are currently—and I am sorry Mr. Towns left for this particular comment—translating the fraud and abuse pamphlet into Russian because of some particular problems we have been having in the Russian immigrant community in Brooklyn with patterns of illegal behavior.

For all of those Medicare services for which beneficiaries are responsible for a copayment or a deductible, we do now routinely supply them with what is called the Explanation of Medicare Benefits, which is a report to the beneficiary that a claim has been paid on their behalf, identifying the provider, the date of service, and the nature of the service, and all of those forms that beneficiaries receive in the hundreds of millions a year contain information on how to report health care fraud or raise questions about the claim.

We are in the process of replacing the Explanation of Medicare Benefits with a monthly summary notice to cut down on the paperwork everyone has to live with, which will also permit us to highlight more centrally where the beneficiary can turn for assistance with questions or to report any problems of one sort or another.

In addition, in previous administrations, the practice of sending such notices for services such as home health visits where copayment or deductibles were not required was discontinued in order to save money. We have reinstituted the process of sending such notices for home health beneficiaries in the southeastern part of the United States in a pilot project that we expect to expand to the rest of the Nation within the next few months, again as part of the expanded process of enlisting beneficiaries in detecting and identifying fraud and abuse problems.

Last year, our contractors received more than 100,000 tips, most of them from beneficiaries, their family members or providers about potential instances of fraud and abuse. They are, in fact, along with our computerized pattern analysis of the sort I will refer to in a moment, the largest source of information from which we initiate investigations about potential fraud problems in the program; and we expect that number to continue to grow very substantially for reasons I will get to in a minute or two in my testimony.

Second, to say a few words about the process of detection, over the last 3 or 4 years we have engaged in a major effort with the Medicare contractors, the insurance companies with whom we contract to actually process claims and pay bills to totally revamp the way in which they review medical claims and to apply some of the modern technologies of pattern analysis in particular forms of computerized review to more effectively identify fraudulent or abusive claims.

Over time, the most important step we will take on the detection front in identifying patterns of fraudulent billing is the development and implementation of the Medicare transaction system which will replace the 10 different sets of software administered separately by 62 different contractors with a single, unified, national claims processing system with the most sophisticated modern pattern analysis and fraud detection software built into it.

At the moment, it is still possible for criminal or abusive providers to shop from one carrier or one intermediary to another because claims are processed separately and under somewhat different systems. It is possible for providers who have been identified conducting inappropriate behavior in one part of the country to set up shop in another part of the country, and it is a number of months before the centralized data system picks up the reappearance of such a carrier.

As we move forward with the implementation of MTS, within a couple of years we will have a single, national, on-line system that will contribute very importantly to our ability to detect such patterns and ultimately to deter them.

Mr. SHAYS. I am sorry, when did you say that would be?

Mr. VLADECK. We expect to begin implementation of the Medicare transaction system in 1997, and to have it fully up and running within about 15 to 18 months thereafter.

Third, we need to cooperate substantially better with enforcement agencies. To be blunt about it, I think there was some history within the Health Care Financing Administration growing out of past history of an attitude that fraud and abuse problems are the Inspector General's responsibility, the FBI's responsibility, and we have other things to do. As part of our emphasis—as a central part of our emphasis on the importance of program integrity, we have invested enormous resources and energy in substantially strengthening our working relationships with the Inspector General, with the Department of Justice, with the components of the Department of Justice such as the FBI and the U.S. attorneys, not only in Washington where it is critically important, but more importantly in the field, at the level of relationships between individual contractors, individual U.S. attorneys offices, local FBI offices, and so forth. We have somewhat more about that in my statement, but frankly I am happy to defer to my colleagues from the Inspector General and from the Department of Justice to tell you more about how some of those relationships work.

You asked us to comment specifically on abusive providers and those who have been identified in the system and what to do to get them out of the system. Again, as you know, the process of excluding providers from the system is one that under the law is the responsibility of the Inspector General. I would defer to her in talking about that process. But I want to tell you a little bit about some of our new efforts to deal with the front end of the process, the process by which providers enter the Medicare or Medicaid systems, which is our responsibility, which in the past has not been exercised with sufficient care, and where we have begun a series of very aggressive efforts to address the issue of who gets into the system in the first place.

Our first initiative in that regard has focused on suppliers of durable medical equipment and home medical supplies where there have been consistent patterns of problems over the years. Beginning in 1993, we centralized the processing of claims for durable medical equipment in four regional carriers and identified one of them, Palmetto in South Carolina, is responsible for creating a single national supplier clearinghouse. As part of that process, we established for the first time formal standards and requirements for

DME suppliers to enter the program and established a single national registry of those suppliers.

In the past year, we have reviewed the information initially submitted by applicants to the program and have revoked the billing numbers of almost 2,000 suppliers whom we found had provided us with questionable or inaccurate information. We are also in the process of systematically verifying the information about capabilities, about organizations and so forth provided to us by DME suppliers throughout the United States, taking such new steps, for us, as actually in some parts of the country physically inspecting the premises from which we were being billed to make certain that there are functioning operations there, of calling during business hours to make sure that these are real organizations, not fronts for criminal activity of one sort or another, and so forth.

In the area of home health care, where we have had some particular problems with program integrity and particularly rapid rates of increase in program expenditures, we are in the process of revising our conditions of participation and basic regulations under which providers participate in the Medicare program in order to address the entry problem more appropriately. At the same time we have put in a number of administrative steps to scrutinize more carefully the characteristics of new providers who seek to be entering the system.

Let me just also, in response to one of your questions, say very, very briefly that as you know the Medicaid program, as opposed to Medicare, is fundamentally a partnership between the Federal Government and each of the States. We do require a set of basic administrative activities on the part of all States, including automated claims processing and information retrieval systems, and since the enactment of OBRA 93, the operation of a Medicaid fraud control unit.

Each State's Medicaid program is required to operate a surveillance of utilization review system which again looks at automated techniques for identifying aberrant, potentially criminal or aberrant patterns of billing and fraud, and we also are requiring all States to move more aggressively in the area of utilization review of prescription drugs to address some of the kinds of problems that were addressed earlier.

I want to spend just another minute or two, if I may—I am trying to respond, Mr. Chairman, to your instructions about a fuller statement, but if I am overdoing it, please don't hesitate to signal in that regard—about some activities we have been undertaking in south Florida under Ms. Berek's leadership, which have demonstrated to us, we believe, the utility of some of these approaches and some of these techniques and provide the basis for us to move forward throughout the Nation more systematically in the months and years ahead.

Medicare and Medicaid expenditures in south Florida are especially high, and we have had some particularly serious problems of fraud and abuse in that area. We established a formal task force, including all of the relevant Federal and State agencies, all of our Medicare contractors, and quite critically the State Medicaid agency, the State facilities licensure agency, as well as the Medicaid

fraud control unit. Mr. Noble from Florida will be testifying later this morning. The task force was formally constituted in October.

Since then, we have identified more than $100 million in recoupments in savings of averted expenses and in pending cases from the work of that task force.

Much of our planning in terms of national programs on both the prevention and detection areas is being field-tested in the south Florida task force with some very promising results which we are beginning to expand to the rest of the country. Central to that expansion is Operation Restore Trust, which, like the south Florida work group, pulls together the Inspector General of the Department of Health and Human Services, HCFA, the Department of Justice, State agencies and our private contractors in a systematic and focused effort to crack down on Medicare and Medicaid fraud. We have targeted the five most populous States—New York, Florida, Illinois, Texas, and California—which, among them, comprise 40 percent of Medicare and Medicaid beneficiaries and expenditures. We are targeting nursing facilities, home health agencies, durable medical equipment suppliers in those States. We are putting together a new kind of task force and a new team of teamwork which is already, even in just a few months into the process, beginning to show us some very positive results.

Finally, in response to your other question and the best part of this discussion from my perspective is that we do believe we need further legislation to strengthen our capacity to prevent, detect, and pursue fraud and abuse in Medicare and Medicaid; and we will be formally proposing legislation within the next very few days to create a Medicare Benefit Quality Assurance Program and a Health Care Antifraud and Abuse Reinvestment Fund. Under the benefit quality assurance program, we would change some of the budget and accounting rules to permit us to undertake multiyear contracting with particular contractors to finance appropriate kinds of program integrity activities. We would also be able to provide a stable, long-term funding source for those activities. It will help us shift our emphasis from pay-and-chase and postpayment recoveries to prepayment strategies designed to ensure that claims are paid correctly the first time.

The Health Care Antifraud and Abuse Reinvestment Fund, about which I think the Inspector General will say some more, will allow the Department of Health and Human Services to put some of the savings from court awards in health care fraud cases into a fund that can be used to finance additional investigative activity. Our experience has shown that these investments in antifraud and abuse activities yield a very high return, yet as I am sure you well know, the exigencies of budgetary rules and jurisdictional concerns within the Congress have for a long time prevented us from reallocating resources to these very high-rate-of-return sorts of activities. The proposed legislation would permit us to do that much more effectively and efficiently.

Mr. Chairman, I share your concern that in the current environment, in particular, we can no longer afford to tolerate fraud and abuse against the Medicare and Medicaid programs. Their financial consequences are severe. More important, fraud and abuse against Medicare and Medicaid endangers in both the immediate and long-

term sense the health and well-being of the 70 million beneficiaries of those programs who, by definition, are among our most vulnerable citizens—the aged, the disabled, people with low income. It is our job at the Health Care Financing Administration to see to it that those folks get the best health services they can when they need them. In order to do that, we have to make sure that every dollar expended in the program is used as efficiently and directly as possible. With the broad support of Members of Congress from both committees, with our renewed commitment, and frankly, with the use of some modern technologies that are becoming increasingly available to us, we are confident about our ability to strengthen our fraud and abuse prevention and deterrence activities, and in collaboration with our partners from the law enforcement sector, to move forward to reinstate the status of Medicare and Medicaid as models for the entire health care industry of how to better perform these activities.

I am happy to answer any questions you might have.

Mr. SHAYS. Thank you, Mr. Vladeck.

[The prepared statement of Mr. Vladeck follows:]

PREPARED STATEMENT OF BRUCE C. VLADECK, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Subcommittee: I am pleased to discuss the Medicare and Medicaid program's efforts to prevent and detect health care fraud and abuse. I am strongly committed to acting aggressively against all forms of fraud and abuse in Medicare and Medicaid. In the past two years, HCFA has substantially increased its efforts, forged new partnerships, and developed new strategies to assure integrity of its programs.

To help provide leadership, I created a position in my immediate office to focus on reducing fraud and abuse and to address payment integrity issues across HCFA's programs My appointment of Judy Berek, who is accompanying me today, provides a high-level focus on the detection and deterrence of health care fraud and abuse in the Medicare and Medicaid programs.

HCFA'S THREE POINT STRATEGY

HCFA has a three pronged approach to curbing fraud and abuse in Medicare and Medicaid. This approach calls for preventive efforts, early detection, and cooperation with enforcement agencies.

Prevention

Our primary prevention goals concentrate on paying the right claims for the right services in the first place, thus avoiding opportunities for fraud and abuse. Otherwise, we are engaged in "pay and chase," attempting to recover payments that should not have been made, or in uncertain, lengthy, and expensive enforcement actions.

One of the most effective ways to prevent fraud and abuse is through educating providers, beneficiaries, and Medicare claims-payment contractors.

- Providers need information about what services are covered, proper coding, and billing practices. Well informed providers make proper coding choices which eliminates the need for additional claims reviews. HCFA holds training sessions for providers on how to correctly prepare and submit forms for processing.
- Beneficiaries can be our "eyes and ears." We recently revised our Explanation of Medicare Benefits (EOMB) form, which lists services and charges and is sent to each beneficiary when a service is rendered. When beneficiaries have information confirming services provided to them and know what has been paid by Medicare, they can report any incorrect information to the contractor.

For example, the usual practice is to suppress the notice of home health services to beneficiaries because there is no beneficiary liability for the cost of services. However, last month we started a four-state demonstration in parts of Florida, Georgia, Alabama and Mississippi that gives beneficiaries who receive home health services a notice of utilization that verifies home health services

provided to them. Beneficiaries are asked to report any discrepancies concerning those services to the fiscal intermediary in their area.

- Contractors benefit from information provided by HCFA and other sources regarding trends in fraudulent activity and "best practices" in detection and pursuit.

Detection

Contractors utilize data systems to identify and monitor services that may be vulnerable to abuse. By identifying abusive patterns of services to beneficiaries, we can prevent the occurrence of future problems.

For example, three years ago HCFA contractors noticed a tremendous rise in the number of claims for surgical dressings from nursing homes and suppliers. By inserting prescreening edits at our durable medical equipment regional carriers (DMERCs), who only process medical equipment claims, we were able to reduce the amount paid for surgical dressings by 37 percent without denying necessary services for beneficiaries.

Cooperation With Enforcement Agencies

Medicare and Medicaid work closely with the agencies that have major responsibility for enforcement actions, referring cases and supporting their activities. These agencies include the Office of the Inspector General (IG), the Department of Justice, the FBI, and the U.S. Attorneys' Offices.

- Contractors play a major role in managing the Medicare program. Each contractor is required to conduct payment safeguard activities and to identify any suspicious behavior. Cases are developed and forwarded by the contractors to the IG's office for further investigation. The U.S. Attorney's office prosecutes when appropriate.
- Medicaid programs are administered by the State Medicaid Agencies. These agencies cooperate with the State Medicaid Fraud Control Units, which are Federal-State funded entities devoted to the investigation of Medicaid fraud. The IG, the FBI and the U.S. Attorney's office are also involved in investigation and prosecution.
- Later in this testimony, I will tell you about Operation Restore Trust, a Federal/State collaborative effort to curb fraud and abuse.

ABUSIVE PROVIDERS

Since the Subcommittee is particularly interested in how we deal with abusive providers, let me discuss our procedures in some detail.

We have been working to better control who is able to do business with us in the first place. By controlling entry, we may be able to avoid dealing with potentially abusive providers before problems arise. In general, providers and suppliers who want to do business with Medicare and Medicaid can do so, as long as they are appropriately licensed or certified. With institutional providers or physicians, few problems arise in these areas. Other categories of providers or suppliers can be more problematic, partly because of absence of state licensure laws or provisions for certification by HCFA.

HCFA has focused attention recently on durable medical equipment (DME) suppliers. We have created a system of unique national supplier numbers for nearly 120,000 DME suppliers using our National Supplier Clearinghouse (NSC). The NSC maintains information on suppliers of durable medical equipment, prosthetics and orthotics.

In order to bill the Medicare program each supplier must complete a registration application to obtain a supplier number. The form requires the company to disclose information about ownership, managing employees, and other related business. Upon signing the application, the supplier attests that it will comply with the Medicare Supplier Standards, which relate to information disclosure and to adequacy of services provided to beneficiaries.

Any failure to comply with these standards is grounds for revocation of the supplier's number. The NSC is required to check whether applicants for supplier numbers are sanctioned by the IG. By requiring the specific information on ownership and prior relationships with the Medicare program, we are able to detect practices and relationships that may pose a problem in the future .

As a result of these reviews, the NSC recently revoked the billing numbers of more than 1,900 suppliers. These suppliers are located primarily in five states, Florida, California, New York, Ohio and Pennsylvania. HCFA suspended payment of claims for about 200 of these providers prior to revocation to recoup overpayments. These steps result in millions of dollars in savings.

Based on further review, 500 suppliers have been reinstated as Medicare suppliers. We will continue to carefully screen all claims submitted by these suppliers to insure the integrity of the Medicare Trust Funds.

Under Operation Restore Trust, which I will discuss later in further detail, onsite investigations will be conducted on a demonstration basis to see if review of 100 percent of suppliers will be cost-effective for Medicare.

While the operations of the NSC have been extremely useful, it is limited only to durable medical equipment suppliers. We are now examining whether similar processes would be useful for other areas within the Medicare program. We are considering other devices to help ensure Medicare's providers and suppliers are legitimate businesses and provide appropriate services to Medicare beneficiaries.

HCFA does not have independent authority to remove fraudulent or abusive providers from the Medicare or Medicaid programs. When we discover a potentially fraudulent situation, we take immediate action to protect the Trust Fund and the beneficiary by suspending or denying payment and recovering overpayments. Of course, this is done in a cooperative effort between HCFA and the IG and other agencies responsible for enforcement. Over the past two years, Medicare contractors have referred more than 1000 cases to the IG.

As part of its enforcement tools, the IG administers the sections of the Social Security Act that specify appropriate legal procedures for the exclusion of providers from Medicare and Medicaid where fraud or abuse can be documented. Providers convicted of fraud against these programs must be excluded from them for a minimum of five years. Exclusion can be longer, or even permanent; the length of exclusion is decided by the IG based on published regulations.

Once a provider has been excluded, the IG informs HCFA, its contractors, and State Medicaid and licensure agencies, and others. All Medicare and Medicaid claims processors ensure that providers being paid or applying for billing numbers are not currently under an IG exclusion. We are currently working with the Public Health Service to include this information on the National Practitioner Database. This database is used by hospitals and HMOs across the nation to help screen physicians.

MEDICARE INITIATIVES

We are also taking aggressive action to combat fraud and abuse through several other initiatives. Each relies on improvements in technology and on cooperation of a number of HCFA's partners, both public and private.

Home Health Initiative

One of the areas most vulnerable to abusive practices is the home health benefit. Since 1993, a HCFA inter-disciplinary team has been working to improve the operation of the Medicare home health benefit. We are pursuing reforms in billing, documentation, and medical review to improve our ability to detect and prevent the fraudulent and abusive practices. We are also examining ways to improve detection and control of overutilization through focused medical review performed in collaboration with regional home health intermediaries (RHHIs) and State survey agencies.

HCFA is also revising the Medicare conditions of participation for home health agencies; the revised conditions will institute measures to further protect benefit integrity.

Improving Anti-Fraud Capabilities of Claims Processing Systems

The Medicare Program of the 21st century will include a single, national automated system that will efficiently process both Part A and Part B claims. The Medicare Transaction System (MTS), currently under development, is scheduled to begin operation in September 1997 and will be fully implemented by late 1999.

At present, Medicare claims processing is done by 77 fiscal intermediaries and carriers using 10 automated systems at 56 sites. Under MTS, claims processing will be performed at a limited number of operating sites. Our current contractors will then be able to concentrate their efforts on customer service and program safeguards. Also, we will be proposing legislative changes to create even more contracting flexibility, improving cost effectiveness, customer satisfaction, and program safeguards.

A single system will have a greater capacity to monitor and detect fraud and abuse by maintaining data on both Part A and B claims in a centralized, integrated system. For example, one beneficiary may have many different health care needs. This often means that four different providers prescribe varying treatments. Each claim might be processed by four different carriers that cannot easily check other claims. Under MTS, a single system will track all claims for each beneficiary and be able to identify any suspicious activities.

We also support and are in the forefront in the use of innovative anti-fraud computer software. Currently, our contractors in Pennsylvania and Florida are working to incorporate such applications into their processing systems. Iowa, California and Tennessee have implemented new systems that focus on identifying aberrant claims and provide quick access to information by medical reviewers on both Part A and B claims. We are also developing new approaches to analyze patterns of Medicare claims that will be tested by Medicare contractors.

We will also improve our contractors' capabilities to detect billing abuses, inappropriate coding and other aberrances in claims submitted for payment. We are now assessing available, off-the-shelf software packages to determine their potential utility for the Medicare program. Last month, five vendors made presentations of their packages to a HCFA assessment team. The software holds promise but must be consistent with Medicare medical and payment policies.

MEDICAID'S ANTI-FRAUD ACTIVITIES

The Medicaid program is not a national program with uniform coverage policies and benefits. The Medicaid program is essentially 50 different State health plans under the guidance of the Federal government. HCFA provides States with broad guidelines on a core group of benefits that must be included in any State plan and on additional benefits that States choose to provide. The mandatory core benefits include hospital care, physician services, and nursing facility services.

Medicaid provides beneficiaries with freedom to choose a health care plan or group of providers. Also, the Medicaid program has an automated claims processing and information retrieval system—called the Medicaid Management Information System (MMIS)—which is in place in all States except Nevada. The system controls provider access to the Medicaid program through provider agreements and assures that providers are licensed or otherwise qualified to furnish services. MMIS also allows providers to easily verify the eligibility of beneficiaries, and edits each claim before it is paid to assure it is proper.

Medicaid uses a post-payment utilization system, called Surveillance and Utilization Review (SUR), to identify those providers and beneficiaries with aberrant patterns of Medicaid use. The SUR is often used as a vehicle to identify gross abuse and fraud and as a source of information to recover inappropriate payments. In addition, SUR can produce detailed reports on specific providers to investigate possible upcoding or misuse of prescriptions for drugs.

State Drug Utilization Review programs focus primarily on clinical and quality of care uses, but they also may prevent and detect prescription drug fraud and abuse.

As I mentioned earlier, the State Medicaid programs have designated fraud units called Medicaid Fraud Control Units (MFCUs). MFCUs are Federal-State funded law enforcement entities devoted to investigating and prosecuting Medicaid fraud in the courts. These units target Medicaid providers, employees of State Medicaid Agencies, and persons physically abusing Medicaid patients in long-term care facilities.

Medicare and Medicaid have learned from each other about ways to control fraud and abuse. Through Medicaid's experience with capitated managed care, States have learned invaluable lessons in monitoring quality of care, and the Medicare managed care program has been able to benefit from this experience. For example, the State of Arizona, which processes more than four million HMO encounters annually, has developed highly sophisticated management information systems that monitor utilization patterns of providers. They are able to generate comparative patient data which helps plans monitor the activities of their providers and identify deviations in appropriate patterns of service. Medicare is looking at approaches such as this to enable its contracting plans to better monitor activities of providers and become more effective at detecting fraud and abuse.

This learning experience also occurs in the reverse. For example, under the South Florida initiative, the Medicare contractor was able to identify 700 out of 1200 independent physiological laboratories as potentially fraudulent. Savings of several millions of dollars for the Medicare program were realized. This information was passed on to Medicaid, which achieved significant savings. It is estimated that over $10.8 million will be saved over six months.

FOCUSSING ON FRAUD: THE SOUTH FLORIDA WORKGROUP

A successful partnership was created to tackle serious fraud and abuse problems in South Florida. Medicare and Medicaid expenditures in Florida are among the highest in the nation, and fraud and abuse is a serious factor in a variety of health care settings. In order to address this problem, we established a joint initiative including HCFA, our claims payment contractor, the Florida State Medicaid agency,

the HHS Office of the Inspector General, and the Florida Attorney General's Office Medicaid Fraud Control Unit.

The workgroup was formed to provide support and recommendations to HCFA and the Florida contractors about what could and should be done to combat the chronic fraud and abuse in South Florida. The group's effort represented an unprecedented degree of coordination. As a result of its work, we have identified over $100 million in savings and recoupments over five months. HCFA is looking carefully at areas identified as particularly vulnerable to fraud including home health services, durable medical equipment and independent physiological laboratories.

- Because of fraud-related investigations, HCFA suspended payment to 44 South Florida providers since August, preventing the payment of $2.2 million in Medicare funds.
- The U.S. Attorney's office, acting on information detailed by HCFA contractors, has frozen more than $4 million in bank accounts pending further investigation of several providers.
- As a result of our coordinated effort to share information on fraud activities with our contractors, the Florida Medicare contractor conducted intensive medical review of claims for outpatient therapeutic mental health treatment programs. As a result of this review, the contractor denied 77 percent of services billed for 1994. Medicare has saved $3 million in Dade and Broward counties alone in 1994.

As an outgrowth of the South Florida project, Judy Berek has recently formed the Program Integrity Group to help identify possible areas of program weaknesses and will help coordinate its activities. The Program Integrity group consists of high level HCFA officials whose expertise will help identify problems in the Medicare and Medicaid provider enrollment process.

This group is currently examining ways of limiting participation of suppliers and providers to those that appear to be legitimate business entities. When considering these options, however, we must assess the reporting burden and costs that new requirements may pose for honest providers.

OPERATION RESTORE TRUST

The South Florida workgroup involved an unprecedented degree of cooperation between public and private entities. Based on our successful experience in South Florida, HCFA and the Inspector General have formed a new partnership of Federal and State agencies to crack down on Medicare and Medicaid fraud and abuse.

This partnership, Operation Restore Trust, is a demonstration targeting five of the most populous states—New York, Florida, Illinois, Texas and California. These five states account for nearly 40 percent of all Medicare and Medicaid beneficiaries. Our partners include the Office of the Inspector General, the Administration on Aging, the Department of Justice, state government and private sector representatives.

The partnership will identify and penalize those who willingly defraud the government. It will alert the public and industry to known fraud schemes. The partnership will also help identify and correct the vulnerabilities in the Medicare and Medicaid programs. The initiative will target three types of health care providers—nursing facilities, home health agencies, and durable medical equipment suppliers.

Tactics will include HCFA and IG financial audits; stepping up criminal investigations, civil and administrative penalties, and recovery actions; and increasing surveys and inspections of long-term care facilities in cooperation with State officials. In order to inform beneficiaries, the public and industry, the HHS Inspector General will issue special fraud alerts to notify the public and the health care community about schemes in the provision of home health services, nursing care and medical equipment and supplies. In addition, a fraud and waste report hotline will be available for public use.

Under Operation Restore Trust, there will be improved communication between Federal and State agencies. In addition, we will demonstrate the use of State quality surveyors to scrutinize possible fraud and abuse at targeted providers. If our experience in South Florida is any indication, this joint effort should yield a substantial savings to the Government.

NEXT STEPS: LEGISLATIVE INITIATIVES FOR PROGRAM INTEGRITY

As the forgoing discussion illustrates, HCFA and the IG are accelerating its efforts against waste, fraud, and abuse. In order to help maintain this momentum, we are proposing legislation to create the Benefit Quality Assurance Program for Medicare and the Health Care Anti-Fraud and Abuse Reinvestment Fund.

Under Benefit Quality Assurance Program, HCFA would establish specialized, multi-year contracts for program integrity activities.

This instability makes it difficult for HCFA to invest in innovative strategies to control fraud and abuse. Our contractors also find it difficult to attract, train, and retain qualified professional staff, including auditors and fraud investigators.

The Benefit Quality Assurance Program would provide a dependable, long-term funding source for program integrity activities. Putting the funding of this investment on a stable footing seems only prudent.

This proposal would allow HCFA the flexibility to invest in new and innovative strategies to combat fraud and abuse. It would help HCFA to 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.

The Health Care Anti-Fraud and Abuse Reinvestment Fund would allow the Department to fund savings from court awards in health care fraud cases in a fund that can be used to finance further fraud investigations.

Experience has shown that investment in anti-fraud and abuse activities yields a high return. Our proposals would help provide stable funding for these activities and thus help assure that we reap this return.

CONCLUSION

As technology changes and our health care system becomes more complex, HCFA continues to ensure access to high-quality, cost effective health care to 70 million of our most vulnerable Americans—the aged, disabled and citizens with low incomes. For the past thirty years, HCFA has efficiently paid the health care bills of virtually all senior citizens and today pays for the care of about 20 percent of the nation's children. However, just as medical care improves and changes so must the Medicare and Medicaid programs.

HCFA is firmly committed to pursue aggressively the threat of health care fraud and abuse. Through the use of better information technology and partnerships with government agencies and industry we can save Medicaid and Medicare from waste. We can only accomplish these worthy goals through the use of new ideas and strategies. I look forward to working with members of this Subcommittee on ways to strengthen our abilities to curb fraud and abuse in Medicare and Medicaid.

I would be happy to answer any questions you may have at this time.

Mr. SHAYS. At this time, I would ask the chairman of the Government Reform Committee if he has any questions.

Mr. CLINGER. Thank you very much, Mr. Chairman. Mr. Vladeck, thank you for your testimony. The first question is, you indicated that you were going to——

Mr. SHAYS. I would like to interrupt the gentleman. These mikes don't seem to work very well—if you could speak a little louder.

Mr. CLINGER. I will get closer to it. You mentioned you are going to be submitting some legislation within the next few days, as I understood it.

Mr. VLADECK. Yes, sir.

Mr. CLINGER. I didn't quite get clear all that was going to be involved in that proposed legislation. Would it, for example, include some suggested changes in the exclusion rules under the antifraud statutes?

Mr. VLADECK. No, the legislation which is immediately at hand would not. It is not clear to us that our problem in terms of expanded exclusion activities is one of statutory authority. Again, I am going to have to defer most of that discussion to the Inspector General whose authority it is, but we view the issue of exclusions to a considerable extent as both a resource and an emphasis problem; that is to say, we haven't had the investigative or legal resources to pursue all of the cases that have been identified.

Mr. CLINGER. The charge that has been made is that they have not utilized, the existing exclusionary provisions have not been utilized to the extent that they could be to get at the problem; and you are saying that that is probably——

Mr. VLADECK. We believe this is more a resource problem and a coordination problem than a statutory authority problem, and that is why our proposed legislation will speak primarily to resources and to the integration of various Government functions.

Mr. CLINGER. GAO, my opening statement indicated that their snapshot would indicate that 10 percent of Medicare and Medicaid costs are fraudulent and that that could amount to about $26 billion this year. That was a snapshot.

Can you quantify whether that is going up, decreasing? Is the problem getting worse or better in your experience?

Mr. VLADECK. Mr. Chairman, this is a very difficult question to answer, not because I wouldn't like to be able to answer it, but because I believe, as is true in many forms of administration or law enforcement of this sort when you have a significant problem and you don't know how large it is, the more resources you invest in dealing with the problem, the more you uncover, but you don't know what proportion of it you are uncovering.

So—Mr. Shays, for example, talked about the increasing reports and the increasing number of cases we are seeing of fraud and abuse against the programs. I think that is in some part because there are more FBI agents at work on these cases because we are working better with the Inspector General, because our contractors are referring more cases to law enforcement, and so we are finding, we believe, a larger proportion of the total.

But if we knew what the total was, in a sense, we wouldn't be entirely doing our jobs or we would be misleadingly complacent, I believe; and I don't think we are far enough along in our efforts to really tackle these problems to say with any confidence what the scope of them is. We are pretty confident that we don't have it all, we don't have nearly all of it, but how much more there is that we don't have, I would be very reluctant to estimate.

Mr. CLINGER. You talked about that you are going to be—hopefully, have on line the MTS system by somewhere in 1998, I think, would be a fair time?

Mr. VLADECK. Yes, sir.

Mr. CLINGER. How much of the problem will that system, do you think, address? In other words, how much of it really does evolve out of people, bad actors setting up shop, getting caught, moving on, setting up shop somewhere else, that you are now not able to catch in a timely fashion; and how much of that problem—how much is that of the overall problem, and will MTS, do you think, solve it?

Mr. VLADECK. I don't think that is a major part of the overall problem, but having a single national claims processing system will help us address other issues as well as the folks who move around or the folks who do contractor shopping, as it were. For example, taking——

Mr. CLINGER. You are saying you don't think that is a significant part of the problem?

Mr. VLADECK. I don't think it is a major part; I don't think it is a large fraction. I think there are a lot of folks who are able to continue to engage in these kinds of activities without ever leaving home, so that the folks moving around—moving around from one place to another is not as much of a problem.

We are seeing in home care, and it is one of the focuses of Operation Restore Trust, and in durable medical equipment, individual corporations operating in many different parts of the country with which there are significant problems, and MTS will be very helpful in addressing that; but a new claims processing system will also help us, for example, if we identify a pattern of abusive billing for a service in Pennsylvania and we want to send out an alert to all our carriers around the country that they should be looking at, to try to detect that particular pattern that may reemerge elsewhere in the United States.

There is a lot of custom programming and a lot of additional work that needs to be done with 13 different software systems and 62 different contractors that we will be able to do much more quickly and much more efficiently with a national backbone for the claims process.

Mr. CLINGER. Thank you, Mr. Vladeck. My time has expired.

Ms. BEREK. It will also expand our ability to do quick prepay review on claims. For example, if we now are suspect in terms of claims that come in when there are doctors' prescriptions for, like, durable medical equipment and home health, the doctors' claims are processed in a different contract from where the durable medical equipment and home health claims are processed by the nature of our system so that in order to get information——

Mr. SHAYS. I must ask you to move the mike to be heard for the record.

Ms. BEREK. In order to get information on whether or not that doctor has really been seeing that patient, the contractor now has to either wait for all the bills to go through a common working file or contact the other contractor, so that it is an expensive process and a time-consuming process for us to implement.

With everything on one system, we will have the ability to do automated prepay screens so that before a claim even gets into the payment system, we will know whether or not a doctor has been the doctor seeing a patient when they are prescribing other services. So there will be many gains from the system in terms of things we can do easily on an automated basis to eliminate pay-and-chase that we can't do now with the multiple contractors and systems.

Mr. CLINGER. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

For the record, I would like to note that we now have Mr. Green from Texas, and also Mr. Schiff from New Mexico. At this time, I would ask unanimous consent that all members of the subcommittee be permitted to place any opening statements in the record and that the record remain open for 3 days for that purpose.

Without objection, so ordered.

And I also ask unanimous consent that our witnesses be permitted to include their written statements in the record.

Without objection, so ordered.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I appreciate the hearing today; and I want to thank Dr. Vladeck for being here, and I just have some questions.

One, congratulations on Operation Restore Trust. I followed that from last month and the success in your testimony in Florida of $100 million. I think everybody is against fraud and abuse, and we just have to see how we can get to it.

Let me ask you, since you brought it up on the legislative side, you have a bill you are preparing, I know our committee reported out a bill last year—in fact, our colleague, Mr. Towns, has introduced H.R. 1850. And again, we are not a legislative side, but the bill was reported out last year with bipartisan support; and I would be interested, if you could, to compare the two, if you know what the committee did last year as compared to what you may be aiming for this time.

I will let Mr. Towns go much further, but let me talk about how the fraud in the system——

Mr. SCHIFF. Would the gentleman be willing to yield for just a moment on that point?

Mr. GREEN. Yes. In fact, you were a cosponsor of the bill last year.

Mr. SCHIFF. Yes. I thank the gentleman for yielding.

I want to say that Chairman Towns of the subcommittee and I, as ranking member at that time of this subcommittee, put together and reported out a health care fraud bill that was intended to be part of a health care policy bill if we passed it.

It is my intention, working with Congressman Towns, Congressman Shays, our subcommittee Chairman, and, of course, Congressman Clinger to put together a new Medicare-Medicaid health care fraud bill. I am offering to do it because I am both a member of this committee and a member of Judiciary, and I suspect there will be a joint referral to such a bill; and I would invite members of the subcommittee and the agencies involved for any and all recommendations as to what should be in it; and I thank the gentleman for yielding.

Mr. GREEN. Great. I look forward to working with you on it.

Doctor, let me talk about, because we hear in our office so often about, you know, the best people to report fraud are actually the clients or the recipients and the beneficiaries; and I have senior citizens who call and they will send me their bills and what have you. I know in your testimony you said that they should go directly to their contractor, if it is in Texas where I am from or somewhere else, and if you could, just walk us through this for whatever time I have.

If a senior citizen or a Medicaid recipient who is not a senior feels like there is fraud, if you could just walk us through how they would do it and how the agency responds to it.

Mr. VLADECK. Let me add, if I may, that under Operation Restore Trust, one of the things we are testing in that demonstration project is a new hotline, particularly in the five States in which the demonstration is being conducted; and I will let the Inspector General give you more details about that because she is very appropriately, I think, proud of its central role in some of our strategies going forward. But we are going to very broadly publicize a new hotline number for issues of fraud and abuse against all sorts of Government programs.

However, the way in which we get most of our tips or complaints now is that, again, 500 million times a year, roughly, beneficiaries receive in the mail from their Medicare contractors the form that we call the Explanation of Medicare Benefits, which says on such and such a date we paid for such and such a service for you provided by such and such a provider; here is what we paid, here is what the provider charged, here is what you are responsible for, and so forth. And that form contains the number of the Medicare carrier intermediary, generally an 800 number, whom the beneficiary can call if there is a question or a problem about it.

In addition to which we distribute information to senior centers through senior organizations and other places with information about where to receive calls; and social security continues to get a lot of calls, having had a responsibility for administration of Medicare for its first decade and being the principal place to which many seniors turn for assistance with public programs, which they refer to us and which increasingly they will automatically route to us.

In each of those instances, we undertake a review of the particular circumstances. We have dedicated staff in all of our contractors whose job it is to evaluate such complaints, and if, whatever the nature of the complaint, it appears to create a suspicion of inappropriate or improper behavior, we will then investigate more of the patterns of billing, the patterns of service rendered, and so forth; and if a determination is made that something does indeed look out of line, at that point, we will be in communication, depending on the area in which we are working, the relative workloads of various folks and the nature of the particular concern either with local offices of the department's Inspector General or with local law enforcement, Federal law enforcement officials to turn the information over to them so they can make a determination whether to begin a formal investigation.

Mr. GREEN. Mr. Chairman, I know my time is up. If you could share with the members of the committee——

Mr. SHAYS. The gentleman has a little bit more time since he was asked to yield.

Mr. GREEN. Thank you, Mr. Chairman; I appreciate the flexibility—a flow chart on how that happens, because I do have some seniors who say that it doesn't do any good to call or what have you, and so we can then, you know, have some accountability in the system.

I know—again, someone else may ask this—but estimates of fraud on the system, I know estimates are anywhere from 3 to 10 percent; GAO says 10 percent in medical care generally. Maybe you could address that somewhere along the way, what you estimate on Medicare and Medicaid, if they are the same or if there are different percentages of fraud on each program.

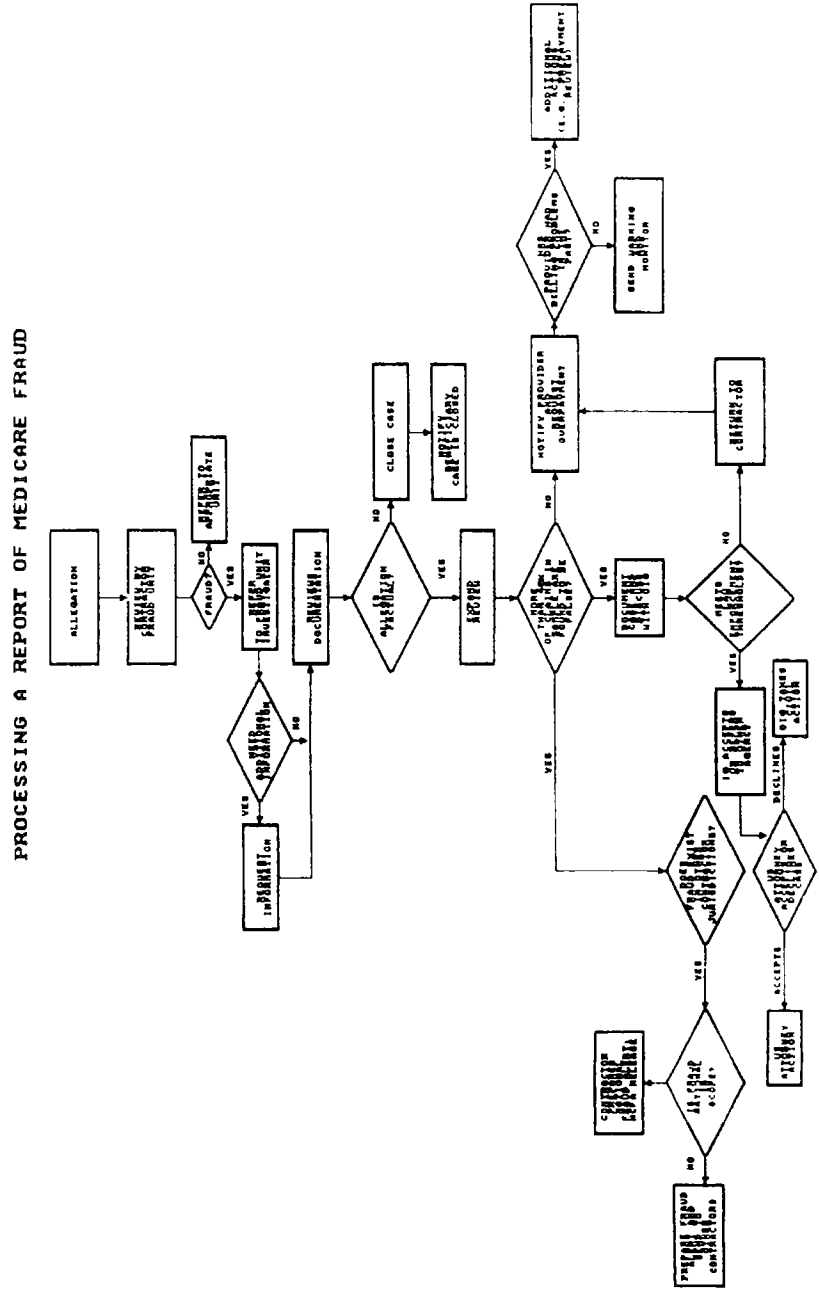
Thank you, Mr. Chairman, for the courtesies.

[The information referred to follows:]

No accurate way exists to measure the amount of fraud in HCFA programs. Although the GAO has made very rough estimates of the size of fraud, neither we nor they have any firm figures.

A flow chart of how HCFA responds follows:

PROCESSING A REPORT OF MEDICARE FRAUD



Mr. SHAYS. I would like to get into two general areas first. Candidly, I am concerned by the attitude that is coming across to me, which is that revoking of billings is the responsibility of the Inspector General.

Are you prohibited from recommending that a license be revoked?

Mr. VLADECK. I don't believe there is anything that prohibits it, and in major cases, we are in regular communications with the Inspector General and the Department of Justice about——

Mr. SHAYS. Let me pursue that. You are "in communication." Does that mean that when you see someone who has defrauded the system, you do not weigh in and say, "there is no way in hell we should allow this person to continue to be in the system?"

Mr. VLADECK. We generally do weigh in when we are asked.

Mr. SHAYS. Why do you wait to be asked?

Mr. VLADECK. Well, again, we are the ones in most of these instances who initially refer cases over. Our desire is to achieve several goals with doing that. One is to get bad providers out of the program; two, when appropriate, to see that appropriate punishments are metered out; and third and perhaps more important, to have whatever process occurs serve the maximum deterrent effect. As I am sure you understand, again we are in an advisory capacity.

Mr. SHAYS. No, no, Mr. Vladeck, I know you didn't create any of the problems that you are dealing with. This has gone from one administration to another.

I am not blaming you for the fraud that exists in Medicare and Medicaid, but now you are in charge, and I would like to think that there is a moral authority emanating from you that would be outraged to deal with anyone who has been defrauding the system and to think that they are still allowed to participate.

I want to know if you are exercising the moral authority and leadership to get these crooks out of the system?

Mr. VLADECK. I think our major concern is to get these crooks punished as effectively as possible, including getting them out of the system. But in addition, where we do have authority, which we are exercising with increasing aggressiveness, we don't have the authority to kick people out of the system. We have authority under some very specific regulations to stop paying people whom we suspect of being crooks, while investigations or other activities are proceeding, and we are doing that with increasing frequency and have begun a process of totally turning around.

Mr. SHAYS. That is nice to know, but you haven't answered my question.

Are you saying to us that you do not have both the responsibility and obligation to recommend that a billing number be revoked?

Mr. VLADECK. No, sir. What I am saying is that we are pushing everywhere where we can the exclusion.

Mr. SHAYS. So you do have that authority?

Mr. VLADECK. That is correct.

Mr. SHAYS. What I am hearing from you is, in a sense, passing the buck to someone else. So I want to know if you believe that you should be a little more outspoken on this issue.

Mr. VLADECK. I think you are right. I think your point is well taken, and we will be more outspoken.

Mr. SHAYS. Along these lines, do you think that there are presently people in the system whose billing numbers should be revoked?

Mr. VLADECK. Absolutely.

Mr. SHAYS. OK. I would like a list of those numbers, and I would like to know that you are going to recommend to the Inspector General that they be revoked.

Let me ask you another question. Why are we more likely to revoke the billing numbers of people providing equipment than other services? I missed that part of your testimony.

[The information referred to follows:]

When we believe that a provider should be excluded from the program, we refer the case to the IG, which has the statutory authority to exclude providers. Last year, HCFA referred over 600 cases to the IG for investigation. The names and numbers of these providers are protected from public release in order to avoid compromising the investigations. In our view, if the providers involved in these cases are found by the IG to have committed fraud, they should be excluded from Medicare.

HCFA, through its contractor fraud units, refers cases of potential fraud to the IG for investigation and subsequent referral to other law enforcement agencies. Once the case has been forwarded to an Assistant U.S. Attorney, he or she decides whether to prosecute civilly or criminally, or to return the case to the IG for administrative sanctioning. A person or entity convicted of fraud against Medicare or Medicaid must be excluded for a minimum of 5 years. HCFA is not asked for its recommendation on the length of the excl

Mr. VLADECK. Well, in a sense, what we have done on the durable medical equipment is a prototype or a lead for the direction in which we need to go in other services; but there is a rather long history in the Medicare program of durable medical equipment being an area that was particularly vulnerable to a whole variety of fraud and abuse.

Mr. SHAYS. See, what I suspect is that it is easier to withdraw a billing number of someone who is providing equipment because you can go to someone else to provide that.

On the other hand, for those who provide services, we seem to be less likely to revoke the billing number, and more likely just to ask for compensation. I'd like you to tell me why we are not revoking some of these large operations that truly have defrauded the system? They're crooked, and we just catch them and say, "pay it back and continue to do business."

Mr. VLADECK. Well, I understand the question very well. I think it was true historically that an argument was made with certain categories of providers of service that if you kick them out of the program, you might create problems of access to services for beneficiaries. We no longer accept that rationale. If someone is guilty of that sort of fraud, I don't see any justification for their continued participation in the system.

On the other hand, we have—and again I don't wish to pass the buck. There are times when in the interest of appropriate settlement of both criminal and civil fraud cases, settlements are entered into where we're not directly a party to the negotiations that don't involve exclusion from the program. We're going to push harder to see that that is part of the deal.

Mr. SHAYS. You have to weigh in on the settlement?

Mr. VLADECK. No. Historically, there has been no participation by us in the settlement. Since this—since Mr. Stern came to the Justice Department, we have been consulted more routinely.

Mr. SHAYS. Well, I would hope that you would be asked to weigh in, and, when you think it's wrong, that you would be saying "no way." I'd like to invite Mr. Towns to question the witness, and I would also like to acknowledge the fine work both of you achieved in the last session. I'm the new kid on the block here, and I look forward to working with you in your capacity in the judiciary.

Mr. TOWNS. Mr. Chairman, I thank you very much for your kind words, and also would like to add to that, the ranking member in the last session was extremely helpful in terms of looking very seriously at this issue. And of course, I am happy that you're continuing to do that, because I think this is an area we really need to address, because I think fraud and abuse is running rampant.

Let me make certain that I understood your answer to the chairman. You're saying that some companies will just sort of get out the way and sort of, you know, make a deal and move on? Is that what you're saying?

Mr. VLADECK. No. What I'm saying, Mr. Towns, is that there have been in the last couple of years several extremely large fraud cases against Medicare and Medicaid programs, the resolution of which did not involve exclusion of those providers from the program. Those were part of settlements that involve substantial payments to the Government, substantial steps for remediation of behavior on the part of the providers of service, and in at least one instance a sort of formal compliance system on the part of the offending corporation that I believe is a potential model for certain kinds of cases.

Now, personally, I don't—I don't feel that exclusion from the program in those settlements has been pushed hard enough by us, but frankly, I'm a little reluctant, I think, to be as strong in my statement as the Chairman would like because those settlements do involve very complex negotiations by professional law enforcement people, professional prosecutors and professional—other law enforcement people and senior folks in the Department of Justice. We are, as I said, increasingly consulted about the settlements, but I'm very reluctant to substitute my judgment of what an appropriate outcome is in those cases for their expertise.

I take the Chairman's guidance to heart very seriously that we will be more vociferous in the future about program exclusion as part of the settlement. But again, I'm just—in trying to be responsive to some of the questions, there may well be a time when a prosecutorial official in appropriate exercise of his discretion trades off one part of a settlement for another.

Mr. TOWNS. I understand that, you know, but I just sort of would have to think, as we talk about this, that some companies or some people will make a deal so they could continue to defraud.

Mr. VLADECK. Well, I think we need to be increasingly vigilant not to permit that to happen.

Mr. TOWNS. Doctor, you have suggested that certain laws and regulations on the books limit HCFA's use of resources to address certain problems. Is this true?

Mr. VLADECK. Well, the major problem to which I have been referring has been the problem which we're going to seek to address in our proposed legislation of the so-called "fire wall" in the Budget Enforcement Act, in which we could demonstrate that there were activities that, if expanded, could generate savings to the Medicare trust funds, for example, or to the Medicaid program. But since those savings were on the entitlement side of the budget and the expenditures would need to be from the domestic discretionary side of the budget, there was no way to tradeoff those savings against the increased expenditures needed to do them. That's, I think, been our major source of frustration in these areas, over the last—over the last several years.

Mr. TOWNS. You know, I can't help thinking about the fact that everybody is eager, and anxious almost, to cut back and to eliminate. And I think about when we look at fraud, and that how people have been able to sort of beat the system; for example, a person's license is taken in one State, and they just go across the bridge to the next State, in some instances—no bridge—and just set up a practice there and continue to defraud.

With all the cutbacks, will you have the resources to set up the kind of mechanism to stop this?

Mr. VLADECK. Well, again, that's one of the reasons why we think this legislation we're going to be proposing is particularly important, because it would, in a sense, protect some of the resources necessary for program integrity activities.

I would point out, however, in addition, Mr. Towns, that in this administration, even while we've been in very, very tight circumstances for discretionary spending, we have protected and in some instances increased by a reasonable margin the amount of resources we're putting into these activities already.

Mr. TOWNS. All right. Let me just say in closing, Mr. Chairman, I would hope that you would look at the bill that was put in last year by Congressman Schiff and myself, and give us some feedback on it. I think that is an area that needs to be addressed, and I think that the legislation we're proposing, helps you to address it, because it eliminates a lot of the duplication. It puts the resources right at the problem in terms of fraud and abuse.

Mr. VLADECK. I would be happy to do that.

[The information referred to follows:]

H.R. 1850, the "Health Fraud and Abuse Act of 1995," would require the Inspector General (IG) to establish a program to prevent, detect, and control health care fraud and abuse that considers the activities of Federal, State, and local law enforcement agencies and Federal and State agencies responsible for the licensing and certification of health care providers. It calls for the establishment of State Health Care Fraud and Abuse Control Units to submit an annual plan to the IG for preventing, detecting, and controlling health care fraud and abuse.

The bill would establish a Health Care Fraud and Abuse Control Account, funded through administrative penalties, fines, civil penalties/damages, and proceeds of seizures and forfeitures relating to health care fraud. This account would pay IG expenses and reimburse other agencies for some of their expenses in combating health care fraud and abuse.

While we support the idea of coordinating fraud and abuse detection efforts and the establishment of a fund financed, in part, through civil penalties, we believe that attention also needs to be paid to prevention. That is, we must get away from "pay and chase" by focussing on paying right the first time and avoiding opportunities for fraud and abuse. By controlling entry to the Medicare program, increasing provider and beneficiary education, and utilizing data systems to identify and mon-

itor services vulnerable to abuse, we are committed to reducing Medicare and Medicaid fraud and abuse.

On June 30, 1995, Secretary Donna E. Shalala, sent a letter to House Speaker Newt Gingrich, and Vice President, Albert Gore, Jr. The letter contained the Department's language for legislation to combat Medicare and Medicaid fraud and abuse. On September 7, 1995 Representative Dingell introduced H.R. 2280, the Medicare and Medicaid Integrity Act of 1995.

We look forward to working with you and other members of Congress in passing this legislation, and on other ways to strengthen our abilities to curb fraud and abuse.

Mr. TOWNS. I yield back.

Mr. SHAYS. I thank the gentleman. I'd just like to note for the record we're joined by Mr. Fattah from Pennsylvania, and now I will ask Mr. Chrysler if he has any questions.

Mr. CHRYSLER. Home health care is paid for by Medicaid after the first 20 days of Medicare. What do we have to do to include Medicare—or include home health care in Medicare and not have it in Medicaid?

Mr. VLADECK. I am afraid I don't understand your question, sir.

Medicare pays for an unlimited number of home care visits when they meet the criteria of appropriateness under the Medicare benefit. We now, in—last year, of those Medicare beneficiaries who received Medicare-covered home health services, the average number of visits was about 55. So I am puzzled by your question.

Mr. CHRYSLER. OK. Let's try another one. GAO offered 11 solutions over the last 3 years. How many have you implemented?

Mr. VLADECK. I'd have to see the list of the specific suggestions you're talking about to respond to that.

Mr. CHRYSLER. Improving the kickback laws.

Mr. VLADECK. The Congress—and again I'd also have to see the timing of that—Congress acted on the referral statutes which relate to anti-kickback laws in OBRA 1993, and made some additional changes in legislation last year.

Mr. CHRYSLER. Expanding the list of health care fraud schemes.

Mr. VLADECK. I'd have to again—sir, I would have to take a closer look at that recommendation.

Mr. CHRYSLER. They were in the letter, that you received; I'd appreciate it if you could look at them and send my office a response.

Mr. VLADECK. I'd be happy to do that.

Mr. CHRYSLER. That was on June 9 you got the letter.

Mr. VLADECK. Thank you.

Mr. SHAYS. Sorry. I thank the gentleman.

Mr. Souder, I'm going to go to you and then to Mr. Fattah and then to Mr. Schiff.

Mr. SOUDER. In the number of people who are found fraudulent, a lot of times you hear 10 percent of the people cause 90 percent of the problems in a given area. Here you're catching them at different stages of the process, so it's very difficult to estimate, but how many would you say are major abusers versus midrange versus kind of hit or miss, barely worth following through?

Mr. VLADECK. Let me give you my answer. I'd be curious to hear—I hope you ask the same question of the law enforcement folks who will be here; it would be interesting to hear if we hear the same answer.

I tend to think of this problem as sort of three layers. I think the overwhelming majority of providers in all classes of services are

honest, and to the extent we have problems, they tend to be inadvertent or billing errors or things of that sort. I think at the core there's a very small number, in the hundreds or the low number of thousands, of real full-time health care criminals, as it were, who account for a very large share of the fraud and abuse against the programs. And I think then there's a number of maybe several percent of the providers, higher in some services than in others who, sort of like folks in every aspect of life, sort of behave to a considerable extent in the gray area between unquestionably correct activity and borderline kind of activity.

Mr. SOUDER. That was my follow-up. You clearly said those that are kind of inadvertent billing errors, those who are kind of blatant rip-off artists versus those who take advantage of every opportunity and loophole in that, are—you feel that those, there are more in the blatant rip-off category than those who are capitalizing on the vagueness; or do you believe that there is some lack of clarity in the rules that people are capitalizing on?

Mr. VLADECK. No, I believe—and it's one of the things that we're trying do a lot more of. I believe there are a lot of instances in which our existing rules or procedures are insufficient to either deter people from engaging in borderline behaviors or sufficiently confusing that people don't know what the right behavior is to begin with.

Mr. SOUDER. Could that not be one difference in how you approach what the Chairman is suggesting? In other words, when you see a sign of somebody who's a flagrant or a rip-off artist, you go after them with everything you've got from stop payments to decertifying them as quick as possible and recommending it. And those that are in the gray area, you push it, but that's a more complicated legal question?

Mr. VLADECK. Well, no, I think it's a somewhat different strategy. Let me give you an example, if I may.

In the area of home health, where we're spending a lot of time and resources and where the Inspector General and we've been working particularly closely, there are some physicians, as well as some home care providers who are—who are crooks.

We also have a problem, however, both in program integrity and in quality of services in the home care program, that many physicians routinely sign orders for home care or plans of care for home care patients without actually being sufficiently involved in the care of that patient or adequately informed. They've always viewed it—and it's always operated within hospitals or within certain communities as, you know, just another piece of bureaucratic paperwork despite the fact that the form the physician is signing in fact engenders a claim against the Medicare program, implies a certain pattern of care for a certain patient.

And so what we need to do and are beginning to do in Florida, and then will bring elsewhere in the country, is first a major educational job in the physician community to say, this is a serious obligation and this is a serious responsibility and, in fact, if you don't take it seriously, you create a legal liability for yourself that's very serious. Do that first, make it clear to the folks in the gray area that this is something they have to be much more careful and much more scrupulous about.

Once you've done that, there will continue to be the hard-core guys who will continue abusing the system, and there's where you focus your investigation and law enforcement resources.

Mr. SOUDER. I was really intrigued by your comments earlier on the stop payment, and you said you're doing that with increasing frequency.

Do you have any kind of data on that that you could give us in the committee about how many cases that happens, compared to the past, and do you intend to keep increasing that?

[The information referred to follows:]

Medicare contractors have the authority to approve, deny, or suspend claims. Suspension is a temporary, administrative action. Its purpose is to limit potential loss to the trust funds, not to punish a provider. A suspended claim is a processed claim with the payment to the provider withheld.

Contractors may suspend claims for two reasons: (1) the provider owes Medicare an overpayment and the contractor offsets this overpayment by suspending payment; or (2) the contractor believes it may be making an inappropriate payment if they pay the claim. In the second case, the contractor withholds the money until it determines whether the provider may be defrauding Medicare. If it is later determined that the claim should be paid, the money is released to the provider.

Here are some specific instances:

- Medicare suspended over $360,000 in payment to five lymphedema pump suppliers in New Jersey. One of these entered into a settlement with the government to repay $875,000 in overpayments; three suppliers' claims are still suspended pending negotiation of a settlement, and one had its suspension removed and is negotiating a settlement.
- Medicare suspended payment to a durable medical equipment (DME) supplier in May 1995, because of improper billing, upcoding, and misrepresentation of services. Once the provider was notified, they stopped billing Medicare. This case was developed by the Medicare carrier and is now being investigated by the IG and the FBI.
- Two DME suppliers under common ownership had their payment suspended by Medicare because they were billing for orthotics and providing seating systems in nursing homes. Medicare does not pay for such seating systems. The Medicare Carrier sent a demand letter for $2.2 million in overpayments. The IG is investigating the case and this supplier is in bankruptcy court.
- Payment was suspended to an optometrist who was billing Medicare Part B and Medicaid for services not provided. Over $185,000 was suspended over a year-and-three-month period; a civil suit was filed against the optometrist; and the U.S. Attorney's office is now negotiating a settlement and a permanent exclusion.
- A DME supplier had over $1 million suspended for billing for services not rendered. The Medicare carrier suspended payment in June 1994, pending further investigation. In October 1994, the company was determined not to be legitimate, and their supplier number was deactivated.
- Two suppliers under common ownership had their payment suspended because they were billing for urinary incontinence supply kits but were providing disposable diapers, which are not covered by Medicare. The suspension began in August 1994. The IG is pursuing this case.

Mr. VLADECK. The answer to your second question is, yes.

The first question is, we'll pull together some instances of actual stopping of payment.

I have to tell you that for many of our contractors, when Judy instructed them to stop payment to certain providers, again, people turn over in these organizations. But we got the question how, that it had been so long since they had been asked to do so that they didn't even have their own procedures to do it. So the numbers, however impressive or unimpressive they may be, will be an enormous percentage increase, and we expect that percentage to increase and we will provide you some.

Mr. SOUDER. Thank you. As we go through the Medicare debate, I may have some additional questions. I don't want you to keep from a tracking down people who are cheating the question, but if you could help from time to time.

Mr. VLADECK. Be my pleasure. Thank you.

Mr. SHAYS. Mr. Fattah.

Mr. FATTAH. Thank you, Mr. Chairman. Let me regret that I got here late. And let me compliment you on the work that is being done to get at this issue.

I could tell you, however, that, you know, there is a growing perception that somehow, even though many of us in the Congress want to get tough on crooks who are out there preying on the public, that we really don't mean people like S&L bandits or people who rip off millions and millions of dollars from the Medicare or Medicaid program. We're really talking about other kinds of more minor criminal activity where we want to get tough, and that—when we look at these kinds of issues—we talk about this whole issue of exclusion. And I can say see that we're making progress, but in many of these cases we're really talking about criminal fraud. And it should at some point be appropriate when people are taking millions and millions of dollars to put them in jail.

In Philadelphia, we had an instance with one provider who, was billing millions and millions of dollars for prescription drugs that were fraudulent. A deal was cut, he was able to keep his house on the Main Line and away scot-free.

Now, I know that wasn't your department, that was the U.S. attorney General's office who made the deal. But it creates a perception under which one cast of characters who are criminals gets treated in one way, and other people get treated in a different way. And so even though I want to compliment you, I will tell you that there's still, I think, a concern among some of us in the Congress, and I know a great many people in the public about the way these things get handled.

Mr. VLADECK. Thank you. I'm actually—will point with pride to the setting of agendas and the actions of this Attorney General and let her Special Counsel comment more on the extent to which that sort of white collar crime is a priority for the administration second only to that of violent crime. And the extent to which the willingness to seek appropriately severe penalties against white collar criminals is increasingly a priority in the Department of Justice. I think they have a good record on that. I think they can appropriately speak to that.

Mr. FATTAH. I don't have any more questions, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

Mr. Schiff.

Mr. SCHIFF. Thank you, Mr. Chairman.

Mr. SHAYS. I would just note for the record that we've been joined by Mr. Martini from New Jersey.

Mr. MARTINI. Thank you, Mr. Chairman.

Mr. SCHIFF. I'll be brief, Mr. Chairman. First, I just want to commend your leadership in pursuing this area of inquiry. Under Chairman Towns in the last Congress, we spent a great deal of time on the issue of health care fraud, both generally as it affected Federal programs, such as Medicare and Medicaid—I might add

the Judiciary Committee spent a fair amount of time on it also. And I want to say, what stands out here and what you've identified is, if we could substantially reduce the amount of fraud in the system, we could expand health care services in the country without raising taxes and without reducing services to anyone else. It's just a waste in terms of total dollars spent. We have to get a better grip on it.

I want to say that my offer—in my offer to put together a new bill and look for HCFA's ideas and the Department of Justice's ideas, I intend to proceed as a member of your subcommittee with your direction, Mr. Chairman, on how you wish to proceed.

Mr. Vladeck, I do have a question. That is, I note your discussion of the settlement negotiations that might occur with respect to alleged health care fraud, and I assume you're talking about negotiations that are handled on the Government side by the Justice Department; am I right?

Mr. VLADECK. Yes, sir.

Mr. SCHIFF. And I note that you talk about, well, sometimes they negotiate whether someone can stay in the program or not stay in the program. And to tell you the truth, I'm surprised to hear that is this sense.

I know the Justice Department can negotiate whether they will pursue jail or not jail, that's their prerogative, and I sometimes have some difficulty with how they've handled those cases, which I've made known to the Justice Department; but I'm surprised to learn that they can control in the negotiations whether someone can continue to do business with your department. I would think that your department would retain an independent role and ability to make that decision for itself.

So I wonder if you could clarify that. Did I understand that right?

Mr. VLADECK. Well, that's in fact what I said. I'm a little bit concerned that the folks who in fact have—who participate in those roles answer your question appropriately. It is the Inspector General who has the authority to initiate exclusion proceedings for Medicare and Medicaid. They are very much a part of settlement discussions in cases of this sort. And in terms of answering your question appropriately, without trying to evade responsibility, I really think I have to defer that to them, sir.

Mr. SCHIFF. To whom?

Mr. VLADECK. To the Inspector General and to the representative of the Department of Justice, who are the next witnesses this morning.

Mr. SCHIFF. All right. Well, I guess—I may or may not be able to be here for the next panel, which is my problem, but I would still ask you, as the head of the agency, if you know—if not, deferral is fine—does the Justice Department, independent of your agency, make an agreement as to whether someone can continue to be in your program that is somehow binding upon you as Administrator of the program?

Mr. VLADECK. My understanding, and again, as an observer in this process, my understanding is in a couple of prominent cases with which I've been familiar, in order to achieve both a settlement and rapid remediation of some of the problems in consultation with

the Inspector General, whose authority it is we're talking about, a decision has been made not to exclude a provider from the program. That's part of the whole package of settlement. And that is done primarily as a consultative relationship between the Department of Justice and HHS, as represented in those interests by the Inspector General.

Mr. SCHIFF. I understand your answer, and I want to say that I have a problem with the Agency going that far—I mean, the Department of Justice. If the Department of Justice wants to set a condition, if you want to stay in the program these are the remedial measures we expect, I have no problem with that. If they then impose that upon your agency, I have a real problem right there. I think your agency should be the final controller of who's doing business with your agency.

One more thing, and that is, you were referring to automating the Medicare system. When do you believe that will be accomplished?

Mr. VLADECK. Well, it's—we have an automated system. It's really integrating our automated system. And again, we expect to be beginning in one part of the country in 1997 and to be nationwide in 1998.

Mr. SCHIFF. What will you be able to do in a fully integrated automating system? If you could answer briefly, I would appreciate it. My time has expired.

Mr. VLADECK. Again, we will be able to have a single on-line data base which has all providers, all beneficiaries, and all claims in the system, accessible through a single data base and data system, with modern computer technology with the very short times in order to get into those subsystems in order to do analyses or to do automated edits and pattern analyses of information coming up through the claims system.

Mr. SCHIFF. All right. Thank you, Mr. Vladeck.

I yield back, Mr. Chairman.

Mr. SHAYS. Thank you. Before asking Mr. Martini if he has any questions, I'd just like to say that once again I'm troubled by your terminology. You said, "as an observer in the process." I feel like somehow you're a janitor watching what is happening, and not the person in charge. I want to say to you, that I think you have to be more than an observer in this process.

Mr. GREEN. Mr. Chairman, if I could—I apologize for interrupting, but I share your concern. In fact, as the head of the agency, I would hope that if we don't—if you don't have that authority, then you should have it, and whether it's through our committee or through some other committee, to take a more aggressive role in it.

Mr. SHAYS. Thank you.

Mr. Martini.

Mr. MARTINI. Yes, Mr. Chairman, thank you. I'd like to yield just a moment to Mr. Souder.

Mr. SOUDER. I wanted to ask a follow-up question.

Mr. SHAYS. Could you use the mike, sir—the other mike?

Mr. SOUDER. I wanted to ask a follow-up question on the computer automatization.

Mr. VLADECK. Yes, sir.

Mr. SOUDER. Have you made a decision on the computer companies or are you starting that process? Is 1997 really a feasible goal?

Mr. VLADECK. We are well along. We let the design contract, which—through the usual competitive procurement, which was awarded to GTE, in early 1994. So we're about 8 months—18 months, not quite 18 months into that design contract. We also have what's called an independent verification and validation contract to sort of oversee GTE's work on the contract. And we are now on a time line which we're well along, in which the prototype site, processing site, which becomes the first regional site, goes up in the third or fourth quarter of 1997, and then rolls into national implementation in 1998. So we are very much on that timetable.

Mr. SOUDER. Thank you.

Mr. MARTINI. Thank you, Mr. Chairman. I apologize. My apologies to the witnesses for not having the benefit of their testimony; and I hope these questions aren't repetitive, but I do have two.

One is actually, I would like to share a thought with you based on my recent visits to a number of senior centers in my district. And in discussion of Medicare, much to my surprise, when we discussed the Medicare issue and the need to make it more effective and to get rid of some of the excesses in the system, I was, I guess, very surprised to see that many of the seniors came forward and shared with me personally the excessive amount of treatments that they often are urged to receive. And they even themselves questioned the need for much of the treatment that the health providers are urging them to come back for and revisits, et cetera. So that was one observation that I made.

So it's clear to us that there has to be something within the system that would minimize that encouragement of excessive treatments. And that brings me to the topic of putting the control of the treatments in the hands of the beneficiaries through perhaps a voucher type of a system, in which we give the principals, the elderly in the Medicare system, a certain sum of money each year, up to a certain sum of money to be able to be used for their medical care, with some benefit to them that if they don't use the entire amount, they get some—some benefits by retaining some amount or putting it toward the next year, et cetera.

Now this is a concept that I think has been raised and discussed a little bit, but it was one that I had some discussions with the seniors in these different groups. Do you have any thoughts on that?

Mr. VLADECK. Yes, sir. The problem with that is twofold. One gets to the fundamental nature of insurance. Medicare beneficiaries are very heterogeneous in terms of their need for services. And the ability to attach to an individual a voucher that adequately reflects their relative risk at the individual level creates all kinds of problems.

For example, about 10 percent of Medicare beneficiaries use no Medicare billed services in the course of any year. When we talk about an average cost of $4,800 per beneficiary, these 3 million people whose cost is zero are a part of that insurance pool. If you take those folks and gave them a $4,800 voucher, you would be out a substantial amount of money.

Mr. MARTINI. I guess the voucher concept was more—I should have been clearer in the discussion. I think it—my knowledge on

this is somewhat limited, but it's a concept that I've been hearing. It's more toward the purchasing of insurance, so that there's a sum that they would be allotted, and then if they want the Cadillac of insurance coverage, they would be spending more. If they want a pure HMO, they would be spending less, but they would have incentives within that system to avail themselves of different types of insurance and retain some of the savings, I guess, themselves directly. But that may not get to the excesses of treatment.

Mr. VLADECK. If you look at the market for individual insurance at the moment, you have a number of problems there that would be exacerbated for a Medicare population.

First, if we learned one thing in health reform, we learned that the least expensive way to provide health insurance is through marketing individual policies, that it's the large groups that do the best job both of keeping their administrative costs low and of negotiating good deals with health care providers in terms of prices.

Second, it is almost impossible as a practical matter, without a very large bureaucracy, to prevent risk selection behaviors, or so-called "creaming" among private insurers. And again, given a population that's very heterogeneous with respect to risk, any system of the kind you're describing creates an enormous incentive for insurers to profit not by more efficiently providing services, but by only covering the least expensive people.

The third and most basic problem is really a philosophical one. The Medicare benefit is a defined set of benefits to which beneficiaries are entitled in large part by virtue of the contributions they made during their working lives. What the sort of voucher you're talking about does is turn it into a defined contribution in which the Government says to the beneficiary, here is a check for $4,800 or $5,000 or whatever. If you can buy something better in the private market, more power to you. If you can't, you're out of luck. And that seems to me to be a fundamental reneging on the commitment that the Medicare system represents to the folks who contributed to it.

Mr. MARTINI. I see my time has expired.

Mr. Chairman, I just have some comments I'd like it submit for the record.

Mr. SHAYS. Without question, then they will be submitted.

Mr. MARTINI. Thank you.

[The prepared statement of Hon. William J. Martini follows:]

PREPARED STATEMENT OF HON. WILLIAM J. MARTINI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Thank you Mr. Chairman. I want to join in congratulating you for holding today's hearing. I feel that of all the hearings we will hold this year this may be the most important issues we will deal with in the 104th Congress.

The reality is hard to swallow, but Medicare will be bankrupt in seven years. If this Congress does not do anything to save Medicare by 2002, no one will be able to receive the benefits of the Medicare system.

Once Medicare funds are depleted, Medicare will simply not be able to pay the bills. I cannot just sit back, as other Congresses have done, when faced with major public policy problems. I cannot let Medicare become obsolete. This program affects the lives of too many Americans and too many constituents.

While we in Congress begin the process of developing a strategy to save Medicare, one of the main aspects to that strategy must to be the elimination of waste, fraud and abuse in the Medicare and Medicaid system.

The American people have demanded a solvent Medicare system and a Federal bureaucracy that is smaller, smarter, and less costly. Today, we must begin a dialogue on how to deliver these services more efficiently and at a cheaper cost. We must control the growth of Medicare so that our seniors will have a viable system today and in the future.

While it is important that we control costs, it is imperative that we banish the waste, fraud and abuse that permeates the Medicare and Medicaid programs. I am dismayed that the American taxpayer may be funding as much as $24 billion a year in Medicare and Medicaid fraud. We can no longer tolerate this! Every dollar lost in waste is one less dollar that can go to services of real participants in this program.

The consequences of this widespread abuse are devastating. I commend the Clinton administration for it's "Operation Restore Trust Initiative". However, I believe that we can go further and we owe it to the American people to do a better job of curbing abuses in the Medicare and Medicaid programs.

One program, in particular, with which I have great concerns is the Non-Emergency Transportation (NEMT) program. For those of you who are not familiar with NEMT, this is the program in which taxpayers get taken for ride!

Mr. Chairman, taxicab companies and medical transport services across America are getting rich off this Federal debacle. One company in Palm Beach County Florida billed the Government for over $4 million last year alone.

This program does not allow people to pick up their food stamps or welfare checks, but the American people in many cases pay for them to go to the doctor or some cases the mall.

The evidence of abuse in the NEMT program is overwhelming, and yet the Federal Government continues to fund this program year in and year out.

It is time to re-examine the NEMT program. I would hope that in your efforts to combat waste, fraud, and abuse in Medicare and Medicaid you will closely examine the merits of this questionable program.

I would also call upon this committee to take steps to beckon to those beyond the Washington crowd to the vast majority of individuals beyond the beltway to find other examples of waste, fraud and abuse in the system. Who better to find the deep rooted problems in the system, then the people in the trenches who must deal with these issues every day of their lives.

Mr. Chairman, in my congressional district I have established a Medicare Advisory Panel, referred to as MAP. Because these individuals represent a broad spectrum of the medical community, they will be better able to devise unique strategies to both save the Medicare system and give a grassroots perspective of where we can eliminate waste.

Mr. SHAYS. Is there any Member here who would like to ask another question before we go on to the next panel?

Mr. Chrysler.

Mr. CHRYSLER. If I could just correct the record, I mentioned home health care is paid for my Medicare. I meant nursing home care. I apologize for that, in that question.

Mr. VLADECK. Thank you.

Mr. CHRYSLER. If there was just one more question that I could ask, why does the health care program continue to do business with providers who have been found guilty of fraud?

Mr. VLADECK. Again, when possible, we try to see that they're excluded from the program. And unless they have been formally excluded under a process that's specified in law which gives them certain due process protections, we're obligated to keep them in until we can get them out.

Mr. CHRYSLER. What additional authority do you need to not do business with them?

Mr. VLADECK. Well, I think the message is that the legal—the statutory authority is probably adequate. What we felt for a long time we needed were the resources to more effectively pursue these cases. And we have some proposals and suggestions for how to do that.

Mr. MARTINI. Mr. Chairman, do we have time for one short——

Mr. SHAYS. If you would like to ask another question, I'd open it up to both sides and be happy to have you ask a question.

Mr. MARTINI. If I may, just as a follow-up to a question that I had asked during another hearing some time ago of the Secretary with respect to the NEMT program and a lot of the abuses that exist in that program, and I guess the question that comes to mind, and there's probably a good answer for it, but maybe you can bring that one, with all—in the face of all of the abuses in that program, which I think have been acknowledged by virtually everyone; why should we even continue that program?

We have other services such as food stamps, welfare benefits, et cetera, where people have to go and receive, to pick up, get the benefit of those programs. And again—or what can we do to make that a more efficient program? I have not gotten an answer from the Secretary on that. She had indicated she would provide us with an answer as to some of the steps that have been taken, but we haven't yet heard from her.

Mr. VLADECK. Well, thank you, sir. I apologize that it's taken that long for the Secretary's response, and I can promise you you'll have it today. But let me say more generally that, again within the structure of the Medicaid program, nonemergency medical transportation is one of those things where we have traditionally permitted the States to decide whether that's going to be a covered benefit or not. And in many instances they've decided that in order to get people in rural areas or in certain inner city communities to services, if they don't provide nonemergency transportation, they end up calling 911 and Medicaid ends up paying for an ambulance.

Now, in order to address some of the abuses you've discussed, there are several things we need to do. One of them is to raise again the question of whether we should reduce the matching rate for States which are using that as a service rather than administrative cost.

And a second issue is to address specifically some of the ways in which the kinds of abuses you've talked about and helped identify can be controlled in some of the ways that, for example, folks in New Jersey have begun to do much more effectively, we think, over the last few months.

And again, the Secretary's response has some more of the details of that. We'll be happy to go into that with you.

Mr. MARTINI. Thank you very much.

Mr. SHAYS. I appreciate your testimony, Mr. Vladeck. This subcommittee is going to follow up on the work done in the past, and will be very active with HCFA.

We know you have a tremendous task and fraud is just one part of it, but it's a gigantic part, and we intend to have you back before this subcommittee to get into this in depth. We want to encourage you to be very outspoken on waste and fraud in the months to come.

Mr. VLADECK. I appreciate that. I look forward to being invited back and to working with you, and I thank you very much.

Mr. SHAYS. Thank you very much.

Our next panel is June Gibbs Brown, Inspector General of HHS; and Gerald Stern, Special Counsel, Health Care Fraud, Depart-

ment of Justice. I'm sorry, I should have asked you to remain standing so I could swear you in. Since—Ellen Boyd?

Ms. BOYD. Eileen.

Mr. SHAYS. I'm sorry, Eileen. Since you may be asked to speak directly and respond to a question, we'll swear you in as well. If you would raise your right hands.

[Witnesses sworn].

Mr. SHAYS. For the record, all three witnesses responded in the affirmative.

And we welcome your testimony. You obviously are free to summarize, and we look forward to asking you questions.

We'll start with you, Ms. Brown.

STATEMENTS OF JUNE GIBBS BROWN, INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY EILEEN BOYD, ASSISTANT INSPECTOR GENERAL, OFFICE OF CIVIL FRAUD AND ADMINISTRATIVE ADJUDICATION; AND GERALD STERN, SPECIAL COUNSEL, HEALTH CARE FRAUD, U.S. DEPARTMENT OF JUSTICE

Ms. BROWN. Thank you, Mr. Chairman.

Mr. SHAYS. You need to bring the mike closer to you.

Ms. BROWN. OK. Can you hear now?

Mr. SHAYS. Yes, except if you—you know, it might work better to have it in front, even if it's further away, so it's getting your voice directly. You can move the water.

Ms. BROWN. Good morning, Mr. Chairman——

Mr. SHAYS. Good morning. We hear you.

Ms. BROWN [continuing]. And members of the subcommittee. I'm June Gibbs Brown, Inspector General of the Department of Health and Human Services. With me is Eileen Boyd, the Assistant Inspector General for our Office of Civil Fraud and Administrative Adjudication. Mrs. Boyd is also a member of the board of directors of the National Health Care Antifraud Association.

As requested by the subcommittee, I'll focus my testimony this morning on administrative sanctions and our efforts to protect Medicare and Medicaid from repeat offenders.

Our office works closely with the U.S. Department of Justice in identifying and prosecuting fraudulent and abusive health care providers. When the Department of Justice declines a case for criminal and civil prosecution, then we decide whether to independently exercise HHS authorities for imposing administrative sanctions. These sanctions include civil monetary penalties, assessments and/or program exclusions. I'll describe the sanctions briefly.

Mr. SHAYS. Could you just suspend for 1 second? Are you planning to come back, Mr. Souder? If you and the ranking member could leave right now, we could continue with the testimony and then try to hold on for questions.

Thank you.

Ms. BROWN. The Civil Monetary Penalty Law was enacted in 1981 as an administrative alternative to civil prosecution under the False Claims Act. The CMPL provides a means to impose these civil monetary penalties and assessments on individuals and entities who submit false or improper claims for payment under Medicare, Medicaid, and other State health care programs. The CMPL

also authorizes the exclusion of a provider from program participation.

In addition to the CMPL, there are mandatory exclusion provisions in the Social Security Act. These provisions require the OIG to exclude any individual or entity for a minimum of 5 years, based on a conviction for Medicare or Medicaid program related fraud, or for patient abuse and neglect.

Other provisions of the act authorize, rather than require, exclusion from program participation if under certain criteria the OIG determines an exclusion of a provider would be warranted. Once a program exclusion is imposed, Federal program payment may not be made to any individual, business or facility for items or services furnished, ordered or described by an excluded individual or entity. The OIG-imposed exclusions apply not only to HHS programs, but also to all other executive branch procurement and nonprocurement programs and activity.

At the conclusion of the specified exclusion period, reinstatement to Medicare, Medicaid and other State health care programs is not automatic. A provider may be reinstated only if the OIG determines that certain criteria are met. HHS regulations specify the factors that are to be considered. Violating the terms of an OIG-imposed program exclusion could result in criminal prosecution and/or civil monetary penalties against the excluded provider.

Attached to my written testimony is a chart entitled Historical Data. I have brought an enlargement of this chart with me today. Of the 8,583 exclusions that have been implemented, 1,335 health care providers have met the criteria for and have been reinstated. Currently, 7,202 providers, or 83.9 percent, are either eligible to apply for reinstatement or are still within their specified period of exclusion. Of these, 1,546 are eligible to apply, but have not been reinstated either because they did not request it, their request was denied, or they have abandoned their request by not providing necessary authorization and information.

We've identified 46 providers as repeat offenders. This means that a second problem occurred either while an exclusion was in effect or shortly after reinstatement occurred. And that second problem triggered a new or additional sanction to be imposed. Repeat offenders represent about 0.5 percent of the total exclusions imposed in 1984—or since 1984.

In order to curb recidivism by health care providers, OIG initiatives have brought investigators, auditors and evaluators together as a team, communicating with HCFA officials to review problem areas. For example, we've been seeking the development of a uniform provider application and agreement. This would be used by all physicians and other providers when applying for participation in the Medicare program. We will continue to encourage HCFA in this matter.

Also, the OIG has been working with HCFA on utilizing unique physician identification numbers, also known as the UPIN numbers. Including UPIN numbers in recordkeeping allows the Medicare contractors to more readily identify excluded physicians. The process by which provider numbers are issued is undergoing improvement, and as a result of OIG inspections, HCFA has undertaken several initiatives to address the problems identified and to

improve its provider number process. An opportunity to increase awareness of sanctioned providers is through the National Practitioner Data Bank, administered by the Public Health Service. This data bank tracks malpractice payments, clinical privilege, and licensure actions taken against physicians and dentists. The information is then available to all hospitals and licensing boards for their use. We're seeking data input and retrieval access to this system.

Apart from the PHS data bank, we support establishing an independent central repository for the reporting of final adverse actions taken against health care providers. Along these lines, we're working with HCFA, the Medicaid Fraud Control Units, and the FBI to create a data base for health care fraud and abuse purposes.

There are still some loopholes that allow fraud and abuse to thrive, and I'd like to mention two examples specifically. We have found that unscrupulous owners often simply reincorporate an excluded company into another company, and continue doing business with the Federal Government.

As the law currently provides, if an owner is convicted and excluded, then we can exclude any company associated with that individual. However, if it is the company that's convicted and excluded, we have no recourse to take action against the owner of the company. That individual is free to reincorporate or start another business with no fear of exclusion. We would propose an amendment to provide the Department with the authority to exclude certain individuals when the company is convicted and excluded.

The second situation involves health care providers who bill Medicare, Medicaid or other State health care programs for services rendered, ordered or directed by an excluded employee. Currently, the strict liability standard for imposing monetary penalties for services rendered, ordered or directed by an excluded individual only applies to the excluded individual. Expanding CMPL coverage to employers of excluded individuals would encourage them to ascertain the participation status of employees prior to submitting claims.

Moreover, such an amendment to the CMPL would give the OIG authority to hold the employer strictly liable for health care claims submitted in connection with an excluded employee. We encourage the committee to consider such amendments to the Department's administrative authorities.

This concludes my oral testimony, and I would be pleased to answer any questions.

Mr. SHAYS. Thank you.

[The prepared statement of Ms. Brown follows:]

PREPARED STATEMENT OF JUNE GIBBS BROWN, INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Mr. Chairman and members of the Committee. I am June Gibbs Brown, Inspector General of the U.S. Department of Health and Human Services (HHS). With me is Eileen T. Boyd, Assistant Inspector General for our Office of Civil Fraud and Administrative Adjudication. Ms. Boyd is also a member of the Board of Directors of the National Health Care Anti-fraud Association.

As requested by the subcommittee, I will focus my testimony this morning on administrative sanctions for health care fraud and abuse and our efforts to protect HHS programs from repeat offenders—health care practitioners who have defrauded or abused our health care financing programs and/or beneficiaries and who may

seek to continue their aberrant behavior at the taxpayers' expense. Specifically, I will focus on our civil and administrative authorities with respect to participation in Medicare, Medicaid, Maternal and Child Health Services Block Grants, and Block Grants to States for Social Services programs.

OFFICE OF INSPECTOR GENERAL—OVERVIEW

The Office of Inspector General (OIG) at the Department of Health and Human Services was created by statute in 1976 and is charged with protecting the integrity of departmental programs, as well as promoting their economy, efficiency, and effectiveness. The OIG meets this challenge through a comprehensive program of audits, program evaluations, and investigations designed to improve the management of the Department and to protect its programs and beneficiaries from fraud, waste, and abuse. Our role is to detect and prevent fraud and abuse and to ensure that beneficiaries receive high quality and necessary services at appropriate payment levels.

INTERAGENCY COOPERATION ON FRAUD CONTROL

Investigations

The OIG works in cooperation with other law enforcement officials outside our Department. For example, along with the Department of Justice, we established an Executive Level Health Care Fraud Policy Group. The group includes representatives of the Attorney General's office, the Civil and Criminal Divisions of the Department of Justice, the Federal Bureau of Investigation, and our office. We have been working to identify new methods of proceeding against health fraud, identifying priority areas for increased enforcement, and breaking down "red tape" barriers.

In addition, we and the Inspectors General of five other Federal agencies have formed an Inspector General Health Care Fraud Coordination Council. We also seek to coordinate our efforts with the majority of honest providers who want to see fraud reduced. One very good example of our efforts to coordinate both within the Government and with the private sector is Operation Restore Trust, a program we, the Health Care Financing Administration, and the Administration on Aging have initiated. This initiative includes a voluntary disclosure component and public access to a health care fraud hotline. We are involving a full range of Federal. State and local government, and private resources in this effort. Operation Restore Trust is being piloted in the five States with the largest Medicare and Medicaid populations, i.e., California, New York, Florida, Texas, and Illinois.

Our investigative activities are coordinated with other law enforcement organizations like the Medicare contractor fraud units, State Medicaid Fraud Control Units, the Federal Bureau of Investigation, the Drug Enforcement Agency, the Defense Criminal Investigative Service (the investigative arm of the Department of Defense Office of Inspector General), the U.S. Postal Inspection Service, the Internal Revenue Service, and State and local authorities. These agencies collaborate in investigating matters arising under various Federal and State laws, including alleged misconduct by health care providers and others participating in the Medicare, Medicaid, and other State health care programs.

Prosecutions

We work very closely with the U.S. Department of Justice in identifying and prosecuting fraudulent and abusive health care providers. We refer cases for prosecution to the DOJ (including United States Attorneys' offices) to initiate criminal or civil actions in Federal court. If the DOJ action results in a program-related criminal conviction, the convicted health care provider is excluded from program participation for a minimum period of 5 years.

Alternatives to Prosecution

When the DOJ declines a case for criminal or civil prosecution, the OIG must decide whether to exercise the Department's administrative authorities for imposing sanctions such as civil monetary penalties, assessments, and/or program exclusions. Because of its delegated authority to impose such sanctions, the OIG is an important component in "triaging" a health care fraud or abuse case; that is, determining the best legal remedy or combination of legal remedies to be utilized.

Thus, although, in certain cases, prosecution by DOJ may be ruled out, we are able to assure, through the imposition of sanctions, that those health care providers who have defrauded or abused our programs or beneficiaries are precluded from exploiting the system in the future. To insure that appropriate legal remedies are utilized in each particular case, the OIG reviews all of the available case file material, determines which, if any, administrative sanctions would be most appropriate, and

coordinates its efforts across the Government, e.g., with other Federal and State law enforcement agencies.

In Fiscal Year (FY) 1994, the OIG assisted in the collection of more than $440 million in penalties and assessments and imposed 1,265 administrative exclusions.

The administrative sanctions imposed by the OIG are derived from authorities provided to the Department by sections 1128, 1128A and 1156 of the Social Security Act (Act). The Secretary has delegated these administrative sanction authorities to the OIG. A chart listing the authorities is attached.

CIVIL MONETARY PENALTIES AND ASSESSMENTS

The Civil Monetary Penalty Law (CMPL), section 1128A of the Social Security Act, was enacted in 1981 as an alternative administrative remedy to civil prosecution under the False Claims Act. It provides a means to administratively impose civil monetary penalties and assessments on individuals and entities who submit false or improper claims for payment under Medicare, Medicaid, and the other State health care programs. The CMPL also authorizes for the exclusion of the provider from program participation.

Penalties may be imposed for amounts up to $2,000 per false or fraudulent line item or service on a claim. An assessment may also be levied for not more than twice the amount claimed for each item or service which formed a basis for the penalty. These penalties may be imposed for a variety of fraud or abuse violations including fraud, billing or charging violations, patient and beneficiary protection issues, circumvention of regulatory requirement, physician protection, or improper disclosure of information. (See attached chart on the CMP process.)

PROGRAM EXCLUSIONS

Mandatory Exclusions

The most significant exclusion authority in terms of OIG priority and workload are the mandatory exclusion provisions in section 1128(a) of the Social Security Act. The implementation of this authority is closely allied with the criminal enforcement provisions of the law. This section of the law requires the OIG to exclude any individual or entity for a minimum period of 5 years based on convictions for Medicare or Medicaid program-related crimes or for patient abuse and neglect. In FY 1994, the OIG processed 288 exclusions derived from the conviction of a program-related crime and 183 derived from patient abuse or neglect convictions.

Permissive Exclusions

Various provisions in section 1128(b) of the Act authorize, rather than require, the exclusion of individuals or entities from program participation if, under certain criteria, the OIG determines an exclusion to be warranted. Permissive exclusions may be taken based on convictions for non-Medicare/Medicaid health care fraud, theft, financial misconduct or controlled substance violations. Exclusions may also be imposed based on license suspensions and revocations and sanctions imposed by other Federal or State health agencies.

The OIG may also impose an exclusion based on a State peer review organization (PRO) recommendation that an individual or entity has failed to meet statutory obligations. These obligations are to provide care that is medically necessary, meets professionally recognized standards of health care, and is properly documented. A determination of unwillingness or inability to comply with these statutory obligations is necessary before any exclusion can be imposed.

If an excluded individual has a direct or indirect ownership or control interest of 5 percent or more in any health care entity (such as a hospital or clinical laboratory), or is an officer, director, agent, or managing employee of that entity, that entity may also be excluded from participating in the programs.

The OIG is also required to exclude health care providers who have failed to repay or to enter into an agreement to repay a Federal health education assistance loan (HEAL program). These providers remain excluded until the debt is completely repaid.

Effect of Program Exclusions

Once a program exclusion is imposed, Federal program payment may not be made to any individual, business or facility, e.g., a hospital or home health agency, for items or services furnished, ordered, or prescribed by an excluded individual or entity. There is an exception for emergency items or services, under certain conditions. Additionally, no Federal funds can be used to pay any administrative or management services, including a salary or fringe benefits, related to the delivery of a health care item or service rendered to a program beneficiary.

Scope of Exclusions

As set forth in departmental regulations, OIG exclusions are effective with respect to participation in Medicare, State health care programs, and all other Federal non-procurement programs, e.g., the Federal Employees' Health Benefits Program (FEHBP). These regulations are currently being broadened in light of the recent enactment of the Federal Acquisition Streamlining Act of 1994 which mandates and expands the government-wide effect of all debarments, suspensions, and other exclusionary actions to Federal procurement, as well as non-procurement programs. Thus, all OIG imposed exclusions will apply not only for HHS programs, but also for all other Executive Branch procurement and non-procurement programs and activities.

This means, for example, that a health care provider excluded from Medicare, Medicaid, and other State health care programs will be unable to continue participating in the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program administered by the Department of Defense or in the Federal Employee Health Benefits Program administered by the Office of Personnel Management.

Appeals Process

An exclusion notice sets forth the effect of the exclusion and the subject's appeal rights. If the exclusion was imposed under the Civil Monetary Penalty Law or due to violations of the Medicare/Medicaid anti-kickback statute, the excluded party may request a hearing before implementation of the exclusion. In all other instances, the exclusion is in effect while the appeals process is being conducted. Appeals of exclusions are heard by administrative law judges in the Department, with review by the Departmental Appeals Board. The subject may then appeal the administrative decision to the district court (or court of appeals for CMPL cases). Less than one percent of implemented exclusions have been reversed on appeal.

REINSTATEMENT AFTER EXCLUSION

Reinstatement to Medicare, Medicaid, and the other State health care programs at the conclusion of the specified exclusion period is not automatic. When an exclusion notice is issued to a health care provider, the notice specifies that, at the conclusion of the period of exclusion, the provider has the right to apply for reinstatement under the provisions of the statute and the regulations.

Reinstatement Process

Upon receipt of a request for reinstatement, the OIG furnishes the subject an authorization to be signed allowing the OIG to obtain information from peer review organizations, private health insurers, probation officers, professional associates, investigative agencies, and such others as may be necessary to determine whether reinstatement should be granted. In addition, the OIG requires the subject to complete a questionnaire which elicits specific information concerning the subject's activities during the period of exclusion and indicates whether the subject has or is likely to repeat the prohibited types of conduct which resulted in the original exclusion.

If the subject signs the authorization and provides the requested information, the OIG will thoroughly review the information. Where warranted, the OIG will contact interested parties to establish whether or not the subject has committed acts which would preclude reinstatement. If the subject fails to furnish the required authorization and requested information. the exclusion remains in effect.

Criteria for Reinstatement

A provider may be reinstated only if the OIG determines that, during the period of exclusion, the subject has not committed an act for which a civil monetary penalty could be assessed or has not committed an act that would result in an additional exclusion being imposed.

The regulations specify the following factors to be considered:

- the conduct of the subject prior to the date of exclusion, if not known to the OIG at the time of the exclusion;
- the conduct of the subject after the exclusion;
- whether the fines and all debts due and owing (including overpayments) to any Federal, State, or local government that relate to Medicare or any State health care program have been paid or that satisfactory arrangements have been made to fulfill these obligations; and,
- there are reasonable assurances that the types of actions which resulted in the original exclusion have not and will not recur.

Action if Reinstatement Approved

If the OIG approves the subject's request for program reinstatement, the OIG notifies the subject and other appropriate parties including the HCFA, Medicare contractors, Medicaid and other affected State agencies. Upon receipt of the notification from the OIG, the State health care programs (e.g., Medicaid) must also reinstate the subject into their programs unless reinstatement is not available under State law or the State health care program had established a longer period of exclusion under its own authorities and procedures.

Action if Reinstatement Not Approved

If the OIG does not approve reinstatement, the excluded provider may present written documentation and/or oral argument to an OIG official. If, after reviewing the additional documentation, the OIG decides to continue the exclusion, the subject is so notified and advised that no subsequent request for reinstatement will be considered until at least one year after the date of denial.

ENFORCEMENT OF EXCLUSIONS

Ensuring Public Awareness

When a program exclusion is imposed, the OIG makes every effort to publicize it. This high level of communication has a far-reaching effect. It informs third-party payer agencies that all program reimbursement must cease; it alerts employers that the subject has been shown to be untrustworthy and has a history of disciplinary action; it puts third party payers and licensing board authorities on notice that a sanction has been imposed and the reasons for it; and, it provides an opportunity for the ongoing exchange of information between Federal and State law enforcement agencies.

Proactive Communication:

Listed below are the ways we communicate the exclusion actions to organizations and the Public.

- Individual notification letters with personal identifier information regarding the excluded provider are sent to all State health care program agencies, Medicare contractors, licensing board, and known employer in the State where the subject practices medicine or provides health care services. Personal identifier information includes the social security number, date of birth, unique physician identification number (UPIN), program provider number, license number, etc.
- Copies of the exclusion notice are sent to the subject's attorney (if known), the Office of Personnel Management, the Public Health Service, Department of Justice, U.S. Attorney, and any State peer review organization that may be deemed appropriate.
- Notice is given to the agencies administering the Block Grants to States for Social Services and Maternal and Child Health Service Block Grants; the Federation of State Medical Boards; Federation of State Podiatric Boards, Office of Civilian Health and Medical Program of the Uniformed Services, Department of Labor, Social Security Administration, Veterans Affairs, and General Services Administration (GSA).
- Monthly reports of all exclusions being implemented are released to all third-party payer agencies; specific notice is provided to the Health Care Financing Administration (HCFA) for its use in notifying all Medicare contractors, Medicaid and other affected State agencies, and private insurance companies of the exclusion action (HCFA Publication 69.)
- A cumulative sanction report of all exclusions in effect is published twice a year and routinely released to recipients of the monthly reports and payer agencies and, on a request-specific basis, to all other interested parties. Excluded providers are removed from the cumulative list if and when they are reinstated. (To date, the OIG has distributed more than 540 copies of the February 1995 cumulative report.)
- The public is notified of the exclusion action through a monthly publication in the Federal Register.
- The public is also notified by a Medicare contractor when claims are submitted by beneficiaries for services rendered by an excluded party. The Medicare contractor will pay the first claim submitted by the beneficiary and inform the beneficiary that no more services are reimbursable because of the provider's exclusion.
- The Federal Debarment List, which prevents the excluded provider from participating in the Government-wide procurement and non-procurement contracts, is updated through information that the OIG provides to the General Services Administration.

Reactive Communication

During the last six months, the OIG has responded to 6,729 written requests and more than 1,000 telephone requests for exclusion information on specific health care providers, mostly medical doctors. These calls originate from the general public, Medicare contractors and State fiscal agents, other Federal and State agencies, credentialing agencies, licensing boards, health maintenance organizations, hospitals, and other members of the health care industry.

Consequence of Violations

Violating the terms of an OIG imposed program exclusion could result in criminal prosecution by the DOJ, and/or the imposition of civil monetary penalties against the excluded individual/entity or the employer by the OIG. Under the current Civil Monetary Penalty Law, the OIG has the authority to impose penalties against health care providers who have previously been excluded from the Medicare, Medicaid, and other State health care programs, and who persist in treating beneficiaries and billing the programs for services allegedly rendered.

For example, in one case, a New York City optometrist, Dr. Andrew Portoghese, was determined to have rendered services to program beneficiaries while he was excluded and billed Medicare through claims submitted by another optometrist. Based on 28 fraudulent Medicare claims, an administrative law judge imposed liability totalling $59,885. This decision was recently upheld by a Federal district court.

REPEAT OFFENDERS

Number Identified

Since 1984, 7,795 individuals and 788 health care entities have been excluded from participation in the Medicare and State health care programs. Of the 8,583 exclusions that were implemented, 1,335 health care providers have met the criteria for and have been reinstated. Of those who are eligible to apply for reinstatement but have not been reinstated (1,546 providers); a request was not made, their request was denied, or they abandoned their request by not providing necessary authorization and information.

We have identified 46 providers as "repeat offenders," meaning that a second problem occurred either while an exclusion was in effect or shortly after reinstatement occurred and that second problem triggered a new or additional sanction to be imposed. This represents about 0.5 percent of the total exclusions imposed since 1984 (See attached chart entitled "Historical Data 1984–1995.)

Case Examples

Following are some case examples showing the cyclic nature of repeat offenders:

Sunil B. Lahiri—In February 1992, the OIG excluded Sunil B. Lahiri, M.D., a California oncologist, for a period of 10 years because the OIG had determined that the doctor has rendered over 3,900 excessive, substandard, unnecessary, and potentially risky services to seven Medicare beneficiaries over a 6-year period of time. In August 1992, the OIG excluded Dr. Lahiri under a different sanction authority for another 10 years to run concurrent with the first exclusion period. This second exclusion was because the peer review organization for the State of California had determined that the doctor had failed to comply substantially with his obligations in the care of six Medicare beneficiaries with 10 hospital admissions. This care was found to have included, among other violations, inappropriate blood transfusion, inappropriate treatment with supplemental iron therapy, failure to obtain appropriate cultures in a patient with suspected sepsis, failure to detect the development of a decubitus ulcer while the patient was under medical care for a prolonged hospitalization. The administrative law judge upheld the OIG's authority to exclude Dr. Lahiri under the first sanction authority and determined that, in order to fully protect the programs and be consistent with the remedial purposes of the Act, the exclusion should be permanent. In the latter case, the ALJ dismissed the hearing request due to untimely filing; that dismissal was upheld by the Federal District Court. Although the State licensing authority and various payer agencies have been investigating this physician for many years, the OIG took the lead in implementing disciplinary actions against him. However, once the OIG excluded Dr. Lahiri, the licensing board revoked his license. The board then stayed its revocation and put his license on probation as long as he adhered to the stringent requirements it established. The licensing board is now attempting to repeal its stay and reinstate the revocation of Dr. Lahiri's license.

Daniel C. Law—In September 1993, Daniel C. Law, a Wisconsin podiatrist, was excluded under two separate sanction authorities for an indefinite period because he had defaulted on his health education assistance loan. In 11/93, his exclusion

was stayed after he entered into a settlement agreement to repay this loan which, with interest, amounted to almost $68,000. After being notified by the U.S. Attorney's office that Dr. Law had defaulted on his settlement agreement, his exclusion was reimposed. Under the terms of the settlement agreement, Dr. Law is excluded until his entire debt is repaid. In May 1995, Dr. Law was excluded again for a 10 year period. This mandatory exclusion is the result of Dr. Law's being convicted of submitting false claims to the Medicaid program. As a result of all of these exclusions, Dr. Law will not be eligible to apply for reinstatement to program participation until the 10 year period has expired and his entire debt is repaid.

Ulrick Pardo—Ulrick Pardo, an Illinois physician, was excluded in September 1988 for 2 years. This exclusion resulted from the OIG's agreeing with the recommendation of the Crescent Counties Foundation for Medical Care, the Illinois PRO, that Dr. Pardo had grossly and flagrantly violated his statutory obligation to provide services of a quality that meets professionally recognized standards of health care in his treatment of two patients. In October 1989, Dr. Pardo was again excluded. This exclusion was for a 5-year period concurrent with the remainder of his 2-year exclusion. This exclusion was also the result of a recommendation from the Illinois PRO that in seven cases Dr. Pardo had violated his statutory obligation to provide services of a quality that meets professionally recognized standards of health care.

OIG/HCFA COORDINATION TO PREVENT RECIDIVISM

In order to reduce the rate of recidivism by health care providers, OIG-wide initiatives have brought the OIG's investigators, auditors, and evaluators together as a team communicating regularly with HCFA officials to conduct reviews of problem areas.

Uniform Provider Agreement

In 1988 the OIG notified HCFA of program vulnerabilities caused by the lack of uniform requirements in the assignment of provider numbers. The OIG provided recommendations for the minimal amount of information needed to make effective a standard comprehensive application, including a certification wherein the provider would attest to the correctness of the information being provided. Since that time, the OIG has been encouraging the development and implementation of a uniform provider agreement. The goal of such a uniform agreement is to aid in the deterrence of fraud within the program on a national level, to assure consistency between Medicare contractors, and to protect the programs by not allowing excluded individuals to be paid. The OIG continues to work with HCFA in seeking to have a uniform provider agreement implemented on a national basis.

National Registry

Section 9202 of Public Law 99–272, the Consolidated Omnibus Budget Reconciliation Act, required HCFA to establish a unique physician identifier for each physician furnishing services to Medicare patients. To that end, HCFA established a National Registry to assign a unique physician identification number (UPIN) to each physician. The OIG has been working with the National Registry to update its exclusion data by including the UPIN with the subject's personal identifier information. When known, that number is carried on all exclusion notification letters sent to payer agencies and Medicare contractors and is included on all OIG sanction reports. Including these numbers allows the Medicare contractors to more readily identify excluded physicians and lessens the chance that physicians who move from State to State or who use more than one provider number (e.g., group numbers and/or multiple location numbers) can obtain Medicare reimbursement.

We look forward to the day that HCFA expands the Registry to include Medicaid and all other State health care agencies, and also covers non-physician practitioners, group identification, and tax identification numbers (social security and employer numbers). Such information should substantially reduce the opportunities for recidivism by health care providers.

OIG Information to HCFA

The OIG regularly informs HCFA of specific problems involving Medicare carriers who continue to pay excluded providers. The OIG provides HCFA with the names of these individuals and entities, the amounts of overpaid monies (where known), and any other pertinent information specific to each case. At the OIG's behest, HCFA recently issued notice to all Medicare contractors instructing them to check their payment systems for excluded providers, check the OIG cumulative exclusion list, and check the UPIN against the National Registry's list to assure that no payments are being made to those providers. The OIG will continue to notify HCFA

of any excluded providers who are found to be receiving program reimbursement inappropriately and any Medicare contractors who continue to pay claims after being informed of a provider's exclusion status.

OPPORTUNITIES FOR IMPROVEMENT

Part B Provider Numbers

In an effort to identify procedural shortcomings, the OIG conducted an inspection of how Medicare carriers assign provider numbers to qualified providers of Part B services. These numbers are used in processing claims and establishing Medicare pricing and utilization profiles. Carriers are responsible for determining if providers meet Medicare criteria before assigning a provider number. The OIG determined that HCFA had not provided sufficient practical direction to carriers about the provider number assignment function. The lack of direction had contributed to carrier provider number assignment weaknesses and vulnerabilities. We found that carriers did not adequately document assignment procedures; they obtained and maintained too little information on the providers; they did not verify provider qualifications; and many carriers assigned additional provider numbers solely for a provider's bookkeeping convenience.

Based on these findings, HCFA has undertaken several initiatives to address the identified problems and to improve the provider number process. The HCFA action plan includes modifying the Medicare Carrier Manual to clarify the responsibility of carriers to ensure that only those practitioners and providers with legal authority to practice are given numbers; to require carriers to stay abreast of changes in laws and regulations concerning medical practice requirements: to make every reasonable effort to receive updates from licensing authorities; and to clarify carrier requirements for maintaining provider records and purging inactive, unlicensed, and/or excluded providers from the provider number list. The HCFA will continue to vigorously implement and enforce compliance with the UPIN system. It also initiated reforms to the carrier process for dealing with suppliers of items such as durable medical equipment and prosthetics, including concentrating the monitoring and servicing of these suppliers through four designated regional carriers.

National Practitioner Data Bank

The National Practitioner Data Bank, administered by the Public Health Service (PHS), tracks malpractice payments, clinical privilege actions, and licensure actions taken against physicians and dentists. This information is then available to all hospitals and licensing boards for their use on a continuing basis.

Public Law 100–93 expanded the scope of the data bank so that any State authority responsible for the licensing of health care practitioners or health care entities must track disciplinary actions taken against health care practitioners or entities. Section 5 of Public Law 100–93 provided for the expansion of the data bank to include the OIG's access and use of the bank; however, funding to PHS to make this possible has not been forthcoming. Consequently. the OIG has never been able to access to or input data in the bank.

Access to the bank's files would allow us to establish a provider's history of disciplinary actions and follow current practice patterns. We also need to have OIG sanction data added to the bank's files, and would prefer to have direct access to the data bank for both input to and retrieval from the bank's data. The addition of such information would enable hospitals and licensing boards in the course of their required responsibilities to familiarize themselves with the current exclusion status of all physicians and dentists. The OIG has the exclusion information ready and available for PHS's use in updating the data bank.

The HCFA has been negotiating with PHS to have Medicare provider information, including sanction data, added to the bank's files. Once the Medicare provider information is included in the PHS files, then OIG sanction information would become relevant. We would support the data bank's expansion because it is a viable way for hospitals and interested parties to track current practices of known aberrant health care providers.

Adverse Action Data Bank

Various data bases and methods for reporting many types of disciplinary or malpractice actions involving health care providers exist. These include the National Practitioner Data Bank, the Federation of State Medical Boards Data Bank, and certain requirements of the Joint Commission on the Accreditation of Healthcare Organizations. However, there is no comprehensive data base for the mandatory reporting of "final adverse actions", such as criminal proceedings, civil judgements, settlements, administrative proceedings, and disciplinary actions imposed against all health care providers

We support the establishment of a central repository for the reporting of final adverse actions taken against health care providers which would permit Federal, State, and private payers to become aware of and take reciprocal actions to sanction health care providers who abuse or defraud health care financing programs. This data bank would be entirely separate from the existing National Practitioner Data Bank and would be independently administered. We suggest that this data bank also be made available to the public so that beneficiaries can be informed and vigilant about health care providers and practitioners that they utilize.

Along these lines, we are cooperating with HCFA, the Medicaid Fraud Control Units, and the Federal Bureau of Investigations to create a data base for health care fraud and abuse purposes. The establishment of a this type of adverse action data bank would facilitate broader communication across the entire spectrum of public and private health care organizations. Beyond the first stage, we need to enhance communication between governmental and private payers. It is important that Federal, State, and local governments, and third party payers communicate with one another with respect to sanctioned providers.

NEED FOR EXPANDED AUTHORITIES

The OIG's sanction authorities are an important enforcement remedy. We have made great strides, not only in excluding aberrant providers from our programs, but also in ensuring that they don't continue to abuse our health care financing systems and our beneficiaries. However, there are still some loopholes that allow fraud and abuse to thrive at the expense of the programs, the taxpayers, and the Medicare patient population. We believe that more can be done. The following are two examples.

"Mobile" Owners of Excluded Companies

We have found that unscrupulous company owners move from company to company after a company is convicted and excluded. As our authority now stands, if an owner is convicted and excluded, then we can exclude any company associated with that individual. However, if a company is excluded, such as because of a program-related conviction, then we have no recourse to take action against the owner of the company. That individual is free to reincorporate or start another business with no fear of exclusion. If we were empowered to act against the culpable individuals in such a situation, then we would be able to close the door on "mobile" owners.

Employers of Excluded Individuals

We suggest that section 1128A (CMPL) of the Social Security Act be further strengthened by expanding its coverage to encompass employers who bill Medicare, Medicaid, and other State health care programs for services rendered, ordered, or directed by excluded employees.

Currently, the "strict liability" standard for imposing monetary penalties only applies to the excluded provider for claims submitted, or caused to be submitted, for services that he/she renders while excluded. Expanding CMPL coverage to the employers of excluded providers would encourage health care employers to ascertain the program participation status of employees prior to submitting claims for program payment for services rendered, ordered, or directed by such individuals. Moreover, such an amendment would give the OIG the authority to hold the employer "strictly liable" for health care claims submitted for services rendered, ordered, or directed by an excluded employee. We encourage the Committee to consider such an amendment.

Sections of Social Security Act Under Which Exclusions Are Imposed

1128(a)(1)—Program-related conviction
1128(a)(2)—Conviction for patient abuse or neglect
1128(b)(1)—Conviction relating to health care fraud (non-HHS)
1128(b)(2)—Conviction relating to obstruction of an investigation
1128(b)(3)—Conviction relating to controlled substances
1128(b)(4)—License revocation or suspension
1128(b)(5)—Suspension or exclusion under a Federal or State health care program
1128(b)(6)—[Formerly 1862(d)(1) (B) and (C)]—Excessive claims or furnishing of unnecessary or substandard items and services
1128(b)(7)—[Includes former 1862(d)(1)(A) cases]—Fraud, kickbacks and other prohibited activities
1128(b)(8)—[Formerly 1128(b)]—Entities owned or controlled by a sanctioned individual
1128(b)(9)—Failure to disclose required information

1128(b)(10)—Failure to supply requested information on subcontractors and suppliers
1128(b)(11)—Failure to provide payment information
1128(b)(12)—Failure to grant immediate access
1128(b)(13)—Failure to take corrective action
1128(b)(14)—Default on health education loan or scholarship obligations
1128Aa—[Formerly 1128(c)]—Imposition of a civil money penalty or assessment
1156(b)—[Formerly 1160]—PRO recommendation
* Suppliers that are wholly owned by a convicted individual that have been excluded as a result of the owner's conviction.

Mr. SHAYS. As soon as a member returns from voting, I'm going to reconvene. We're going to be at recess until then, because we need to go and vote. When a new member comes back, we'll start right away.

So we are at recess.

[Recess.]

Mr. SOUDER [presiding]. Could the witnesses take their seats? Thank you for your patience. We tried to set a sprinting record.

Mr. Stern, if you could give us your testimony.

Mr. STERN. Certainly. Thank you, Congressman Souder.

Members of the subcommittee, I am Gerald Stern, the Special Counsel for Health Care Fraud at the Department of Justice. I thank you very much for this opportunity to discuss the pressing problem of Medicare and Medicaid fraud and abuse, and the Department of Justice's health care fraud enforcement program.

You've heard that health care fraud is a very costly problem for our country. It also can undermine the quality of health care that individuals receive. For both of these reasons, the Attorney General in 1993 determined that health care fraud enforcement would be her No. 2 new initiative, behind violent crime. And she asked me to coordinate the Department of Justice's effort in this regard. Our program has involved increased resources, investigations and prosecutions, greater cooperation among investigative and regulatory agencies, and coordinated use of all available sanctions, criminal, civil, and administrative.

My written statement details the dramatic increase in the number of FBI investigators addressing health care fraud and the increase in the criminal and civil health care fraud cases handled by Federal prosecutors. In particular, in the past year—and I go around the country speaking to health care providers to try and demonstrate to them that things have changed, we emphasize that in the past year we've had criminal jail sentences imposed in one case of over 20 years for two individuals, and in another case, civil recoveries of over $379 million. Since both of those occurred in the past year, that gives me the opportunity to go around the country and indicate that criminal and civil remedies are going to be severe if the people do not clean up their own act.

Our current cases reflect the full range of health care fraud schemes, false billings for unnecessary services, for services never rendered, or for services rendered by inappropriate personnel. We also prosecute providers who pay or receive kickbacks and who impermissibly make referrals to themselves.

Successful health care fraud enforcement requires close collaboration among Federal and State investigators and prosecutors. In that regard, in November, 1993, we established an executive-level health care fraud policy group which has been meeting monthly

ever since. It involves the high-level folks at the Department of Justice and the Inspector General of HHS; and since Judy Berek has come on board with HCFA, she has been attending our meetings as well.

In addition, we have health care fraud coordinators now in each U.S. attorney's office, in many cases, a civil health care fraud coordinator and a separate criminal health care fraud coordinator.

We also have a health care fraud working group at the national level. This group has been meeting now for a number of years on a quarterly basis. We have them on regional and local levels, which allow the Federal and State prosecutors and investigators to share information on emerging frauds and enforcement techniques.

Better communication among all of us has allowed us to choose the most appropriate sanction or sanctions to address particular health care fraud problems. Increasingly, we pursue parallel proceedings so that responsible companies and officials are convicted criminally and at the same time civil damages—damages and penalties are recovered.

The Justice Department's chief responsibility is the prosecution of criminal and civil violations. But we also recognize our responsibility to assist HHS in its duty to protect the Medicare trust fund and Medicaid program by ensuring that unscrupulous providers do not receive payments. Our assistance takes place at several times during the payment process, during the time when suspension of payments should be made to providers, a time when enjoining fraudulent practices and freezing providers' assets, including Medicare payments, can stop the payments and freeze the moneys so that they can't be sent out of the country in some cases; and revoking providers' or suppliers' authorization to participate in the Medicare program. And you have heard that the Medicare carrier can suspend payments to a provider when there is reliable evidence of an overpayment, of fraud or willful misrepresentation.

The Department of Justice works with these carriers and with HCFA to seek suspension in appropriate cases. For example, our Civil Division worked with HHS to effectuate suspension of providers who systematically upcoded billing for manufactured lymphedema pumps, when they were falsely claiming that they provided the most expensive pump.

The Department of Justice also uses other means to prevent fraudulent providers from obtaining Medicare funds. For example, a prosecutor can, and we do, seek court orders to enjoin ongoing fraudulent schemes or to freeze assets to prevent their dissipation.

It is also the HHS Inspector General's job to decide whether to exclude providers from Medicare. But we can assist in that, and we do by providing all available nongrand jury information. In determining whether to exclude an individual or an entity, the Inspector General often considers whether or not that entity will implement a corporate compliance program in the future if they are not excluded. We strongly support the corporate compliance program in the appropriate cases; and when I first came to the Department of Justice, I was concerned that one of our major settlements did not include any kind of corporate compliance program going forward. And I have made it part of my duty and job to encourage these corporate compliance programs so that in the future if there is a viola-

tion, the person or the entity can be excluded merely by—because they violated the compliance program and you don't have to go back and reprove a new violation of health care.

We also share information with HHS about unscrupulous providers and practices so they are not permitted to enter the Medicare-Medicaid program in the first place. For example, a Miami assistant U.S. attorney has conducted a number of DME investigations and prosecutions, and she learned firsthand the various ways that DME suppliers defraud Medicare by using aliases, by using beeper numbers, by using mail drops for company addresses. She was quite incensed about all this. She reported this and kept reporting it, so that HCFA ultimately revoked supplier numbers for numerous unscrupulous providers and suspended payment from others.

I would like to share one recent case with you just to give you an example of how many of these different remedies come into play. In San Diego, an ophthalmologist had been billing Medicare and other health care plans more than $38 million for medically unnecessary cataract and eyelid surgery. On some days, he saw more than 150 patients. On other days, he performed 35 to 45 surgeries, with each patient receiving six separate surgical procedures, unrelated to medical need.

In 1992, after a search warrant was executed, Medicare suspended all payments to the physician. While he was awaiting trial, the State of California revoked his medical license. The U.S. attorney's office obtained a court order repatriating $7.5 million, which he had shipped offshore.

Last March, after a multimonth jury trial, he was convicted of 132 counts of false claims, mail fraud and money laundering, and the jury found that the $7.5 million that had been forfeited should be forfeited to the Government. He will be sentenced on June 26 of this month, and then he will be subject to mandatory exclusion under our present laws for at least 5 years because of the conviction.

We intend to coordinate use of criminal, civil and administrative sanctions in the HHS Department of Justice Operation Restore Trust initiative you heard about. We enthusiastically endorse HHS's focus on home health care, on nursing homes, and ancillary services such as DME. Our health care fraud coordinators in the 5 target States, in the 12 United States districts, have been meeting with their HHS counterparts already to ensure that we vigorously prosecute wrongdoers, return moneys lost to Medicare and Medicaid, and prevent future frauds. Wrongdoers who disclose voluntarily their misdeeds will be met with expedited and equitable redress.

Congress can assist our efforts in several ways. The establishment of an antifraud control account to fund health care audits, inspections, investigations and prosecutions, financed by certain monetary recoveries in health care fraud cases would help with resources. It would help to have a general health care fraud offense on the books. At the moment, we use mail fraud, wire fraud, money laundering, other statutes. It would be nice to have, and useful to have, a general health care fraud offense itself. It would be helpful to create a criminal and civil bar on kickbacks in all Federal health care plans. It would be helpful to permit the use of administrative

subpoenas by the Attorney General and the use of grand jury material by civil prosecutors in health care fraud cases.

This concludes my prepared remarks. I appreciate very much your invitation to us to appear today, and I am prepared to respond to any questions.

[The prepared statement of Mr. Stern follows:]

PREPARED STATEMENT OF GERALD STERN, SPECIAL COUNSEL, HEALTH CARE FRAUD, U.S. DEPARTMENT OF JUSTICE

Chairman Shays and Members of the Subcommittee on Human Resources and Intergovernmental Affairs: Thank you very much for this opportunity to discuss the pressing problem of Medicare and Medicaid health care fraud and abuse and the health care enforcement program of the Department of Justice.

As you know, health care fraud imposes an enormous cost to the health care system and to our nation's economy as a whole. Health care fraud and abuse presently may account for as much as 10 per cent of all health care expenditures, or as much as $100 billion each year.

While most health care providers are honest and care first and foremost about their patients' welfare, fraud is perpetrated by every kind of provider. At times, health care fraud has even placed patients at serious risk of physical harm. A San Diego ophthalmologist billed Medicare and other health plans for more than sixteen million dollars for medically unnecessary cataract and eyelid surgery. This physician often saw more than 150 patients a day and, on other days performed 35 to 45 surgeries a day, with each patient receiving six separate surgical procedures unrelated to any medical need. In another case, a mobile medical clinic billed for medical tests and provided no follow up care, even when patients' tests indicated possible cancer and AIDS. In some instances, health care fraud has even caused unnecessary deaths. For example, patients died when a Fortune 500 company sold unapproved heart catheters to hospitals because it preferred immediate profits to waiting for Food Drug Administration clearance.

As you can see, health care fraud can undermine the quality of health care provided to patients, and at the same time increase the cost of care, a price paid by individual consumers, health plans and American taxpayers.

For these reasons, the Attorney General has named health care fraud enforcement her number two new initiative, behind violent crime. She asked me to coordinate the Department's health care fraud enforcement program. This program involves increased resources, increased investigations and prosecutions, greater cooperation among investigative and regulatory agencies, and coordinated use of all available sanctions—criminal, civil, and administrative.

INCREASED RESOURCES, INVESTIGATIONS, AND PROSECUTIONS

First, the Department dramatically increased the investigative resources devoted to health care fraud. The Federal Bureau of Investigation is expending approximately 300 FBI agents workyears handling these cases, up from 163 FBI agent workyears at the end of fiscal year 1993. The FBI anticipates that this number could rise to 450 by the end of fiscal year 1995.

The numbers of health care fraud investigations and cases handled by federal prosecutors consequently also has risen dramatically over the last few years. At the end of fiscal year 1994, the FBI had 1,500 pending health care fraud cases, up from 657 in November 1992. The FBI and other investigative agencies make referrals of health care fraud cases to the Department of Justice and the 94 United States Attorneys. At the end of fiscal year 1994, the Department of Justice had 1,066 criminal health care fraud matters, a 211 percent increase over the 343 matters pending in fiscal year 1992. The numbers of defendants charged and convicted similarly increased: 241 defendants charged, as of the end of fiscal year 1994, a 76 percent increase over the 157 charged in fiscal year 1993. The number of defendants convicted also increased during this time period, often with long sentences.

The Department of Justice also vigorously prosecutes health care fraud through the civil justice system. Eight hundred and nineteen civil health care fraud matters were pending at the end of fiscal year 1994, a 203 per cent increase over the 270 pending in fiscal year 1992. In fiscal year 1993, the Department of Justice obtained one hundred eighty million dollars in health care fraud judgments and settlements. The FBI has estimated that monetary recoveries in fiscal year 1994 exceeded $500 million.

PROSECUTIONS OF NUMEROUS HEALTH CARE FRAUD SCHEMES AND PROVIDERS

Current cases reflect the full range of health care fraud schemes. We are pursuing providers engaged in fraudulent billing schemes such as false billings for unnecessary medical services, for services never rendered, or for services rendered by inappropriate personnel. We also are investigating health care providers who pay kickbacks or bribes or who impermissibly make referrals to benefit themselves.

The Department's most recent and largest success to date involved National Medical Enterprises, Inc. ("NME") whose subsidiaries had bribed doctors and other referral sources to refer patients for admission to NME psychiatric hospitals and substance abuse facilities and, in one instance, to an acute care hospital. We also alleged that NME paid for referrals of patients, the company improperly waived Medicare copayments for patients and then claimed reimbursement from Medicare of these waived amounts as bad debts and engaged in billing fraud, and billed for services not rendered and for treatment that was not reasonable or necessary.

NME signed a criminal plea and civil and administrative settlement including $379 million in criminal fines, civil damages and penalties for kickbacks and fraud at NME psychiatric and substance abuse hospitals in 30 states. This included a payment to several states of a total of $16.3 million negotiated between NME and the National Association of Medicaid Fraud Control Units for harm caused the state-funded portion of Medicaid and other state health programs. The administrative settlement includes a ground breaking corporate integrity agreement in which NME has agreed to the implementation of a program designed to insure its corporate integrity in its relations with the government, and its quality of care.

In addition, the Department of Justice, through its United States Attorneys, have investigated and prosecuted many individuals who implemented NME's scheme, including hospital and psychiatric center administrators, physicians, psychologists, and counselors. To date, eight individuals have been prosecuted and convicted for paying or receiving kickbacks, making false claims, theft of public money, forgery and obstructing justice. Their sentences have ranged from eight years to thirty months to probation. Others await sentencing. Investigations of the responsible individuals continue.

Another major prosecutive success, the so-called Rolling Labs case, involved a billion dollar medical insurance scheme, which required more than five years of investigative efforts by multiple federal and state investigative agencies. A chain of mobile diagnostic testing services and clinics in the Los Angeles performed medically unnecessary tests on unsuspecting patients after promising free and low-cost examinations and preventative diagnostic tests. Bills were fabricated to make it appear these preventative services were performed by a doctor and were "medically necessary" to treat patient illnesses, when they were not. Not only were the tests virtually useless for the majority of patients, who were in normal health, but the health and even lives of patients were threatened by the defendants' slipshod examinations, failure to obtain proper medical histories, and failure to follow up on abnormal symptoms and test results. The defendants were convicted of mail and wire fraud, conspiracy, money laundering, and racketeering in connection with this scheme. Two key men who perpetrated this fraud each were sentenced to over 20 years imprisonment, plus restitution and forfeiture orders. Looking only at a sampling of developments during the past two months illustrates the wide range of cases the Department is pursuing:

- On April 4, 1995, U.S. Homecare Corporation, a New York based home health care agency agreed to pay $650,000 to settle claims that it had submitting false claims relating to forged nurses signatures, false medical information and canned nursing notes related to beneficiaries in Miami.
- On April 11, a Virginia psychiatrist was sentenced to three years probation, 180 days of home confinement, 360 hours of community service after pleading guilty to a criminal information that he had submitted false claims to CHAMPUS and Medicare, inflating the time spent in psychotherapy sessions with patients for a loss of $35,576.05.
- On April 17, 1995, a Honolulu psychologist pled guilty to three counts of mail fraud for billing CHAMPUS for psychotherapy that never took place and altered patient files. The psychologist faces a maximum sentence of 5 years imprisonment and a $250,000 fine on each count.
- On April 17, 1995, one of the defendants in the Rolling Labs case was sentenced to 41 months incarceration, 6 years probation, $750,000 fine and included in $41.1 million restitution order.
- In an outgrowth of the NME case, on April 17, 1995, owner and operator of the Center for Human Growth, in Burleson, Texas, was sentenced to 97 months in prison, forfeited $1.5 million in restitution and ordered not to practice psychology in the

health care industry. He had pled guilty to conspiracy and mail fraud for being compensated for referring patients to the Psychiatric Institute of Forth Worth.

• On April 18, a Bridgeport Connecticut federal grand jury returned an indictment on wire fraud against an individual who participated in a scheme to defraud CIGNA and its subsidiary for submitting false claims. Two others had pleaded guilty to related counts.

• On April 29, 1995, in New York, three physicians, two employees of medical equipment companies, and a patient broker, were indicted for participating in a conspiracy to defraud Medicare of $15 million through false reimbursement claims for medical equipment. According to the indictment, the companies billed Medicare for wheelchairs and hospital beds, but provided unauthorized and far less expensive items such as air conditioners. microwave ovens and beach chairs.

• On May 4, 1995, a Philadelphia jury found six durable medical equipment companies and their owner guilty of defrauding Medicare of approximately $3 million in a sophisticated "boilerroom" telemarketing operation which delivered unnecessary medical equipment such as heating pads, air mattresses, and paraffin wax baths to approximately 5,000 elderly Medicare beneficiaries, located in ten Mid-Atlantic and Mid-West states. The owner was convicted of 205 counts of mail fraud, false claims, and money laundering and other crimes.

• On May 18th, Metpath, Inc. of Teterboro, New Jersey, a nationwide medical laboratory agreed to pay the government $8.6 million to settle civil fraud claims with respect to metpath's dealings with Medicare, CHAMPUS and Railroad Retirement Board for billing for tests that were not performed such as when a laboratory sample was lost, spilled or otherwise unsuitable for testing.

• On May 19, 1995, an Ohio physician pled guilty to receiving a kickback in return for referring patients to Nova Medical Labs in Cleveland for laboratory tests which were not medically necessary.

• On May 24, 1995, an FBI initiative was announced which has targeted staged automobile accidents and related casualty and health insurance fraud. The initiative included arrests, search warrants and indictments in 31 states. It involved 41 of the FBI's 56 field offices and U.S. Attorney's Offices in numerous large metropolitan areas such as Miami, Philadelphia, Chicago and Atlanta as well as smaller cities. For example in Florence South Carolina, the investigation has resulted in 31 indictments and 22 convictions. In Portsmouth, Ohio, 28 of 31 individuals charged with staging vehicle accidents, arson and theft have pled guilty.

• On May 25, 1995, the United States Attorneys offices in Columbus, Ohio and Charleston, South Carolina and the Federal Trade Commission announced a coordinated attack on telemarketing health care fraud schemes filing several actions against companies in Ohio and South Carolina with deceptive practices in selling medical equipment.

• On June 6th, an Alexandria, Virginia jury found guilty a chiropractor, his brother and the corporation, for false claims, mail fraud and conspiracy on 45 counts.

• Washington state's largest preferred provider organization, Integrated Network Systems, Inc., and its chief executive officer skimmed $1.4 million from medical service bureaus who provided services to hospitals. On June 7th, the company pled guilty to mail fraud, money laundering and submitting false claims to the United States. The officer pled guilty to mail fraud and false claims and filing a false income tax return and making false statements to federally-insured banks. They agreed to pay $2.2 million in restitution and damages and penalties, and an additional $339,000 for the tax violations. The officer faces imprisonment.

• An Atlanta, Georgia company, International Convalescent Transport Inc., falsely billed Medicaid for more than $850,000 for ambulance stretcher transportation services where no services were performed, the services were not medically necessary because patients were ambulatory or were dead, or where the services were misrepresented as the mileage was inflated. On June 8th, the owner was convicted of 33 mail fraud counts, 96 false claims counts and 12 money laundering counts. Sentencing and resolution of the asset forfeiture counts will occur in the future.

These cases represent the results of our increased health care fraud enforcement efforts.

IMPROVED INTERAGENCY COOPERATION

These and other successful investigations and prosecutions of health care fraud require close inter-agency-collaboration among federal and state investigators and prosecutors. The Department of Justice has long worked with the Department of Health and Human Services Office of Inspector General ("HHS OIG") to investigate and prosecute health care fraud in Medicare and with the HHS OIG and the state-

based Medicaid Fraud Control Units ("MFCUs"). Other federal investigatory agencies also committed to combatting health care fraud include, but are not limited to, the Defense Criminal Investigative Service, the United States Postal Inspector, the Railroad Retirement Board, the Department of Veterans Affairs Inspector General, the Pension and Welfare Benefits Administration and Inspector General of the Department of Labor, Office of Personnel Management Inspector General and the Tennessee Valley Authority Inspector General.

We have established several structures to facilitate communication and coordination among law enforcement entities. Last November, I established an Executive Level Health Care Fraud Policy Group, to develop national health care fraud enforcement policy. The members of the Executive Level Health Care Fraud Policy Group include the Assistant Attorneys General for the Criminal Division and Civil Division, a United States Attorney representing the Attorney General's Advisory Committee, the Department of Health and Human Services Inspector General, Health Care Financing Administration's Senior Adviser on Program Integrity, a senior FBI official and myself. Representatives of other federal agencies and State Medicaid Fraud Control Units also have attended. This forum permits policy development and coordination at the highest levels of the Department of Justice and the Department of Health and Human Services.

To facilitate communication at the local and state level, every United States Attorney's Office now has a criminal and civil health care fraud coordinator. There are health care fraud working groups at the national, regional, and local levels, which include federal and state prosecutors and investigators from FBI, HHS OIG, and other federal agencies as well as state Medicaid Fraud Control Units.

In conjunction with Health and Human Services Office of the Inspector General, the Department of Justice is working closely with the Health Care Financing Administration ("HCFA") to implement this multi-pronged strategy with respect to the Medicare program. For the first time, we hold regular meetings attended by the Department of Justice ("DOJ"), HHS OIG, HCFA and the Medicare contractors at the national, regional and local levels. Prosecutors, investigators and health care administrators discuss trends in fraudulent practices and devise possible solutions to stopping ongoing fraud.

BETTER USE OF ALL AVAILABLE SANCTIONS: CRIMINAL, CIVIL AND ADMINISTRATIVE

With the greater communication among health care investigators, prosecutors and administrators, we can facilitate the selection of the appropriate sanction or sanctions to redress particular problems in health care fraud. The Department of Justice and the Department of Health and Human Services agree—that government is most effective in combatting health care fraud when we pursue the panoply of criminal, civil, and/or administrative remedies, or those appropriate to the particular case. Increasingly, our cases include parallel proceedings where the responsible companies and/or officials plead guilty or are convicted criminally and at the same time, civil damages and penalties are collected. The Department of Justice has several civil fraud initiatives, which target frauds not previously prosecuted. For example, several United States Attorneys' Offices have targeted hospitals with credit balances and with duplicate billing records; others have targeted physicians who bill patients more than permitted under Medicare or the Federal Employees Health Benefit Plan. Thanks to these efforts, health care fraud which may not constitute criminal activity nevertheless is prosecuted; the government recovers its damages, civil penalties are paid and the victims of health care fraud receive restitution.

Determining whether to bring a criminal or civil case, of course, involves a serious consideration of the facts and applicable law in a particular instance. With respect to criminal cases, a prosecutor recommends federal prosecution if he or she believes that the person or company's conduct constitutes a federal offense and the admissible evidence will probably be sufficient to sustain a conviction, unless in his or her judgment prosecution should be declined because no substantial federal interest would be served by the prosecution; the person is subject to effective prosecution in another jurisdiction or there exists an adequate non-criminal alternative to prosecution. Civil and administrative remedies are possible noncriminal alternatives which are considered.

With respect to civil cases, a similar inquiry takes place. The determination of damages in a particular case is a fact specific inquiry which turns on the number of claims submitted, the falsity of those claims, the culpability of the parties, the damage to the federal health care programs, the amount of any kickbacks paid, litigation risks and other relevant issues. The information on which the Department of Justice bases our calculations in Medicare cases typically is supplied by the Department of Health and Human Services.

While the Department of Justice's chief responsibility is the prosecution of criminal and civil violations, we also recognize our responsibility to assist the Department of Health and Human Services in their duty to protect the Medicare Trust Fund and Medicaid program by ensuring that unscrupulous providers do not receive payments from Medicare and Medicaid. This assistance can take place at several times during the payment process: first, the Department of Justice has provided information to the Health Care Financing Administration about unscrupulous providers and practices so that such companies are not permitted to enter the Medicare and Medicaid program in the first place.

Second, with respect to providers and suppliers who already participate in the federal health care programs, and who are suspected of committing fraudulent acts, the Department of Justice works with the Department of Health and Human Services to prevent them from receiving further payment of Medicare funds. For example, Federal regulations authorize a Medicare carrier to suspend Medicare payments to a provider when the carrier has reliable evidence that an overpayment exists or that future payments may be incorrect. 42 C.F.R. Secs. 405.370(a)(2) & (b).

In cases, where the suspension is predicated on reliable evidence of fraud or willful misrepresentation, the carrier may suspend Medicare payments without furnishing the provider advance notice or an opportunity to explain why the suspension should not be imposed. 42 C.F.R. Sec. 405.371(b). The Department of Justice works closely with the carriers and the Health Care Financing Administration to ensure suspension is imposed in the appropriate cases and in the most effective manner. For example, our Civil Division has worked with HHS to effectuate suspension of certain providers who systematically upcoded their billing for manufactured lymphedema pumps, falsely representing to the carrier that they were providing a pump more expensive than one actually provided. Similarly, the United States Attorney's Office for the Northern District of Georgia has worked with the Department of HHS to propose suspension in appropriate health care fraud cases. We have emphasized the importance of pursuing suspension to keep Medicare dollars out of the hands of unscrupulous providers during this years' training of prosecutors as well as of employees at the Health Care Financing Administration and at the Medicare contractors.

The Department of Justice also uses means other than suspension to prevent fraudulent providers from obtaining Medicare funds. For example, where there is evidence of fraudulent scheme and the threat of dissipation of assets, federal prosecutors may ask a federal court to enjoin the fraudulent scheme, and to freeze assets to prevent dissipation of assets. The Department can use the Mail Fraud Injunction Act and the Federal Debt Collection Act to seek injunctive relief. For example, the U.S. Attorney's Office in the Southern District of Florida successfully prosecuted Part B Medicare fraud committed by durable medical equipment companies, clinic/practitioners and non-invasive testing companies in cases brought under the False Claims Act and the Federal Debt Collection Procedures Act. In seven cases filed since May of 1994, over $1.5 million in assets has been frozen and over $2 million has been suspended (in stop payment orders, claims processed and claims pending). One such action was brought on September 1, 1994 against Change Llemi DME Corp. ("Change") and two of its principals. In that case, Change, who held itself out as a supplier of nutritional supplements, submitted 2578 claims to Medicare totaling almost $3 million. Approximately 98% of the $895,296 that Change was paid in Medicare funds was recovered by the quick action of the U.S. Attorney's Office of the Southern District of Florida. Similar aggressive action has been used to save Medicare money in cases across the country

Of course, notwithstanding the vigilant actions of the Department of Justice and the Department of Health and Human Services, unscrupulous providers continue to defraud Medicare and Medicaid. The Department of Justice is committed to bringing criminal and civil actions to punish the providers and to recover monies for past wrong doings. It is the responsibility of the Department of Health and Human Services to decide whether such entities should be permitted to continue to participate in the Medicare and Medicaid systems. Although the decision whether to exclude an individual or a company rests with the Department of Health and Human Services Office of Inspector General, under 42 U.S.C. Sec. 1128, the Department of Justice provides this and other exclusion authorities with all available non grand jury information which may be helpful to them in making the determinations. In determining whether to exclude an individual or entity, the Inspector General often considers the commitment to implement corporate compliance plans in the future. We strongly support this effort in the appropriate case.

This coordinated use of criminal, civil, and administrative sanctions constitutes the enforcement component of the joint DOJ-HHS Operation Restore Trust initiative. The Department of Justice enthusiastically endorses HHS's focus on home

health care, nursing homes and ancillary services such as durable medical equipment. Our health care fraud coordinators in each of the target states—California, Florida, Illinois, New York, and Texas—have been meeting with their counterparts at HHS OIG and HCFA to ensure that wrongdoers are vigorously prosecuted, monies lost to Medicare and Medicaid are returned, and future frauds prevented. Wrongdoers who disclose voluntarily their misdeeds will be met with expedited and equitable redress.

ADDRESSING FUTURE HEALTH CARE FRAUD

Unfortunately, notwithstanding our best efforts, health care fraud will continue. Perpetrators of health care fraud will seek to prey on any health care system the market produces or Congress adopts. Where there is money, unscrupulous providers simply shape schemes to fit the particular form of reimbursement. The Department of Justice, however, is committed to meeting this challenge with vigorous enforcement. In recognition of the growth in managed care, for example, we have established a Managed Care and Fraud Working Group. Federal and state investigators and prosecutors meet with health care plans to learn about emerging problems and determine the appropriate oversight and sanction—criminal, civil or administrative, federal or state. We stand together to face the frauds of the future.

There are ways this Congress can assist in our efforts.

A fundamental issue in ensuring health care fraud enforcement involves the need for adequate resources. Health care fraud cases are extremely resource intensive. They are among the most document intensive of all white collar crimes cases. Investigation of false billing cases, for example, requires extensive storage space, computer information management systems, and financial analysis. Various pending legislative initiatives would enhance fraud control by providing a secure source of resources for anti-fraud efforts. They establish an Anti-Fraud Control Account to fund audits, inspections of health care programs and health care fraud investigations and prosecutions, financed by certain monetary recoveries in health care fraud cases. We support such efforts.

We also endorse efforts to strengthen criminal, civil, and administrative remedies for health care fraud, which will give prosecutors new tools in their efforts to stop health care fraud, punish its perpetrators and recover funds for the government and other victims. These provisions create a general health care fraud offense prohibiting schemes to defraud health plans or persons in connection with the delivery of or payment for health care, establishment of a criminal and civil bar on kickbacks in any federal health care program, authorizing administrative subpoenas in health care fraud cases, and permitting use of grand jury material by civil health care fraud prosecutors. Such measures would give us additional critical tools to combat this scourge on our nation's health care plans.

Mr. Chairman, this concludes my prepared remarks. I will be pleased to answer any questions that you or the other Members may wish to ask.

Mr. SOUDER. Thank you. Thank you, Mr. Stern.

Mr. Towns, would you like to start?

Mr. TOWNS. Yes, thank you very much.

Let me—the same criticisms have been made about the ability of both the IG and DOJ to prevent fraudulent activity. How do you respond? If we don't know the size of the problem, how can we be assured that we have the tools to prevent it? And we don't know the——

Ms. BROWN. You're absolutely right, sir, that we don't know the totals. We do know the kinds of results we get with the resources we're able to put into this effort. And I believe there are too few resources right now available.

This is one reason we support a control fund where some of the penalty money would go into a fund; or when a court makes an award to repay the cost of an investigation, it would go into the fund. The fund could then be seed money to finance more investigative and prosecutive resources. Right now, there is no such mechanism, and we depend on strictly discretionary money.

Fraud control efforts are being cut along with other cuts in Government. We know that we're losing ground because of that.

Mr. TOWNS. I guess, Mr. Stern—we heard from the head of HCFA earlier that the Justice Department can negotiate a settlement that allows a fraudulent provider to remain in the program. Can DOJ impose a settlement on HCFA that forces HCFA to continue the relationship with a fraudulent provider?

Mr. STERN. No, we cannot, nor do we. The decision with respect to exclusion from Medicare or Medicaid is a decision made by the Inspector General of HHS. We are very careful not to engage in a tradeoff of criminal and civil prosecutions for a decision whether or not to exclude. That's true not only in health care fraud, it's true with respect to—across the board with all the agencies we deal with. So the answer is no, we cannot impose, nor do we impose, decisions with respect to exclusion.

When a decision is made not to exclude, a decision by the Inspector General, I do encourage that there be some kind of policing mechanism going forward if that entity is going to remain in the system. That is where I have been pushing for compliance programs, so that if in fact there is a violation in the future, exclusion would be much easier.

Mr. TOWNS. Thank you. Let me ask, recognizing that as we move forward it is clear there is going to be limited resources, everybody's talking about cutting, and I'm very concerned about wasting manpower and womanpower.

When you have local law enforcement authorities involved in investigating at every level, and then of course you get involved, how do you develop a mechanism to prevent wasting time and effort? I know of one instance in New York where I think it was a local police officer was locked up because he was also investigating, and your department didn't know and he didn't know, and they were trying to lock up each other. So how do we try to avoid that kind of waste of manpower and womanpower?

Mr. STERN. Let me respond in a couple of ways. First, I am from industry before I came to the Justice Department to become Special Counsel. My first reaction, when I saw what we were doing in the health care fraud area, was that we are doing this on a retail basis, case-by-case prosecution.

We cannot solve this problem on a retail basis, we have to find some way to encourage industry itself to self-police; and so I looked around to see ways in which I could do that. One was to require compliance programs in settlements as we went forward and then to suggest to industry—and I do this as I go around the country—that they ought to themselves be putting into effect compliance programs, because that would be a factor that we would look at when it came time for prosecutions if we ever caught them.

I emphasize to them that there are whistleblower statutes on the books, the Qui Tam laws which are encouraging all kinds of litigation against those who commit health care fraud; and what I say to these companies is that you have—every time that you fire an employee you have given a hostage to the Qui Tam bar. Those folks are going to go there and the Qui Tam law is now called the former employees—the "former disgruntled employees retirement act." You have now given great incentive to anybody you fire who knows about fraud in your company to go and tell us about it, because

they can get lots of recovery, so there is great incentive for companies to themselves self-police.

I tell them about our results, the 20-year criminal sentence, jail sentence that we obtained last year in the case in California. I tell them about the $379 million civil damage recoveries. So they are beginning to get the message.

In fact, I spoke—just yesterday, defense counsel came up to me and said, you know, it used to be, Mr. Stern, before you were out speaking on this subject that if I tried to raise with one of my clients that they ought to consider a compliance program, they laughed at me. He said, now they come to me and say, how do I put in effect a compliance program.

Second, we have this Operation Restore Trust program we are about to embark on. Part of that includes a voluntary disclosure program. We have it now in a written form with an encouragement to companies to try and self-police, come forward to us, to the HHS and work with us on that. So in terms of prevention, clearly we have to show that we are tough with our sentencing and our recoveries, and we have to show that they are going to get caught, and they therefore have to have an incentive to come forward. That is our first goal with the self-police.

Second, the coordination effort. I have to coordinate, among ourselves and the law enforcement side so we don't step on each other. That is why we have created a Health Care Fraud Coordinator in every office of the U.S.attorneys in this country, that is why we have been working with the HHS and all the law enforcement people through the executive level group that I chair to set priorities, to make sure that we are all going in the same direction.

The particular priorities for Operation Restore Trust are ones we all agree on, that is, home health care, nursing homes, and durable medical equipment. It is a big job, but we are trying to do it, both on the coordinating side from our side and on forcing industry itself to begin to self-police.

Mr. TOWNS. How long has the coordinator been in place?

Mr. STERN. I started in this job at the end of 1993. Health Care Fraud Coordinators in every district went into place last year, and the meeting of our executive-level group has been going on since November 1993.

Mr. TOWNS. Just a quick one, Mr. Chairman. What percentage of OIG referrals are prosecuted? What percent are actually prosecuted?

Mr. STERN. I don't have a number to actually tell you. That is done, again, normally, on a district-wide basis. The case would be at the U.S. attorney's office; they will be deciding, is this a case we want to prosecute criminally? Civilly? Is it a case that doesn't rise to that level? Should we decline the case and let the Inspector General do that case, do a civil monetary penalty?

So I don't have a specific answer for you, Congressman Towns.

Mr. TOWNS. Ms. Brown, would you know?

Ms. BROWN. I don't have the exact figure. I could get that for you.

Mr. TOWNS. Ms. Boyd, would you know?

Ms. BOYD. No, I don't. I am sorry.

Mr. TOWNS. OK, Mr. Chairman, I would like to hold the record open to get that information. Thank you.

Mr. SHAYS. Are you making a specific request that this be provided?

Mr. TOWNS. Yes.

Mr. SHAYS. Who is going to provide it?

Ms. BROWN. We will provide it.

Mr. SHAYS. Mr. Souder.

Excuse me 1 second. I want to make sure, that this is followed up on. Ms. Brown, you will be providing this information to the committee, so we can make sure that both minority and majority have it?

Ms. BROWN. I will.

[The information referred to follows:]

REFERRALS TO THE DEPARTMENT OF JUSTICE

From January 1990 through December 1994, in health care matters, the OIG presented about 1800 individuals for prosecution. During the same period the Department of Justice declined prosecution of about 500 individuals, and 1300 were accepted for prosecution by the Department of Justice.

MEDICARE PROVIDER UNIVERSE

The Health Care Financing Administration informed us that the Medicare provider universe as of November 1994 was approximately 1,074,000 This figure was derived from 3 databases. The OSCAR system includes institutions, hospitals, skilled nursing facilities, and laboratories (209,000 providers). The National Supplier Clearinghouse (NSC) includes durable medical equipment suppliers (115,000 providers). The Universal Provider Identification Number (UPIN) system includes individuals (750,000).

Mr. SOUDER. Mr. Stern, in your statement, I wasn't clear whether you said it is possible or you would like it to be possible that if somebody had been found in violation and were now in a compliance program, that you wouldn't have to redo the whole thing.

Mr. STERN. That is right.

Mr. SOUDER. So that is law now and you can exercise that, or you would like to see that being done?

Mr. STERN. No, let me be specific.

In a settlement where there is a compliance agreement, it is my desire that in that compliance agreement, which is an agreement negotiated by HHS with the entity, I would prefer—and have encouraged that it include that kind of provision—that if the entity violates the compliance agreement, that they can be excluded. You don't have to go and prove that they violated some other health care fraud——

Mr. SOUDER. Why should that be discretionary? In other words, is that not something that should—what would be a reason not to have that be mandatory? In other words, like any other probation when you violate your probation?

Mr. STERN. I think it should be in every compliance agreement.

Mr. SOUDER. Is there——

Ms. BOYD. I would like to elaborate on that a little bit.

We have that in existing settlement agreements now. The compliance agreement is in addition to, but there are some settlement agreements, I can certainly share with you, where there are clauses in the existing settlement agreements but no compliance

provisions, that if you default in terms of the settlement agreement, you will automatically be excluded.

The compliance plan gives us a stronger handle in working with corporate America. They are putting back in the programs and are allowed to continue in the programs while having some kind of additional policing on them. If we decide that we want to continue to do business with them, there are sections in the settlement agreements now where they can be automatically excluded if they default.

Mr. SOUDER. Thank you.

In the whistleblower area—I am not proposing this, I am just running it up the flagpole—have you ever looked at and what do you think the impact would be if you gave some sort of a financial tip, if it led to a—much like you have all the different crime stoppers programs and so on, if there was an actual incentive—if somebody is convicted, based on a tip, what you think that would do in bringing in more specific complaints?

Mr. STERN. Well, the whistleblower statute does provide great financial incentive right now.

Mr. SOUDER. OK. Have you given quite a few out? Is that something exercised quite frequently?

Mr. STERN. It is done by Congress. Congress created the statute. The statute provides that if somebody knows of fraud against the Government and brings that to our attention and there is a recovery, they can receive 25 percent of that recovery, various ranges, but 25 percent is fairly standard one, and there are people who have recovered.

In the *NHL* case, *National Health Laboratories* case, a competitor concerned about why his competitor NHL was doing as well as it was uncovered fraud, brought that to the attention of the Government in a lawsuit, and I think that man ended up recovering about $25 million.

Mr. SOUDER. Now, have you had very many like that? Are people aware of that?

Mr. STERN. I try to make everyone aware by going around and speaking on it, and, yes, we have had an increasing number of—Qui Tam is what it is called—whistleblower cases brought to the Justice Department in the past year. I think we have over 85 cases pending now, a large number of cases pending around the country. Many of them are under seal. The way it is done, they are filed under seal. If we decide to support the case, we then take it over.

Mr. SOUDER. It is like a Government lottery. $25 million is a big lottery.

Mr. STERN. It is well known in the health care world that the Qui Tam statute and the whistleblower statute give great incentive to people to come and tell us about fraud, not only competitors. And I did this in a speech last week in Illinois. I spoke about, look, it is your job to police your own industry. You know better than I do what your competitors are doing, which is taking business away from you because they are doing it fraudulently. After the meeting—this is a meeting of 1,700 people—I had people standing in line to give me their cards and ask me, who do I call? This is a great incentive on companies to do, to help police others.

Mr. SOUDER. When you negotiate settlements, how much does the amount that the company owes enter in and how much does—or it was raised the question of access? In other words, do you at all consider that if you take this company out of the market people may not get care?

Mr. STERN. The question of taking them out of the market is the Inspector General's. Mine is just the criminal and civil dollars and sentencing—not sentencing, the judge does that, but criminal fines.

Mr. SOUDER. So on the criminal side, things like what is owed, settlement agreements, don't matter. In other words, if somebody is guilty, you will nail them in the—whether or not they can continue as a future provider, those variables may be considered?

Ms. BROWN. Currently, people are looking for global settlements, so they want to know what is going to happen on both the Department of Justice side under their authority, plus what our authority would have. Frequently we have to get together on these issues and reach some agreement, and we sign off. Everybody has to sign off and agree that it is a fair settlement before it is then imposed. I think the thing you are getting at, of course, is your concern that people are getting off free. Frequently, if it is a large company, it is some segment of that company and certain individuals who have committed the fraud; so, in a case such as NME, where there was a $379 million settlement, although the company wasn't excluded, we excluded five individuals, including the regional vice president for the Texas region, who was the mastermind of the fraudulent scheme. In addition, the company had to divest itself of its psychiatric hospitals. All but four of them which were teaching hospitals. The rest had to be divested: so, in effect, they got out of that business, and that was part of the settlement agreement.

It is more likely that a very large company might not be excluded because we try to narrow in on where and what the fraud was, exclude that portion of it, and allow other portions of the company to continue. There is an agreement as to how they will operate with high integrity. We will go after the individuals in those cases and that portion of the company where the fraud has occurred.

Mr. SHAYS. Thank you. This kind of hearing begs more than 5 minutes, doesn't it?

Mr. Green, you are next.

Mr. GREEN. Thank you, Mr. Chairman. I can relate to the need for more time. Let me first say, if you were here earlier, I am a second-termer in Congress, and I was surprised that the Inspector General is really the antifraud unit, whereas I didn't think that was the case in other agencies. So with HCFA, the Inspector General, instead of saying, you know, that the Administrator is responsible for the whole program, the Inspector General really serves as the antifraud unit?

Ms. BROWN. The Inspector General does have the criminal investigative responsibilities in an agency. I have been Inspector General now in five agencies, and that is always the case. The program offices do have some responsibility, of course; and HCFA, under its contracts, has people in each of the contract units who make the payments, they have people who are there to deter fraud, and they do research. They will partially develop cases and then contact us when they think they have a situation. Sometimes we give leads

to them, and they will do basic research on it. Then it will come back to our office, where I have criminal investigators. We will continue the case, and then bring it to the Department of Justice at an early point so we will work in conjunction with the U.S. attorneys.

Mr. GREEN. I have one main question, but let me ask of the Justice Department, I know in my experience in Texas a lot of times on welfare fraud it was hard to get our local district attorneys to be interested in it because it wasn't that, depending on the time of year, that sexy an issue, so to speak, but I know in Houston now they have created a welfare fraud unit, the DA and various law enforcement agencies.

Is there any hesitation by local U.S. attorneys to make welfare fraud a higher priority? I know Attorney General Reno has made it her second, after health care fraud, as an issue. I was wondering if that goes down to the U.S. attorney level instead of just being here in Washington.

Mr. STERN. You are talking about health care fraud?

Mr. GREEN. Health care fraud in general. Of course we are today on particular issues, but health care fraud in general.

Mr. STERN. The U.S. attorney announced this to all the U.S. attorneys—the Attorney General announced this priority to all U.S. attorneys when we met back at the end of 1993. In fact, I was asked to give the luncheon speech to all of them to kick off the fact that health care fraud was going to be her No. 2 new initiative. So as a result of that, I then went around the country with the FBI to major and, in many cases, smaller U.S. attorneys' offices to make certain that they understood the message.

We now have—it is not difficult anymore to get them encouraged to do this. They think these are very exciting cases and do want to work on them. Texas, in particular, has a terrific health care fraud effort, including a coordinated effort with the State, which is pretty advanced in this area.

Just as an example, within the next 2 weeks I am going to New Haven, CT, where they are having a health care fraud conference the U.S. attorney is overseeing, which brings together everybody in the community who might be interested in the health care area. They have done these—I have gone to Miami, FL, to speak on one there as well.

These have been occurring now by the U.S. attorneys on their own. They decide this is something they want to do. Sometimes they bring us in, sometimes they do it on their own.

So the simple answer is, the message has gotten out, they like these cases, they all have family or relatives who understand the problems of health care fraud, they have had elderly folks who have been cheated and don't understand what has been happening to them. The same with the FBI agents. They really identify with these kind of cases. Health care is something they understand about.

Mr. GREEN. Let me ask, in the Department of Justice—and I know oftentimes when you settle or forgo prosecution and typically in the case, because I did practice law at one time in my life, is it the result of insufficient evidence from the OIG or do you have—can you go out and investigate on your own through the FBI?

Mr. STERN. What we do is we decide who would be the best to investigate the case. It might be a postal inspector, it might be somebody from DCIS, it might be the Inspector General, you try to use your resources the best you can. But one of the things that the Inspector General and I did early in our coordinated effort was to give the FBI direct access to the contractors' information. It used to be we didn't have direct access. So they can investigate these cases directly.

That decision, whether to prosecute or not, is based on the evidence in large part, of course, but it is not because of our inability to get the evidence that we wouldn't do a case.

Mr. GREEN. Do you feel like the cooperation with the OIG and the sufficiency of the evidence that they are providing, I mean, obviously we could always do better, but is there a—are you coordinating and working together and do you feel like the OIG is providing that information to the Department of Justice?

Mr. STERN. The answer is yes to the extent that the IG has resources available in the particular districts or States. Unfortunately, the IG has had to cut back on investigators in many States in this country, so there are States with no HHS IG investigators at all.

Connecticut is an example where we have a real problem because the HHS IG has had to cut back on resources there, so the answer is, I think my relationship and the Justice Department relationship with the HHS IG is terrific, but they are strapped for resources, which does affect us.

Mr. GREEN. And so often, Mr. Chairman, again so often when we provide the resources, we receive much more money in savings or return than ever the cost of those resources, I know that is true in a lot of other antifraud efforts over the years.

Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman. I would like to ask some questions now unless, Mr. Barrett, you are ready?

Mr. BARRETT. No, I will pass on this round.

Mr. SHAYS. I need to get a handle on where we are headed here. I am going to start by trying to understand why you would have gone to the trouble to do this chart, Ms. Brown, because there is nothing in it that is particularly helpful. I must not be seeing it correctly, or else what I infer from it is different from what you infer. What do you find helpful and encouraging in that chart?

Ms. BROWN. It was really in response to some of the early questions that were given to us by the staff as to whether or not we were exercising the exclusion authority.

Mr. SHAYS. So this is in response to what we asked?

Ms. BROWN. Yes, sir.

Mr. SHAYS. Then you are not necessarily saying this represents something favorable?

Ms. BROWN. That is right.

Mr. SHAYS. OK, fair enough. I appreciate knowing that. Let me tell you, from my standpoint, when I looked at 1984–1995, my first question was over the 8,583 exclusion actions in a period of 11 years. I would have thought that would be what would happen in a period of 1 year, so that was a big surprise to me. Then I looked and said, "well, what does this represent? How many were so-called

'mandatory exclusions' and how many were in fact judgment calls on your part?"

Ms. BROWN. I don't have it for that chart. I could tell you for 1994. In 1994 we had 471 mandatory exclusions and 794 permissive exclusions.

Mr. SHAYS. So basically a 2–1 ratio of permissive-to-mandatory?

Ms. BROWN. That is pretty much the pattern.

Mr. SHAYS. What is the rationale in reinstating? If someone is taken off the system, what do they do that makes them qualified and capable and meritorious to be allowed back into the system?

Ms. BROWN. They have to apply to come back. They aren't automatically reinstated. I am going to ask Mrs. Boyd to give you some detail.

Mr. SHAYS. Mrs. Boyd, I didn't get your title, and I know it is written down there, but I can't read it. Can you tell me your title?

Ms. BOYD. It is the Assistant Inspector General of the Office of Civil Fraud and Administrative Adjudication. It sounds like a Middle Eastern dance.

Mr. SHAYS. Do you know your mission? That is what is important.

Ms. BOYD. I know my mission. I may not know my title.

Mr. SHAYS. What is your mission?

Ms. BOYD. My mission is to work with the Inspector General to try to ensure that we exclude providers and entities from the Government that are referred to us through State agencies and through the Department of Justice. We execute civil monetary penalties and exclusions to ensure that the beneficiaries are protected.

Mr. SHAYS. You get involved in exclusions and also penalties?

Ms. BOYD. Yes, I do.

Mr. SHAYS. You wanted to respond to the question—I am sorry.

Ms. BOYD. Yes. The question you asked I think was how does one get back in the program, how is one reinstated.

When an individual is excluded, we send them a letter and the letter which informs them of the time period that they are excluded, for how long, what they did that caused them to be excluded. It also has, in the very bottom of that letter, an announcement that indicates that in order to be allowed back into the program—and it has the due process requirements also—but to be allowed back into the program after the period of exclusion, the provider has to send a letter and apply back to the Inspector General's Office to be allowed into the program.

Mr. SHAYS. So in this case, we had 15.6 percent fully reinstated, of that total number of 8,583.

Now, I don't have a keen sense of how many providers have a billing number. How many are we talking about in the system right now?

Ms. BOYD. Right now, I don't know how many are in the system, but you hit on something that is very complicated and very interesting to us because one of the things that we are working very diligently on with HCFA is a universal PIN number. The hardest thing in the world for us at the Department of Health and Human Services, at OIG, is tracking and trying to make sure that the people that we exclude from the program do not get an additional

number and are allowed to come back into the program to bill. That is a problem.

There are recommendations that we have made on this issue. We will continue to make them because very often these people are allowed, through mistakes on the part of State agencies or what have you, to somehow, if they are providers who are excluded, to be allowed to get back into the program. This has been a problem for us. Overall, those people who are excluded should not have a number to get into the program or to build Medicare or Medicaid.

Mr. SHAYS. That is really an understatement. That is basic.

Ms. BOYD. Yes.

Mr. SHAYS. Are we talking a million, are we talking a half-million?

Ms. BOYD. I am sorry, I don't know that answer.

Mr. SHAYS. I don't know why you wouldn't know that. I don't understand.

Ms. BOYD. Maybe I am missing your question.

Mr. SHAYS. Maybe I am asking the wrong group.

Are we talking about 8,583 total exclusions divided by 11 years? Are we talking less than a thousand excluded a year out of—what—a million, out of a hundred thousand, out of 50, out of 10,000? It is just not helpful without that other information.

If there is someone else here who knows or someone who works for the department who can find that out and report to this committee before the end of the hearing, it would be helpful. This is an extraordinarily low number to me.

I mean, it just seems to me to be pretty pathetic, given our sense of the problem.

I am going to come back to some questions, but first, Mr. Barrett, do you have any?

Mr. BARRETT. I will pass.

Mr. SHAYS. Mr. Souder.

Excuse me, Mr. Green, do you have some questions?

Mr. Towns first. I am going to do another round of questioning here, so if you have some——

Mr. TOWNS. I pass.

Mr. SHAYS. I would like to proceed then, if that is all right.

Mr. Souder, do you want to——

Mr. SOUDER. I just have one question. I have to run out for a couple of minutes.

Mr. SHAYS. Then go ahead.

Mr. SOUDER. One of the things about politics is getting pictures taken with high school kids. A number of you made references that you are very confident that if you pursue fraud it would more than pay for itself if you had more people to do that. In the recovery dollars that you get in fraud cases, do you get to keep that in your department now?

Ms. BROWN. No. It goes into the U.S. Treasury. Even if a court specifies a million dollars for the cost of the investigation or something like that, it still goes to the U.S. Treasury, it does not come back to the Department or to the investigative unit.

Mr. SOUDER. And would you be confident enough—this is crossing areas, and I realize this is kind of a generic question of how confident the prosecutorial arm is—that if we set aside a certain

amount of funds for the fraud, figuring that we were going to make that actually an income division, that if it fell short of its income projections, that it would actually come out of Medicare beneficiary payments, are you that confident that you would be able to get more money in?

In other words, if we said, we will give you $50 million more for prosecuting fraud cases, expecting to get the revenue of $100 million, but if you fall short of the $50 million at least that you are investing in that, that comes out of Medicare, in other words is this kind of a, yeah, I think I can or is this an absolute?

Ms. BROWN. Oh, I think there is no doubt that we could get it. For each person on my staff—this wasn't all fraud, some of it was mispayments and other things—but we collected $4.6 million—I am sorry, 6.4 million per individual on the staff last year. That is, for every $1 spent there was a $80 return. So there is no doubt in my mind that we can utilize additional funds and collect far more.

Most of the money that is collected is going back into the programs. The amount that has been defrauded from Medicare or Medicaid or from even the States, is returned to those programs.

Mr. SOUDER. So when it goes into the general treasury, you are saying it goes back into the——

Ms. BROWN. The additional money, like fines and penalties, goes to the treasury.

Mr. STERN. But the direct restitution to the fund goes to the fund.

Mr. SOUDER. Yes, that would make very much sense. We are really talking about the others, because many of us who are really tough budget cutters, the problem we get is everybody knows how to spend the money, the question is, is there incentive to really spend it the tightest and wisest way? Because the classic example of this is when we gave county prosecutors more flexibility in child support, all of a sudden they collected a lot more child support, expanded their departments in many ways, so I understand the principle. I am just trying to see how confident you are.

Thank you very much.

Mr. SHAYS. Mr. Green.

Mr. GREEN. Mr. Chairman, let me just say I would hope we wouldn't have that carrot-and-stick, Mr. Souder, that we would lose money from Medicare if they don't do their job. There is bound to be some other way we could do it more direct, or if they don't meet their quotas or whatever.

But let me ask you one question, and I am glad in your testimony you talked about some of the suggestions, including your suggestion of 1128 A, about the employers' excluded individuals, and I would hope whatever bill this committee or our full committee puts together would recognize that, because of the mobility of individuals from different plans and different providers.

One of the concerns I have from both the first panel and yours is the fragmentation of the health care fraud issue. You have kind of set it straight that you are the one, that the Inspector General is the one that is responsible for it, and I guess, how many Federal agents you share jurisdiction with—the Inspector General of HHS and also the DOJ. And would you say the lines of enforcement authority are clear? And what can we do to help on that, maybe on

a statutory basis or maybe you could do between your two agencies; and how can we address the problems of overlapping if there is unclear jurisdiction of the Federal health care law enforcement agencies?

Ms. BROWN. I think there has been a remarkable improvement in the last couple of years. We have the group that Mr. Stern heads that brings the Department of Justice, including the FBI, both the Criminal and Civil Divisions, and HHS together.

In addition, we have oversight responsibility of the Medicaid Fraud Control Units. Seventy-five percent of the cost of those units which reside in almost all the States are paid for by HHS through our office. So we are coordinating with them.

I meet with a group of IG's—there are five other IG's besides myself who have health care responsibilities—on a regular basis. We coordinate our work and get together on various projects where the offender crosses agency lines, which is quite common. Most of these big settlements were joint efforts, and money was returned to all of the different funds from the different agencies.

Operation Restore Trust, which we have recently launched, is just such an effort. I felt it would be effective if we could really get together with all of the people who have some area of health care responsibility. Even the ombudsmen that work for the elderly in the various States have been brought into the program. They are very enthusiastic. We have been meeting in the States, bringing those people together so they all know their roles and how information is being transferred from one to the other.

We have started Operation Restore Trust in five States. We are doing it as a pilot program just to show what can be done if we really coordinate all the resources that are available. We have had results already, and we will be reporting regular updates on that progress just to prove how wise it is to do it that way.

Mr. TOWNS. Would the gentleman yield?

Mr. GREEN. Yes.

Mr. TOWNS. What five States?

Ms. BROWN. Illinois, New York, Florida, Texas, and California.

Mr. GREEN. Thank you. And, again in the earlier panel, I congratulated the department and the agency for Operation Restore Trust. I hope it builds.

Under Operation Restore Trust, have you set some prosecution or enforcement target limits for the initiative and also do you have an evaluation process to see where you are going, or your success?

Ms. BROWN. Yes, we have an evaluation process that is going to be in place. In fact, we are having an outside contractor do it. HCFA is arranging for that. My office has the lead on Restore Trust to keep it objective. I am sure that we will be able to show the dollars spent, how those were used; and what the results have been. There are different areas of results such as improving care and stopping very flagrant schemes.

Mr. GREEN. In working with your other five IG's, do you coordinate, do you share resources? Obviously, you share information, but can you share resources between the other Inspectors General?

Ms. BROWN. We have authority only if our agency has some involvement. If two agencies are involved, which is very common, we both put resources into the project. If it is CHAMPUS, for instance,

through the Department of Defense, they would participate with us.

Mr. GREEN. Or the Department of Labor?

Ms. BROWN. The IG's are Labor, Defense, Office of Personnel Management, Veterans Administration, and Railroad Retirement Board.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman. I would like to ask a few more questions here; and then we will get to our third panel. I appreciate the patience of our third panel.

Mr. Stern, your Health Care Fraud Report, fiscal year 1994, talks about lab service settlement agreements with two of the Nation's largest independent blood testing laboratories that agreed to pay the United States $1.1 million to settle allegations that they submitted false claims to the civilian health and medical program of the uniformed services, CHAMPUS, for unnecessary blood tests.

Then the Government alleged that MetPath, a subsidiary of Corning, Inc., and UniLab Corporation, formerly doing business as MetWest Inc., manipulated doctors into ordering medically unnecessary blood tests whenever doctors ordered certain basic blood tests. This settlement followed settlements with National Health Laboratories for $100 million, and with MetPath and MetWest for $39.8 million, each based on allegations of marketing schemes that generated claims for unnecessary tests to the Medicare program and to the CHAMPUS program for NHL.

This is a lot of settlement dollars, so in one sense I feel good that we got this money. My sense is, however, that there was a lot of illegality going on.

Let's just take National Health Laboratories, $100 million. I need to be clear as to what happened, because as I look at the settlement agreement, it says, in addition, the U.S. Department of Health and Human Services through its office of Inspector General agrees to release and refrain from instituting or maintaining any further actions.

Mr. STERN. Yes, for a short period of time; as I recall, it was only 3 months. He was also excluded for 5 years, based on the conviction under MediCal.

The vice president was excluded for 1 year.

Mr. SHAYS. After 5 years and after 1 year, respectively, they can get back into the business?

Mr. STERN. Well, again, you will have to speak to HHS about how they get back in after exclusion.

Mr. SHAYS. OK. Well, this is interesting. I need to understand what the Department of Justice does here.

Certain people were sent to jail. It was done by the U.S. attorneys in the respective States?

Mr. STERN. Yes.

Mr. SHAYS. Coordinated through your office?

Mr. STERN. In that particular case, there was coordination.

Mr. SHAYS. Sometimes not?

Mr. STERN. Sometimes the U.S. attorney will handle a case without any need to deal with national Department of Justice office here.

Mr. SHAYS. The bottom line is, you were able to determine that a few people were guilty, basically the people in charge. Did you make a decision that everybody else under them didn't know that they were breaking the law?

Mr. STERN. Well, you look again at the evidence. If you had evidence of somebody individually breaking the law, you go after them. What these cases are, the big ones are usually settlements with the entity itself and part of that settlement requires that they cooperate with us to go after the individuals.

To be more specific with the NME case, which showed that example of going forward, NME was a settlement with the company. Part of that, they had to cooperate with us to go after individuals; and in NME since that settlement—NME was a $379 million settlement that you have heard a lot about—I think in the NME thing we have had, if I can be specific with this——

Mr. SHAYS. I am missing the name.

Mr. STERN. National Medical Enterprises was a chain of psychiatric hospitals, and the settlement there was $379 million. Since then, we have——

Mr. SHAYS. But all I am saying to you is, the higher the number, the more convinced I am that things were going on that shouldn't have happened. This hearing is about people who rip off the system and somehow manage to stay in it; and I am just trying to think of what the disincentive is here.

You have people who are defrauding the Government of hundreds of millions of dollars still somehow in the system. I would be happy, Ms. Brown to have you explain to me the concept of the 1 year and the 5 years. What is that?

Ms. BROWN. The mandatory exclusion is for a 5-year period, and the permissive exclusions give us a range from which we can make a determination.

Mr. SHAYS. OK, now, why wouldn't you in the settlement have said, no way are you all ever going to be in this business again? That is kind of the question that I have to have answered.

Mr. BARRETT. That is a good question.

Ms. BOYD. One of the issues about NME, as it is with large corporations—and we had a recommendation that we try to change the law. One of the problems with NME is that we could exclude the company and tomorrow, Mr. Shays, the company could go out and reincorporate under a new name and come back and get a provider number and continue to bill and set up a separate corporation.

So we could exclude the company, but the company could come back in the back door again. It is a front door; it is not even the back door. They would be allowed to get a separate number, they would be allowed to apply to HCFA through the process and start over. It is almost like an empty action sometimes when you exclude the company, because you know that they have that ability to go out and start over. So it may be merely a statistic that you exclude the company.

Mr. SHAYS. I wouldn't think it would be entirely an empty action because a company builds up a clientele, a name and so on, and they would have to rebuild from scratch.

That raises another question. You are basically saying that since no individuals were found guilty, other than a few, those others who were with the company, are supposedly law-abiding citizens? There has to be a way of going after more of the individuals involved.

I just can't believe that only two people in a company this large are dishonest and everyone else is honest and above board. I mean, it defies my sense of logic.

Ms. BOYD. I don't disagree with you. But what I would like to say to you is that in NME we also put in a very strong compliance plan. The entire company is under a very strong compliance plan. They are now coming back, the end of next month, to the Department of Health and Human Services to share with us everything that they have done, including their annual reports. There are still ongoing investigations that right now are going on with some others in NME—some other individuals who may have been involved in some wrongdoing.

Mr. SHAYS. I am going to pursue this issue further. I am wondering why, if this company was basically corrupt, why others in the company didn't speak out and say, "Hey, this is wrong, we are ripping off the system."

Ms. BROWN. One of the proposals that we mention in our written testimony is to give us that authority to go further, so that key people in the company can be included as well as the company.

Mr. SHAYS. I am not just thinking of key people. What is your definition of "key"? Maybe you could reenlighten me again as to what that specific recommendation is.

Ms. BROWN. When there are individuals that are in responsible positions, you can't always prove that they knew what was going on and had intent to defraud, but if they had responsible positions in the company, they should have known, and if we had the authority to go forward and impose an exclusion on them so that they couldn't reincorporate, we would be in a much better position to protect the programs.

Mr. SHAYS. Well, we will pursue this. I don't expect to have the answer today.

Ms. BROWN. We could give you more detail on how that proposal might work.

Mr. SHAYS. I think what we will do, unless there are any other questions, which I don't think there are, we will go to our third panel.

I look forward to working with all of you in the future.

We have testimony from Jonathan Ratner, who is Associate Director of Health Finance Issues, GAO; William Mahon, executive director, National Health Care Anti-Fraud Association; and Rufus Noble, inspector general, Health Care Administration, Florida. This is our third and last panel.

I appreciate our panel being so patient. I would like to administer the oath, so if you would remain standing, Mr. Noble, we will proceed.

[Witnesses sworn.]

Mr. SHAYS. For the record, all three have responded in the affirmative.

In terms of order, Mr. Ratner, we will go with you first, then Mr. Mahon, and then we will go to Mr. Noble.

Welcome. We are happy to have you summarize your testimony, and look forward to asking questions.

STATEMENTS OF JONATHAN RATNER, ASSOCIATE DIRECTOR, HEALTH FINANCE ISSUES, GENERAL ACCOUNTING OFFICE; WILLIAM MAHON, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION; AND RUFUS NOBLE, INSPECTOR GENERAL, HEALTH CARE ADMINISTRATION, STATE OF FLORIDA

Mr. RATNER. Thank you, Mr. Chairman, members of the subcommittee. We are pleased to be here today to discuss ways for Medicare to avoid spending billions of dollars unnecessarily.

You have just heard from previous witnesses about enforcement efforts against wrongdoers who try to defraud Medicare. These downstream efforts to pursue and penalize those who commit fraud and abuse are essential, but our work focuses on the equally vital upstream phase of fraud-fighting, prevention, and detection.

In essence, Medicare loses possibly billions of dollars each year because its unrestricted fee-for-service reimbursement system is too easily exploited. A combination of four conditions makes Medicare an attractive target. We reported on these conditions to this subcommittee in March, so I will briefly summarize them today.

First, Medicare pays higher than market rates for many services and supplies. Second, Medicare's net of antifraud and abuse controls has many holes. Providers can submit claims for improbably high charges or manipulate billing codes and too often get paid without raising questions. Currently, Medicare pays over 700 million claims annually but reviews only 5 percent or less. Of the upward of 600,000 to perhaps a million providers, Medicare reviews only 3 in 1,000 providers each year.

The third condition, Medicare's checks on the legitimacy of providers are too superficial to detect the potential for scams.

And fourth, Medicare's efforts to penalize wrongdoers are still too limited and weak and fail to serve as deterrents.

The private sector faces the same types of fraudulent schemes and abusive billing patterns. Ironically, until the early or mid-1980's the private sector lagged Medicare in techniques of fighting fraud, but in the past decade private payers have taken the lead by shifting toward an approach of vigilant management of care and costs. To price health care, they assess the market options; to detect manipulation of billing codes, they use state-of-the-art software; to monitor excessive utilization, they use computerized systems to screen providers so they deal only with legitimate ones. They use per-admission review and preferred provider networks which, by the way, also help control utilization.

Why doesn't Medicare operate in a similar fashion?

As you have heard today, Medicare has taken some important steps in this direction. Nonetheless, Medicare's controls over utilization and its pricing methods for many services and supplies were reasonably well suited to health care financing and delivery 10, 15 years ago. But often they are not well aligned with the revolutionary changes in the health care market of today.

Moreover, Medicare's day-to-day operations are shaped by three principles on which it was founded in 1965: First, the Government must not interfere in medical practice; second, patients should be free to choose their own health care providers; and third, attempts to alter public programs require public comment and discussion. These are widely viewed as sensible principles with broad appeal, but they have not been reinterpreted in light of the contemporary health care marketplace and today's demands for fiscal discipline in public programs.

Given this situation, what can the Congress do to help Medicare accelerate its shift from a passive payer of claims to a more prudent payer of similar successful private payers? We believe there are promising strategies, ones that particularly target the fastest-growing, least-managed components of Medicare, such as home health and rehabilitation therapy services. You have heard about those already.

First, Medicare should be allowed to price services and procedures more competitively. For example, the regulatory processes HCFA uses to revise excessive payment rates could be streamlined. Opportunities also could be created for competitive bidding and negotiating of prices.

Second, Medicare's fraud and abuse detection efforts should be enhanced. This could include completing the modernization of Medicare's claims processing and information systems. Another initiative would permit recoveries from antifraud efforts to be reinvested. You have heard about HCFA's proposal today. We have proposed amending the Budget Enforcement Act.

Third, providers should be required to demonstrate their bona fides, their suitability as a Medicare vendor before being given billing rights that are unlimited, unrestricted. This could include Medicare's establishment in the preferred provider networks' development of more rigorous criteria for authorization to build a program and use of private entities to accredit providers or certify their legitimacy.

Mr. Chairman, this concludes my statement. I will be pleased to answer any questions.

Mr. SHAYS. That is quite a summary. Thank you.

[The prepared statement of Mr. Ratner follows:]

PREPARED STATEMENT OF JONATHAN RATNER, ASSOCIATE DIRECTOR, HEALTH FINANCE ISSUES, GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee: We are pleased to be here today to discuss ways for Medicare to avoid spending billions of dollars in unnecessary payments. As we testified before this Subcommittee in March and have documented in numerous reports and other congressional testimony, Medicare sustains billions of dollars in losses to waste, fraud, and abuse. (See app. I for a list of related GAO products.)

Today this Subcommittee is exploring the legal and administrative enforcement tools available to Medicare to punish those providers who defraud or abuse the program. the beneficiary, and the taxpayer. While strengthening enforcement is critical, our work focuses on an equally vital but earlier phase of fraud fighting—identifying the program's vulnerabilities and the measures needed to curb losses. Therefore, you asked us to examine, using our findings on waste, fraud, and abuse, the weaknesses responsible for Medicare's vulnerability to provider exploitation and ways to remedy these weaknesses.

In brief, Medicare's vulnerability stems from a combination of factors: (1) higher than market rates for certain services, (2) inadequate checks for detecting fraud and abuse, (3) superficial criteria for confirming the authenticity of providers billing the

program, and (4) weak enforcement efforts. Various health care management techniques help private payers alleviate these problems, but these techniques are not generally used in Medicare. The program's pricing methods and controls over utilization, consistent with health care financing and delivery 30 years ago, are not well aligned with today's major financing and delivery changes. To some extent, the predicament inherent in public programs—the uncertain line between adequate managerial control and excessive government intervention—helps explain the dissimilarity in the ways Medicare and private health insurers administer their respective "plans."

We believe a viable strategy for remedying the program's weaknesses consists of adapting the health care management approach of private payers to Medicare's public payer role. Such a strategy would focus on pre-enforcement efforts and would entail (1) more competitively developed payment rates, (2) enhanced fraud and abuse detection efforts through modernized information systems, and (3) more rigorous criteria for granting authorization to bill the program.

BACKGROUND

Medicare is the nation's largest single payer of health care costs. In 1994, it spent $162 billion, or 14 percent of the federal budget, on behalf of about 37 million elderly and disabled people. Approximately 90 percent of Medicare beneficiaries obtained services on an unrestricted fee-for-services basis: that is, patients chose their own physicians or other health care providers, with charges sent to the program for payment. This set-up mirrored the nation's private health insurance indemnity plans, which prevailed until the 1980s.

Since then, revolutionary changes have taken place in the financing and delivery of health care. Greater competition among hospitals and other providers has enabled health care buyers to be more cost-conscious. Private payers, including large employers, use an aggressive management approach to control health care costs. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), is Medicare's health care buyer. HCFA's pricing of services and controls over utilization have been carefully prescribed by statute, regulation, or agency policy.

HCFA contracts with about 73 private companies—such as Blue Cross and Aetna—to handle claims screening and processing, and to audit providers. Each of these commercial contractors works with its local medical community to set coverage policies and payment controls. As a result, billing problems involving waste, fraud, and abuse are handled, for the most part, at the contractor level. This arrangement was prompted when the program was established in the mid-1960s by concerns that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

ABOVE-MARKET RATES FOR MANY SERVICES ENCOURAGE OVERSUPPLY

Medicare pays substantially higher than market rates for many services. For example:

- The HHS Office of Inspector General reported in 1992 that Medicare paid $144 to $211 each for home blood glucose monitors when drug stores across the country sold them for under $50 (or offered them for free as a marketing ploy).[1] HCFA took nearly 3 years to reduce the price to $59
- For one type of gauze pad, the lowest suggested retail price is currently 36 cents. The Department of Veterans Affairs (VA) pays only 4 cents. Medicare, however, pays 86 cents for this pad. Indeed, Medicare pays more than the lowest suggested retail price for more than 40 other surgical dressings. Medicare pays more than VA for each of the nine types of dressing purchased by both VA and Medicare. For all practical purposes, HCFA is prohibited from adjusting the prices for these and similar supplies.[2]

[1] Home blood glucose monitors enable individuals to determine the adequacy of their blood glucose levels. The manufacturers have an incentive to promote the sale of their brand of monitor to ensure future sale of related test strips. According to HCFA, the income generated in 1 month by the sale of test strips can exceed the total income generated from the sale of the monitors.

[2] 42 U.S.C. 1395m(i) required HCFA to establish a fee schedule for surgical dressings based on average historical charges. However, because the benefit was expanded, HCFA did not have such data. Instead, it used a gap-filling process based on the median price in supply catalogs. This is necessarily higher than the lowest price (given any variation at all). HCFA cannot change the methodology for determining the fee schedule, nor can it adjust the schedule if retail

Continued

• Medicare was billed $8,415 for therapy to one nursing home resident, of which over half—$4,580—was for charges added by the billing service for submitting the claim. This bill-padding is permissible because, for institutional providers, Medicare allows almost any patient-related costs that can be documented.

Such excessive payment rates can encourage an oversupply of services and thus foster a climate ripe for abuse.[3] Our work has shown that Medicare's excessive payment rates for certain services have supported the proliferation of costly technology.

Magnetic resonance imaging (MRI) equipment is a case in point. As we reported in 1992,[4] high Medicare payments for MRI scans supported a proliferation of MRI machines in some states. The problem is that, once a new medical procedure is approved for coverage, HCFA does not systematically review payment rates as technologies mature and become more widely used, and as providers' costs per service decline. In the absence of systematic adjustment, the Congress has had to act legislatively, reducing rates for various covered benefits, such as overpriced procedures, selected durable medical equipment items, clinical lab tests, intraocular lenses, MRIs, and CT scans.

EVIDENCE OF ABUSIVE BILLING INDICATES MEDICARE'S CHECKS ON PAYMENTS ARE NOT ADEQUATE

Medicare's claims processing contractors employ three basic electronic controls to detect waste, fraud, and abuse. Some are programmed into claims processing software and are designed to spot filing errors. For example, if a provider's billing number or beneficiary identification number is incomplete or otherwise manifestly incorrect, the computer automatically holds the claim until the data are corrected. Other controls are designed to stop processing when claims do not meet certain conditions for payment. For example, one control flags claims that exceed the allowed threshold of 12 chiropractic manipulations a year per beneficiary. A third kind of control, postpayment review of data, is intended to enable Medicare to spot patterns and trends of unusually high spending.

However, our work shows that improbable charges or unlikely payments often escape the controls and go unquestioned. For example, none of the contractors who process claims for medical equipment and supplies automatically reviews high-dollar claims for newly covered surgical dressings.[5] In consequence, one such contractor paid $23,000 when the appropriate payment was $1,650. Similarly, Medicare paid a psychiatrist over a prolonged period for claims that represented, on average, nearly 24 hours a day of services. Neither of these abuses came to light through a systematic examination of claims data.

In congressional testimony earlier this year, we reported the results of our study on private sector technology—computer software controls—used to detect certain billing abuses.[6] We compared what Medicare actually paid providers against what would have been paid by four commercial firms that market computerized systems to detect miscoded claims.[7] We invited each firm to reprocess 200,000 statistically selected claims that Medicare paid in 1993. On the basis of this sample, we estimated that, had Medicare used this commercial software, the government would have saved $3 billion over 5 years by detecting these billing abuses.

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prices decrease. While HCFA is authorized to increase payments annually based on the consumer price index, it lacks authority to reduce such payments.

[3] The HHS Inspector General is authorized (under 42 U.S.C. 1320a-7(b)(6)) to exclude from Medicare any providers charging Medicare in excess of their usual charges without good cause. However, no regulations to implement this provision have been developed, and the authority has never been used.

[4] *Medicare: Excessive Payments Support the Proliferation of Costly Technology* (GAO/HRD–92–59, May 27, 1992).

[5] In March 1994, Medicare's surgical dressing benefit was greatly expanded to include various types and sizes of gauze pads not previously covered and to extend the duration of coverage to whatever is considered medically necessary.

[6] See *Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually* (GAO/T–AIMD–95–133) and *Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse* (GAO/AIMD–95–135), both issued May 5, 1995.

[7] Providers bill their charges to Medicare according to an official book of procedure codes. By manipulating these codes, a provider can charge Medicare more than the appropriate code would permit. For example, a comprehensive code covers the fee for removing a ruptured appendix, which includes making the incision to reach the appendix and closing the wound. A physician could miscode the claim by including three separate codes—one for making the incision, one for closing the wound, and the correct one—the comprehensive code covering removal of the appendix.

INSTANCES OF BILLING SCAMS SUGGEST MEDICARE'S CHECKS OF PROVIDER BUSINESSES ARE SUPERFICIAL

Our studies and those of the HHS Inspector General have found that unscrupulous individuals or companies can be authorized to bill Medicare even if they do not qualify as legitimate providers. This puts them in a position—from within Medicare—to deploy fraudulent or abusive billing schemes. This problem has become more acute as providers that are less scrutinized or more transient than doctors and hospitals use elaborate, multilayered corporations to bill Medicare.

The following examples show instances in which such providers obtained Medicare provider numbers and billed the program extensively over the past several years:

- Five clinical labs (that Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the alleged submission of false claims. The labs' mode of operation was to bill Medicare large sums over 6 to 9 months; whenever a lab received inquiries from Medicare, it went out of business.
- A wheelchair van service obtained a Medicare provider number as an ambulance service. The provider was not licensed by the state as an ambulance service, nor did the provider have the equipment required by Medicare to qualify as an ambulance service. Over 16 months, on behalf of just one beneficiary, the van service billed Medicare $62,000 for 240 ambulance trips—about 1 trip every 2 days at nearly $260 per trip.
- A therapy company added $170,000 to its Medicare reimbursements over a 6-month period, while providing no additional services, by creating a "paper organization" with no space or employees. The company simply reorganized its nursing home and therapy businesses so that a large portion of its total administrative costs could be allocated to Medicare.
- A medical supply company serving nursing facility patients obtained more than 20 different Medicare provider numbers for companies that it controlled. The companies, all in the same state, were nothing more than shells that allowed the supplier to spread its billings over numerous provider numbers to avoid detection of its overbillings.

The conditions of program participation for Medicare providers range from stringent to minimal, according to the type of service or supply provided. For most provider categories, these conditions are established by statute.[8]

- For some professionals, such as physicians, state licensure is required. Licensing boards typically perform background checks on the applicant's medical education, disciplinary actions, and related information.[9] However, states are slow to take action to penalize health care providers that engage in abusive billing practices.
- Institutional providers (hospitals, clinics, home health agencies, rehabilitation agencies, etc.) are surveyed and certified by state agencies as meeting Medicare requirements (and perhaps additional state conditions). However, as our cited cases illustrate, there are many ways in which these precautions prove inadequate.
- Nonmedical providers, such as suppliers of medical equipment, have historically been subject to few such provisions. Even though HCFA has recently taken steps to improve the application process in this area, in some respects the requirements remain superficial. The National Supplier Clearinghouse was created to issue supplier numbers to providers desiring to submit claims for durable medical equipment, prosthetics, orthotics, and supplies. To apply for a supplier number, the provider must complete a detailed application. Because of privacy concerns, however, the clearinghouse cannot verify the accuracy of two important items on these applications—social security and tax identification numbers. Also, the clearinghouse does not routinely perform background checks on the owners or verify that supplier facilities really exist.

EFFORTS TO PENALIZE WRONGDOERS LARGELY INEFFECTUAL AS DETERRENTS

Currently, providers who defraud or otherwise abuse health care payers have little chance of being prosecuted or having to repay fraudulently obtained money. Al-

[8] While the Secretary may impose additional requirements—and has done so, in some instances—these must relate directly to patients' health or safety. See, for example, 42 U.S.C. 1395x(e)(9) for hospitals and 1395x(o)(6) for home health agencies.

[9] This is done using sources such as the American Medical Association profile, kept on all licensed physicians; the Federation of State Medical Boards' data bank; and the National Practitioners Data Bank.

though legal and administrative enforcement tools are available to Medicare,[10] few cases are pursued. Even when they are, many are settled without conviction, penalties are often light, and providers frequently continue in business. These are characteristics of health care fraud (and of white collar crime in general) and are not confined to Medicare.

Our review of Medicaid prescription drug fraud cases illustrates problems that are typical of health care fraud prosecution—the consequences for the convicted wrongdoer are often nominal. We found that few providers went to prison, and few had their licenses suspended or revoked. In many cases, convicted individuals or organizations resurfaced as health care providers serving Medicaid patients. In more than half the cases reviewed, assessed restitution amounts were $5,000 or less. In one instance where a provider was assessed $220,000 for restitution, Medicaid recovered only $4,000. In a New York case in which only $50,000 of a $300,000 assessment was collected, eventual repayment of the remainder was contingent upon the owner's success in selling his pharmacy and the building that houses it. Opportunities exist for convicted owners to avoid repayment by various actions, including hiding assets under other names, transferring funds overseas, or declaring bankruptcy.[11]

Moreover, our reviews in Medicare have shown that often suspicious providers either are not or cannot be adequately pursued. We have found the following:

- In some cases providers are asked to repay only nominal amounts of the estimated overpayments made by Medicare. To illustrate, a psychiatrist who in 1993 received about $440,000 in Medicare payments was submitting questionable bills. The Medicare contractor selected 15 of the psychiatrist's patients as a sample, reviewed their claims, and found that 75 percent were overstated (a total of about $5,700) due to miscoding or misrepresentation. Rather than project the overpayment amount to estimate and recoup Medicare's total loss, the contractor requested recoupment of only the $5,700, sent the psychiatrist an educational letter,[12] and closed the case.
- In many cases providers submitting improbable claims are not reviewed. For example, in an ongoing assignment, we asked the Medicare contractor to obtain and review the medical records supporting 85 high-dollar medical supply claims. These included supply claims for a month in excess of $17,000 for some patients. In 45 percent of the cases (totaling almost $500,000), the providers did not submit the supporting medical records and had the claims denied. The contractor does not routinely follow up in cases where a provider does not submit requested documentation to ascertain why and whether documentation is available for the provider's other claims.
- In some instances technicalities preclude holding any individual or entity responsible for large, documented losses. Medicare contractors, for example, lack authority to assess overpayments using claims for care that physicians order from suppliers or laboratories. In one case, a contractor could not collect a $123,000 overpayment assessed from a laboratory affiliated with a scheme that defrauded Medicare. An administrative law judge ruled that, since the laboratory acted on physicians' orders, the laboratory could not be held liable for the costs billed.

PRIVATE SECTOR MANAGEMENT TECHNIQUES SUGGEST WAYS TO REMEDY PROGRAM WEAKNESSES

Medicare does not use (or in some cases use widely enough) private sector strategies to manage three of the factors that attract unscrupulous providers—excessive payment rates, inadequate safeguards over billing, and ineffective controls over providers. For example, private insurers and managed care organizations commonly use pricing strategies that take advantage of their buying power and of the competitive marketplace. These private payers also employ a range of techniques focusing on utilization: they examine tests and procedures for their appropriateness and their volume, and they screen providers for their practice styles and quality of care. Some price and utilization strategies that could have applicability to Medicare are detailed in table 1.

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[10] For example, 42 U.S.C. 1320a–7, 1320a–7a, and 1320a–7b authorize exclusion from Medicare, civil monetary, and criminal penalties, respectively.

[11] Medicare and Medicaid overpayments once had priority in bankruptcy cases, but this was eliminated by the Bankruptcy Reform Act of 1978 (P.L. 95–598). The HHS Office of Inspector General, in a May 1992 report, recommended that HCFA propose a legislative change to restore this priority.

[12] Educational letters are sent by claims processing contractors to notify providers of billing errors. HCFA—seeking to maintain a good relationship with the physician community and to limit provider hassle—emphasizes education as an appropriate tool to get providers to bill correctly the first time.

Table 1: Commonly Used Private Sector Techniques and Applicability to Medicare

Private Sector Technique	Description	HCFA's Current Practice	HCFA Explanation
Prompt reaction to market prices.	Change prices quickly when paying more than competitively necessary.	Prices generally not adjusted for declines in the price of product or service [a].	Pertinent statute generally permits appropriate adjustments only after completing a complex administrative process [b]
Negotiate with select providers.	Selectively contract with providers to deliver certain services, such as hip replacements, at a specific price.	Same payments generally made to any provider selected by beneficiary to provide services.	Statute does not permit providers to be excluded unless they engage in certain prohibited practices [c]
Competitive bidding and negotiations.	Set prices for services or service packages based on competitive process.	Prices are set under complex formulas, but demonstration involving competitive procedures is proposed.	Statute generally provides only for all area providers to be paid the same amount for service; [d] legislation specifically prohibits proposed demonstration [e]
Preferred provider network ...	Promote use of a network of selected providers meeting price, practice style, and quality criteria.	Payments generally made to any provider selected by beneficiary to provide medical services.	Statute guarantees beneficiary freedom to choose providers; [f] limited statutory authority to contract with managed care networks [g]
Preadmission review	Require prior approval of hospitalization for select procedures.	No prior approval of hospitalizations for any procedures.	No viable statutory authority for requiring prior approval; statute prohibits interference with practice of medicine [h]
Case management	Assist high-cost patients in selecting appropriate services efficiently.	Assistance not provided to patients in selecting services efficiently.	Statute prohibits interference with practice of medicine [i]
Contract with utilization review companies.	Use companies specializing in utilization review to monitor and adjudicate claims.	HCFA contracts with private entities—generally insurance companies—to process claims [j].	Statute provides no specific authority for contracting with utilization control organizations [k]

[a] For example, although 42 U.S.C. 1395u(b)(8) and (9) provide HCFA with authority to adjust payments when the established rates under a fee schedule are found to be inherently unreasonable, detailed procedures are mandated that include a lengthy notice and comment period.

[b] For example, 42 U.S.C. 1395m(a)(10)(B) provides HCFA with authority to adjust prices for durable medical equipment, excluding surgical dressings, but only after completion of a cumbersome administrative process. The one time this process was used, it took 3 years to complete.

[c] 42 U.S.C. 1320a–7 provides for mandatory and permissive exclusion of providers who are, for example, convicted of certain program-related crimes.

[d] 42 U.S.C. 1395f establishes conditions of and limitations on payment for services.

[e] In 1985, HCFA started the process to perform a demonstration of competitive bidding related to laboratory services, and it was set to begin in 1987. That year and in several subsequent years, however, provisions were included in the respective budget reconciliation laws specifically prohibiting its implementation. Eventually, HCFA abandoned plans for the demonstration, but has since requested authority to introduce competitive bidding, without success.

[f] 42 U.S.C. 1395a, the so-called freedom of choice provision, expressly provides that beneficiaries may obtain health services from any willing provider.

[g] 42 U.S.C. 1395mm authorizes HCFA to contract with certain managed care entities to provide care to Medicare beneficiaries under prescribed circumstances.

[h] 42 U.S.C. 1395.

[i] 42 U.S.C. 1395.

[j] These companies may arrange for utilization review to be done under subcontract.

[k] 42 U.S.C. 1395h provides detailed authorization for HCFA to contract with private entities without competitive procedures to handle part A claims, and 42 U.S.C. 1395u provides similar authority for part B claims.

For the most part, the pricing and utilization and quality control mechanisms used in the private sector are not available to Medicare, constraining HCFA and its contractors from adopting similar measures.[13] For example, HCFA is generally unable to

- negotiate with providers for discounts, promptly change prices to match those available in the market, or competitively bid prices for widely used items or services, such as pacemakers, intraocular lenses, cataract surgery, and wheelchairs. This has resulted in Medicare paying higher prices than other large payers. (We

[13] 42 U.S.C. 1395b–1 provides detailed authorization for experiments and demonstration projects related to incentives for economy while maintaining or improving quality in the provision of health care, but HCFA has found it of limited value.

elaborated on competitive bidding and negotiation strategies in congressional testimony last month.[14])

- differentiate between providers who meet utilization, price, and quality standards and those who do not, and provide incentives to encourage beneficiaries to use the "preferred providers." This has hampered Medicare's ability to encourage beneficiaries to use providers meeting Medicare's standards.
- use preadmission review or other utilization control practices to curb the excessive or unnecessary provision of expensive procedures, or use case management to coordinate and monitor high cost patients' multiple services and specialists. This has limited Medicare's ability to emphasize cost efficiency in its dealings with those suppliers, physicians, and institutions that habitually provide excessive services.

FACTORS LIMITING HCFA'S FLEXIBILITY

Three principles on which Medicare was founded—as interpreted by HCFA, providers, the courts, and the Congress—help explain why Medicare practices and private payer management techniques are dissimilar:

- First the government must not interfere in medical practice.[15] Medicare legislation essentially delegated many day-to-day administrative decisions to private insurers to further lessen the risk of undue federal interference and to better ensure that Medicare would treat its beneficiaries no differently than the privately insured.[16] The functions delegated include establishing policies on when claims for services are medically necessary—and today most such "medical policies" are still established by Medicare's private contractors.
- Second, Medicare beneficiaries should be free to choose their own health care providers.[17] However, many of the private sector innovations credited with cost savings rely on managed care techniques that structure and constrain that choice. Staff- and group-model health maintenance organizations (HMO) explicitly restrict a patient's choice of health care providers (e.g., to a set of plan-approved physicians and hospitals), while looser forms of managed care, such as preferred provider networks, give financial disincentives to the patient who chooses providers outside the plan-approved list. Although Medicare offers an HMO option to beneficiaries, HCFA has only limited statutory authority to pursue other managed care options.[18]
- Third as a public program Medicare changes require public input and are difficult to make without consensus. Past experience suggests that changes made by HCFA will typically be contested. Given the high stakes for providers, legal challenges are apt to be pursued vigorously by those who fear that program changes would result in their receiving lower payments. Although the ultimate outcome is always uncertain, litigation—whatever the outcome—can take years to resolve.[19] Consequently, in considering cost-saving initiatives, HCFA must weigh the resulting expense and disruption as well as the risk of ultimate failure against anticipated savings. These circumstances foster HCFA's reluctance to act without specific statutory authority.[20]

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[14] *Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems* (GAO/T–HEHS–95–174, May 24, 1995).

[15] 42 U.S.C. 1395.

[16] 42 U.S.C 1395h provides authority and detailed instructions for HCFA to contract with such entities to handle part A claims, while 42 U.S.C. 1395u provides similar guidance related to part B.

[17] 42 U.S.C. 1395a, the so-called freedom of choice provision, expressly provides that beneficiaries may obtain health services from any willing provider.

[18] 42 U.S.C. 1395mm authorizes HCFA to contract with certain managed care entities to provide care to Medicare beneficiaries under prescribed circumstances. Our analysis suggests, however, that under the current statutory prescriptions this has not harnessed the cost-saving potential of managed care. See our recent testimony, *Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems* (GAO/T–HEHS–94–174, May 24, 1995).

[19] For example, HCFA has in recent years made a more diligent effort to recover payments made mistakenly when other private insurers would have said for a medical service. In 1989, the Congress permitted HCFA to begin performing a data match with the Internal Revenue Service to help identify such mistaken payments, with the result that millions have been recovered and millions more were expected to be recovered. This effort was dealt a serious blow, however, when a federal court ruled in 1994 that HCFA is bound by the claims filing deadlines set by private insurers and may not recover from third party administrators who handle claims processing for private insurers. *Health Ins. Ass'n of America. Inc.* v. *Shalala*, 23 F.3d 412 (D.C. Cir. 1994), cert. denied, 115 S.Ct. 1095 (1995). As a result, HCFA may be unable to recover millions in mistaken payments and may have to repay some funds previously recovered. See our testimony on this subject, *Medicare's Secondary Payer Program: Actions Needed to Realize Savings* (GAO/T–HEHS–95–92, Feb. 23, 1995).

[20] The courts are not the only forum where those questioning HCFA's exercise of its Medicare responsibilities might seek redress. In 1985, HCFA started the process to perform a demonstra-

These principles were consistent with the predominantly fee-for-service and unmanaged method by which health care was delivered and paid for three decades ago. Today, however, HCFA's capabilities to manage Medicare are misaligned with the state of the art in health care delivery and financing.

CONCLUSIONS

In conclusion, Medicare's vulnerability to exploitation can be summarized as follows:

- Despite the current competitive health care market, Medicare often pays more than the market price for medical services and supplies.
- Although payment of claims for services provided constitutes the program's chief administrative function, Medicare does not use available state-of-the art technology to screen claims for overcharging or overutilization.
- Despite the increase in nonmedical providers billing for services and supplies, Medicare does little to scrutinize the legitimacy of providers billing the program.
- Despite the availability of legal and administrative enforcement tools, few wrongdoers are convicted or otherwise penalized.

The problems facing Medicare confront private insurers as well, but they are armed with a larger and more versatile arsenal of health care management techniques than HCFA currently has. These techniques may not be wholly applicable to Medicare, but in general they offer a menu of options for devising ways to make Medicare more cost effective. Commercial contractors, which play a key role in administering Medicare, routinely employ management-of-care techniques and use state-of-the-art technology in their capacity as private insurers. If they were able to apply these techniques to Medicare, the program's weaknesses could be significantly remedied.

Given Medicare's vulnerabilities, a more modern approach tailored to the program would adopt the following three strategies:

1. Allow Medicare to price services and procedures more competitively. This could include streamlining processes required to revise excessive payment rates, and competitively bidding and negotiating prices.
2. Enhance Medicare's antifraud and abuse efforts. This could include completing the modernization of Medicare's claims processing and information systems and expanding the use of state-of-the-art computerized controls.
3. Require providers to demonstrate their suitability as a Medicare vendor before being given unrestricted billing rights. This could include HCFA's establishment of preferred provider networks, development of more rigorous criteria for authorization to bill the program, and use of private entities to provide accreditation or certification.

Mr. Chairman, this concludes my statement. I will be pleased to answer any questions.

APPENDIX I—RELATED GAO PRODUCTS

Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T–HEHS–95–174, May 24, 1995).

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/HEHS/T–95–157, May 16, 1995).

Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T–AIMD–95–133) and *Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse* (GAO/AIMD–95–135), both issued May 5, 1995.

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS–95–23, Mar. 30, 1995).

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T–HEHS–95–110, Mar. 22, 1995).

Medicare's Secondary Payer Program: Actions Needed to Realize Savings (GAO/T–HEHS–95–92, Feb. 23, 1995).

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T–HEHS–95–75, Feb. 6, 1995).

High-Risk Series: Medicare Claims (GAO/HR–95–8, Feb. 1995).

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tion of competitive bidding for laboratory services, and it was set to begin in 1987. That year and for several subsequent years, however, provisions were included in the respective budget reconciliation acts prohibiting its implementation. Eventually, HCFA abandoned plans for the demonstration, but has since requested authority to introduce competitive bidding without success.

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS–94–42, Apr. 28, 1994).
Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T–HEHS–94–124, Mar. 17, 1994).
Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS–94–35, Mar. 2, 1994).
Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD–94–79, Jan. 25, 1994).
Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T–HRD–94–59, Nov. 12, 1993).
Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (GAO/T–HRD–93–8, Mar. 8, 1993).
High-Risk Series: Medicare Claims (GAO/HR–93–6, Dec. 1992).

Mr. SHAYS. Mr. Mahon.

Mr. MAHON. Thank you, Mr. Chairman.

Mr. Chairman, in our written statement there is a great deal of detail, including a fact sheet that outlines the makeup of our organization, so I will be concise and summarize by saying——

Mr. SHAYS. Could I ask for the record, since I am, candidly, not very familiar with your organization, that you tell me who you represent? The providers?

Mr. MAHON. No, definitely not the providers, Mr. Chairman.

We are a 10-year-old private-public nonprofit organization that combines the private sector antifraud operations of commercial health insurers, Blue Cross and Blue Shield plans, self-funded corporations, with the public sector law enforcement resources who have jurisdiction to investigate and prosecute health care fraud. In recent years, we have also broadened our public-sector membership to include representatives of the Health Care Financing Administration. I would emphasize in this vein that although the Health and Human Services Inspector General and several other inspectors general and the Justice Department and others are represented on our organization's board, I don't in any way testify on their behalf.

Mr. SHAYS. Do you include Government officials, also State and local officials?

Mr. MAHON. Yes, representatives of—through their national organization, of the State Medicaid Fraud Control Units. Among our individual members, some 725, we have many State attorneys general, staff members, State insurance fraud bureau personnel.

Mr. SHAYS. So the bottom line is, what we are doing is right up your alley?

Mr. MAHON. Precisely. Our main mission, formally stated, is to improve the detection, investigation, and the civil and criminal prosecution, and as a by-product of all that, the prevention of health care fraud.

We do that through two principal areas of activity: one, cooperative education and training in the specifics of those aspects; second, very importantly, we act as a medium for the legally conducted sharing of investigative information, both between private insurers and law enforcement, but most importantly among private insurers. So that Company A has a means of legally learning that Company B is investigating Provider Smith and for what types of suspected fraud.

Mr. Chairman, I was first concerned when I saw the title of the hearing that our testimony might go somewhat beyond the scope

of what you are examining today, but I think, given all the discussion of legislation just introduced and prospective legislation, I hope my comments will be much in the mainstream.

I would like to limit my oral testimony to one principal area representing a view from the private sector which, as Mr. Ratner suggested, needs a strong voice in this discussion; and in keeping with your charge to Mr. Vladeck, I will be outspoken and hope that that is of service to the subcommittee.

Mr. Chairman——

Mr. SHAYS. Let me say for the record, I haven't heard anybody be outspoken yet.

Mr. MAHON. Well, it is subjective, I think I am, but I will let you be the judge.

I'd like to focus on several basic realities of health care fraud, which must be taken into account in any effort to address fraud against Medicare and Medicaid. One is that almost never do fraudulent providers defraud one payer at a time. The only smart way to commit health care fraud is to spread your activity among enough payers, so that you remain relatively inconspicuous with each one for the longest possible time. That has two effects. It makes detecting many of these schemes very difficult, and it has the effect of making big cases look like very small cases in the context of only one payer's claims exposure. What might be a $50,000 fraud against one company, may be the tip of a $2.5 million fraud involving 20 companies plus Medicare, plus CHAMPUS and Medicaid.

The second truism of the subject is that almost never do fraudulent providers defraud either the private or the public sector exclusively. If they do it to Medicare, to Medicaid, to CHAMPUS, they could it to employers health insurance, to Blue Cross and Blue Shield, and to Aetna and all the other private payers. You could take any 100 cases at random, and I would venture a guess that in 95 percent of those you're going to find fraud against both the private and the public programs.

In the cases that have been discussed earlier today, National Medical Enterprises and National Health Laboratories, there was enormous fraud committed against the private payers in addition to that for which the Government obtained settlements. When you're dealing with a problem of that nature, Mr. Chairman, the only logical way to approach it and the most effective way to approach it is through a concerted private-public effort that involves the sharing of investigative information and takes both sides of the equation into account.

One story that's not often told is that the private insurers have long had very aggressive and very active antifraud operations in place within many companies. Oftentimes, their operations have been hindered by legal constraints. They enjoy far less legal authority to pursue health care fraud than does the Federal and does the State government, and until recent years, law enforcement was very difficult to interest in criminally investigating or prosecuting health care fraud. As you've heard today, that has begun to change, very beneficially for all, in the last several years, but for many years the private sector was essentially a voice in the wilderness on this subject, with the exception of Medicare and Medicaid fraud.

We believe, Mr. Chairman, that in trying to address Medicare and Medicaid fraud, Congress and law enforcement have an obligation and an opportunity to do it most effectively by addressing both sides of the equation. My outspoken comment, if you will, is that if Congress feels it has addressed Medicare-Medicaid fraud, but does not go beyond that into private payer fraud, it is shortchanging itself, shortchanging the taxpayers, shortchanging all the people who pay for private health insurance in the country.

I think this implies two things. From a legislative standpoint, any legislative approach to health care fraud or to Medicare-Medicaid fraud that Congress might take must take the realities of the problem into account and must also follow the all-payer approach that has been at the heart of most of the health care fraud legislation introduced since 1992 on both sides of the aisle. That legislation essentially creates a Federal crime of health care fraud, it makes illegal against all payers, private and public, what is currently illegal only against Medicare and Medicaid; and essentially it would give the private sector a better legal foundation with which to approach the problem from its side of the fence.

I think, from a law enforcement standpoint, there are a number of practical steps that have to be taken in addressing the problem. To me, it implies taking the private-payer fraud into account in government prosecutions, settlements, compliance agreements, exclusions from Federal programs, and the penalties that are imposed, including the provision of restitution to victims. We think especially in health care fraud, as a white collar crime area, stiff penalties, heavy fines and jail time have a very beneficial deterrent effect on the people who perpetrate this.

Mr. Chairman, to put my comment in a positive vein, I think this spells a two-way benefit for the public sector. By taking this all-payer approach and by taking the private fraud into account in its cases, government can leverage every last ounce out of the tax dollars that are spent on these enforcement activities, to the benefit of the public.

At the same time, by better equipping the private payers to pursue this legally, government is going to realize a reciprocal benefit in terms of earlier detection and more effective investigation and assembly of evidence in cases where the same providers who are doing it to the private payer turn out to be doing it to Medicare and Medicaid. It is very much a two-way street, and that's at the heart of what our organization is and does.

If I may, Mr. Chairman, I would like to just offer an observation or two on some of these nuts-and-bolts matters, as I call them, that currently hinder private-public cooperation. Within the Medicare system, in the private insurance carriers who act as Medicare claims payers or intermediaries, you have a network of Medicare fraud and abuse information coordinators. Perhaps across the hall from those people, within the private insurance companies, you have the company's private side antifraud unit or special investigations unit. By law, the Medicare intermediary antifraud people cannot share case information with the private side of that insurance company's antifraud operations.

At the same time, the Inspector General's office publishes annually and updates periodically a list of all the providers sanctioned

from the Medicare program for fraud and for other related violations. They provide that as a public document, they provide copies to our organization on disk and on paper. However, it is equally problematic and illegal for them to provide taxpayer identification and/or social security numbers for those providers who are sanctioned. Those happen to be the pieces of information that render the information useful to private payers in screening their own dealings with those sanctioned providers. There are certain areas of the law like that that represent practical obstacles to a more efficient two-way public-private approach to this.

Finally, if I may offer one comment on the National Health Laboratories case, the $112.5 million settlement that has been discussed, there may have been some miscommunication back and forth this morning. My understanding is that as part of its plea agreement, National Health Laboratories was never charged with Medicare fraud. They agreed to plead guilty to defrauding several Medicaid and CHAMPUS programs, but I believe it is not the case certainly that the Justice Department was trying to impose any nonexclusion rule on the Health Care Financing Administration.

[The prepared statement of Mr. Mahon follows:]

PREPARED STATEMENT OF WILLIAM MAHON, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTIFRAUD ASSOCIATION

Mr. Chairman, Members of the Subcommittee: The National Health Care Anti-Fraud Association appreciates your invitation to testify today concerning the substantial problem of fraud against the Medicare and Medicaid programs and how it may be addressed more effectively.

As the accompanying Fact Sheet [APPENDIX I] indicates, NHCAA is a 10-year-old private-public non-profit organization that combines the anti-fraud operations of private-sector health care payers with those of the public-sector agencies responsible for investigating and prosecuting health care fraud.

Our mission is to improve the private and public sectors' detection, investigation, civil and criminal prosecution, and ultimately, prevention of health care fraud.

From the private sector, NHCAA numbers 65 commercial and not-for-profit insurers as Corporate Members. The public-sector members of the Association's governing board are:

- the Assistant Inspector General for Investigations and the Assistant Inspector General for Civil Fraud and Administrative Adjudication of the Office of Inspector General of the Department of Health and Human Services;
- the Assistant Inspector General for Investigations of the Department of Defense;
- the Deputy Chief Inspector for Criminal Investigations of the US Postal Inspection Service;
- the Senior Auditor in Charge of the US Office of Personnel Management;
- the Deputy Director of the Office of Medicare Benefits Administration in the Bureau of Program Operations of the Health Care Financing Administration; and
- the Medicaid Fraud Counsel of the National Association of Medicaid Fraud Control Units.

In addition, NHCAA maintains working "law enforcement liaison" relationships with officials of the Department of Justice, the FBI and the Criminal Investigation Division of the Internal Revenue Service.

We also number 725 individual members, from the ranks of health care insurers, third-party administrators, self-insured corporations and from a wide variety of other state and federal law enforcement organizations. As such, our membership constitutes the nation's body of experts who have long worked to curtail health care fraud and thus are intimately familiar with the dramatic effect of health care fraud on its victims and the health care payment system.

Internally, NHCAA pursues its mission through two principal areas of activity:

- cooperative education and training in the specifics of health care fraud detection, investigation, prosecution and prevention; and
- the sharing of information on convicted, indicted and, most important, suspected frauds—both among private insurers and between insurers and law enforcement agencies.

Externally, we serve as a resource for a wide variety of parties concerned with the nature, scope and impact of health care fraud and the development of more effective measures to combat the problem.

PRIMARY FOCUS IS ON FRAUD BY HEALTH CARE PROVIDERS

Although individual patients can and do commit or conspire in health care fraud, our principal focus as an organization is on health-insurance claims fraud committed by dishonest health care providers, because:

(1) it is health care providers who, if so-inclined, are equipped with all the tools needed to commit fraud on a broad scale and an ongoing basis; and

(2) it is fraud by dishonest providers that accounts for the overwhelming majority of the financial loss and that directly exploits the patient population, sometimes putting those patients at physical risk or even subjecting them to invasive procedures in the furtherance of fraud schemes.

ESTIMATED ANNUAL LOSSES TOTAL TENS OF BILLIONS

By its nature, the amount lost to any ongoing fraud can never be quantified to the exact dollar and thus must be estimated in an educated context. In that context, NHCAA estimates the loss to outright fraud at between 3% and perhaps as much as 10% of what we spend as a nation on health care each year.

In 1994 alone, then, when the Department of Commerce estimates that our health care expenditure totaled $1.006 trillion, that translated to a minimum loss to outright fraud of at least $30 billion—and in all likelihood substantially more, perhaps as much as $100 billion.

PRIVATE PAYERS ARE EQUALLY VICTIMIZED

Any discussion of health care fraud must also acknowledge the reality that the public's loss to health care fraud is two-fold.

According to 1993 figures from the Health Care Financing Administration, for example, most of the nation's total health care bill—57%—is paid with private-sector dollars (39% by private health plans and 18% by consumer out-of-pocket payments).

Especially because it is more risky for providers to defraud the government than private payers, there is every reason to believe that the private sector's loss to fraud is at least proportionately equal to, if not greater than, that of the Medicare, Medicaid and other government programs. In this context, the public is often being twice victimized—once through fraud against those tax-funded government programs, and again when private health insurance plans are the target.

TYPES OF FRAUDS ARE ALMOST LIMITLESS

Frauds by health care providers run the gamut, occurring virtually everywhere the opportunity exists, or can be created, to bill for a health care service:

- from individual providers who routinely and deliberately fabricate claims or bill for higher-priced services than the ones they actually provided;
- to medical equipment and home health businesses that target the Medicare program and private payers, often paying kickbacks to dishonest physicians who facilitate the fraud;
- to free-physical schemes such as "rolling lab" operations established solely as vehicles for committing diagnostic-testing fraud;
- to physicians and chiropractors who support false-injury claims as part of staged auto accident rings operating throughout the country;
- to local taxi companies that routinely pad or fabricate claims to state Medicaid programs for transporting Medicaid recipients to and from sites of medical care;
- to psychiatric-hospitalization schemes that masquerade as spa-like weight loss programs, falsifying victims' admission diagnoses and treatment information for false-billing purposes;
- to institutional frauds by hospitals, laboratories and clinics, all or part of whose basic business operation revolves around the systematic commission of fraud.

CASES ILLUSTRATE SCOPE OF PRIVATE-PUBLIC LOSS

What these various schemes have in common is the quite deliberate, and criminal, intention to defraud [see APPENDIX II, Guidelines to Health Care Fraud]. As such, they represent the actions of the small proportion of health care providers who are dishonest and, increasingly, of professional criminal entrepreneurs to whom the health care system is a highly vulnerable and thus appealing target. However, because health care is "where the money is" today, even a small minority can amass enormous amounts in fraud proceeds before their activities come to light.

The cases are legion of individual fraudulent providers whose fraud proceeds have totaled in the hundreds of thousands to several millions of dollars over relatively short periods of time—e.g., two to three years—prior to their detection.

In March of this year, for example, a La Jolla, California ophthalmologist was convicted of 132 counts of fraud and money laundering related to claims for medically unnecessary surgeries that prosecutors said defrauded the government and private payers of $16 million over the course of only four years. (Among other things, that physician deliberately distorted patients' vision-test results and, on that basis, advised them that without cataract surgery, they would fail to qualify for driver's-license renewal.)

At the other end of the spectrum, the so-called California Rolling Labs scheme, whose two principal perpetrators were sentenced last September to 22 and 20 years respectively, in federal prison, accounted for just under $1 billion in false claims against government programs and private insurers over a ten-year period.

In 1992, meanwhile, National Health Laboratories—a nationwide clinical-laboratory enterprise—pled guilty to criminally defrauding the United States and is paying penalties totaling $112.5 million; in 1994 National Medical Enterprises reached a similar settlement, totaling $379 million, with the United States following charges of widespread billing fraud on the part of many of its private psychiatric hospitals. In both cases, private payers had long been equal targets of the activities in question.

Although the primary financial victims of such frauds typically are private health insurers, employers and government programs, the cost of the crime obviously is ultimately manifested both in higher health insurance premiums and in higher taxes for individuals and employers—both of which have a direct impact on living standards and employee benefits.

In New Hampshire in 1991, for example, one of the state's largest employers—the Sturm, Ruger company—canceled its employees' prescription-drug benefit after the costs of the benefit increased so dramatically as to force the company to raise the employee's prescription co-payment from $3 to $20.

Only later was it discovered that a Newport, NH pharmacist had defrauded that and other prescription plans—as well as the state Medicaid program—for a total of $373,278 between April 1989 and July 1991. (That pharmacist subsequently pled guilty to billing more than 1,200 times for prescriptions that he did not dispense and is serving six sentences of 7 to 14 years each in New Hampshire state prison.)

ANTI-FRAUD APPROACHES MUST GO BEYOND MEDICARE/MEDICAID

All of these case examples also illustrate several fundamental realities, which MUST be taken into account in addressing Medicare and Medicaid fraud:

(1) *Almost never do dishonest providers defraud only one payer at a time.* Logic dictates that the safest approach (and the most lucrative) is to defraud multiple payers simultaneously in less conspicuous increments—the better to avoid or at least prolong detection by any one of those payers;

(2) *Almost never do dishonest providers defraud either the private or the public sector exclusively.* The provider who defrauds Medicare, Medicaid and other government programs in all likelihood is defrauding private insurers, and vice-versa. Experience has also shown that fraudulent providers who are simply barred from billing Medicare and Medicaid rarely stop committing fraud. Rather, they tend to compensate by intensifying their fraud against private payers; and

(3) *That multiple-target, private-public fraud can be addressed most effectively through concerted private-public efforts*—both in general and at the level of individual cases.

At the same time, many private insurers have long maintained aggressive and effective anti-fraud operations—in the face of still-significant legal constraints and, until recent years, in a law-enforcement environment where health care fraud was not the priority that it is today.

In this context, government has both an obligation and an opportunity to maximize the public benefit of any new legislative and/or enforcement measures by aiming those measures not simply at Medicare and Medicaid fraud, but also at fraud against private payers.

From a legislative standpoint, this suggests following the so-called "all-payer" approach featured in virtually all of the legislative proposals on health care fraud, many of them bipartisan, set forth since 1992—the essence of which is:

- to create a federal crime of health care fraud, encompassing actions against private and public third-party payers;
- to make illegal in dealings with private and other government payers what today is illegal only in dealings with the Medicare and Medicaid programs;

• to effectively bar providers guilty of fraud from dealings with any health insurance plan, private or public; and

• to coordinate the activities of federal and state law enforcement agencies and to provide for their coordination of activity with private payers.

[See APPENDIX III, Maximizing Private-Public Cooperation in Fighting Health Care Fraud.]

From the law enforcement standpoint, it suggests taking private-payer fraud into account in government-program fraud prosecutions, settlements, compliance agreements and penalties—including restitution to victims. In this context, we believe that the imposition of stiff penalties on the guilty parties—individual or corporate will have a significant deterrent effect.

By taking this approach, government can:

(1) effectively maximize the public-protection impact of every tax dollar spent on public-program enforcement activities, and

(2) realize a reciprocal benefit, by virtue of earlier private-sector detection and more effective investigation and prosecution of providers who are also victimizing publicly funded programs.

DETECTION IS DIFFICULT & INCREASINGLY TECHNOLOGY-DEPENDENT

As a general observation, health care fraud represents the efforts of a small proportion of providers to defraud a huge, diversified and changing system that rests on an assumption of honesty and thus is designed to pay health care claims efficiently and—often by statute—faster than ever before. In that context, private and public claims payers are being called on both to pay claims faster and faster, AND to put a stop to fraud in the system—two demands that are not easily reconciled.

Putting a stop to a given fraud means (1) detecting it through one or more of the various means employed for that purpose; (2) investigating it properly with regard for appropriate procedures; (3) in the private sector, involving law enforcement and prosecutorial authorities at the appropriate stage; and (4) in the case of prosecutions, proving the case.

Detecting most fraud is itself no easy matter, because taken at face value, any one fraudulent claim may appear perfectly legitimate. Generally, it is only when fraudulent claims are pieced into a given pattern, or when the payer's attention is otherwise called to them, that they become suspect.

In addition to relying on shared investigative information from other payers, private payers today increasingly are applying computer-based analysis of provider-behavior versus pre-established norms. While these new "fraud-detection" systems generally do not discretely identify a given claim as fraudulent, they can be highly effective in identifying providers whose billing behavior clearly warrants scrutiny.

MANAGED CARE DOES NOT INHERENTLY PRECLUDE FRAUD

Any discussion of health care fraud and of proposed new countermeasures must also recognize that both government and private health care plans are evolving toward more and more types of "managed care" delivery and financing methods.

We can be sure, however, that wherever more than $1 trillion continues to change hands annually, some will always try to steal from the system. Contrary to many initial impressions, that is as true in managed care as it has been in the indemnity, or fee-for-service, environment.

In 1994, a special NHCAA Task Force performed the first broad-based analysis of the anti-fraud implications of managed vs. fee-for-service health care provision.

Among the conclusions that the Task Force reported:

• The nature of fraud is altered by some managed care models, but managed care does not inherently eliminate incentives and opportunities to commit fraud.

• Whereas in fee-for-service medicine, the dishonest provider's incentive is to do more (or claim to have done more) in order to bill and be paid more, under so-called "capitated" provider-payment plans, the dishonest provider's incentive is to provide less treatment than the patient requires in exchange for the fixed capitation payment.

• Whereas dishonest fee-for-service providers falsify claims, dishonest managed-care providers will falsify reports of patient encounters, treatment outcomes and treatment costs in efforts (1) to disguise undertreatment and (2) to artificially inflate the amounts of future capitation payments.

• Few plans represent "pure" managed care: In almost all managed-care models, many services and patient options are not covered by fixed prepayments but rather are billed and paid on a fee-for-service basis—meaning that payers will still encounter all of today's familiar frauds while having to deal with new frauds spawned by managed-care structures.

• Detecting and investigating managed-care fraud are far more challenging, and they require (1) a sophisticated understanding of the contractual agreements with providers, the financial workings and the nature of providers' financial risk in any given managed care plan; and (2) far greater reliance on analysis of data pertaining to treatment outcomes and costs in given plans.

Meanwhile, as government places more and more emphasis on converting Medicare and Medicaid to more managed care-oriented programs, there is cause for significant concern related to various states' conversion of their Medicaid programs from fee-for-service to private health maintenance organizations (HMOs).

Specifically, in their zeal to place as many Medicaid recipients as possible into private HMOs—where competing HMOs will receive capitation payments from the state for each person they enroll—the states must carefully guard against false enrollments designed only to trigger those capitation payments, partly by paying close attention to the marketing efforts that those HMOs undertake in pursuit of the states' maximum-enrollment objectives.

For example, based on its experience to date, Florida is in the process of creating tighter restrictions on Medicaid HMOs' marketing activities and commissions and has notified one such HMO that it will not renew its Medicaid contract due in part to "fraudulent enrollment of over 1,200 of your members, resulting in hundreds of thousands of dollars on contract overpayments."

In Tennessee, investigators uncovered cases of numerous false enrollments in the state's Medicaid managed care program, TennCare. One individual there was recently indicted for falsely enrolling some 200 state prison inmates, whose health care is already covered through the state prison system. In another case, state investigators discovered forged enrollments of 75 Saturn automobile employees. In both cases, the objective of the fraud was to start the flow of per-head payments from the TennCare program.

As recently as this week, meanwhile, the Maryland Attorney General announced that 16 Medicaid-HMO sales representatives and 8 social-service workers have been charged with bribery or forgery related to the sale of Medicaid recipients' names for purposes of door-to-door enrollment solicitation by commission-based HMO representatives. Five of those defendants reportedly have entered guilty pleas.

In citing these examples, by no means is NHCAA is arguing against managed care, which plays an increasingly central role in government and in the health insurance industry. Rather, we are simply cautioning that managed care is not a panacea for health care fraud, and that the private and public sectors can ill afford to let down their guard in the managed-care environment.

ELECTRONIC CLAIMS SYSTEMS MUST BE DESIGNED WITH FRAUD IN MIND

Similarly, the private and public health care payment systems are evolving more and more toward a "paperless" electronic-claims environment, which when universally achieved will yield significant efficiencies and savings in administrative costs—estimated at several billions of dollars each year.

Like managed care, the evolution toward so-called electronic data interchange, or EDI, is a fact of life in health insurance operations; and just as in managed care, its implications for the detection, investigation and prosecution of fraud demand careful examination.

Certain of those implications are immediately apparent. For example, the loss of physical scrutiny by experienced human claims processors, and the loss of the "paper trail" and familiar physical evidence used to investigate and prove most fraud cases.

We must also realize that the speed and efficiencies of electronic claims processing will be enjoyed by honest and dishonest providers alike—increasing payers' vulnerability to "big scores" by criminal entrepreneurs who drop from sight with the fraud proceeds long before payers know they have been victimized by computer.

By their nature, EDI systems also necessitate the linking of payers' internal computer systems with many other systems in the "outside world"—increasing their vulnerability to such schemes as claims diversion and the creation of phony provider accounts by criminal computer hackers.

Fraudulent providers also may view the electronic claims environment as being more conducive to the commission of fraud by virtue of the ease and perceived anonymity of carrying out the crime at the touch of a button.

In the long run, an all-electronic claims environment should be conducive to more effective detection of claims fraud by virtue of its broader and deeper bodies of standardized data, within which patterns suggestive of fraud might be more readily seen—but only if:

• fraud detection is taken into account and appropriate technical safeguards are incorporated in the design and implementation stages of electronic claims systems;
• in their electronic filing agreements with providers, payers ensure (1) that providers assume responsibility for all claims filed on their behalf, and (2) that providers maintain all original paper documentation related to those claims and make it available for examination by payers upon request;
• federal and state anti-fraud laws keep pace with the health care system's technological evolution, so as not to leave legal loopholes for electronic claims fraud; and
• health care fraud investigators and prosecutors develop the thorough working knowledge needed to detect and prove electronic-claims cases.

Another NHCAA Task Force is conducting an in-depth examination of EDI's impact on health care fraud and will publish a formal report this month, at which time we will be happy to share its findings with members of this Subcommittee.

Again, Mr. Chairman, we appreciate your invitation to offer our perspective today, and we firmly believe that Medicare and Medicaid fraud—and thus the public interest—can best be addressed through a well-rounded public-private approach that reflects the realities of our overall health care fraud problem.

We hope that our comments have been useful, and we look forward to assisting you and the Subcommittee in your ongoing efforts.

APPENDIX I—NHCAA FACT SHEET

Founded in 1985 by several private health insurers and federal/state law enforcement officials, the National Health Care Anti-Fraud Association (NHCAA) is a unique, issue-based organization comprising private-and public-sector individuals and organizations responsible for the detection, investigation, and prosecution of health care fraud.

MISSION STATEMENT

Purpose: To improve the detection, investigation, civil and criminal prosecution, and prevention of health care fraud.

Goals:

• Establish and maintain a pro-active stance in the fight against health care fraud.
• Conduct national seminars to educate the public and private sectors in effective methods of combatting health care fraud.
• Expand the investigative capabilities of health care reimbursement organizations through education in the detection, investigation, prosecution, and prevention of health care fraud.
• Provide an information-sharing network, with appropriate safeguards, to aid in the investigation of health care fraud.
• Assist law enforcement agencies in their investigation and prosecution of health care fraud.

ANNUAL TRAINING CONFERENCE

Each year, NHCAA conducts a 3-day educational conference featuring training workshops on a wide variety of anti-fraud topics and addresses by prominent leaders in the field. Future Annual Training Conferences are scheduled as follows:

1995: November 12–15 Marriott Hotel—Marco Island, Florida
1996: November 20–23 Marriott World Center—Orlando, Florida

MEMBERSHIP

Corporate Membership is open to private for-profitor not-for-profit health care reimbursement organizations approved for membership by the NHCAA Board of Governors. Individual Membership is open to persons occupying managerial, supervisory or professional positions in such reimbursement organizations; in local, state or federal law enforcement, prosecutorial or regulatory agencies; or in professional associations or professional disciplinary organizations approved for membership by the Board of Governors.

PRIVATE SECTOR

Founding Corporate Members

Aetna Life & Casualty; CIGNA; Employers Health Insurance; The Guardian; METLIFE; The Mutual of Omaha Companies; Pennsylvania Blue Shield; The Travelers Companies

Corporate Members

Allianz Life Ins. Co. of North America; Allmenca Financial; American Republic Insurance; Arkansas Blue Cross/Blue Shield; Blue Cross/Blue Shield Association; Blue Cross/Blue Shield of Connecticut; Blue Cross/Blue Shield of Florida; Blue Cross/Blue Sheld of Georgia; Blue Cross/Blue Shield of Illinois; Blue Cross/Blue Shield of Louisiana; Blue Cross/Blue Shield of Maryland; Blue Cross/Blue Shield of the National Capital Area; Blue Cross/Blue Shield of New Hampshire; Blue Cross/Blue Shield of New Jersey; Blue Cross/Blue Shield of the Rochester Area; Blue Cross/Blue Shield of Texas; Blue Cross of California; Blue Cross of Washington & Alaska; Blue Cross of Western Pennsylvania; Blue Shield of California; CalFarm Life Insurance Co.; Central States Health & Welfare Fund; Chubb LifeAmerica; Community Mutual Blue Cross/Blue Shield; Delta Dental Plan of California; Delta Dental Plan of Michigan; Empire Blue Cross/Blue Shield; Federated Mutual Insurance; Foundation Health Federal Services; General American Life; Golden Rule Insurance Company; The Hartford Life & Accident; Hawaii Medical Service Association; Home Life Financial Assurance; Humana, Inc.; Independence Blue Cross; Jefferson-Pilot Life Insurance Co.; John Deere Health Care; King County Medical Blue Shield; Massachusetts Mutual Life; The Mutual Group; National Travelers Life Co.; New York Life Insurance Co.; North American Benefits Network, Inc.; Northwestern National Life; Phoenix Home Life; Physicians Health Services; Pioneer Life Insurance Co.; Principal Financial Group; The Prudential; Time Insurance Co.; Trigon Blue Cross/Blue Shield; Trustmark Insurance Co.; The United States Life Insurance Co.; Washington National Insurance Co.; WEA Insurance Group; WellPoint Health Network; Wisconsin Physicians Service

PUBLIC SECTOR

Agencies represented on NHCAA Board of Governors

National Assn. of Medicaid Fraud Control Units; US Dept of Defense, Office of Inspector General; US Dept of Health & Human Services—Health Care Financing Administration, Office of Inspector General; US Postal Inspection Service; US Office of Personnel Management, Office of Inspector General

Agencies represented by Law Enforcement Liasons

US Department of Justice; Federal Bureau of Investigation; US Department of Treasury—Internal Revenue Service, Criminal Investigation

INDIVIDUAL MEMBERS

NHCAA has more than 700 individual members from private insurance carriers, not-for-profit health insurance plans, health care reimbursement organizations, and state and federal law enforcement and regulatory agencies.

HEALTH BENEFITS PAID

In 1993 NHCAA Corporate Members accounted for an estimated $110 billion in private-sector group and individual health benefits paid, not including benefits paid on behalf of self-insured or government programs.

APPENDIX II—GUIDELINES TO HEALTH CARE FRAUD*

Health care fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party.

The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are almost invariably criminal, although the specific nature or degree of the criminal acts may vary from state to state.

The variety of fraudulent reimbursement and billing practices in the health care area is potentially infinite. The most common fraudulent acts include, but are not limited to:

1. Billing for services, procedures and/or supplies that were not provided.
2. The intentional misrepresentation of any of the following for purposes of manipulating the benefits payable:
   a. The nature of services, procedures and/or supplies provided;
   b. The dates on which the services and/or treatments were rendered:

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*Adopted by the NHCAA Board of Governors November 19, 1991.

c. The medical record of service and/or treatment provided;
d. The condition treated or diagnosis made;
e. The charges or reimbursement for services, procedures, and/or supplies provided;
f. The identity of the provider or the recipient of services, procedures and/or supplies.

3. The deliberate performance of unwarranted/non-medically necessary services for the purpose of financial gain.

APPENDIX III—MAXIMIZING PRIVATE-PUBLIC COOPERATION IN FIGHTING HEALTH CARE FRAUD

NHCAA is a public/private cooperative organization whose goal is to aid cooperation between the private sector and public law enforcement in fraud investigations and to strengthen the combined forces deployed against health care fraud. In response to numerous requests from federal and state government agencies and legislative bodies, NHCAA outlines the accompanying principles and policy options to strengthen the private sector's anti-fraud capability.

The legal environment in which the private sector operates today constrains the ability of the private sector to fight fraud. When insurers or other private parties participate in the investigation of criminal fraud, whether on their own initiative or in cooperation with law enforcement officials, they risk civil liability (e.g., defamation, invasion of privacy, malicious prosecution) to the targets of these investigations—typically affluent, sophisticated health care practitioners whose entire livelihood may be in jeopardy. This threat discourages some private payors from active anti-fraud programs. While the members of NHCM generally are prepared to run these risks, they too are troubled by their unfair jeopardy in conducting good-faith fraud-fighting activities.

In addition, both the criminal and civil processes constrain insurers' ability to recover the proceeds of fraud. Insurers and other third-party payors properly look to the availability of legal relief for both its deterrent effect and its opportunities for financial recoupment. Both deterrence and cash recoveries help control the cost of health care. In the criminal process, insurers and third-party payors support (1) continued broad restitution, (2) participation by third party payors as victims at early stages of criminal prosecutions and (3) efforts to increase awareness by prosecutors and judges of the importance of restitution. These steps will benefit not merely insurers, but, by extension, consumers, who ultimately bear the burden of fraud.

Private payors also see civil litigation as an important source of financial relief. However, many state common-law civil actions are of limited viability against the complex, multi-state schemes that are prevalent today. Moreover, in situations where assets are limited or disappear, or where substantial assets may be forfeited to the government, successful civil claimants may nominally prevail at the end of a long road only to find that no significant recovery is available. Therefore, while existing civil remedies are often useful, the ability of insurers and other private payors to recover the proceeds of fraud needs to be strengthened.

To combat these problems, the following policy options should be evaluated:

- continued mandatory restitution as part of the criminal process to insurers and other reimbursement organizations that have paid fraudulent health care claims;
- uniform federal legal protection from tort liability for good-faith participation in fraud investigations and in the sharing of information intended to aid in such investigations; and
- a federal civil cause of action, modeled on the federal False Claims Act, that will allow the private sector an effective means of recovering the proceeds of fraud.

These policy options, along with the general acknowledgment of the private sector's ability and willingness to fight health care fraud more effectively, represent potentially very positive steps in effecting the concerted effort required to stem this very significant crime problem.

I. PRIVATE PARTIES SHOULD BE ENCOURAGED TO PROSECUTE HEALTH CARE FRAUD

Legal action against perpetrators of health care fraud promotes two important goals: It deters future fraud and it allows the victims to recoup their losses to the detriment of the perpetrators. Private payors play a vital role in the detection and prosecution of health care fraud. Because the private sector accounts for nearly 60% of health care payments, private payors are often the primary target of sophisticated defrauders. Insurers and other private payors provide important detection and investigative resources to fight fraud and, therefore, should be encouraged to fight fraud aggressively, rather than remain disadvantaged by today's legal environment.

A. Problems With The Current Situation

1. Restitution: Under federal law (The Victim and Witness Protection Act), restitution is available to all victims of fraud, including the government, individuals, and private insurers. The problem: Some current legislative proposals would make restitution mandatory in the case of health care fraud only if the victim is the government or an individual. If the victim is a private insurer (and ultimately the premium-paying consumer), restitution would be "discretionary."

2. Civil Litigation: The Federal False Claims Act is a powerful force against the perpetrators of health care fraud. It provides a minimum penalty of $5,000 per claim in addition to recovery of damages. The problem: Only the government can use it, in relation to government claims. There is no comparable or equally effective recovery alternative available to the private sector for large scale fraud schemes.

B. Policy Options

1. Restitution: Denying mandatory restitution to private third-party payors makes no sense. Private losses, which ultimately add to the overall costs of health care, are paid for indirectly by all health care consumers, just as are losses suffered by the government. The solution: All victims, including private third-party payors, should receive fair treatment when the government distributes assets seized from health care criminals. Furthermore, restitution laws should not discriminate among classes of victims when it comes to mandatory repayment of fraud proceeds.

2. Civil Litigation: A federal false claims act applied to private claims would make health care fraud less profitable for its perpetrators, would help to shift the potential losses from fraud away from the health care system and onto the fraud perpetrators and would provide private payors with an effective means of recovering the proceeds of fraud. Such activity also would make federal investigations more potent by allowing the government to pursue claims involving all victims. The solution: If a statute modeled on the Federal False Claims Act applied to private claims, both private insurers and the government could pursue fraud involving private payors. To be effective, that extension would include important procedural elements such as nationwide service of process, a statute of limitations running from the discovery of the fraudulent act and covering the full reach of a fraudulent scheme, and an ability for insurers and other third-party payors to sue on behalf of plans for which they act as claims administrators.

II. PRIVATE PARTIES SHOULD BE PROTECTED FROM LIABILITY FOR GOOD FAITH PARTICIPATION IN FRAUD INVESTIGATIONS

Public policy strongly supports the participation of private parties in law enforcement investigations. The law protects individual rights, but balances this protection by encouraging reasonable private participation in the investigation and prosecution of crime. All citizens have a duty to communicate information on crime to the proper officials. In the health care area, private insurers and other third-party payors play a prominent role in many fraud investigations, through initiation of an investigation or cooperation with law enforcement officials in active investigations.

Because fraud is hard to detect and often harder to prove, many perfectly proper investigations do not result in convictions. The targets of those investigations routinely sue (or threaten to sue) the private third-party payor that scrutinized them. This threat discourages some insurers from active anti-fraud programs. An insurer faces heavy financial burdens both in defending lawsuits, even when the insurer eventually prevails, and through the limited (but very real) risk of substantial open-ended punitive damage awards.

A. Problems With The Current Situation—Immunity

1. Immunity: Those engaged in health care fraud typically target a broad range of victims, including the government, private individuals, insurers and other third-party payors across the country. Because there are multiple victims of most fraud schemes, and this fraud may not be detectable except by reviewing claims submitted to multiple payors, fraud cases are most effectively detected and investigated through group activity, by cooperative sharing of information among private payors and with law enforcement.

The need for a concerted anti-fraud effort involving the sharing of information among private payors and with law enforcement is being widely acknowledged. However, while many states provide some immunity protection for those engaging in good faith fraud investigations, this protection varies tremendously by state; many states have no immunity statute. There is no uniform federal immunity provision.

The problem: This piecemeal state legislation simply does not protect insurers and other payors in many states or in multi-state investigations. Where immunity pro-

tection is not available or effective, private payors understandably may be reluctant to fully participate in fraud investigations or to share information on these investigations with others who may be targets of the same or similar schemes.

B. Policy Option

Because most fraud investigations cross state lines and therefore affect interstate commerce, immunity protection could be standardized at the federal level, so that private payors can prudently participate across the country in fraud investigations. The operating premise would be that good-faith activities undertaken in support of health care fraud investigations should not be the basis for liability.

Therefore, Congress should consider enacting an immunity statute that would immunize private payors' good-faith efforts to fight fraud and provide immunity from state tort liability. Such a statute would preempt the inconsistent, vague and often ill-considered state law jeopardy faced by insurers and other payors (much as ERISA preempts various state remedial schemes constraining employee benefit plans) and would create a standardized and effective tool to encourage fraud fighting.

Like many state statutes, this immunity protection would not be absolute, and reasonably would be limited to those investigations conducted with good faith or the absence of malice. However, to make this protection effective, Congress should consider the addition of a provision, modeled on Rule 9(b) of the Federal Rules of Civil Procedure, that requires a person to plead with specificity the facts that constitute malice or bad faith in order to invoke this exception to immunity. Unless these facts could be reasonably asserted, insurers and other private payors would be protected from potential liability across the country for their good-faith participation in fraud investigations.—(Adopted August, 1993)

Mr. SHAYS. Hold on a second. What is your bottom line point?

Mr. MAHON. Bottom line point, the National Health Laboratories case subjected private payers to tens and tens of millions of dollars of fraud for the very same activity with which the Government settled criminally——

Mr. SHAYS. Right.

Mr. MAHON [continuing]. In that case.

Mr. SHAYS. So what's the bottom line?

Mr. MAHON. The bottom line was that the private payers' reaction to the settlement and to the fact that no private fraud was taken into account was that National Health Laboratories was very much allowed to stay in business and to do business with Medicare and other government agencies with no consideration given to the fact that this was not just fraud against the government programs, it was victimizing the public through all of the private payers.

Mr. SHAYS. OK. I understand that, but what was the miscommunication? I mean, that's an extraordinarily valid point, but what was the miscommunication that you thought happened earlier?

Mr. MAHON. My understanding is that as the case played out, it was not the case that the Justice Department imposed on the Health Care Financing Administration an agreement through which NHL would not be barred from Medicare, but rather that in the process of bringing the charges, the agreement was made not to charge them with Medicare fraud in the first place. I don't think it was an after-the-fact situation imposed on HCFA.

Mr. SHAYS. What does that mean?

Mr. MAHON. I think I was just trying to offer that as a clarification, Mr. Chairman. It's not central to the point I made.

Mr. SHAYS. OK. You made so many other pertinent points, I thought that was a big point in this. I'm sorry.

Mr. MAHON. Perhaps I was being incorrectly outspoken there. I think the point in that case, Mr. Chairman, there was a strong re-

action from the private sector to the nonexclusion, and in fairness to the prosecute—the prosecutor who handled the case is an outstanding government prosecutor, and I think it was partly a practical matter of the government saying, this is the best agreement we can reach in this particular case.

Mr. SHAYS. I would assume that they think it's the best settlement they can get, based on the evidence.

But it seems as if the leadership is saying money is more important than exclusion. Maybe, maybe not getting as much money, but putting people out of business so others say, "My God, you know, we're going to go out of business" would have been a better tactic.

Mr. MAHON. Oh, I agree entirely, Mr. Chairman. In that case, the conventional wisdom was that a Medicare exclusion would have been an effective death sentence for the company, given that it had so much Medicare business.

Mr. SHAYS. It would have.

Mr. SHAYS. Earlier, we were told that in response to exclusion, companies would just go back in business. I am not quite sure that it's as easy as that, but I don't have the information to refute it.

Mr. BARRETT. Do you agree with the assessment from the previous panel that that would have been a meaningless sanction?

Mr. MAHON. I don't know, Mr. Barrett. I wasn't privy to the ins and outs of the settlement.

Mr. SHAYS. The question is, if you take away their billing number, will they be in business the next day under another name?

Mr. MAHON. It's possible, it's certainly conceivable, as Mrs. Boyd suggested. It can happen and has happened, and it requires careful policing. What concerned me most, at the time, Mr. Chairman, there was a secondary or an implication that there was a by-product consideration that excluding them from Medicare would somehow jeopardize the jobs of several hundred people who worked for that particular company, to which the reaction of the private payers was, is that the government's problem to be concerned about? Isn't that more the problem of the company that committed the fraud?

Mr. SHAYS. But as soon as the comment was made that they'll be right back in business, it became clear that that's not really a consideration. I believe that part of the justification may be that they don't want to put people out of work. But since the business still has to be done, it just means another company that's honest will get the business.

The bottom line is that you're having to do business with companies that are crooked, and I want to know what the Government is doing to prevent that from happening

I'd like the panel to stay, and I'm going to come back because this is very interesting.

Mr. Noble, you've been so patient. Thank you. We'll try to get your testimony done before we go to vote.

Mr. NOBLE. Thank you, Mr. Chairman, members of the subcommittee. Thank you for the opportunity to appear before you today to discuss Medicaid fraud and abuse. As Inspector General of the Florida agency for health care administration, I have the responsibility to ensure accountability, integrity and efficiency in programs of the agency. Medicaid program integrity is one of the func-

tions that I oversee. The Medicaid program integrity unit is an audit arm of Medicaid, charged with responsibility of deterring, detecting and dealing with fraud and abuse.

We must note that of Florida's total estimated Medicaid expenditures this year of approximately $6.1 billion, more than 60 percent of those payments are to institutional facilities, primarily nursing homes and hospitals, and also payments to the Federal Government under the Medicare program. All hospitals are audited annually, and nursing homes are audited at least once every 3 years. Our audit program in these facilities is a significant deterrent against fraud and abuse. We feel that our more significant problems exist in the noninstitutional settings, and with providers that are not otherwise closely regulated.

A number of initiatives have been implemented in Florida over the past several years to enhance the war against Medicaid fraud and abuse. No. 1, several years ago the legislature appropriated new positions, doubling our resources for investigations, computer system support, and legal support. We've opened an office in the Miami area which covers the south Florida area; our Medicaid fraud control unit has been transferred from the auditor general's office to the attorney general's office; the State has enacted a false claims act very similar to the Federal False Claims Act; we have instituted a very intensive prepayment review process; and we have begun working very closely with the Federal false claims task forces that are chaired by the U.S. attorneys.

We have also proposed State legislation to enhance our law in fraud and abuse. This legislation emphasizes avoiding payments of public moneys to abusive providers, cutting off the flow of Medicaid time—Medicaid dollars timely, upon discovery of the suspected illegal action, and imposing greater civil penalties and administrative sanctions.

Our focus must be through strategies of prevention, early detection, and expeditious applications of penalties. We feel that the Operation Restore Trust, recently announced, presents an opportunity for us all to focus on combined—on the use of combining our resources on fraud and abuse.

One of the major issues that you want to address here today deals with ways to keep providers who have been convicted of defrauding the system, or who are consistent abusers, from continuing to bill the government. We feel like—we feel that the heart of this problem lies in the provider enrollment process. One of the—currently, a provider submits an application containing, among other things, the provider's name, address, social security number, Federal tax ID, proof of a valid license and other information regarding the provider's articles of incorporation, principal owners, past criminal convictions, disciplinary actions, and Medicare or Medicaid exclusions or terminations. A corporation enrolling in the program must identify all owners with 5 percent or more principal interest in the business.

In Florida, we have recently undertaken the task of reviewing the entire enrollment process, and also substantially revising our Medicaid provider agreements with noninstitutional providers. The chief purpose in changing the provider agreement is to better protect the program from fraudulent and abusive providers from be-

coming enrolled. Some of the changes that the agency is considering include requiring all persons with a 5 percent or greater ownership or control interest in the entity to be jointly and severally liable with the provider for any payment, any overpayments or fines imposed; requiring a bond or a letter of credit for certain provider groups; a provision whereby the provider expressly agrees that there's no property right in and to a Medicaid provider number; a provision whereby the provider agrees that the agency will have jurisdiction to resolve all matters other than those in equity through informal hearing; a requirement of all providers to submit an affidavit under penalty of perjury swearing that they will not provide fraudulent claims. Such a provider—should a provider submit such an affidavit and subsequently file a fraudulent claim, they could be convicted of perjury, which is a third degree penalty, punishable in Florida by 5 years——

Mr. SHAYS. Can I ask you what page you are on in your statement? I just wanted to mark something.

Mr. NOBLE. I'm reading, I have a summarized version. I can——

Mr. SHAYS. Oh, this is a summary statement?

Mr. NOBLE. Yes, sir.

Mr. SHAYS. I just want to make sure I note those points.

Mr. NOBLE. It's in the latter part of the prepared—the written testimony, I believe.

Mr. SHAYS. We'll find it. I'm sorry, I didn't realize you were reading from a summary.

Mr. NOBLE. Page 11, I believe.

Mr. SHAYS. OK, thank you.

You may continue.

Mr. NOBLE. OK. The agency would recommend these changes to provider agreements also be put in Federal law or regulation as appropriate, so as to create a uniformity among the States and to eliminate liability loopholes for corporations enrolling as providers.

Thank you again, Mr. Chairman. That is a brief summary of my written statement. I will be happy to respond to any questions.

[The prepared statement of Mr. Noble follows:]

PREPARED STATEMENT OF RUFUS NOBLE, INSPECTOR GENERAL, HEALTH CARE ADMINISTRATION, STATE OF FLORIDA

INTRODUCTION

Good Morning Mr. Chairman, Members of the Committee: Thank you for the opportunity to appear before you today to discuss Medicaid fraud and abuse. As Inspector General of the Florida Agency for Health Care Administration, I have the responsibility to ensure accountability, integrity and efficiency in programs of the agency. The agency is working to ensure that all Floridians have access to affordable, quality health care services.

MEDICAID PROGRAM INTEGRITY

Medicaid Program Integrity is one of the functions that I oversee. The Medicaid Program Integrity organizational unit is an audit arm of Medicaid charged with the responsibility of deterring, detecting and dealing with fraud and abuse. We conduct audits and investigations, initiate recovery of any overpayments, apply administrative sanctions to providers when warranted, and refer providers to other agencies. This includes referrals of cases of suspected fraud to the Medicaid Fraud Control Unit in the Office of the Attorney General for full-scale criminal investigation.

Program integrity functions include detection, professional review, utilization review, provider audit and preliminary criminal investigations. Program Integrity has

developed and placed into operation advanced computer-based detection and auditing methods.

Notwithstanding these methods, providers from whom overpayments are sought or to whom sanctions (including fines, suspensions or terminations) are applied, must be dealt with one by one. Each action must be taken carefully and each provider must be afforded the opportunity of a hearing.

FRAUD AND ABUSE IN MEDICAID

Medicaid, like other third party payers, is susceptible to fraudulent and abusive practices by providers. Many persons involved with Medicaid in the federal government and in state governments have provided estimates of the extent of fraud and abuse in Medicaid nationally and in individual states. Since it is not possible to measure, except inferentially, something that has not been detected, those estimates are approximations based on experience with fraud and abuse that has been found.

We must note that of Florida's total estimated Medicaid services expenditures this year of $6.1 billion, more than 60 percent are payments to institutional facilities (nursing homes and hospitals) and payments to the federal government under the Medicare program. All hospitals are audited annually and nursing homes are audited at least once every 3 years. Our audit program in these facilities is a significant deterrent against fraud and abuse. We feel that our more significant problems exist in the non-institutional settings and with providers who are not licensed or otherwise regulated.

BARRIERS TO COMBATING FRAUD AND ABUSE

Weaknesses in existing laws hinder efforts to control health care fraud and abuse. Providers can receive a billing number, steal substantial amounts of money, declare bankruptcy, and reopen. Even when the state suspects that a provider has committed fraud or abuse, current state law requires that costly reimbursements continue until there has been a finding of fraud or abuse.

Despite the diverse sources of information found in data bases within state, federal and private organizations, there are many instances where agencies and private participants are prohibited from sharing that information, especially for ongoing investigations and litigation. Earlier detection through information sharing could reduce health care expenditures dispersed to the perpetrator of fraud, and could reduce the costs of investigations leading to prosecution. There are, however, various technical, risk management, legal and ownership barriers to sharing data which must be addressed. There remains tremendous need to improve coordination among the various organizations that have responsibilities for identifying, investigating, and prosecuting health care fraud and abuse. While some intergovernmental coordination and information sharing among public and private organizations occurs, more could be done. At the federal level, the Justice Department, the Postal Service, the Drug Enforcement Agency, the Food and Drug Administration, and the Department of Health and Human Services all have related investigatory responsibilities.

At the state level the participants include the Agency for Health Care Administration, the Department of Legal Affairs, the Department of Insurance, the Department of Elder Affairs, the Department of Banking and Finance, the Department of Business and Professional Regulation, the Department of Labor and Employment Security, and the Department of Law Enforcement Improved coordination and cooperation among the various players would enhance the ability to tackle the problem.

INITIATIVES IMPLEMENTED IN FLORIDA TO ENHANCE THE WAR AGAINST MEDICAID FRAUD AND ABUSE

Within the past several years in Florida, we have:

- Expanded twofold the staff involved in detection and auditing of providers, including opening a satellite office in Miami.
- Established the Health Care Fraud and Abuse Workgroup, which brought together experts from throughout the state and nation to evaluate Florida's detection and recovery efforts and make recommendations for improvement.
- Transferred the Medicaid Fraud Control Unit from the Office of the Auditor General to the Office of the Attorney General resulting in a more effective relationship between the investigative and prosecutorial processes.
- Implemented a provider enrollment monitoring process leading to early identification and prevention of payments to potentially abusive providers.
- Established new working relationships through the health care fraud task forces chaired by U.S. Attorneys. This includes local, state and federal regulatory/

enforcement agencies providing a more efficient exchange of information resulting in a coordinated approach to attacking fraud and abuse.

- Enacted a False Claims Act mirroring the federal false claim legislation allowing prosecution in the state judiciary system.
- Implemented a management information system with major enhancements for integrating fraud and abuse detection strategies and identifying common linkages among fraudulent providers.

PROPOSED STATE LEGISLATION TO ENHANCE THE WAR ON FRAUD AND ABUSE

We have proposed and will continue to pursue legislation which emphasizes avoiding payments of public funds to abusive providers, cutting off the flow of Medicaid dollars immediately upon discovery of suspected illegal acts and imposing greater civil penalties and administrative sanctions.

- Provide for use of peer review findings as evidence.
- Allow the agency to pursue civil remedies while criminal investigations are ongoing.
- Clarify a provider's duty to submit valid claims supported by records made at the time services are provided.
- Clarify the agency's authority to obtain medical records of a provider during a period of litigation.
- Prevent billing agents from being paid based on a percentage of amounts billed or amounts providers receive.
- Allow for withholding of payments if there is reliable evidence of fraud or willful misrepresentation.
- Provide for sanctions if any felony is committed and add sanction provisions if there are business relationships with a previously sanctioned provider.
- Increase maximum penalties and sanction amounts for submitting fraudulent or improper claims.

PROBLEMS REQUIRING FEDERAL ASSISTANCE TO ENHANCE THE WAR ON FRAUD AND ABUSE

There will never be enough resources to fight fraud and abuse. However, pooling resources and improving communications among the entities could enhance our chances of success. Operation Restore Trust, recently announced by the President and Secretary Shalala, is an initiative to detect, prosecute and prevent fraud in the Medicaid and Medicare programs. This demonstration project is sponsored jointly by the HHS Office of Inspector General, the Health Care Financing Administration, and the HHS Administration on Aging, with the assistance of health care and law enforcement officials in the States of New York, Florida, Illinois, Texas and California. It presents the opportunity to focus our combined resources on fraud and abuse in these five states.

I would like to mention several other problems that could be addressed at the federal level.

Problem: Historically, the sharing and coordinating of information among various agencies with interests in health care fraud has been less than ideal. The Health Care Fraud and Abuse Task Forces have contributed to more information sharing than ever before. The National Anti-Fraud Association has also taken steps to create a national registry and clearinghouse. However, there is no systematic sharing of names of persons creating problems, details of schemes being used for fraud, or means of detection. Additionally, there are significant obstacles to such sharing of information presented by public records statutes.

Potential Solution: There should be a statutory exception that would limit access to certain information until an investigation is completed.

Problem: There appears to be a reluctance, not in theory but in practical application, on the part of the states to participate with federal prosecutors in False Claims actions. The reason for this reluctance appears to be that procedures have not been formalized for guaranteeing the states that the money recovered via this process will be shared with the states. This is extremely important to some states since much of their funding for fraud and abuse activities is received from recoveries.

Potential Solution: Codify in Federal Regulations procedures for cost sharing

PROVIDER ENROLLMENT ISSUES

One of the major purposes of this meeting is to examine ways to keep providers who have been convicted of defrauding the system or who are consistent abusers, from continuing to bill the government. The heart of this problem lies in the provider enrollment process.

When the Medicaid program was created in 1970, it was anticipated that providers would be reluctant to provide services to Medicaid recipients. The basis for that belief lie in the lesser amount of Medicaid reimbursement compared with that of private payers and the perceived delay and paperwork involved in submitting and processing claims. To remedy these problems and encourage providers to serve Medicaid recipients, the Florida legislature crafted statutes, and administrators of the Florida Medicaid program in turn designed a system, which simplified and expedited the process for enrolling and processing claims. In recent years, Medicaid reimbursement rates have also become more competitive.

With a simple system for enrolling and timely processing of claims, along with competitive reimbursement rates, the Florida Medicaid program has achieved its initial goal of attracting health care providers. Currently, we have over 80,000 service providers, about 1.6 million recipients, and process nearly 100 million claims per year. Unfortunately, however, a whole new set of problems has emerged in the form of fraud and abuse, which in part may be attributable to regulations that allow for simple, expeditious enrollments and expeditious processing of claims.

STANDARDS FOR ENROLLING IN THE MEDICAID PROGRAM

The process for enrolling in the Florida Medicaid program was designed to be expedient and simple. Currently, a provider submits an application containing, among other things, the provider's name, address, social security number, Federal tax number, proof of valid license, and information regarding the provider's or, if a corporation, principal owners', past criminal convictions, disciplinary actions, and Medicaid/Medicare exclusions or terminations. A corporation enrolling in the program also must identify all owners with 5% or more principal interest in the business. Once such application is received by Medicaid, the program's fiscal agent checks the application to ensure the provider has a Federal tax identification or social security number and, when applicable, a valid license.

Although a provider is required to submit information regarding past criminal convictions, disciplinary actions, and Medicaid or Medicare exclusions or terminations, there currently is no clear statutory authority for the Medicaid program to exclude a provider with past convictions, disciplinary action, or Medicare/Medicaid exclusions. While the Agency for Health Care Administration has in the past two years vigorously pushed for legislation enabling it to exclude such providers as well as take other steps to curb fraud and abuse, such legislation has yet to pass.

Absent from the current enrollment process is any systematic on-site inspection of medical facilities or offices, a criminal background check, and any personal contact with the Medicaid applicant. The lack of such procedures is mainly attributable to the cost in terms of personnel and to the delays such careful review would cause in the processing of applications. In the long run, any delays and costs may be offset by the savings the Medicaid program would reap from preventing significant sums of money from leaving the program through fraudulent and abusive providers.

THE MEDICAID PROVIDER AGREEMENT

The Florida Medicaid program has recently undertaken the task of substantially revising the Medicaid provider agreement for non-institutional providers. The chief purpose in changing the provider agreement is to better protect the program should fraudulent and abusive providers become enrolled. Some changes to the provider agreement which the Agency is considering include:

- Requiring all persons with a five percent or greater ownership or control interest in the entity to be jointly and severally liable with the provider for any overpayment or fine imposed by the Agency (in a final order). Such a provision would eliminate the frequent problem of corporate entity providers escaping liability after submitting fraudulent claims to the Medicaid program.
- Requiring a bond or letter of credit for certain provider groups. Such bond or letter of credit would only be required for non-institution, non-licensed entities, and certain other providers unless such providers can show that they have enrolled in the Medicaid program for a specified period of time without a sanction being imposed by the Agency for Health Care Administration. A provider subject to a bond may also request a hardship waiver if it is unable to comply with the above-stated bond requirements. This bond requirement would enable the Medicaid program to recoup overpayments from corporate entities who fraudulently bill the program and then go out of business, leaving a corporation without any funds to pay a fine or overpayment back to the state.
- A provision whereby the provider expressly agrees that there is no property right in and to a Medicaid provider number. Such a provision will prevent a provider from demanding due process rights prior to an Agency action such as termi-

nation. In the past, provider's have successfully argued they have a property right to a Medicaid number in order to require that they be afforded the right to a hearing prior to a final order of termination.

• A provision whereby the provider agrees that the Agency will have jurisdiction to resolve all matters, other than those in equity, through informal hearing. The provider also agrees that the Leon County Circuit Court will have jurisdiction of all equitable matter. Currently, all appeals of Medicaid actions go to the Florida Division of Administrative Hearings ("DOAH"). Without going into specifics, the hearing process at DOAH can be cumbersome and time consuming. The Agency believes that many Medicaid disputes involving overpayments or reimbursement can be resolved more efficiently within the Agency itself. Of course, a provider could always appeal the Agency's decision in an informal hearing to the appropriate appellate court.

The Agency would recommend these changes to the provider agreement also be put in Federal law or regulation as appropriate so as to create uniformity among the states, and more importantly, to eliminate liability loopholes for corporations enrolling as providers. There is no question that often providers enroll as corporations for the purpose of avoiding liability. Another measure worth consideration which would impede fraud and abuse in Medicaid and Medicare is to require all providers, to submit an affidavit under penalty of perjury swearing that they will not file fraudulent claims. Should a provider submit such an affidavit and subsequently file a fraudulent claim, he could be convicted of perjury, a third degree felony punishable in Florida by 5 years in prison.

METHODS FOR PREVENTING KNOWN ABUSERS FROM BILLING/ENROLLING

The Agency's best tool for preventing known abusers from continuing to bill the Medicaid program is to terminate the provider number and then ensure that neither the individual provider nor any officer, director, or significant (5% or greater) shareholder is permitted to enroll in the Medicaid or Medicare program again using a different corporate entity. At the outset, terminating a provider number in Florida is no easy task. The Florida Administrative Procedures Act requires that a party be given the opportunity to request a formal or informal hearing whenever a state agency takes an action which determines that party's substantial interests. To the extent that terminating a Medicaid provider number will always determine a party's substantial interests, Medicaid must afford a provider the opportunity to request a formal or informal hearing. Should a provider request a formal hearing, as is often the case, a final order of termination can take anywhere from six months to more than two years to issue. In that time, a provider can continue billing the Medicaid program and continue being paid by Medicaid, potentially draining the program of significant Medicaid dollars which are difficult at best to recoup.

One way Florida has tried to avoid this problem is through prepayment review of provider claims. Prepayment review enables Medicaid to require a provider to supply the Agency with medical records or other documentation to justify the claims billed prior to payment for those claims. Past experience using prepayment review shows that oftentimes fraudulent providers will not submit documentation to justify claims as requested. As a result, the Agency, in those cases, will never have to pay for claims submitted after prepayment review.

In addition, many fraudulent providers stop billing the Medicaid program altogether once they are notified of prepayment review.

There are, however, drawbacks to prepayment review. If a provider does submit documentation, significant Agency resources are required to review such documents. Accordingly, prepayment review must be used sparingly.

A better approach, which Florida is considering, permits the provider to seek a hearing only after the termination action has occurred. As stated above, Florida is proposing a specific provision in the provider agreement wherein the provider would expressly waive any property right in his Medicaid number. On a national level, the same result could be accomplished by passing specific laws stating that a Medicaid provider number is not a property right or that a provider terminated for fraudulent enrollment is only entitled to a hearing after termination has been effected.

The Agency may also bypass the immediate right to a hearing by using its emergency order powers. Under Section 120.59(3), Florida Statutes, a state agency may enter an immediate final order, without providing the opportunity for an administrative hearing, if the agency head finds that there is "an immediate danger to the public health, safety and welfare." There is some question, however, as to whether economic losses alone constitute an immediate danger to the public health, safety and welfare and, in that regard, whether the Agency could justify using an emergency order to terminate a Medicaid provider.

On the other hand, to the extent that the Agency could argue potential harm to Medicaid recipients in addition to economic losses, an emergency order will usually be appropriate.

The Agency has not yet used an emergency order to terminate a provider. Consequently, neither a hearing officer nor a judge has ever explicitly ruled whether a Medicaid provider could be terminated on an emergency basis. It bears mention that even where the Agency uses an emergency order, a provider will still have the opportunity to challenge the Agency's action in an administrative hearing. Though, in an emergency order situation a provider still has the opportunity to a request a hearing after the terminated has been effected. At least immediate termination enables the Agency to immediately stop paying a provider for claims submitted and prevents the provider from continuing to submit claims.

Most importantly, immediate termination from Medicaid triggers termination from Medicare. Once terminated, principal shareholders of a corporate provider, as well as individual providers, would be prohibited from enrolling in another state's Medicaid program.

Thank you, Mr. Chairman for the opportunity to appear before you today. I will be happy to respond to any questions.

Mr. SHAYS. I'm sorry, gentlemen, I have to ask you to wait. All three of your testimonies have been very helpful.

Mr. Ratner, I hope I didn't insult you because you had some very strong points as well.

Mr. RATNER. Thank you.

Mr. SHAYS. You're welcome. I will be right back. We are in recess.

[Recess.]

Mr. SHAYS. I'd like to call the hearing back to order, and thank you for staying here until 2. It's just me, so it won't be too long.

I may expose my ignorance here, but the purpose of the hearing, after all, to learn.

I'm assuming that it's against the law to defraud the Government or the private sector. But it's two separate statutes?

Mr. MAHON. It is against the law. There is no Federal statute pertaining to health insurance fraud. As I think Mr. Stern indicated, today private payers generally have to bring charges of mail fraud and/or wire fraud related to the submittal of false claims, or they return payment by mail of false claims for health insurance benefits. Many States increasingly are adopting statutes, either particular to health insurance fraud or applicable to insurance fraud generally, but there is as yet no Federal law that makes it illegal.

Mr. SHAYS. Would both—Mr. Noble, you work for the State of Florida in terms of your——

Mr. NOBLE. Yes.

Mr. SHAYS [continuing]. Your obligations; and Mr. Ratner, for the Federal Government, obviously.

Is there—is there logic to—I mean, I get the sense, before I started, that you have—you can do business in one State and then go do business in another State; and to the extent that we will be block granting and giving more responsibility to States, particularly as it relates to Medicaid, this is going to be even more likely in the future. So I recognize the challenge of coordinating information between one State's agencies and others as it relates to fraud against the Government in Medicare and Medicaid.

Is there logic, however, in pursuing a coordinated effort with the private sector?

Mr. Ratner.

Mr. RATNER. Brief answer, yes.

Mr. SHAYS. OK. What would be the benefits and how would we do it?

Mr. RATNER. Well, I think that Mr. Mahon has spoken well to the benefits of the all-payer approach to fraud and abuse. I mean, I think the basic point is that if you have somebody who is defrauding Medicare, that they are likely engaged in similar activities against private payers. If you are able to prosecute them for their activities across—across providers, you maximize whatever deterrent power you have from just going after that one case. And I think that's one major effect and gain from an all-payer approach.

Mr. NOBLE. Yes, I would agree with the statements as well.

In Florida, we do have an insurance fraud statute; and the all-payer approach, we certainly feel, would be more——

Mr. SHAYS. How does it actually work?

Mr. NOBLE. Basically, we have a—it's criminal penalty, fraud is defined as a penalty, and we have a State department of insurance that—there is a division of insurance fraud that, basically, they administer that program and they deal primarily with the private insurer fraud cases.

Two years ago, with part of our reform efforts in—health care reform efforts in Florida, again recognizing the severity of the fraud problem, we—our agency chaired a health care fraud work group. We had about six public hearings in the State that included Federal, State and private insurers, pooling together those experts in all those—from all of those areas to make recommendations to our legislature on that very issue.

Mr. SHAYS. How does the private sector exclude someone?

Mr. MAHON. Generally speaking, Mr. Chairman, they cannot exclude anyone, unless you are getting into questions of network, membership in a managed care network.

Mr. SHAYS. Let me ask it this way.

If Aetna decides it doesn't want to deal with this provider, it just simply says, "we're not going to deal with it?"

Mr. MAHON. Aetna literally cannot do that in most cases. A private insurer's contractual obligation generally is to pay 80 percent of covered charges on behalf of the insured, whomever that insured patient might see as a provider. So, typically, if a private payer receives claims from Dr. Smith, and just last week it discovered that Dr. Smith was defrauding it in six other areas, it still cannot refuse to pay this week's claims from Dr. Smith for another patient, until and unless it establishes a firm basis or firm suspicion that those specific claims are fraudulent.

Mr. SHAYS. So insurance companies are allowed to deal with just certain providers, but then it's a formal program?

Mr. MAHON. Yes, you get into more managed care where an insurance company will put together, say, an exclusive provider organization or a preferred provider organization. There are many questions beyond the scope of what we do related to any willing provider legislation, and so on, but that does tend to provide a degree of selectivity to the insurers, but in the indemnity fee-for-service environment, that's one of the fundamental problems.

Government can refuse to do business with a fraudulent provider. Insurance companies have to pay any claim unless they de-

termine it to be fraudulent, or establish the strong suspicion that it's fraudulent. So it is no easy matter on the private side, and they lack some of the legal tools that government has.

It's not illegal to routinely waive copayments as a marketing hook in private payer dealings. It is not illegal to pay kickbacks for referrals in private-patient dealings, as it is against Medicare and Medicaid. Those kinds of steps are at the—again, at the heart of this all-payer approach, as it's called.

Mr. SHAYS. The private sector does a much better job screening—they have more up-to-date computer systems and more advanced techniques than HCFA has. They're way behind in this area, as GAO and the Inspector General have pointed out.

Do you think that the private sector is doing a better job than the Government getting at fraud and abuse in the system?

Mr. MAHON. I wouldn't say they're doing a much better job. They are doing a much better job in relation to what they themselves were doing 10 years ago.

Mr. SHAYS. OK.

Mr. MAHON. More private insurers have become much more aggressive about going after the problem. And, again, many of the States are now mandating specific antifraud activities on the part of health insurers who want to do business in those States. So far, no one has the market cornered, but the essence to detecting the problems earlier on is the sharing of information among payers, which is perfectly legal to do, contrary to some impressions that it is against the antitrust laws and so on.

But, again, given the nature of the problem, oftentimes the way that a private insurer learns that it has a potential fraud on its hands is by learning that half a dozen other private companies are also investigating a given provider. If it has significant dealings with that provider, it's going to use that knowledge as the basis for conducting its own investigation of its business with that person in question. So that sharing of information and the fact that you have to detect fraud most effectively by going beyond any one payer's claims universe is really one of the new fronts that has to be much more fully used.

Mr. SHAYS. One thing you have done, Mr. Mahon, is make me feel that we need to get into the whole issue of fraud as it relates to the private sector as well.

We have to decide how to weigh into this, how we can be the most effective, and what our overall objective is.

If you have any suggestions, we would love you to make them to the committee afterwards.

I'm the head of the task force on the Republican side of the aisle on Medicare-Medicaid in the Budget Committee, and so the work I'm doing there and the work I'm doing here are very compatible. I don't know of a bigger area to realize savings than in this particular one.

Mr. Ratner, is there anything you want to say before we conclude?

Excuse me, I'm sorry, I'd like to recognize the gentleman from Michigan. We're not concluded, thankfully, because this is important. You have as much time as you want.

Mr. CHRYSLER. Maybe just a couple of quick questions for Jon.

Jon, what steps should HCFA take to bring sound business practices to the health care purchasing activities?

Mr. RATNER. I think that there are some broad categories of steps, and under each one of those categories there's lots of detail which we could discuss with you or provide you with some examples of.

I think one thing is this business of pricing of many services and supplies on a more competitive basis. An example, really, there is, there should be quick reaction to what the market prices are. There are examples that we've discussed before this subcommittee in which in the market something was being sold for $50, sometimes even given away in marketing activities for free, and Medicare was paying $144 to $200 for up to 3 years before they finally were able to reduce the price. The procedures there are very cumbersome.

And there's some—there's some real difficulties in the way the government—a government program, with its requirements, has to—public disclosure and everything, has to grapple with this. But there really are some ways that they can streamline that. But that should really be a matter of days.

I hope I'm outspoken enough on that.

Mr. CHRYSLER. Do you know why there is such a disparity between what the VA and the HHS pay for the same services and supplies as Medicare?

Mr. RATNER. That's a good question, actually. I haven't pursued that. We'll look into it.

Mr. CHRYSLER. OK. Why have Medicare programs failed to pursue and prosecute identified cases of fraud?

Mr. RATNER. There are a number of reasons. I think that one of the things that you've heard is that these are very time- and resource-intensive activities to pursue. Often these are pretty complicated cases, and as you've heard from the Department of Justice and the IG, to develop the case and then, in particular, to develop enough information that says, here is clear and convincing evidence of the intent to defraud, is a challenging task. So they concentrate their resources on the things that they think are payoffs.

And this is one of the cases where, or instances where, if you were to add some more resources there—from where they would come, I don't know—but if they were to be added, then you would see some of these cases that have been identified but perhaps are not quite at the—at the pinnacle of their cost or potential payoff, they would be pursued as well.

Mr. CHRYSLER. OK. I think our whole procurement and purchasing system in this entire Federal Government really needs a long, hard look. We are really missing the boat and certainly not enacting some great private-sector ideas.

Are there any administrative changes you can make to improve your purchasing efforts?

Mr. RATNER. Well, I think that the—the point that you're making really is a very pertinent one to Medicare, if I understand the thrust of your question. If you look at the efforts that have been going on at reforming Federal procurement, where, for example, the Department of Defense actually buys goods and services, you will see that there's an effort to shift the mode from a legal regu-

latory mode with the Federal acquisition regulations and all the constraints on common sense, often, that that imposes on people in the purchasing roles in DOD, to more of a business mode by, actually, means that some people do have some discretion to use some good judgment.

There's some responsibility and some risk there. And in Medicare, where you don't have actual purchase of services, but reimbursement, you have an analogy. And what we're really talking about is that similar efforts at re—at reconceptualizing how Medicare views its role, might have similar payoffs there in getting away from bureaucratic things and actually getting some good results and efficiencies.

Mr. CHRYSLER. Thank you, Mr. Chairman.

Mr. SHAYS. Thank you.

Mr. Barrett, I know you just walked in. I could ask a question now or if you're ready, I am happy to call on you.

Mr. BARRETT. I'm set.

Mr. SHAYS. You're all set.

Mr. Barrett from Wisconsin.

Mr. BARRETT. Mr. Ratner, I was looking through your written testimony and a couple things jumped out at me. One was, when you were talking about, for example, the home blood glucose monitors—that's your testimony, isn't it?

Mr. RATNER. Yes.

Mr. BARRETT And the surgical gauze pad and this kind of stuff that makes great 60 Minute segments or Prime Time, something like that. And you state, for all practical purposes, HCFA is prohibited from adjusting the prices for these and similar supplies. What should we be doing right now to give them the ability to do that?

Mr. RATNER. I think that what you really need to do is to ask them for their understanding, their view, of what the statutory limitations are. We've identified some there, based on our conversations with HCFA, and there are the statutory prohibitions there. It's locked in really on how the surgical dressing price or reimbursement rate, rather, should be set. You can get a legislative proposal from them on that and on similar things, that would give them the authority to do some more sensible, businesslike things.

Mr. BARRETT. Do you think HCFA is opposed to that? This seems again to be such a common-sense problem that no one paying the bills would object to it.

Mr. RATNER. Well, I think that in our discussions with people at the staff level—I think that they understand that some of these situations are pretty amazing, and that it would be good to be able to do things more expeditiously. I think that really you need to address the question—it's not just about some particular supply, like surgical dressings.

Mr. BARRETT. I understand.

Mr. RATNER. That's a key exam—that is an example of really what is a problem with a number—certainly not all, but a number of supplies and services. And it just really requires a good look to see then what authority would yield more sensible results.

Mr. BARRETT. You also made reference to the MRI's. If you could describe again just how you analyze the problem and how it can be addressed.

Mr. RATNER. The case of the MRI's is an interesting one. There you have a new technology, and when Medicare set its reimbursement rates, it set them at the rates that presumably were something like what was prevailing early on, when MRI's came into the picture. As experience was gained with MRI's, and as volume of utilization increased, the unit cost dropped, prices in the market dropped. But the same sort of difficulty that we were discussing with surgical dressings appeared with MRI's.

The process for review and change in those reimbursement rates was slow, and so you have high rates persisting for a long time. This has the perverse result then of encouraging, particularly in some areas, the large supply of these things, and when they're there, people use them. And so you have real disparities in use, higher spending, sort of an unfortunate circumstance.

Mr. BARRETT. From your perspective, what agency or agencies should be responsible for monitoring the market prices of these goods and services? And what techniques should be followed to ensure that they follow the market closely?

Mr. RATNER. We think that it is an important thing for someone at HCFA to be paying attention to what is going on in the marketplace for the range of services and supplies that——

Mr. BARRETT. So this is a HCFA——

Mr. RATNER. Yes, this is a HCFA responsibility.

Mr. BARRETT. Do you think they're adequately doing this?

Mr. RATNER. My understanding is that there isn't a focus on that. I would say right now, no.

Mr. BARRETT. We heard from the assistant to the assistant, the woman who didn't know her title, and I don't—I don't know if she's still here, and I don't mean that disparagingly, but do you know whether there is a department in HCFA that has as its mission monitoring these prices?

Mr. RATNER. To my knowledge, no. Not in a systematic manner.

Mr. BARRETT. OK.

Mr. Mahon, is that your name? If I could just ask you a couple of quick questions, you talked about the private sector being somewhat strapped, and that some of the laws that apply to Medicare and Medicaid don't apply to the private sector. Can you be a little bit more specific as to where you see the shortcoming there?

Mr. MAHON. Yes, certainly. And I would emphasize that under today's law, they apply only to Medicare-Medicaid and not to other government programs, such as CHAMPUS, the Federal Employee Health Benefits Plan and so on.

I mentioned earlier, specifically, that it is illegal to pay kickbacks for referrals of patient service or for inducements of delivery of services when Medicare-Medicaid patients are involved, but not when private health insurance dealings are the target. Similarly, it is explicitly illegal to routinely waive patients' copayments, which you most often see as a marketing hook used to lure people into what turns out to be a fraudulent billing scheme, such as a rolling lab scheme or a prescription drug scheme, where the ad says, "Get your prescriptions free," or, "Free physicals," this sort of thing.

Again, unless it is a matter—unless State law somehow addresses it, which only a handful of State laws do, that is not illegal in

private-payer dealings as well. So one of the central premises of taking an all-payer approach is that after government is through making whatever exceptions need to be made for legitimate managed care financial arrangements, which is a somewhat of another topic—whatever remains illegal against a government program should in all logic be illegal against a private insurance plan as well.

Mr. BARRETT. Are you able to—or are private payers able to get restitution? You made reference to restitution in your testimony.

Mr. MAHON. Private patients sometimes do. However, the other reality of it is that in many of these schemes, the private patient's financial interest has been mooted at the outset by this waiver of copayment or deductible obligation. In those cases, the sole financial victim turns out to be the third-party payer, who, in any event, is generally out 80 percent of the money; if a patient is out anything at all, it's usually 20 percent.

Mr. BARRETT. OK. If I could ask one more question, please?

Mr. SHAYS. Sure. You can ask more, if you like.

Mr. BARRETT. Mr. Noble, I'm asking you. Obviously, one of the major goals and one of the reasons you're here is, we're looking for a more effective relationship between the Federal Government and State governments for Medicaid abuse. If you were in Nirvana and had one tool that you need from the Federal Government or a couple of tools, what would those be? What could we do most to help you?

Mr. NOBLE. I think one of the things that several people have touched on already, and the sharing of information among various entities is one of the, I think, more critical weak links that we have within the system now.

We've started the task forces; that has been helpful. But the—there's no systematic way, overall, to share information as it relates to who the perpetrators are, what the schemes are, what is happening to all of those in any kind of consistent manner. And I'd say any activities or any ways to strengthen or to clarify——

Mr. BARRETT. Would a provider have a Medicaid number and then a Medicare number? I don't know enough about this. Are those separate numbers?

Mr. NOBLE. They're two separate numbers, yes, sir.

Mr. BARRETT. And do you have the computer capability to cross-check those?

Mr. NOBLE. No, we don't.

Mr. CHRYSLER. Mr.——

Mr. BARRETT. I'm all done.

Mr. CHRYSLER. Could Mr. Noble——

Mr. SHAYS. Mr. Chrysler, why don't we have the ability? What's the problem with interfacing those two numbers, Medicare and Medicaid?

Mr. NOBLE. Well, basically—well, Medicare is a totally federally administered program, whereas each Medicaid program is administered by each State.

Mr. SHAYS. That is the reason why?

Mr. NOBLE. I think what Mr. Vladeck referred to earlier is this uniform system, I believe, which will incorporate those ID numbers, that he's looking at implementing in the next couple years.

Mr. SHAYS. OK.

Mr. CHRYSLER. Mr. Noble, what would be required to allow Medicaid to exclude providers with past convictions or records of wrongdoing?

Mr. NOBLE. We currently have authority to, once we become aware of a Medicaid fraud violation or an exclusion from the Medicare program, I think the given current regulations and other current regulations, if a provider is excluded from the Medicare program, then if the State becomes aware of that, then we are required to exclude that provider also.

Mr. CHRYSLER. OK. Well, in your testimony on pages 9 and 10, it says that there's no clear statutory authority for the Medicaid program to exclude a provider with past convictions.

Mr. NOBLE. Past convictions of certain criminal offenses, yes, sir, that's correct. It's pretty clear that as far as the Federal regulations go, if that provider has been excluded from the Medicare program, then we must also exclude that provider from the Medicaid program.

Mr. CHRYSLER. I am glad we can cross-reference.

Mr. SHAYS. I have two questions, and then we're going to go vote.

Mr. Ratner, do you think it's necessary for HCFA to have to wait until 1997 to do some of these things? I mean, Mr. Noble is saying they're going to cross-reference the billing numbers of Medicare and Medicaid and so on, when they do the computerized system. But I'm thinking, wait a second, we're talking billions of dollars of waste and fraud and abuse. Is it conceivable they could do some of this with their present system?

Mr. RATNER. I confess you've touched on a subject that's very sensible, but that I don't really have detailed knowledge on. I think that my impression is really that there are these two issues. One is sort of what the legal authority is for the sharing of information by State versus Federal entities; and the second then is the operational question of how—how that information can be shared expeditiously. The MTS certainly is supposed to make the second thing work very well within Medicare. But this is something we need to look into more.

Mr. SHAYS. OK, thank you.

Mr. Noble, you made a very important point relating to holding bonds or letters of credit for certain providers, to protect the Medicaid and Medicare programs against fraud and abuse. How long has that system in Florida been operating?

Mr. NOBLE. I think the point that I referred to is that is something that we are seriously considering.

Mr. SHAYS. But it's not currently in operation?

Mr. NOBLE. No, it's not in operation.

Mr. SHAYS. Let me ask all three of you the positives and negatives of that system. One negative, I guess, would be that some might not be able to post a bond or a letter of credit, so there might be some undue hardship that should be taken into consideration.

Mr. Ratner, what would be the benefit, in your judgment, of posting a bond or a letter of credit?

Mr. RATNER. Well, I think that the—the posting of the bond gives some assurance that there is some recourse if the person turns out to—or the provider turns out to be doing bad things. I think the

thing that we're concerned about is that there may be some other ways, in addition to that, that the certification or accreditation can be done, particularly for the nonmedical, nontraditional medical providers that might be an effective way of getting at some of these problems of really illegitimate providers.

Mr. SHAYS. OK, thank you.

Mr. Mahon.

Mr. MAHON. On the face of it, Mr. Chairman, it strikes me as something that may be one of these nuts-and-bolts measures that has quite a practical benefit. Posting a bond, off the top of my head, might represent a more effective approach. Many of the people who systematically or entrepreneurially defraud Medicare and Medicaid could easily phonyup letters of credit. But a bond might be a more specific way to at least establish their genuineness.

Mr. SHAYS. Thank you.

Mr. Noble, do you want the last word here?

Mr. NOBLE. Yes, sir. One of the—we feel like the bond certainly would provide some financial mechanism up front. Also, generally the bonding company would require some sort of background investigation and that in itself would, I think, add some credibility.

Mr. SHAYS. I would think that would.

Let me say to all three of you that your testimony has been very helpful and I appreciate your staying through this hearing. I also want you to know that I'm absolutely certain that Mr. Towns and myself as well as others on the subcommittee will be looking to pursue this further with you.

Thank you very much, and I would now declare this hearing adjourned.

[Whereupon, at 2:26 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF SARAH F. JAGGAR, DIRECTOR, HEALTH FINANCING AND POLICY ISSUES, GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today to discuss the challenges that face the Congress in seeking health care cost savings. This is an important issue because rooting out fraud and abuse in Medicare and Medicaid can save at least hundreds of millions and perhaps billions of dollars. These two programs account for more than one-fourth of our national health care spending and, in fiscal year 1994, had over $300 billion in federal and state expenditures.

In summary, our work clearly demonstrated that Medicare—serving the elderly and disabled—and Medicaid—serving the poor—are overwhelmed in their efforts to keep pace with, much less stay ahead of, profiteers bent on cheating the system. Various factors converge to create a particularly rich environment for profiteers. For both programs, these include the following:

- Strong incentives to overprovide services: The programs predominantly pay providers on a fee-for-service basis with relatively little management of care.
- Work fraud and abuse controls to detect questionable billing practices: Extraordinarily high volumes of services to individual patients or by individual providers do not necessarily trigger questions by claims reviewers.
- Few limits on those who can bill: Companies using post office box numbers have qualified to bill the program for virtually unlimited amounts.
- Little chance of being prosecuted or having to repay fraudulently obtained money: Many cases are settled without conviction, penalties are light, and providers frequently continue in business.

Solving these problems will require exploring options to make greater use of managed care strategies, such as preferred provider networks or health maintenance organizations (HMOs), greater investment in the people and technology needed to ensure that federal dollars are spent appropriately, more demanding standards for gaining authority to bill the federal programs, and exploring administrative reform

options proposed in various bills introduced in this and the last Congress to address health care fraud and abuse.

BACKGROUND

Both Medicare and Medicaid fall within the administrative jurisdiction of the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). Medicare is the nation's largest health payer. HCFA establishes regulations and policy guidance for the program and contracts with insurance companies—such as Blue Cross and Blue Shield, Travelers, and Aetna—to process Medicare claims and perform payment safeguard or payment control activities to ensure that Medicare dollars are used only to pay claims that are appropriate. These safeguards and controls are programmed into computer claims processing software. They trigger the suspension of payments by flagging claims for such problems as charging for an excessive number of services provided on a single day. The computer automatically holds the claim until the data are corrected. The development and implementation of these safeguards and controls are generally the responsibility of Medicare's contractors. In fiscal year 1994, Medicare contractors paid almost 700 million claims for about 36 million elderly and disabled Americans, totaling $162 billion.

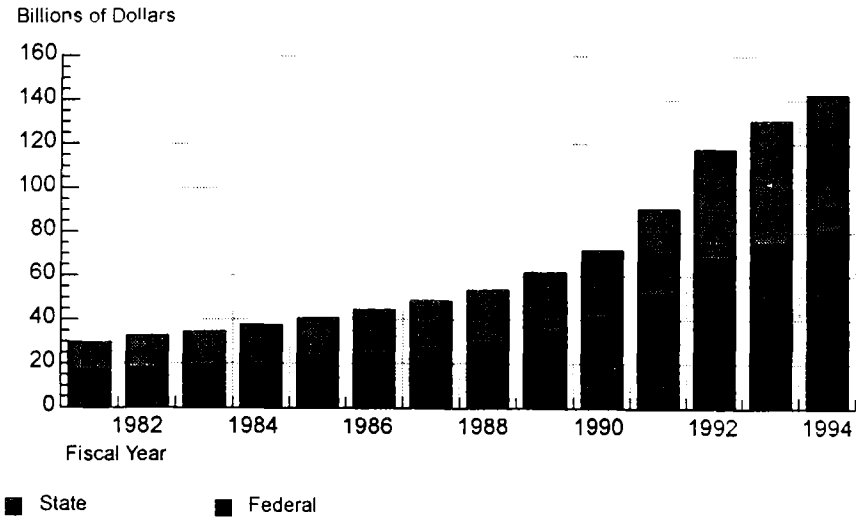

Figure 1: Medicare Spending 1982–94

Medicaid—the largest government health program for the poor—is a federally aided, state-administered medical assistance program. The federal government provides a share of each state's payment for services—between 50 and 83 percent—depending on the state's per-capita income. Each state administers the program through its own Medicaid agency. Each agency is responsible for ensuring that program dollars are spent appropriately in much the same way that Medicare holds its contractors responsible for payment control activities.

Medicaid spent about $143 billion (of which $81 billion was federal aid) on behalf of 34 million recipients during fiscal year 1994. Its size, structure, target population, and state-by-state variations render the program especially vulnerable to false billings and other fraudulent activities.

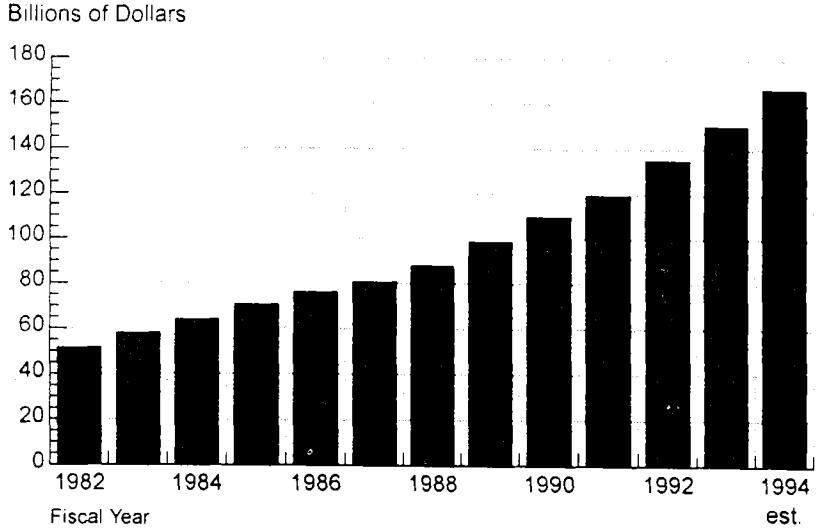

Figure 2: Medicaid Spending 1981–94

The introduction of managed care for Medicare beneficiaries and Medicaid recipients offers some promise of decreasing fraud related to overbilling or to providing unnecessary services. Though the consequences of fraud and abuse are similar—wasteful spending and inappropriate patient care—the forms it takes and the approaches used to address it are generally different for fee-for-service and prepaid health care providers.

In the fee-for-service reimbursement system, providers have the incentive to enhance their income by ordering too many services. Because fee-for-service providers bear little financial risk for the costs of services they prescribe, providers can inflate fees, services provided, or services billed. Fraudulent or abusive practices in the fee-for-service reimbursement system include overcharging for services provided, charging for services not provided, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

In contrast, prepaid health care providers, typically HMOs, are both insurers and providers of care. They bear the financial risk for their members' care in exchange for a fixed, predetermined fee per member. HMOs can, however, enhance their profits by minimizing spending on patient care; that is, by underserving their members. Consistent with this incentive, fraudulent or abusive practices found among some prepaid health plans in the Medicare and Medicaid programs tend to involve avoiding expensive treatments, underfinancing health plan operations, disregarding member complaints, providing poor-quality care, or using deceptive marketing practices, such as failing to reveal significant plan restrictions to consumers.

Although there has been a considerable shift from fee-for-service to managed care in Medicaid (now about 24 percent of enrollees, up from 10 percent in 1991) and to a lesser extent in Medicare (about 9 percent, compared with 6 percent in 1991), most care is still provided on a fee-for-service basis. For the foreseeable future, a significant though lower share of services is likely to continue on a fee-for-service basis, especially for Medicare beneficiaries.

MANY FRAUDULENT SCHEMES COMMON TO BOTH PROGRAMS

Our recent and ongoing work has shown that medical professionals or businesses that engage in fraudulent and abusive practices have targeted both programs, resulting in unnecessary Medicare or Medicaid expenditures.[1] Opportunities for fraud exist in both Medicare and Medicaid because each incorporates incentives to submit claims for services that are not needed, not provided, or overpriced. Moreover, each program has control weaknesses that result in paying providers' claims for improb-

[1] See the related GAO products section at the end of this testimony for a listing of reports and testimonies addressing this issue.

ably high levels of service or cost. The following are examples of abuses that have come to light through whistleblowers or some other fortuitous circumstance, not because program safeguard controls detected them.

- Over 16 months, a van service billed Medicare $62,000 for ambulance trips to transport one beneficiary 240 times.
- For one recipient, Medicaid paid for more than 142 lab tests—mostly duplicative—and 85 prescriptions during an 18-day period. One lab involved in this example billed Medicaid for more than $80 million in 2 years.
- In 1994, five individuals pleaded guilty to defrauding Medicare and Medicaid of approximately $4 million by using illegally obtained beneficiary identification numbers and billing the programs for large quantities of diagnostic services not provided.

Medicare contractors acknowledge that they have difficulty controlling widespread billing abuses for claims submitted for such things as medical supplies and home health, psychiatric, diagnostic, or rehabilitation therapy services. In addition, because the population served by Medicaid is relatively more transient and less likely to form a stable relationship with providers, additional opportunities for fraud result from the difficulty of verifying that patients are in fact eligible for Medicaid. Our recent investigations of Medicaid fraud have implicated psychiatrists, pharmacists, family practitioners, and clinical laboratories, among others.

Table 1 provides typical examples of fraud in both programs, drawn from completed or active fraud investigations.

Table 1: Examples of Medicare and Medicaid Fraud Investigations

Provider	Fraudulent Behavior	
	Medicare	Medicaid
Psychiatrist	Billed Medicare and was reimbursed for sessions that would have required nonstop counseling in excess of 24 hours per day.	Billed Medicaid for 4,800 hours a year or almost 24 hours each workday
Physician	Billed Medicare for flu shots offered "free" to nursing home residents.	Billed Medicaid for abortions on women not pregnant, including one who had a hysterectomy. In 48 separate instances, he billed for 2 abortions within 1 month on the same patient
Ophthalmologist		Performed unneeded cataract operations on Medicaid patients. In 5 years, he obtained $1 million from Medicaid, often telling patients that cataracts were contagious
Physiological lab	Received over $2 million from Medicare for medically unnecessary trans-telephonic EKGs.	
Clinical lab	Received Medicare reimbursement for transporting laboratory specimens—corresponding driving over 4.2 million miles in 2 years or almost 6,000 miles every day.	Bought massive quantities of blood from the poor; billed Medicaid $3.6 million for expensive, unordered, and unnecessary blood tests
Medical supplier	Submitted claims for huge quantities of surgical dressings, far exceeding demonstrated need.	
Podiatrist	Submitted claims for surgical procedures, but services provided were for routine foot care—usually not covered by Medicare.	Billed Medicaid for high-priced custom-made orthotics while providing cheap stock goods
Dentist	Billed and reimbursed for oral cancer examinations while providing routine dental care that was not covered by Medicare.	Billed Medicaid for treatments to nursing home residents already deceased

Moreover, federal and state fraud investigators concur that those involved in these violations rarely confine themselves to a single program, but rather submit inappropriate claims to Medicare, Medicaid, the Civilian Health and Medical Pro-

gram of the Uniformed Services (CHAMPUS),[2] the Department of Veteran's Affairs, private insurers, workers' compensation programs—whatever is convenient.

MANAGEMENT ILLS LEAVE MEDICARE CLAIMS SYSTEM VULNERABLE

Medicare is not managing care more effectively by using its substantial claims data to identify problem areas and implement corrective actions. Nursing homes, for example, provide HCFA an opportunity to reduce costs by adopting basic managed care concepts—identifying high-cost sites and encouraging providers to reduce costs. Nursing home residents are often a primary target of provider schemes to bill for unneeded or excessive services or items; abusive or fraudulent billing by providers serving nursing home residents is widespread. Providers that have recently been prosecuted or are currently under investigation for fraud by Medicare contractors and the HHS Office of Inspector General (OIG) include ambulance companies, suppliers of medical equipment and supplies, podiatrists, psychiatrists, and laboratories, some of which operate in multiple states.

HCFA could identify such schemes by compiling data on Medicare reimbursements per patient per day by nursing home. Identification of high-cost homes would be the first of various analyses to isolate problem nursing homes or services within homes. This approach would serve to pinpoint for HCFA the locations that require attention and the providers that serve those sites. The approach would also allow HCFA to establish benchmarks against which to measure the success of any corrective actions that it stipulates.

HCFA also does relatively little to check contractor controls to spot questionable providers or the overprovision of services. For example, even companies that have used post office box numbers as billing addresses or have little, if any, business history have qualified to bill the program. Further, there are no limits on the volume of bills that a new provider can submit. This makes obtaining a Medicare provider number easy for unscrupulous providers. They can then bill the program extensively and receive large payments over a brief period and disappear before (or soon after) Medicare begins to ask questions. For example, five clinical labs (that Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the possible submission of false claims. The labs' mode of operation was to bill Medicare large sums over 6 to 9 months, and when they would receive inquiries from Medicare, they go out of business.

Moreover, for most services Medicare contractors do not have sufficient computerized checks to flag unusually high volumes of a service or supply item to a beneficiary or to the beneficiaries at a particular care site, such as a nursing home. These weaknesses explain why Medicare contractors processed, without questioning

- over $1.2 million in claims over 12 months from a supplier of body jackets to nursing home residents when the supplier had previously been paid about $8,500 for the previous year for the same item or
- almost $1 million in claims over 12 months for therapy services from a small nursing home that previously had only nominal therapy claims.

HCFA Initiatives

HCFA has begun two major initiatives to address longstanding problems with inappropriate payments. First, HCFA contracted for the design of a single automated claims processing system—called the Medicare Transaction System (MTS)—that promises greater efficiency and effectiveness. By replacing the 10 different claims processing systems now used by Medicare contractors with a single system, MTS is expected to serve as the cornerstone for HCFA's efforts to reengineer its approaches to managing program dollars. The new system, which promises to format claims data uniformly and produce comparable payment data, is expected to provide HCFA with prompt, consistent, and accurate management information. Full implementation is at least 3 years away, however.

HCFA's second initiative involves giving greater prominence to fraud and abuse activities in Medicare. One individual now serves as a focal point for health care fraud and abuse activities, reporting directly to the Administrator of HCFA. Further, HCFA recently established special units at each contractor site to develop and pursue fraud cases within the Medicare program. Before the development of these units, following up on fraud allegations and developing cases for referral to the OIG were often seen as collateral duties and given low priority. HCFA has also taken several steps that make obtaining authorization to bill the program more difficult for fly-by-night providers.

[2] CHAMPUS is a federal medical program for military dependents and retirees that pays for care received from civilian hospitals, physicians, and other providers.

SYSTEMIC PROBLEMS INCREASE MEDICAID'S VULNERABILITY

Medicaid also is intrinsically vulnerable to fraud. First, the program is large, with costs increasing at more than 10 percent a year. By the year 2000, the Congressional Budget Office anticipates that, without major changes, the federal share alone will approach $150 billion, surpassing the current total spent by federal and state governments combined. Medicaid generates a correspondingly large number of claims: approximately 800 million a year. This volume makes examining claims closely for abusive or fraudulent practices difficult.

Second, because Medicaid has traditionally paid providers on a fee-for-service basis and has nominal if any copayments, Medicaid offers no financial disincentives to heavy use by honest recipients, much less those who may participate in dubious schemes.

States have the predominant responsibility to see that claims are processed correctly and that adequate fraud and abuse controls are in place. While some states are experimenting with measures to curb fraud and abuse, including managed care alternatives such as HMOs, their efforts are hampered by the same management problems that affect Medicare, as well as resource limitations. As a result, data are used ineffectively and convicted offenders receive light penalties and their postconviction involvement in federal health programs is poorly scrutinized and inadequately controlled.

Data To Detect Fraud Are Not Effectively Used

State Medicaid agencies have claims data and other records that can be used to identify patterns of potential fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. However, in our recent study of prescription drug diversion, we found that state Medicaid agencies—faced with unreliable and incomplete data—generally do not rely on analyses of their data to identify patterns of potential fraud or abuse. Instead, most alleged abuses are identified through tips or other fortuitous means. Other abuses are referred to prosecutors by the state agency responsible for administering the program, but even these abuses are seldom revealed by routine analysis of existing claims data.

An example from California illustrates how fraud goes undetected far too often. We found that a pharmacist was billing and being reimbursed by Medicaid for dispensing large volumes of prescription drugs. For 3 years the volume of prescriptions was improbably high—in many cases more than 20 prescriptions a day for a single recipient. The state's reporting system, however, did not trigger an investigation of the pharmacist nor of any of the recipients. A tip ultimately revealed the scheme.

Complexity of Administration Makes Extensive Coordination Necessary

Curbing Medicaid fraud is complicated by the numerous jurisdictions having responsibility. For example, a typical drug diversion case may involve five or more state, local, and federal agencies in its investigation, prosecution, and resolution. However, at the time of our study, no organizational unit within HCFA was dedicated to curbing fraud and abuse, and HCFA was not directly involved in drug diversion cases. It is too early to judge whether the recent appointment of HCFA's focal point for health care fraud issues can significantly improve coordination, but the appointment is a step in the right direction.

Financial and Other Penalties Are Light

Unscrupulous providers can reasonably anticipate very light penalties—if they are caught. First, in response to limited resources, prosecutors settle many cases short of conviction. Plea bargaining is common. Many first offenders are subject to what in Florida, for example, is called pretrial diversion, or equivalent agreements whereby their court records are sealed if they abide by the terms of judicially approved probation for 1 year.

Second, financial penalties are light even for a provider whose billings can be in the millions of dollars. In more than one-half the cases we reviewed across four states, restitution amounts were nominal—$5,000 or less. Providers usually paid these amounts. But in cases in which courts set restitution at $20,000 or more, the Medicaid agency recovered only a small percentage of the dollar amount established. In one case in which restitution was set at $220,000, only $4,000 had been repaid over 2 years later.

Although providers convicted of Medicaid fraud are generally excluded from the program, offenders frequently retain some connection with health care delivery and, therefore, have subsequent opportunities to commit violations. Federal laws are in place to exclude convicted providers from program participation, but apparently no one with authority and adequate resources is following up on individuals charged or convicted. In Florida, for example, we found that

- of nine individuals charged with Medicaid fraud in 1990, five—including a pharmacist excluded from program participation—were employed (as of July 1992) in pharmacies that served Medicaid recipients, and
- of five pharmacies charged with fraud in 1990, three were excluded from Medicaid participation. One pharmacist-owner sold his store but is still employed there as a pharmacist, and the other two re-enrolled in Medicaid under new ownership One of the new owners is married to the convicted former owner.

Faced with such problems in following up on crimes within their own borders, it is not surprising that state officials cannot prevent incursion by offenders from out of state. We found that several providers in New York who were suspected or convicted of fraud, were associated with Florida health care facilities: a clinical lab, and a nursing home that reportedly receives both Medicare and Medicaid funds.

Some State Initiatives Appear Promising

States have some systematic controls designed to prevent prescription drug diversion and other types of Medicaid fraud. Because even the best up-front controls are never 100-percent effective, states also have procedures for pursuit, punishment, and financial recovery.

Advanced identification technology and automated systems that can flag suspicious activity can prevent or detect fraud early on. Recent initiatives in some states include (1) the use of identification cards that resemble credit cards and that monitor utilization, (2) prescription-filing systems that can instantly link orders to the filing physician, and (3) data analysis techniques that can promptly identify physicians prescribing and patients receiving high volumes of drugs.

Other initiatives focus on pursuit and punishment. One approach to swifter and more certain pursuit of offenders uses multiagency task forces to coordinate case development. Alternatively, the authorities can bypass the criminal pursuit process through innovative administrative remedies. In New York, for example, providers applying for Medicaid certification agree up front that the state can unilaterally cancel their participation without proof of fraud.

Recovery of program losses is also receiving more attention. Stronger tools are available, such as requirements that certain high-volume providers post performance bonds or other forms of collateral as a condition of program participation.

Although hard evidence of the success of prevention and detection measures and harsher sanctions is generally lacking, encouraging signs exist. For example, a combination of initiatives in New York is associated with an 8-percent decrease over five years in the number of Medicaid prescription claims and a sharp reduction in spending for the most abused prescription drugs.

EXPLORING ADMINISTRATIVE REFORM OPTIONS

In searching for solutions, we should not overlook some suggestions made in this and the last Congress for reducing vulnerability to fraud and abuse. Various administrative reform proposals include options worthy of exploration, such as streamlining and enhancing health care information systems and strengthening laws and enforcement mechanisms.

Regardless of reimbursement method—fee-for-service or managed care—the consensus is that streamlined and enhanced health care information is needed by Medicare and Medicaid. Such information can enhance the detection and pursuit of fraudulent and abusive providers. In addition, the ability to exchange such information across programs and between monitoring and enforcement agencies can further facilitate fraud prevention, pursuit, and punishment. Such information exchange would be one element of a broader program of coordination and cooperation.

Another reform that we and others have proposed involves legislation to enable Medicare program safeguard funding, which produces at least $11 for every dollar spent, to keep pace with the growth in program expenditures. On a per-claim basis, federal funding for safeguard activities has declined by over 32 percent since 1989. Indeed, adjusted for inflation, funding per claim has decreased by 43 percent. In large part, the decline in program spending for these activities corresponds with passage of the Budget Enforcement Act of 1990. That act established limits—or caps—on domestic discretionary spending, including spending for Medicare program safeguard activities. Exceeding these caps in one domestic discretionary account requires budget reductions in other accounts, such as those for education or welfare. This means that even though appropriating additional funds for safeguard activities would result in a net budgetary gain, under current law, it would necessitate offsetting cuts in other areas. Recognizing a similar situation with respect to Internal Revenue Service compliance activities, the 1990 act included a limited exception to the spending caps to facilitate adequate funding for such compliance activities. Therefore, the Congress is able to increase funds for such activities without cutting

funding for other domestic discretionary programs. If a similar exception were provided for Medicare program safeguards activities, it could ultimately lead to significant savings to the federal government.

CONCLUSIONS

As the nation's largest health payer, HCFA should be a leader in developing effective ways to manage health care expenditures. With respect to Medicare, this would entail such things as

- exploring opportunities to improve care management in settings such as nursing homes where fraud and abuse has been a recurring problem,
- seeking ways to strengthen requirements for providers that request authorization to bill the program, and
- developing and requiring contractors to implement better computerized checks to flag questionable claims or providers.

Because these efforts are funded out of the government's discretionary appropriations, however, funding increases would necessitate spending cuts in other government programs. We have been recommending since May 1991 that the Congress consider extending the budget option available to the Internal Revenue Service under the 1990 Budget Enforcement Act. If a similar option was available to Medicare, HCFA would be able to provide its contractors with the necessary incentive to prevent or recover losses resulting from exploitative billings.

With respect to Medicaid, we find similar problems that need to be addressed. Being a state-administered program, however, HCFA's role shifts from that of direct program management to one of leadership. This would entail documenting, guiding, coordinating, and encouraging states' efforts. HCFA could also-address other overarching concerns revealed by our study, such as whether—and how—state laws, federal requirements, and other factors inhibit prosecution or attempts to recover payment of claims subsequently determined not to be authorized by law. Moreover, while all jurisdictions have resource constraints that limit oversight, investigative, and prosecutorial efforts, an absence of federal leadership has kept states from making the best use of the resources they do have.

Finally, the problems facing Medicare and Medicaid are faced by all payers, underscoring the need for comprehensive solutions. Administrative reform proposals from this and the last Congress present features that would help correct systemic weaknesses and oversight problems without unduly restricting the freedom that patients and providers have come to expect when selecting their treatments. Adopting broad-based administrative reforms would significantly enhance the detection and pursuit of fraudulent and abusive providers.

Mr. Chairman and Members of the Subcommittee, I want to thank you for the opportunity to speak before you today. This concludes my prepared statement. I would be pleased to answer any questions.

INVESTIGATIVE STAFF REPORT OF SENATOR WILLIAM S. COHEN, RANKING MINORITY MEMBER, SENATE SPECIAL COMMITTEE ON AGING *

GAMING THE HEALTH CARE SYSTEM: BILLIONS OF DOLLARS LOST TO FRAUD AND ABUSE EACH YEAR

EXECUTIVE SUMMARY

For the past year, the Minority Staff of the Senate Special Committee on Aging under my direction has investigated the explosion of fraud and abuse in the U.S. health care system. This report examines emerging trends, patterns of abuse, and types of tactics used by fraudulent providers, unscrupulous suppliers, and "professional" patients who game the system in order to reap billions of dollars in reimbursements by Medicare, Medicaid, and private insurers.

The consequences of fraud and abuse to the health care system are staggering: as much as 10 percent of U.S. health care spending, or $100 billion, is lost each year to health care fraud and abuse. Over the last five years, estimated losses from these fraudulent activities totaled about $418 billion—or almost four times as much as the cost of the entire savings and loan crisis to date.

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*This report includes the findings and recommendations of the Minority Staff of the Senate Special Committee on Aging. It does not represent either findings or recommendations formally adopted by this Committee.

Our investigation revealed that vulnerabilities to fraud exist throughout the entire health care system and that patterns of fraud within some provider groups have become particularly problematic. Major patterns of abuse that plague the system are overbilling, billing for services not rendered, "unbundling" (whereby one item, for example a wheelchair, is billed as many separate component parts), "upcoding" services to receive higher reimbursements, providing inferior products to patients, paying kickbacks and inducements for referrals of patients, falsifying claims and medical records to fraudulently certify an individual for government benefits, and billing for "ghost" patients or "phantom" sessions or services.

This report provides 50 case examples of scams that have recently infiltrated our health care system. While these are but a small sampling of schemes that were reviewed during this investigation, they serve to illustrate how our health care system is rife with abuse, and how Medicare, Medicaid and private insurers have left their doors wide open to fraud.

Patients—and, in the case of Medicare and Medicaid, taxpayers—pay a high price for health care fraud and abuse in the form of higher health care costs, higher premiums, and at times, serious risks to patients' health and safety. For example,

- physician-owners of a clinic in New York stole over $1.3 million from the State Medicaid program by fraudulently billing for over 50,000 "phantom" psychotherapy sessions never given to Medicaid recipients;
- a speech therapist submitted false claims to Medicare for services "rendered to patients" several days after they had died;
- a home health care company stole more than $4.6 million from Medicaid by billing for home care provided by unqualified home care aides. In addition to cheating Medicaid, elderly and disabled individuals were at risk from untrained and unsupervised aides;
- nursing home operators charged personal items such as swimming pools, jewelry, and the family nanny to Medicaid cost reports;
- 1500 workers lost their prescription drug coverage because a scam drove up the cost of the insurance plan for their employer. The scam involved a pharmacist who stole over $370,000 from Medicaid and private health insurance plans by billing over one thousand times for prescription drugs that he did not actually dispense;
- large quantities of sample and expired drugs were dispensed to nursing home patients and pharmacy customers without their knowledge. When complaints were received from nursing home staff and patient relatives regarding the ineffectiveness of the medications, one of the scam artists stated "those people are old, they'll never know the difference and they'll be dead soon anyway";
- durable medical equipment suppliers stole $1.45 million from the New York State Medicaid program by repeatedly billing for expensive orthotic back supports that were never prescribed by physicians;
- a scheme involved the distribution of $6 million worth of reused pacemakers and mislabeled pacemakers intended for "animal use only." The scheme involved kickbacks to cardiologists and surgeons to induce them to use pacemakers that had already expired; and
- a clinical psychologist was indicted for having sexual intercourse with some of his patients and then seeking reimbursement from a federal health plan for these encounters as "therapy" sessions.

Our investigation found that scams such as these are perpetrated against both public and private health plans, and that health care fraud schemes have become more complex and sophisticated, often involving regional or national corporations and other organized entities. No part of the health care system is exempt from these fraudulent practices, however, we found that major patterns of fraud and abuse have infiltrated the following health care sectors: ambulance and taxi services, clinical laboratories, durable medical equipment suppliers, home health care, nursing homes, physicians, psychiatric services, and rehabilitative services in nursing homes. Our investigation further concludes that fraud and abuse is particularly rampant in Medicaid, and that many of the fraudulent schemes that have preyed on the Medicare program in recent years are now targeting the Medicaid program for further abuse.

GREATER OPPORTUNITIES FOR FRAUD WILL EXIST UNDER HEALTH CARE REFORM

As our health care system moves toward a managed care model, opportunities for fraud and abuse will increase unless enforcement efforts and tools are strengthened. The structure and incentives of a managed care system will result in a concentration of particular types of schemes, such as the failure to provide services and quality of care deficiencies in order to cut costs. In addition, while efforts toward simplification and electronic filing of health care claims offer tremendous savings, they

also pose particular opportunities for abuse. Thus, it is crucial that any such system be designed with safeguards built in to detect and deter fraud and abuse.

FINDINGS OF INVESTIGATION

DEFICIENCIES IN THE CURRENT SYSTEM EXPOSE BILLIONS OF HEALTH CARE DOLLARS TO FRAUD AND ABUSE

A. Current Criminal and Civil Statutes Are Inadequate to Effectively Sanction and Deter Health Care Fraud

Federal prosecutors now use traditional fraud statutes, such as the mail and wire fraud statutes, the False Claims Act, false statement statutes, and money laundering statute to prosecute health care fraud. Our investigation found that the lack of a specific federal health care fraud criminal statute, inadequate tools available to prosecutors, and weak sanctions have significantly hampered law enforcement's efforts to combat health care fraud. Inordinate time and resources are lost in pursuing these cases under indirect federal statutes. Often, even when law enforcement shuts down a fraudulent scheme, the same players resurface and continue their fraud in another part of the health care system.

This cumbersome federal response to health care fraud has resulted in a system whereby the mouse has outsmarted the mousetrap. Those defrauding the system are ingenious and motivated, while the government and private sector responses to these perpetrators have not kept pace with the sophistication and extent of those they must pursue.

B. The Fragmentation of Health Care Fraud Enforcement Allows Fraud to Flourish

Despite the multiplicity of Federal, State and local law enforcement agencies, and private health insurers and health plans involved in the investigation and prosecution of health care fraud, these enforcement efforts are inadequately coordinated, allowing health care fraud to permeate the system. While some strides have been made in coordinating law enforcement efforts, immediate steps must be taken to streamline and toughen our response to health care fraud.

RECOMMENDATIONS

Based on our investigation and findings, we recommend the following to reduce fraud and abuse throughout the health care system:

1. Establish an all-payer fraud and abuse program to coordinate the functions of the Attorney General, Department of Health and Human Services, and other organizations to prevent, detect, and control fraud and abuse; to coordinate investigations; and to share data and resources with Federal, State, and local law enforcement and health plans.

2. Establish an all-payer fraud and abuse trust fund to finance enforcement efforts. Fines, penalties, assessments, and forfeitures collected from health care fraud offenders would be deposited in this fund, which would in turn be used to fund additional investigations, audits, and prosecutions.

3. Toughen federal criminal laws and enforcement tools for intentional health care fraud.

4. Improve the anti-kickback statute and extend prohibitions of Medicare and Medicaid to private payers.

5. Provide a greater range of enforcement remedies to private sector health plans, such as civil penalties.

6. Establish a national health care fraud data base which includes information on final adverse actions taken against health care providers. Such a data base should contain strong safeguards in order to ensure the confidentiality and accuracy of the information data contained in the data base.

7. Design a simplified, uniform claims form for reimbursement and an electronic billing system, with tough anti-fraud controls incorporated into these designs.

8. Take several steps to better protect Medicare from fraudulent and abusive provider billing practices and excessive payments by Medicare. Specifically,

revise and strengthen national standards that suppliers and other providers must meet in order to obtain or renew a Medicare provider number,

prohibit Medicare from issuing more than one provider billing number to an individual or entity (except in specified circumstances), in order to prevent providers from "jumping" from one billing number to another in order to double-bill or avoid detection by auditors;

require Medicare to establish more uniform national coverage and utilization policies for what is reimbursed under Medicare, so that providers cannot "forum

shop" in order to seek out the Medicare carrier who will pay a higher reimbursement rate;

require the Health Care Financing Administration to review and revise its billing codes for supplies, equipment and services in order to guard against egregious overpayments for inferior quality items or services; and

as we revise the health care system, give guidance to health care providers on how to do business properly and how to avoid fraud.

Adoption of these recommendations will go far in shoring up our defenses against unscrupulous providers, patients, and suppliers who are bleeding billions of dollars from our health care system through fraud and abuse. Since Medicare and Medicaid lose as much as $31 billion annually to fraud and abuse, the savings from reducing fraud in these programs would go far toward paying for much needed reforms in our health care system, such as providing access to health care coverage for the uninsured, prescription drug benefits for the elderly, or long-term care for the elderly and individuals with disabilities.

We must not wait to fix these serious problems in the health care system until we see what form health care reform takes. We are losing as much as $275 million each day to health care fraud, and effective steps can be taken within the current system to curb this abuse. With billions of dollars and millions of lives at stake, we can no longer afford to wait.

WILLIAM S. COHEN
United States Senator
July 7, 1994

I. INTRODUCTION AND SCOPE OF INVESTIGATION

When the Senate Special Committee on Aging sought an expert on health care fraud in 1981, it turned to a cardiologist from Philadelphia. His credentials were impeccable: a noted physician, he was also a convicted felon who had defrauded both public and private health insurers in three states for more than $500,000 by submitting $1.5 million in claims for medical services he had never performed.

"The problem is that nobody is watching," the doctor testified. "Because of the nature of the system, I was able to do what I did. The system is extremely easy to evade. The forms I sent in were absolutely outrageous. I was astounded when some of those payments were made."

Apparently, we did not learn much from this doctor's testimony. For now, thirteen years later, he is allegedly still up to his old tricks. Last month, he was arrested by FBI agents in Philadelphia and charged once again with defrauding health insurers for millions of dollars by filing claims for procedures that were never performed. Bail was set at $2 million and he is currently awaiting trial.

According to the U.S. Attorney in Philadelphia, since 1974, this physician has had a total of seven arrests and five convictions for fraud in New York, Connecticut, and Texas. Despite his record, four years ago he was able to get his Pennsylvania physician's license reinstated. He might very well still be in business today if a former patient, who was angry about the false billings, hadn't agreed to go undercover.

How was this physician, with his long record of arrests and convictions for fraud, able to continue to perpetrate the same kinds of schemes against the health care system? Why weren't his blatantly fraudulent activities detected earlier? How could he get a previously suspended license reinstated in one state when he had been convicted for fraud in three others?

The vast majority of health care providers are honest and dedicated professionals, but the alleged activities of this physician is typical of the "bad apples" that threaten to corrupt the entire system.

Therefore, as Congress continues its work on omnibus crime legislation and crafts health care reform, the answers to these questions reveal flaws in our health care system that we simply cannot afford to ignore.

For the past year, under my direction the Minority Staff of the Senate Special Committee on Aging has investigated the growth of fraud and abuse in the U.S. health care system and has worked to identify deficiencies in current federal, state, and private sector efforts to combat these crimes. To demonstrate the scope of the outrageous fraudulent behavior currently plaguing the health care system, this report will detail recent cases in which individuals and companies have been either indicted, convicted or fined. Those cases that have been adjudicated represent the tip of the iceberg of what has come to light—many more go undetected or are still under investigation. For example, in the area of home health care fraud, the New York Special Prosecutor states that "We've just scratched the surface." The Minority staff is continuing its investigation of the areas of abuse identified in this report,

and will issue a series of reports on particular industries engaged in abusive practices.

In addition, this report will examine emerging trends, patterns of abuse, and types of tactics used by fraudulent providers; the inadequacy of current law and enforcement resources and the need for better coordination; and how the move toward managed care presents new and different opportunities for unscrupulous providers to defraud the system. And finally, the report will offer recommendations for correcting the current deficiencies in the system that allow fraud and abuse to flourish.

According to the General Accounting Office, each year as much as 10 percent of total health care costs are lost to fraud and abuse. With annual health care costs in the United States now exceeding $1 trillion, fraud and abuse is costing taxpayers and policyholders about $100 billion each year. Over the last five years, estimated losses from health care fraud and abuse totaled about $418 billion—or almost four times as much as the entire savings and loan crisis has cost to date. With amounts this large at stake, we simply cannot afford to wait any longer to toughen our response to health care fraud.

We would like to thank, among others, the Office of Inspector General of the Department of Health and Human Services, the Department of Justice, the Federal Bureau of Investigation, the Drug Enforcement Administration, the Postal Inspection Service, the National Association of Attorneys General, the Medicaid Fraud Control Units, and the General Accounting Office, as well as numerous health care industry representatives, for their assistance with this investigation and report.

II. Background

CURRENT LAW: HOW THE GOVERNMENT INVESTIGATES AND PROSECUTES HEALTH CARE FRAUD AND ABUSE VIOLATIONS

A. Brief Overview of Health Care Fraud and Abuse Statutes

A number of Government health care programs are regular targets for fraud. Medicaid is financed jointly by the federal and state governments with states contributing up to 50 percent of the program's funding. Medicare is a federal program financed by a combination of federal payroll taxes, general revenues and beneficiary premiums. Other government-sponsored programs include benefits provided to federal employees, retired and active military and dependents, and veterans. Although government health care programs are often targeted, many unscrupulous providers are indiscriminant about who pays.

As this report illustrates, health care fraud and abuse encompasses a wide range of practices including overcharging for services, billing for services not rendered, and rendering services that are unnecessary or inappropriate. Paying kickbacks to physicians for referring patients and routinely waiving copayments or deductibles from patients are also considered fraudulent activities by the Medicare and Medicaid programs. Because kickbacks constitute payments to induce services, they increase insurers' vulnerability to claims for unnecessary services. By forgiving patient copayments and billing an insurer directly, unscrupulous providers may be able to misrepresent services rendered without the patient's knowledge.

While there currently is no specific federal health care fraud statute, Justice Department prosecutors do use traditional criminal and civil authorities, including mail and wire fraud statutes, the False Claims Act, and false statements statutes to prosecute health care fraud and abuse.

There are also criminal statutes directed specifically to prevent fraud and abuse within Federal health care programs. Such authorities include criminal penalties for false claims and statements specifically involving the Medicare and Medicaid programs, and the Medicare and Medicaid anti-kickback statute. The anti-kickback statute prohibits an individual or entity from offering, paying, soliciting, or receiving remuneration with the intent to induce Medicare or Medicaid program business.

The Department of Health and Human Services' (HHS) Inspector General (IG) is responsible for imposing the majority of health care administrative sanctions authorized under the Social Security Act. The Omnibus Budget Reconciliation Act of 1981 specifically authorized the IG, acting on behalf of the Department, to impose civil monetary penalties and assessments against health care providers who have filed false or improper claims for reimbursement under the Medicare, Medicaid, or Maternal and Child Health Block Grant programs. The law authorizes penalties of up to $2,000 for each false claim, and an assessment of up to twice the amount improperly claimed by the health care provider. The law provides a major deterrent to fraudulent and abusive activity.

The Medicare and Medicaid Patient and Program Protection Act of 1987 further increased the Department's authority to exclude both individuals and entities from

from participation in Medicare and State health care programs for fraudulent activities. It amended the existing mandatory and enacted new discretionary (permissive) exclusion authorities. The mandatory provisions cover program-related and patient abuse convictions and require program exclusions of no less than 5 years.

The permissive provisions cover a variety of offenses including convictions for fraud, loss of a license, and kickbacks. Once a decision has been made to impose an exclusion, the provider is given notice and advised of the right to request a hearing before an administrative law judge (ALJ). If the provider is dissatisfied with the ALJ's decision, he may request review by the Departmental Appeals Board and, if still dissatisfied, may take his case to U.S. District Court.

Program exclusions or civil penalties are often the appropriate remedy to be utilized to address health care fraud and abuse.

The HHS Inspector General refers investigative findings directly to the Department of Justice or individual U.S. Attorneys for possible criminal or civil prosecution. Once the Department of Justice has completed or declined criminal or civil prosecution, HHS can consider imposing administrative sanctions. Successful prosecutions may take years, involve an investment of considerable staff time and resources and, in some cases, may never result in actual recovery of federal health care dollars lost to fraud.

B. "Divided We Fall"

LAW ENFORCEMENT AGENCIES SUFFER FROM OVERLAPPING AND UNCLEAR JURISDICTION

The responsibility for investigating and prosecuting health care fraud and abuse is currently dispersed among many agencies at both the federal and state levels. The HHS IG and the FBI, the two federal law enforcement agencies with primary jurisdiction in health care anti-fraud efforts, each devote between 222 and 228 full-time equivalent (FTE) positions to health care fraud investigations.

More than 4 billion claims are processed annually. Although the IG has authority over only federal health programs, the FBI has plenary authority for all health care plans—that means less than 450 federal FTE's are devoted to investigating alleged improprieties in federal public health programs, which represent 40 percent of the nation's health care bill, and to investigating over 1,000 private payers. Thus, the two predominant health care anti-fraud enforcement agencies have only one FTE per approximately 8,890,000 claims. Agencies with some jurisdiction in anti-fraud and abuse enforcement efforts are as follows:

- The Inspector General of the Department of Health and Human Services audits and investigates health care providers accused of fraud against federally-sponsored programs, primarily Medicare and Medicaid. It is authorized to conduct civil, administrative and criminal investigations of frauds associated with the federal program. The Federal Bureau of Investigation has plenary authority to investigate all health care fraud offenses and includes all victims of the crime, whether against Federal programs or private insurance companies, business entities or individuals. Allegations of criminal conduct in the health care industry, at the onset, are presented to the U.S. Attorney's office for a prosecutive opinion. Based on the U.S. Attorney's decision, the FBI either proceeds with the investigation or closes the case.
- The Drug Enforcement Administration monitors and investigates the diversion, misuse, and abuse of pharmaceutically controlled narcotic substances.
- The Department of Justice combats health care fraud by pursuing criminal or civil proceedings when appropriate. Even if health care fraud does not constitute criminal activity, the Justice Department may try to recover damages by seeking the payment of civil penalties and restitution. Exclusions, suspensions or administrative civil penalties are still within the purview of the Department of Health and Human Services' Inspector General.
- The Food and Drug Administration regulates the prescription drug market for noncontrolled prescription medications as well as certain medical devices.
- The Postal Inspection Service enforces a number of statutes which allow them to take action against fraudulent practices involving the use of the mails (the criminal mail fraud statute and the civil postal false representations statute). Since the majority of claims filed by providers (as well as subsequent payments) flow through the mail, the Postal Inspection Service is an active component of health care fraud investigations.
- The Inspector General of the Department of Labor investigates cases involving workmen's compensation claims or fraud in health plans administered by labor unions.

The Inspector General of the Office of Personnel Management investigates when fraud is suspected in federal employee health plans, to which the federal government contributes billions of dollars annually.

• The Defense Criminal Investigative Service seeks to ensure the integrity of all Department of Defense programs, including the military health care system (CHAMPUS).

• The Inspector General of the Railroad Retirement Board Office handles cases regarding railroad workers fraud. Forty-two States currently operate special Medicaid Fraud Control Units.

The Minority committee staff finds that agencies authorized with primary enforcement duty, such as the HHS IG, are seriously underfunded and are urgently in need of additional resources in order to keep pace with the growth in the health fraud crime problem. Many of the agencies dedicated to this effort are stretched thin and are unable to keep pace with the growing number of claims and the evolving relationships of providers and entities as our health care system moves more toward a managed care environment. The committee staff is concerned about the lack of coordination and unnecessary duplication of efforts among agencies with overlapping jurisdiction.

Historically, turf battles have existed, potentially undermining investigations and cases. A muddled chain of command and the decentralized nature of some health care fraud investigations allow many fraudulent actors to perpetrate their schemes without detection. Recently, health care fraud working groups have formed at the national, regional and local levels. Many of these groups include federal and state prosecutors and investigators from FBI, HHS IG, Medicaid Fraud Control Units, and other agencies. We have found that where a task force or working group exists to coordinate investigations of a specific fraudulent or abusive practice, the overall investigation and prosecutorial effort are positively affected.

III. "TIP OF THE ICEBERG"

SELECT CASES OF FRAUDULENT AND ABUSIVE SCHEMES

As stated above, the GAO estimates that fraud and abuse accounts for as much as 10 percent of U.S. health care spending. With health care costs approaching $1 trillion, approximately $100 billion will be lost to fraud and abuse annually. The FBI calculates that fraud accounts for between 3 percent and as much as 15 percent of total health care spending, costing the United States tens of billions of dollars each year. Despite the enormity of the problem, GAO concludes that only a small fraction of the fraud and abuse committed against the health care system is identified.

Those instances that have been detected have involved substantial sums of money, risked patients' health and lives, diverted scarce resources, and contributed significantly to national health care costs. In addition to these tangible costs, health care fraud and abuse by providers can dangerously erode the trust of patients in the quality and integrity of the health care system. The cases described in this report are cases which are based on either recent convictions, indictments or fines so as to not disrupt or prejudice ongoing investigations which may result in future convictions. The committee staff is, however, continuing its investigation of ongoing cases.

A. Durable Medical Equipment (DME)

Over the past several years, the durable medical equipment industry has been repeatedly cited as a major source of fraudulent and abusive practices in the health care system. Ongoing investigations by the Minority committee staff revealed shocking evidence of unscrupulous DME sales practices, often resulting in the sale of unnecessary, overpriced, and even dangerous equipment to Medicare beneficiaries.

While the DME industry has recently taken steps to stamp out abuse, our current investigation of health care fraud cases has concluded, unfortunately, that major abuses continue to occur within this industry. The overwhelming majority of the nation's more than 160,000 DME suppliers are dedicated and honest professionals, but the rapid growth and sheer size of the industry has greatly increased the potential for fraud and abuse. Our investigation reveals that not only do these problems continue to plague the Medicare program, but they are being replicated not only in Medicaid, but in private insurance programs as well.

DME providers are not required to be certified or licensed. In fact, until recently, they have not had to meet any kind of standards whatsoever. Medicare carrier oversight of suppliers has also been lax. Most carriers do not keep track of their suppliers, and their billing numbers are rarely cancelled, even when the supplier has been excluded from the Medicare program. Insufficient carrier oversight also enables sup-

pliers to be issued multiple billing numbers, allowing them to double bill, overbill, or avoid being caught for fraudulent activities.

Largely as a result of Congressional pressure, the Health Care Financing Administration (HCFA) has taken some action to curb fraud and abuse in the Medicare DME program. HCFA has reduced the number of Medicare carriers processing DME claims from 34 to 4, which should bring greater uniformity and consistency to coverage and payment decisions. In addition, all claims must now be submitted to the carrier serving the area where the beneficiary resides and uses the item, thus eliminating the ability of suppliers to engage in "carrier shopping" to locate the carriers paying the highest reimbursement rates in order to get the best price for their overpriced items.

These new requirements are a step in the right direction, however, Medicare and Medicaid clearly remain vulnerable to abuse, and there is more that we can and should do to strengthen the participation requirements and administrative and payment policies for durable medical equipment.

Specific areas of abuse by DME suppliers include billing Medicare and Medicaid for inferior products, billing for items never provided, paying kickbacks to physicians for referring patients to DME suppliers, forging physician signatures or falsifying prescriptions for equipment, and tainting health care products.

INFERIOR PRODUCTS: The problem of selling inferior products at inflated prices is an ongoing problem that this industry still has not cleaned up.

- A DME supplier in Texas defrauded Medicare of over $1 million by charging Medicare for "body jackets," when what he actually provided were wheelchair pads. Legitimate custom-fit orthotic body jackets are used to treat injuries such as vertebra fractures and compressions or to aid in healing following surgery on the spine. A wheelchair pad is a cushioned seating support for the wheelchair. This supplier billed Medicare close to $1,300 for each pad, which actually cost between $50 to $100 to manufacture—representing a mark-up to Medicare of as much as 2,500 percent.
- Body jacket scams have become increasing popular, prompting the HHS IG recently to conduct an inspection to determine whether Medicare was being appropriately billed for orthotic body jackets. The Medicare claims paid remained relatively steady until 1990. Then, the number of claims submitted to Medicare skyrocketed 6,400 percent by the end of FY 1992—from 275 claims in 1990 to 17,910 claims in 1992. Total allowed charges also increased significantly, from $217,000 in 1990 to $18 million in 1992—an 8,200 percent increase.

The IG found that 95 percent of the jacket claims filed in a one year period were for "jackets" which did not meet the construction and medical necessity requirements to be reimbursed by Medicare. According to the IG, an orthotic body jacket costs only approximately $100 to manufacture, while Medicare pays approximately $800 for this item. In 1991, total Medicare payments for jackets that did not meet construction and medical necessity requirements exceeded $7 million.

Medicare requires that a patient's physician complete a prescription—known as a "Certificate of Medical Necessity" (CMN) before a DME can be approved for payment. The IG found that the body jackets were marketed by salespersons before the CMN's were completed by physicians. Typically, DME salespersons marketed their devices to nursing homes for use by their residents.

The IG found that salespersons presented their products to nursing home directors and physical therapists as restraint alternatives to help patients sit upright in wheelchairs. When a patient agreed to purchase a device, salesmen either completed the CMN or gave nursing home staff the proper wording to use and they completed the CMN. The nursing home staff then sent it to a physician for signature. This practice in itself is strictly illegal because, under current law, physicians—not suppliers—are required to complete the CMN.

To market this non-legitimate device as an "orthotic body jacket," DME suppliers took advantage of nursing homes' desires for restraint alternatives. They also took advantage of the fact that these primarily Medicare and Medicaid patients did not have to pay out-of-pocket for the products and also of the fact that physicians are often far too lax in their attention to the CMS requirements.

BILLING FOR ITEMS NEVER PROVIDED: Our investigation found that there are still many cases of sham companies billing for products that are never delivered. This is particularly a problem when nursing home residents are targeted for the sale of items that they never receive and, in some instances, never even ordered.

- The manager of a California DME company billed Medi-Cal, in just less than seven months, for more than $500,000 for merchandise allegedly delivered to needy beneficiaries. In fact, the company was supplying nothing and the beneficiaries had no actual medical need for any of the supplies. An audit re-

vealed that the operation was a virtual sham from its inception, and that the company had never even purchased an inventory of supplies from which deliveries could have been made. All Medi-Cal monies that were received were pocketed by the owner who used the funds to support a heavy gambling habit.

• A search warrant was recently issued in New York after a number of Medicare beneficiaries complained to their local carrier that they never received durable medical equipment listed on their Explanation of Medicare Benefits form as having been delivered to them by a New York DME company. Instead the company often provided non-reimbursable substitute items, such as angora underwear, power massagers, air conditioners and microwaves, in order to induce the beneficiaries to give them their Medicare number.

Medicare beneficiaries would contact the DME company and its sales representatives to learn how they could obtain the "free" household items. After receiving telephone calls from the beneficiaries, the sales representatives would then visit them in their homes and show them household items from a catalog. More expensive reimbursable durable medical equipment, such as hospital beds, wheelchairs, and patient lifts, which were never delivered would then be billed to the carrier using the beneficiaries' Medicare numbers.

It is estimated that Medicare overpaid $1.5 million for the items, but this figure is only based on those beneficiaries who complained to their carrier. The DME company is also accused of conducting an elaborate money laundering scheme in order to obscure the proceeds of the Medicare fraud.

KICKBACKS: Under the Medicare and Medicaid anti-kickback statute, it is illegal to order or pay a profit distribution to physicians to deliberately induce them to refer business under Medicare or any State health care program. However, the practice continues.

• A cardiologist has been charged with receiving $125,000 in kickbacks from a DME company for referrals that enabled the company, which supplied oxygen and respiratory aids, to bill government programs for hundreds of thousands of dollars. The indictment claims the doctor received kickbacks in the form of cash payments, jewelry, and other gifts in exchange for referrals.

• A group of Florida DME companies supplied respiratory equipment to Medicare beneficiaries without any prior physical examinations of the patients or authorization for the equipment. After the companies delivered the equipment, they paid kickbacks to physicians who agreed to write prescriptions for the equipment and medication, without ever seeing the patients. The companies then used the prescriptions as supporting documentation to obtain over $5.2 million in Medicare reimbursements.

ITEM NOT MEDICALLY NECESSARY/FORGING OR FALSIFYING CERTIFICATES OF MEDICAL NECESSITY: Durable medical equipment is reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers circumvent this requirement through aggressive sales practices such as telemarketing, pressuring physicians into signing CMN's, persuading physicians to act in complicity with a fraudulent scheme, or forging physician signatures.

• Two New York DME owners stole $1.45 million from the New York State Medicaid program by repeatedly billing for expensive orthotic back supports that were never prescribed by physicians. The DME sales force used an aggressive personal solicitation and telemarketing campaign, offering free "angora underwear" to Russian immigrants in Brooklyn, in exchange for their Medicaid I.D. numbers. The State was then charged for costly medical supplies that were never authorized by doctors and only rarely, if ever, delivered to patients. As described in a previous case, angora underwear was again used as an inducement to obtain beneficiaries' Medicaid numbers.

• The sales team recruited the Medicaid recipients in the streets with promises of the free underclothes, and then billed Medicaid for high-priced, medically unnecessary orthotic back supports—charging nearly $400 per claim. One of the owners also pleaded guilty to stealing an additional $300,000 over two years by submitting numerous false reimbursement claims from another DME company by stating that the company had provided hundreds of Medicaid patients with oxygen concentrators and nebulizers that were similarly, in fact, never ordered by physicians.

The owner of a DME company in New York was sentenced to five months in jail for Medicare fraud and ordered to pay $100,000 in restitution for falsifying blood tests to justify claims for oxygen equipment and inflating hours of oxygen use to obtain higher reimbursement.

• In Florida, an investigation of physicians, middlemen and DME companies involved in selling and buying Certificates of Medical Necessity led to indictments and imprisonment. One physician was sentenced for selling the certifi-

cates for patients he neither examined nor treated, knowing full well they would be used in filing Medicare claims. Other individuals and companies are also under indictment as part of the overall investigation.

B. Other Practices of Suppliers

UNBUNDLING AND UPCODING: Unbundling is the practice through which providers submit bills piecemeal rather than for the procedure or product as a whole. These illegal practices add enormous costs to the public health care programs. Upcoding is the process of billing for a service by using a reimbursement code for a similar but more complicated service. This results in a higher reimbursement to the provider.

- The case of a Pennsylvania DME company illustrates how providers have used the techniques of "unbundling" and "upcoding" to defraud Medicaid. The DME company billed Medicaid for "incontinence liners" when it was in fact providing residents of a youth home and elderly nuns in a convalescent home with disposable washcloths. The supply company misrepresented the products supplied in order to receive a higher reimbursement. During interviews at the homes, investigators also discovered considerable amounts of durable medical equipment supplied by the same DME outfit, including wheelchairs, geriatric chairs, and accessories.
- A review of the Medicaid bills submitted revealed that the wheelchairs, particularly the motorized ones, had been "unbundled": the supplier was billing separately for components of a wheelchair that are generally provided as standard items. The supplier also billed for more expensive equipment than was actually provided. Company owners were convicted for this fraud.
- Our investigation revealed several fraudulent billing schemes involving reimbursement for incontinence supplies. For example, a husband and wife in Michigan allegedly stole more than $25 million from Medicare in false claims for providing incontinence supplies for nursing home patients. Each time the Medicare carrier initiated proceedings to review claims before paying them, the couple allegedly incorporated a new billing company in order to avoid detection by Medicare.

TAINTING OF HEALTH CARE PRODUCTS: Our investigation also revealed instances in which Medicare and private insurers have been billed for products that pose potentially serious risks to patients, such as through the sale of "tainted" products.

- A former pharmaceutical salesman who was the owner of a company that distributed human heart cardiac pulse generators and human heart pulse generator leads was convicted of altering and misbranding expired pacemaker boxes to make the product appear new. By the owner's estimate, over an eight-year period, he sold about $6 million worth of pacemakers.

Former employees testified he often acquired low cost older models that were near expiration and relabeled them—a process that meant not only implanting pacemakers with older batteries but also jeopardizing the devices' sterility and putting the patient at risk of infection. In addition, accounts stated when authorities raided the owner's office, they found a number of bloody pacemakers, raising suspicions he was reselling devices that had been surgically removed from other patients or even from corpses. One former employee said she saw him wash off a pacemaker battery with tap water. Other problems discovered included implanting devices with lapsed expiration dates, improper sterilization, recycling pacemakers, mislabeling pacemakers intended for "animal use only" and mislabeling standard units as "high output" units.

The owner also provided a variety of kickbacks to attending physicians, cardiologists and surgeons to induce them to implant adulterated, misbranded, or expired pacemakers into their patients. The physicians were given entertainment tickets, vacation trips, office medical equipment, the services of prostitutes and cash for using the heart devices.

According to the Department of Health and Human Services' Inspector General, a retired electrician from Chicago had a "mystery pacemaker" implanted in his chest. The brand, serial number, and even the expiration date of his pacemaker or the lead attached to his heart could not be determined. The patient did not know his pacemaker was subject to failure, which might require a pacemaker replacement operation with all the accompanying risks of further surgery. The patient's cardiologist admitted that he received the services of a prostitute, a trip to Hawaii and other types of kickbacks from the pacemaker dealer. To date, ten individuals have pleaded guilty to the scheme and the owner has been given a 6 year term of imprisonment.

C. Psychiatric Services

Our investigation has concluded that a growing area of health care fraud exists in the delivery of psychiatric and psychotherapy services, including those provided by hospitals, clinics and private practitioners. Our review of recently completed and ongoing criminal investigations indicates that psychiatric and psychological services are rife with abuse, particularly in the following areas: billing for "phantom" psychotherapy sessions; billing for excessively long hospital stays for inpatient psychiatric care; providing kickbacks to physicians; and grossly inflating the number of psychotherapy hours provided in order to reap thousands of dollars in overpayments from Medicare or private insurers.

PHANTOM SESSIONS: We have found a significant increase in cases involving the illegal practice of billing for psychiatric and psychotherapy sessions that never took place.

• A New York Community Center director was indicted for stealing almost $800,000 by fraudulently billing the State for over 25,000 "phantom" psychotherapy sessions Medicaid recipients never actually participated in and for falsifying patients' medical records to cover up the theft. To perpetrate the scheme, the center director offered inducements like free food to attract thousands of Medicaid beneficiaries to the Center.

After obtaining the Medicaid recipients' names and I.D. numbers, the director allegedly used the Medicaid provider number of a psychiatrist to bill for tens of thousands of these "phantom" sessions. The billings were so excessive that the staff psychiatrist would have had to work well over 24 hours a day to handle the number of visits claimed, yet the scheme continued for over three years before being detected and stopped.

• In a similar case, physician-owners of a psychiatric clinic in New York were sentenced for stealing more than $1.3 million from the State Medicaid program by fraudulently billing the State for over 50,000 "phantom" psychotherapy sessions never given to Medicaid recipients. They were also charged with conspiring to falsify patient medical records to cover up the theft.

The doctors had paid neighborhood "steerers" illegal kickbacks of $10 to $15 per session to bring in new patients. Once inside the clinic, the Medicaid beneficiaries (often drug addicts) would sit together in a big room, watch television, fill out so-called homework assignments, eat a meal, sometimes talk briefly to a doctor, and then, before leaving, receive a few dollars cabfare and prescriptions for drugs like Valium. The physicians saw patients on a twice-weekly basis, but billed Medicaid for four to seven visits per week, as well as for dates before the recipients ever even set foot in the clinic. They also billed for visits when the only licensed psychiatrist on staff was absent from the office—often on vacation in France and California.

BILLING FOR EXCESSIVE OR UNNECESSARY SESSIONS:

• A Minnesota psychiatrist was sentenced to prison for defrauding Medicare, Medicaid and the Department of Veterans Affairs by billing for extensive psychotherapy sessions with individual patients in nursing homes and board and care facilities when he either did not see them or saw them only in groups at meals. In addition, his medical license had been suspended for sexual improprieties with patients and for overprescribing medications.

• A Hawaii clinical psychologist, working as a marriage and family counselor, was accused of defrauding the Civilian Medical Health Program of the Uniformed Services (CHAMPUS). He was indicted for having sexual intercourse with some of his patients and then seeking payment for these encounters as "therapy" sessions. He also claimed payment for therapy sessions which never took place; for billing individual sessions as joint sessions in order to receive higher reimbursements; and for falsely certifying to CHAMPUS that he billed and collected a required 20% copayment from his patients when he had, in fact, advised them they were not responsible for the fee. As a result, his patients had no incentive to scrutinize his billings, allowing him to continue his fraud against CHAMPUS.

• A Virginia psychiatrist was recently convicted for billing different insurers for patient counseling sessions that never occurred or whose length was inflated on reimbursement claims. He is accused of defrauding seven insurers including Medicare, Medicaid and CHAMPUS. He was sentenced to home confinement for six months, ordered to perform community service, fined $10,000 and put on probation.

• A record $379 million in fines, damages and penalties will be paid by a large health care corporation for kickbacks and fraud at its psychiatric and substance abuse hospitals in over 30 states. The corporation agreed to plead guilty to six counts of making unlawful payment to induce doctors to refer Medicare and Medicaid patients to the hospitals and one count of conspiracy to defraud the United States. Fraudulent practices included admitting and treating patients unnecessarily,

keeping patients hospitalized longer than necessary in order to use up insurance coverage, billing insurance programs multiple times for the same service and billing when no service was actually provided, and billing Medicare for payments made to doctors that were solely intended to induce referrals of patients to the facilities.

D. Nursing Homes

The investigation revealed a considerable number of cases involving direct targeting of nursing home patients in which both the industries that supply products and services to the homes and the owners and administrators of the home are involved in fraudulent and abusive practices. Nursing home owners have been convicted of charging personal luxury items like swimming pools to Medicaid cost reports. HCFA, the HHS IG, and the Minority committee staff are continuing to investigate nursing homes and the providers of rehabilitative services to nursing homes.

- A Minnesota speech therapist submitted false claims to Medicare for services provided to nursing home residents. The therapist also received Medicaid payments for speech therapy he never actually performed—and the investigation revealed that he had been paid for services "rendered to patients" several days after they had died. He was also observed using flash cards with a blind resident, and then billing for reimbursement.
- The owner of a Pennsylvania rehabilitation service was indicted for allegedly operating a scheme to defraud Medicare by submitting false claims for speech therapy provided to patients in nursing homes. The owner allegedly told speech therapists to recruit Medicare clients even though he knew their therapy would not be covered under Medicare.

Before submitting the paperwork for reimbursement, the speech therapists would rewrite their patient reports so that they would appear to be medically necessary rehabilitation services. The employees then allegedly falsified bills submitted to Medicare, including certifications by doctors that patients needed continued speech therapy, and also falsified patients' medical records.

- A Connecticut nursing home owner allegedly overstated expenses in reports for Medicaid reimbursement over a five-year period resulting in an overpayment by the State of almost $400,000. The nursing home owner allegedly arranged a beneficial financial arrangement with a leasing corporation to procure equipment. The leasing company then sold or leased the equipment back to the owner for a far greater cost than its purchase price. The nursing home was accused of passing on these costs to the State by submitting inflated cost figures and in order to obtain a higher rate of Medicaid reimbursement.
- A supply company in California billed Medicare for $5 million for post-surgery surgical dressings for nursing home patients who had never even had surgery. Medicare paid numerous nursing homes in several States for the surgical dressings, and the homes, in turn, paid a percentage to the supply company.
- Nursing home operators in North Carolina and Pennsylvania have been convicted of charging personal items such as swimming pools, jewelry, and the family nanny to Medicaid cost reports.

E. Clinical Laboratories

Some of the largest health care fraud convictions and settlements to date have involved major national clinical laboratories. These providers have come under intense scrutiny by the FBI, the HHS IG, the Medicaid fraud units, and private insurers for such practices as "sink testing," by which patients' lab samples are dumped down the sink without having had the requisite tests performed, providing and billing for bogus test results; performing extra tests in order to obtain excessive reimbursements; providing kickbacks to physicians for patient referrals; and "unbundling" so that Medicare will pay individually for each test that should be billed as part of a series of tests. Our investigation reveals that clinical labs continue to be a major potential area of abuse, posing the threat of significant losses to Medicare, Medicaid, CHAMPUS, and private insurers, as well as a threat to patients' health care due to faulty or unperformed lab tests.

- Three of the nation's largest clinical laboratories paid over $150 million to settle allegations that they submitted claims for unnecessary blood tests. Part of these cases arose from allegations by a whistleblower who charged that the three companies had submitted thousands of false Medicare and Medicaid claims. The labs were accused of manipulating doctors into ordering additional medically unnecessary tests when the doctors ordered basic automated blood tests. This probe is continuing and several other lab companies have acknowledged receiving subpoenas.

One of the labs, which pleaded guilty to the submission of false claims to the CHAMPUS program and to Medi-Cal, was accused of revising its order form so

that doctors ordered additional tests as part of a standard test without realizing that Medicare would be charged separately for them. The unnecessary tests allegedly cost Medicare millions of dollars.

• In New York, a laboratory that had billed Medicaid more than $39 million over six years was indicted for fraudulently billing for bogus ultrasound and blood tests. It was also indicted for illegally laundering over $1 million in Medicaid profits through the lab in order to generate kickback money. The sales manager of the lab was accused of submitting thousands of false reimbursement claims stating that blood tests and sonograms had been provided to Medicaid recipients, when, in fact, the tests were never medically required. Further, to the extent that services were actually provided, they were done solely to maximize the Medicaid reimbursements.

The lab sales manager then allegedly laundered the Medicaid proceeds by writing checks to fictitious employees and converting the funds to cash in order to pay kickbacks to others and also to make the fraud more difficult for Medicaid to detect.

F. Physicians/Practitioners

When physicians and health care practitioners engage in fraudulent practices they not only violate their own code of ethics but also deceive their patients, add enormous costs to an already beleaguered system, possibly endanger lives and, ultimately, betray the public trust.

• A physician in Hawaii who specialized in internal medicine and oncology used fake diagnoses to justify billings for treatments never provided to patients. Some examples of the physician's billing practices included: billing for treatment of appendicitis in patients who previously had their appendixes removed; billing for office visits that never took place; and billing for laboratory tests that were not performed. The physician is currently under indictment.

• An Arizona physician who practiced as a radiologist is under indictment for obtaining admission into the Medicare Screening Mammography Program by falsely stating that he was certified in radiology by the American Board of Radiology, which is specifically required of interpreting physicians before admitting them to the program. This is done to ensure that a physician meets the requisite conditions for certification such as the necessary experience, continuing education, and written reports requirements.

The physician was also indicted for certain billing practices involving a mobile CT (computerized tomography) scanning service. In addition to performing CT scans of patients, the physician ordered technicians to perform reconstructions of the CT images. He is accused of directing the billing clerk to bill for reconstructions on all CT scans even when he knew that in many cases no reconstruction was done by the technicians.

• Over a two-year period, a Maryland physician's billing to Medicaid quadrupled, prompting an investigation. The physician was subsequently accused of double-dipping both Medicaid and the State Department of Social Services for giving physical examinations to disability applicants. Undercover investigators witnessed an office overflowing with drug addicts, disability papers in hand, being examined in four minute intervals. "Comprehensive" exams lasted no more than two to four minutes. Records showed that the physician sometimes saw upwards of 100 patients per day, even though he only spent six hours a day at his practice.

Patients were told to drop off disability forms one day and come back the next day to pick them up, and it was obvious that the forms were being completed before the patients even met with the physician. The physician was certifying "inability to work" without verifying or treating the complaints. He had a rubber stamp with the diagnosis "lumber spine arthropathy" created to stamp all the "bad back" disabilities. By courting addicts and other potential disability recipients, the doctor built, in a very short time, a practice which billed Medicaid and the State Department of Social Services almost $450,000 a year for services that were so superficial as to be relatively useless. In 1993, the physician filled out more than 9,900 disability forms. Another physician who at one time was in the same practice acknowledged the false certifications, stating that "these people could work."

Unfortunately, the poor care rendered by the physician as a result of his assembly line approach resulted in horror stories of poor patient care—one patient suffered a weight loss of fifty pounds in three months and received no treatment. The physician falsified the blood pressure readings of patients suffering hypertension and these patients often went untreated even though this dan-

gerous problem existed. The physician was eventually convicted of Medicaid fraud and given a suspended sentence.

• Minority staff investigators found numerous cases involving kickbacks for sonograms, ultrasound, and other diagnostic imaging tests. For example, a New York radiologist allegedly stole more than $1 million from the New York State Medicaid program during a two-year period by fraudulently billing for thousands of ultrasound tests he never reviewed. His Medicaid claims jumped from $28,000 in one year to more than $1 million two years later. The radiologist allegedly made kickbacks of 75 percent of his billings to so-called "salesmen" who regularly arrived at his office toting shopping bags full of sonograms collected at Medicaid clinics throughout the city.

The physician has been charged with billing Medicaid for reading and interpreting over 11,000 patients' sonograms and echocardiograms that, in fact, he never reviewed.

• A New York podiatrist stole more than $200,000 from Medicaid by repeatedly billing for orthotics made from high-priced custom foot molds never provided to Medicaid patients. The podiatrist filed thousands of false reimbursement claims stating that Medicaid recipients had received expensive custom orthotics—foot molds reimbursable at $46 each—fabricated from actual foot castings when, in fact, the doctor had furnished patients with cheaper devices which should have been reimbursed at only $18 each.

This case is part of an ongoing statewide investigation into Medicaid abuse involving podiatrists, orthotic labs and orthopedic shoe vendors which has resulted in criminal charges against more than 200 individuals for stealing more than $30 million from the New York Medicaid program. To date, 185 convictions have resulted in more than $25 million in court-imposed fines and restitutions.

• A Georgia chiropractor, his wife and 15 former patients, were ordered to pay a total of $3.2 million in fines after being convicted of Medicare and private insurer fraud. The couple recruited patients for their clinic by promising kickbacks of up to one third the amount that Medicare or the insurance companies reimbursed. Bills were submitted for patients and their families regardless of whether they had been treated. In one instance, bills were submitted for 169 patients supposedly treated in a single day.

• A Utah physician operating a clinic was charged with 34 counts of mail fraud and seven counts of false claims. He had previously been convicted of filing false Medicaid claims in the 1980's. He was to be suspended from the program for a period of ten years.

Following his conviction, however, there was no change in his billing practices. He continued to bill private insurance companies and Medicare and Medicaid (in the names of employed physicians) in the same excessive manner. When he was 'flagged' by insurance companies, he would then set up dummy billing companies to disguise his identity on claim forms. He was recently indicted on, among other things, unbundling services, identifying false diagnoses on claim forms, duplicate billings, misrepresenting the level of service, and billing for services without the knowledge or consent of patients. A jury convicted him on 32 counts.

• A Maryland physician-owned corporation was convicted of Medicaid fraud and ordered to pay $190,000 in restitution for submitting false invoices to Medicaid. The corporation sought payment for several different types of medical services, including office visits and laboratory tests, which had not been done and were not medically necessary. The corporation billed Medicaid repeatedly for unnecessary laboratory tests.

• In one instance, a young boy was rushed to the physician's office with a lacerated chin. The boy's chin was sutured but, in addition to this procedure, Medicaid was billed for a throat culture, a nasal culture, a non-specific culture, and three hearing tests, despite the fact that there was no reason to perform these services and that the boy's mother stated that none of the tests billed to Medicaid were performed by the physician. The investigation also revealed that the corporation had not purchased sufficient laboratory supplies to have been able to perform the laboratory tests for which Medicaid was billed.

• A Pennsylvania physician was convicted of illegally prescribing controlled substances. The physician, also known as "Dr. Xanax," prescribed prescriptions for non-legitimate medical purposes to abusers and dealers. It is estimated that he diverted in excess of 20,000 dosage units of controlled substances per month. He was convicted on 59 counts of illicit distribution of Valium, Adipex, Darvocet and Vicodin.

• A scheme in New York defrauded Medicaid by conducting unnecessary medical tests on drug addicts. The addicts, who were using multiple identities and

Medicaid cards, were recruited from the street and given prescriptions for drugs they abused in exchange for participating in the tests.

The insurance billings generated from these tests were made possible by an agreement between the owners of the clinics and staff physicians. For the use of their provider numbers, the physicians received a 40 to 50 percent kickback for all accrued medical charges. Loss to the Medicare and Medicaid programs in this case is estimated at $10 million. Twenty-one individuals, including seven physicians, have been charged or have entered plea agreements. This was one of the first health care fraud investigations in which Racketeer Influenced Corrupt Organizations (RICO) charges were levied. Money laundering violations served as the predicate offense for the RICO charge.

• A New York physician who operated a methadone treatment center stole more than $1.5 million by fraudulently charging the State for over 25,000 methadone treatments never given to Medicaid recipients. In his illicit four-year billing scheme, the physician not only used the Medicaid numbers of patients who had not yet begun the program or had died, but brazenly appropriated the names and I.D. numbers of patients at a hospital with which he was affiliated who were neither in his care nor even on methadone.

The physician systematically filed thousands of false reimbursement claims stating that he had provided methadone maintenance treatment (reimbursable at almost $60 per week) to over 1,100 Medicaid recipients at his office.

• In New York, nine persons involved in a conspiracy in which Medicaid was defrauded of more than $8 million in a little over a year were given prison sentences. The owner of several medical clinics was sentenced to five years imprisonment and five other doctors were sentenced to lesser terms. The doctors were hired by the clinics for the sole purpose of using their Medicaid provider numbers.

The physicians wrote prescriptions for drugs that have a high street value and that ended up being diverted. The scam included rounding up "patients" for the clinics who had valid Medicaid cards, drawing blood and taking blood pressures, and then billing Medicaid for extensive diagnostic tests. The "patients" were also directed to specific pharmacists who filled prescriptions and billed Medicaid for drugs which were then sold on the street.

G. Non-Physician Providers and Professional Patients

PHARMACISTS AND PHARMACEUTICALS: The investigation has found that the diversion of prescription drugs continues to be a major criminal problem. The buying and selling of prescription drugs on the street poses enormous problems for law enforcement, already stretched to its limits, as well as adding immense costs to society by fueling an addicted population and facilitating illegal drug trafficking.

• In one of the largest fraud cases ever in New Hampshire, a pharmacist stole almost $375,000 from the State's Medicaid program and private health insurance plans. Over a two-year period, the pharmacist systematically billed over one thousand times for prescription drugs that he did not actually dispense.

The pharmacist fabricated prescriptions to justify his billings. According to State officials, he used insurance information provided by his customers to submit false billings to their insurance companies and also double-billed Medicaid and private insurance for the same services.

This case illustrates how health care fraud can have devastating effects on insurance companies far beyond the actual losses. In addition to violating the trust and confidentiality of his customers, the acts of this pharmacist resulted in the loss of prescription drug benefits to many individuals: because the pharmacist's fraudulent activity caused a local company's health plan to incur high costs, the company was forced to drop its prescription drug coverage for about 1500 workers. The loss of the drug card benefit to hundreds of employees is a striking example of how health care fraud victimizes not only insurers, but also employers, employees and their families alike.

• In Michigan, several pharmacists obtained large quantities of sample and expired drugs and dispensed them to nursing home patients and pharmacy customers. Pharmacy technicians were instructed to remove sample drugs from their packages, scrape or rub off the word "sample" on the tablet, and place these drugs in the general stock for dispensing prescriptions. Expired drugs generally acquired from the purchase of other pharmacy inventories were handled in a similar manner. The samples and expired drugs were dispensed to nursing home patients and the Medicaid program was fraudulently billed.

Pharmacy technicians had received complaints from nursing home staff and patient relatives regarding the ineffectiveness of the medications delivered. According to testimony at trial, when the technicians confronted the pharmacy

owner with these complaints, the owner stated "those people are old, they'll never know the difference and they'll be dead soon anyway."

• In Florida, a pharmacist was caught purchasing and selling diverted drugs that were samples provided to representatives of drug manufacturers. The pharmacist, the owner of a Broward County pharmacy, was accused of dispensing samples of Feldens, an arthritic drug, and Naprosyn, an anti-inflammatory drug, which had been adulerated by scraping off the mark "Sample" on the capsules. The pharmacist stated that he bought them for cash from a friend who delivered them in plastic bags on a weekly basis. This was in direct violation of the Prescription Drug Marketing Act which provides penalties for selling drug samples in order to ensure that the prescription drugs purchased by consumers are safe and effective.

• A black market scheme in New York has allegedly defrauded the Medicaid program by illegally buying and selling costly prescription drugs, including the AIDS medication AZT. The drug diverters are accused of warehousing an inventory of drugs pending resale for cash to pharmacies and other diverters at greatly discounted prices. The medications had originally been dispensed to Medicaid recipients in New Jersey and Connecticut.

In this illicit underground economy, Medicaid recipients—often addicts who are seeking to abuse the system—visit unscrupulous doctors and obtain prescriptions for a laundry list of costly brand name drugs. They then either sell the prescriptions to accomodating druggists or have the prescription filled and peddle their goods to street buyers who, in turn, recycle them to other pharmacies.

New York officials stated that this scam was particularly insidious because the ultimate users of the recycled goods—the public—could well be taking drugs that had lost their potency or had been improperly stored and handled. One of those arrested stated that he had just made a $40,000 deal with a New Jersey pharmacy for similar prescription drugs. This case was part of a broader investigation into a vast network of physicians, pharmacists and Medicaid recipients who are engaged in dealing drugs and prescriptions for cash on the black market.

• An Illinois illegal narcotics distribution ring containing three ringleaders and a group of nineteen people was charged with diverting over 60,000 Dilaudid pills. According to the Drug Enforcement Administration, Dilaudid, a synthetic, morphine-like substance, is considered the most powerful prescription pain killer sold today.

The group diverted Dilaudid from legitimate channels by using professional patients who visited doctors on a daily basis. Some of the professional patients who were recruited had cancer. One ringleader collected the Dilaudid and then sold it to individuals who took it out of the State for resale. It costs approximately $.40 a tablet at the pharmacy counter, yet demands a street price of $20 to $80 a tablet depending on availability.

HOME HEALTH CARE: The aging of the population, the increasing preference for home and community-based long term care, and major advances in the development of out patient technology has resulted in the explosive growth for the home care industry in the United States. Unfortunately, commensurate with the growth of this industry has been an increase in home care fraud. Our investigation has revealed that there are two major pockets where some abusive practices have become problematic: in the home health agencies and in home infusion companies (home infusion is an industry that provides intravenous drugs and nutritional therapy for patients who are receiving care at home).

Several patterns of fraud have emerged in home health agencies, such as billing for services not rendered, use of unlicensed or untrained staff, kickbacks to referring physicians, and falsified plans of care for patients. Home health care has tremendous potential to decrease costs of both acute and long-term care and to enhance patients' quality of life. It also, however, presents a disproportionate opportunity for abusive practices, hidden from medical professionals and overseers who cannot watch delivery of at home.

The home infusion industry has been rocked with charges of kickbacks and overcharging. Some companies have allegedly charged patients fees as much as 2,000 percent higher than hospital charges. An examination by the HHS Inspector General has revealed three types of kickback schemes used by home infusion companies to defraud the federal government: direct payment of money to a physician for the referral of patients; stock bonuses based on the amount of referrals; and companies, through the use of recruiters, soliciting beneficiaries rather than doctors.

At the end of 1994, new legislation will prohibit Medicare payment for referrals by physicians to home infusion companies in which they have a financial interest.

However, this payment prohibition only applies to physicians and will not correct the potential kickback violations with the referral of patients for IDPN, an infusion used for nutrition at the same time a patient is undergoing dialysis. The HHS IG has ongoing investigations in six regions targeting home infusion companies. In addition, it has a national case pending against one of the major home infusion companies in the nation. 1993 total revenues for home infusion therapy topped $4 billion.

- The owners of a large New York home health care company stole more than $3.6 million from the New York State Medicaid program by systematically billing, over a three-year period, for services rendered by untrained and unqualified home care aides. The company was accused of grossly inflating, by as much as 30,000 hours, the amount of time these employees actually worked. The company recruited untrained employees who were often immediately assigned to care for homebound Medicaid recipients, assisting them with such personal chores as bathing, dressing and feeding, and other support functions.

This scheme not only cheated Medicaid out of millions of dollars, but it also recklessly sent untrained health care workers—including a 14 year-old girl to care for a 4-year old child with Down's syndrome—into the homes of disabled and elderly residents. According to New York officials, home care has become the fastest-growing part of the New York Medicaid program—ballooning from $400 million to over $2 billion a year since 1986.

- A vivid example of kickbacks for home care patient referrals involved a family in South Florida that established four companies to distribute liquid nutritional supplements, including a milk supplement, to Medicare beneficiaries. These nutritional supplements are reimbursable by Medicare if a physician signs a Certificate of Medical Necessity indicating that the supplement is appropriate for the patient. The companies hired recruiters to go into South Florida communities with heavy concentrations of elderly residents and offer "free medical milk." The senior residents then were signed on as new patients, monthly deliveries of nutritional supplements were made and Medicare was billed for these services.

The recruiters had made arrangements with Miami-area physicians to certify the medical need for the supplement. The company made kickback payments of $100 to the recruiters for the "Certificate of Medical Necessity" obtained, and the recruiters, in turn, paid kickbacks to the physicians who had signed the certifications. In less than two years, the companies had billed Medicare for over $14 million.

None of the elderly residents interviewed by the FBI during the investigation was qualified for the nutritional supplement, which is currently reimbursed by Medicare at a rate of $600 per month per beneficiary. Twelve individuals, including several physicians were indicted.

- A Ohio girl who suffered from cerebral palsy was able to live at home with the help of intravenous drugs and nutritional therapy. Bills generated from her treatments ranged from $95,000 to $120,000 a month. The family filed a lawsuit against the home infusion company alleging overcharging and poor quality of care. In less than a year, the family's two private insurance policies' limit of $1 million was used up. Comparisons showed that it cost close to $1,000 a day more to treat the little girl at home than it would have cost to treat her in a hospital. When the insurance lapsed, a court order was needed to compel the supplier to keep the supply of treatment items coming to the house. The girl's mother was eventually forced to quit her job in order to qualify for Medicaid, ironically to pay for the treatment which was supposed to save money compared to the more expensive inpatient hospital fees.

MEDICAL BILLING SERVICES: The investigation found that the administrative complexity of the current health system has spawned a growth industry of billing companies to file reimbursement claims to both private insurers and federal health care programs. A consequence of this complexity is that billing firms at times falsify claims information with elaborate fraudulent schemes.

- The recent case of a California medical billing service illustrates how easy it is under the current health care system to be reimbursed for services which are never actually provided.

In August 1992, state and federal agents began an investigation into a sham medical billing service that was submitting claims to insurance companies nationwide for laboratory services. The owners of the billing service first gained entry to the system when they were previously employed by another billing service. Without the knowledge of their former employer or co-workers, the con artists photocopied and smuggled home hundreds of claim forms, doctors' billing numbers, and patients' medical information. Armed with this information, the

operators set up their own phony billing service, and submitted over $2.3 million in bogus claims for lab services that were never actually performed.

By the time federal investigators arrested the owners of this company, the operators had set up several "billing services," under at least five separate names. Each of these bogus entities had its own billing address and false business licenses.

Committee staff is concerned that the scheme only came to light after subscribers began to notify their insurance companies that they had received Explanations of Benefits (EOB) for services they had never received or for services performed by a physician they did not even know. Since many subscribers never reviewed their EOB's, some insurance companies continued to pay claims without question. As complaints from subscribers began to mount, however, insurance company investigators began to notice a pattern of fraud, and realized that the companies had each been paid hundreds of thousands of dollars in fraudulent billings.

At the time of arrest, the sham billing company's owners had stolen over $13 million from insurance companies across the country, and had submitted additional false bills for a total of $2.3 million in bogus bills.

AMBULANCE AND TAXI SERVICES: Medicaid-paid transportation services is an area ripe for abuse. For example, a common practice is routinely inflating the amounts billed to the program by overstating the miles travelled. There is also firm competition among operators in these industries to obtain Medicaid business. In one Maryland operation, for example, an unscrupulous taxicab owner violently beat a competitor who was waiting outside a clinic looking for riders.

- In New York, Medicaid pays for a patient's transportation to a medical provider either when mass transit is unavailable in the recipient's area or when the patient, because of a debilitating physical or mental condition, cannot use mass transit.

The owner of a New York taxi firm allegedly stole over $100,000 from the State by fraudulently billing for thousands of taxi rides never given to Medicaid patients. The president of the taxicab company was charged with filing more than 3,000 false reimbursement claims stating that his two taxi firms had provided over 300 Medicaid recipients with taxi service on days when, in fact, no transportation at all was provided.

This case is part of ongoing investigation of New York's medical transportation industry which, to date, has resulted in convictions against 66 individuals.

- The owner of a Massachusetts taxi company was recently indicted on Medicaid provider fraud and state tax violations. He is accused of charging Medicaid for separate rides when two or more recipients shared the same taxi. State Medicaid regulations require that taxi firms split the fare when two or more share the ride. Employees of the company were also indicted for failing to file tax returns over a three-year period.
- A Virginia Medicaid transportation service was convicted of a criminal violation of the federal False Claims Act. The owner of the company submitted claims to Medicaid with inflated mileage for transporting indigent patients to and from health care centers. The owner was sentenced to one year probation.

PROFESSIONAL PATIENTS: Our investigation found that health care providers are not the sole abusers of the health care system. Conversely, our investigation found significant abuse by so-called "professional patients" to scam the system by providing their own medical histories, blood or lab samples as the basis for fraudulent claims. In some instances these patients are provided kickbacks or inducements by health care providers to participate in schemes, while in other instances the patients themselves are the originators of the scams.

- The owner of a New York medical clinic was accused of submitting bills to Medicaid for medical services, blood analysis, drug prescriptions, and laboratory tests which were medically unnecessary. Physician assistants who worked at the clinic said that little medical treatment was actually administered at the clinic. A scheme was allegedly devised in which "patients" would routinely demand certain prescribed drugs, submit to a battery of unnecessary tests, and give blood in order to receive the drugs, which the "patients" would later sell on the street. The owner allegedly paid doctors and physician assistants five dollars per blood sample as a kickback. He then billed New York Medicaid to pay for the analysis the clinic conducted on the blood samples.
- A New York woman, who had four different aliases, was arrested on mail fraud charges for making false claims seeking reimbursement for medical treatment that was never actually rendered. Over a four-year period, the woman had submitted approximately 48 claims for direct reimbursement from her private

insurance carrier. The carrier contacted the treating physicians named on the claims and learned that virtually all the claims were false. In one instance, she claimed that she was treated by a dermatologist on a date when he was actually on vacation.

IV. Findings of Investigation

Deficiencies in the current system impede law enforcement's ability to combat health care fraud

While the cases included in this report represent only a small sample of fraud and abuse perpetrated against public and private health care programs, they serve to illustrate the vulnerability of our health care system. The investigation of these and other cases and our extensive review of current federal and state enforcement efforts lead us to conclude that major deficiencies exist in our defenses against health care fraud, allowing billions of dollars to be lost each year to fraud and abuse. We further conclude that as our health care system moves toward a managed care model, even greater opportunities for fraud will occur, exposing our health care system to even greater dollar losses.

A. Major Patterns of Fraud Exist Throughout the Entire Health Care System and Patterns of Fraud Within Some Provider Groups Have Become Particularly Problematic

Our investigation concluded that vulnerabilities to fraud exist throughout the entire system, affecting federal, state, and private health care plans alike. Major patterns of abuse that continue to plague the health care system are overbilling, billing for services not rendered, unbundling and upcoding services to receive higher reimbursements, providing inferior products, paying kickbacks and inducements for referrals of patients, falsifying claims and medical records to receive excessive reimbursement or to fraudulently certify a patient's eligibility for Medicaid, Social Security disability, or state welfare programs.

While these practices exist throughout the health care system and are perpetrated against both public and private health plans, our investigation found that health care schemes used to victimize payers and patients have become more complex and frequently involve regional or national corporations and other organized entities. No part of the health care system is exempt from these fraudulent practices, however, our investigation raises concerns that major patterns of fraud and abuse have existed in the following health care sectors: ambulance and taxi services, clinical laboratories, durable medical equipment suppliers, home health care, nursing homes, physicians, psychiatric services, and rehabilitative services in nursing homes. Our investigation further concludes that fraud and abuse is particularly rampant in Medicaid, and that many of the fraudulent schemes that have preyed on the Medicare program in recent years are now targeting the Medicaid program for further abuse.

We are continuing to investigate specific fraudulent schemes, particularly with regard to Medicaid and Medicare fraud.

B. Greater Opportunities For Fraud Will Exist Under Health Care Reform

As our health care system moves toward a managed care model, opportunities for fraud and abuse will increase unless enforcement efforts and tools are strengthened. Our investigation concludes that the structure and incentives of a managed care system will result in a concentration of particular types of schemes, such as failure to provide services; quality of care deficiencies; falsification or misrepresentation of professional credentials by providers; subcontractor fraud; submission of false cost data to obtain higher capitation rates; fraudulent or deceptive enrollment practices by health plans; and kickbacks, rebates, and other illegal economic arrangements to increase market share of health care services.

The experiences of several states' Medicaid programs illustrate that managed care systems often provide greater incentives and opportunities for providers to engage in health care fraud.

For example, the Arizona Health Care Cost Containment System Fraud Unit has found that Arizona's Medicaid managed care-style program has been subject to embezzlement of funds paid by the state for client services; fraudulent subcontracts; wire and mail fraud; fraudulent related party transactions; and kickbacks among physicians, osteopaths, home health care facilities, DME suppliers, and physical therapists.

The AHCCCS Fraud Unit concluded that the managed care structure of the Arizona Medicaid program offered opportunities for kickbacks and other types of health care fraud. Similarly, many other states' Medicaid Fraud Control Units have found

that states which require their Medicaid beneficiaries to participate in managed care programs have experienced significant incidences of fraud, such as fraudulent marketing techniques and falsification of enrollments of new members to plans, reduced quality of care, improper disenrollment practices, deceptive marketing practices to potential enrollees, and providing substandard care to enrollees in the managed care plans.

These state experiences with HMO's and managed care plans illustrate that comprehensive health care reform incorporating the principles of managed care will exacerbate the opportunities and incentives for providers to engage in fraud and abuse.

Moreover, two other key aspects of health care reform could affect enforcement efforts. First, while uniform, standard claims forms will go far in reducing the complexity of the health care system, these revised claims forms must be designed with enforcement in mind, so that factors can be built in to detect fraud and abuse more easily. Second, electronic billing systems, while again reducing complexity, will eliminate the paper trail that enables law enforcement to track fraudulent practices. Any such system must be designed with safeguards built in to detect and deter fraud and abuse.

C. Current Criminal and Civil Statutes Are Inadequate to Effectively Sanction and Deter Health Care Fraud

Both the Department of Justice and the Department of Health and Human Services endorse strengthening the tools available to prosecute criminal and civil cases. Currently, Federal prosecutors use traditional fraud statutes, such as the mail and wire fraud statutes, the False Claims Act, false statement statutes, and money laundering statute to prosecute health care fraud.

Additional tools, such as penalties for false claims, anti-kickback statutes, and the authority to exclude providers from participation in Medicare and Medicaid, are now available to redress fraud and abuse in the Medicare and Medicaid programs.

Despite the availability of these criminal and civil remedies, our investigation has concluded that several deficiencies exist in the tools available to law enforcement to combat fraud and abuse most effectively in the health care system. For example:

Inordinate Time and Resources Are Devoted to Apply Traditional Fraud and Money Laundering Statutes to Health Care Fraud

While many egregious cases of health care fraud have been successfully prosecuted under the mail and wire fraud statutes, because there is currently no specific federal health care fraud criminal statute available to federal prosecutors, excessive time and resources must be devoted to developing a nexus to the mail and wire fraud statutes in order to pursue clear cases of fraud. Similarly, extensive resources are spent trying to track the cash flow from health care fraud schemes in order to prosecute under federal money laundering statutes. Relying on these more generic federal criminal statutes for prosecution results in an inefficient use of scarce law enforcement resources.

The case of the bogus medical billing service in California which stole over $1.5 million from insurance companies nationwide before they were arrested by federal agents provides a prime example of how extensive resources are spent on proving a nexus to traditional fraud statutes: the FBI estimates that hundreds of additional investigative staff hours were devoted to proving the trail of expenditures in order to prove money laundering, because a federal health care fraud statute does not exist.

Creation of a new, general health care fraud offense prohibiting schemes to defraud federal or private health plans or persons in connection with the delivery of or payment for health care is necessary to provide a direct response to intentional acts to defraud the health care system.

In addition to providing a more efficient response to health care fraud, the establishment of a federal health care fraud offense sends an important message that health care fraud will be pursued with the same rigor as financial institution fraud, securities fraud, computer fraud, and other areas of white collar crime in which the federal government plays a prominent enforcement role. This type of provision is included in an amendment currently pending on the omnibus crime legislation, as well as in several comprehensive health care reform proposals.

D. Improvements Are Necessary in the Current Medicare and Medicaid Fraud Statutes

Based on our investigation, we find that additional tools are necessary to curb abuse in the Medicare and Medicaid programs. For example, the current remedies for violations of the anti-kickback statute (for kickbacks made to induce the referral

of Medicare or Medicaid business) are criminal prosecution and exclusion from the Medicare and Medicaid programs.

It is important to deter kickbacks in order to deter overutilization of health care services, inappropriate "steering" of Medicare or Medicaid patients to more expensive, unqualified, or poorly equipped providers, and giving an unfair advantage to providers who offer kickbacks. When only criminal prosecution and exclusion from participation in Medicare and Medicaid are available as remedies, however, federal law enforcement may be reluctant to impose such sanctions, consequently allowing the illegal activity to go unaddressed.

Therefore, we conclude that civil monetary penalties should also be available as intermediate sanctions for anti-kickback violations in order to ensure that enforcement actions are taken against anti-kickback violations.

Similarly, it is important to provide a range of sanctions for other fraudulent or abusive activities against the Medicare or Medicaid programs, such routine waivers of copayments (except in appropriate circumstances), and the practice of knowingly submitting claims for a higher reimbursement rate than allowed under Medicare (so-called "upcoding"). Providing a full array of enforcement tools against health care fraud will better enable swift, fair responses to health care abuse.

E. Due to Flaws in Enforcement Efforts of Private Payers, Billions of Health Care Dollars Are Vulnerable to Fraud and Abuse

While the federal government has many authorities available to it to combat fraud and abuse in the Medicare and Medicaid programs, private sector payers are at a greater disadvantage in fighting health care fraud, because they have a more limited set of tools available in their enforcement arsenal.

For example:

Generally, insurers do not have civil monetary penalties or false claims statutes available to them to sanction false claims submitted for reimbursement, false advertising, or false statements made to private health plans.

Further, despite the fact that kickbacks are a common element of many health care frauds against private insurers and health plans, many states do not have adequate anti-kickback statutes in place.

Another major obstacle facing private health plans is the lack of information available on whether a health care provider has been sanctioned for fraud in other parts of the health care system, thus leaving the plans exposed to further fraud and abuse. When a provider has been excluded from participation in Medicare or Medicaid for defrauding the programs, for example, they continue to participate—and may continue fraudulent activities—in private health plans.

Finally, private payers generally have less authority to recover overpayments than is available under the Medicare or Medicaid programs.

In addition to these statutory obstacles facing private enforcement efforts, the sheer number of different payers in the current health care system—now numbering over 1,000—results in a multiplicity of different rules, reimbursement policies, claim forms, multiple identification numbers, coding systems, and billing procedures. The complexity of the current health care system allows fraud and abuse to flourish and go undetected, resulting in billions of health care dollars lost to fraud and abuse each year.

F. The Fragmentation of Current Health Care Fraud Enforcement Encourages Exploitation of the System By Fraudulent Providers

A multiplicity of Federal, State and local law enforcement agencies, as well as private health insurers and health plans, are involved in various aspects of the investigation or prosecution of health care fraud. Since fraudulent providers often infiltrate many different health care plans, it is crucial that law enforcement efforts be as coordinated as possible in order to detect emerging trends in health care fraud, fully shut down fraudulent schemes, and prevent them from recurring in other parts of the health care system.

Inadequate collaboration in combatting health care fraud takes a particular toll on the ability of private sector insurers to reduce fraud, and results in higher premiums for all insured. The costs for an individual insurer to investigate fraud and abuse act as a substantial disincentive to investigate—instead, it is much simpler to increase the overall premiums to cover the losses from health care fraud.

Recently, major efforts have been undertaken to better coordinate federal and state agencies involved in combatting health care fraud and abuse. For example, the Department of Justice and the HHS Inspector General have established an Executive Level Health Care Fraud Policy Group to identify new methods to proceed against health care fraud, identify priority areas for fraud enforcement, and remove bureaucratic obstacles to enforcement efforts. Similarly, the Inspectors General from

federal agencies have begun to better coordinate their responses to health care fraud in programs within their jurisdictions.

Our investigation concluded that substantial progress has been made toward coordinating health care fraud enforcement, but that additional steps are necessary to streamline enforcement procedures, share information among public and private health care agencies, and ensure that health care fraud is reported and referred for appropriate enforcement actions.

V. Recommendations

Based on our investigation and findings, we recommend that several reforms be adopted to reduce fraud and abuse throughout the health care system. Specifically, we recommend the following:

1. Establish an all-payer fraud and abuse program to coordinate the functions of the Attorney Generals Department of Health and Human Services, and other organizations to prevent, detect, and control fraud and abuse, and to coordinate investigations, and share data and resources with federal, state, and local law enforcement and health plans.

2. Establish an all-payer fraud and abuse trust fund to finance enforcement efforts. Establishing a "revolving fund" to finance enforcement efforts would go far in addressing the current resource problems that plague federal health care fraud enforcement efforts. Fines, penalties, assessments, and forfeitures collected from health care fraud offenders would be deposited in this fund, which would in turn be used to fund additional investigations, audits, and prosecutions. Amounts in this fund would increase, not supplant, the operating budgets of federal law enforcement agencies with jurisdiction over health care fraud.

3. Toughen federal criminal laws and enforcement tools for intentional health care fraud. Specifically, create a federal health care fraud offense; provide criminal forfeiture and civil injunctive relief for health care fraud offenses; establish health care fraud as a predicate to the Racketeer Influenced Corrupt Organizations Act (RICO); and expand the Civil False Claims Act to cover claims presented to health plans.

4. Improve the anti-kickback statute and extend prohibitions of Medicare and Medicaid to private payers. Specifically, expand current Medicare and Medicaid anti-kickback statute to private payers and to all federal health care programs; provide civil monetary penalties for anti-kickback violations; and provide injunctive relief for anti-kickback violations.

5. Provide a greater range of enforcement remedies to private sector health plans, such as civil penalties.

6. Establish a national health care fraud data base that includes information on final adverse actions taken against health care providers. Such a data base should contain strong safeguards in order to ensure the confidentiality and accuracy of information contained in this system.

7. Design a simplified, uniform claims form for reimbursement and an electronic billing system, with tough anti-fraud controls incorporated into these designs from their inception.

8. Take several steps to better protect Medicare from fraudulent provider billing practices, such as:

- revise and strengthen national standards that suppliers and other providers must meet in order to obtain or renew a Medicare provider number;
- prohibit Medicare from issuing more than one provider billing number to an individual or entity (except in specified circumstances), in order to prevent providers from "jumping" from one billing number to another in order to double-bill or avoid detection by auditors;
- require Medicare to establish more uniform national coverage and utilization policies for what is reimbursed under Medicare, so that providers cannot "forum shop" in order to seek out the Medicare carrier who will pay a higher reimbursement rate;
- require the Health Care Financing Administration to review and revise its billing codes for supplies, equipment and services in order to update, clarify, and standardize billing codes. HCFA should be required to improve the descriptions used for reimbursement codes so that they accurately reflect the items being furnished and to make them sufficiently explicit to distinguish between items of varying quality and price. Such an updating of the billing codes used by HCFA would be a major step toward eliminating excessive reimbursements for poor quality items and Medicare reimbursements that far exceed a fair price for the item; and
- provide adequate guidance to health care providers on how to comply with anti-kickback and other health care fraud prohibitions. We recognize that due to the complexity of the health care market, many providers have difficulty interpreting

reimbursement policies of public and private health plans, as well as difficulty in determining whether specific relationships with other providers or billing practices are prohibited under anti-fraud provisions. If comprehensive health care reform proposals are enacted, further confusion over what constitutes prohibited activity may result. Therefore, we recommend that the Secretary of HHS, working with the HHS Inspector General and the Department of Justice, develop a system to provide better guidance to health care providers on how to comply with anti-kickback and other health care fraud provisions.

Many of these recommendations are included in health care reform proposals now pending before Senate and House committees. Additionally, the Senate-passed version of omnibus crime legislation, now pending in conference, includes provisions to facilitate criminal prosecution of health care fraud.

While we are pleased that many of these proposals are now under consideration by the Congress, we are deeply concerned that the huge magnitude of health care fraud and the critical importance of improving enforcement efforts immediately has not received adequate attention during the course of the health care reform debate.

With over $275 million being lost each day to health care fraud and abuse, we can no longer afford to wait to toughen our defenses against unscrupulous providers and others who are bleeding our health care system. Accordingly, we recommend a two-step process:

First, action should be taken immediately to strengthen criminal laws and enforcement tools to stop abuses of our current health care system. Too many dollars and lives are at stake to delay what can and should be done now to reduce health care fraud; and

Second, tough anti-fraud and abuse provisions must be built into the foundation of any health care reform plan enacted by the Congress so that unscrupulous providers will not take advantage of health care reform to further game the system.