

HEALTH CARE FRAUD IN NURSING HOMES

HEARING
BEFORE THE
SUBCOMMITTEE ON HUMAN RESOURCES
OF THE
COMMITTEE ON GOVERNMENT
REFORM AND OVERSIGHT
HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

APRIL 16, 1997

Serial No. 105-13

Printed for the use of the Committee on Government Reform and Oversight



U.S. GOVERNMENT PRINTING OFFICE

41-071 CC

WASHINGTON : 1997

For sale by the Superintendent of Documents, U.S. Government Printing Office
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HEALTH CARE FRAUD IN NURSING HOMES

WEDNESDAY, APRIL 16, 1997

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

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

Present: Representatives Shays, Snowbarger, Towns, and Barrett.

Staff present: Lawrence J. Halloran, staff director and counsel; Marcia Sayer, professional staff member; R. Jared Carpenter, clerk; and Ronald Stroman, minority professional staff member.

Mr. SHAYS. I would like to welcome our witnesses; I would like to welcome our guests. Mr. Towns and I are delighted to begin this hearing.

Vulnerable patients. Vulnerable programs. In the nursing home setting, both can be victimized by pernicious forms of health care fraud and abuse that undermine the quality and inflate the costs of care.

When separate vendors provide medical supplies, therapy, and other services to the same nursing home patient, no one is ultimately responsible for the coordination of care. When both Medicare and Medicaid are billed by the same service, health care dollars are wasted. When vendors manipulate Medicare Part A, Medicare Part B, and Medicaid reimbursement rules, decisions about the quality and quantity of nursing home services are driven by the size and source of the payments, not the best interests of the patient.

Today we begin an examination of long-term care expenditures by asking: What makes health care services provided in nursing homes uniquely susceptible to abuse? One answer: the absurd complexity of multiple program eligibility and reimbursement rules. If not the direct cause, program proliferation creates a conducive environment for overbilling, overutilization, and poorly managed care in nursing homes.

Fraudulent and abusive schemes take root and prosper in the definitional cracks and jurisdictional crevices of labyrinthine regulatory constructs in which toenail clipping becomes minor foot surgery and a coffee klatch can be billed as group therapy.

As the single largest purchaser of long-term care services in the Nation, Medicaid covers almost two-thirds of all nursing home residents. Many nursing home patients are also covered by Medicare

Part A for a time. Most elderly are eligible for Medicare Part B reimbursement for physician visits, other outpatient services, and supplies. In 1995, the three programs paid more than \$45 billion for services to nursing home patients.

State Medicaid Fraud Control Units are the first line of defense against nursing home fraud and patient abuse. For that reason, we invited them to testify first today, to describe the scope of the problem and their efforts to protect nursing home residents from perverse financial incentives and unhealthy medical choices.

Both Health and Human Services, HHS, Inspector General, IG, and the General Accounting Office, GAO, have also investigated services to nursing home patients. Their testimony will discuss the vulnerabilities they found affecting the cost and quality of long-term care.

Finally, we invited representatives from the nursing home industry to describe how they meet both their medical and fiduciary duties to those in their care.

As further evidence of the complexity of the problem, we can't even fit all the key players into one hearing. The Health Care Finance Administration, HCFA, equipment and service providers, private insurers, and consumers will be invited to testify later, as we formulate more detailed findings and recommendations for regulatory and legislative solutions to address the problem of nursing home fraud.

In the last Congress, this subcommittee spoke with a strong bipartisan voice, advocating many of the anti-fraud provisions ultimately included in the Health Insurance Portability and Accountability Act. For the first time, fraud against all health care providers, public and private, is a Federal criminal offense.

The new law also mandates and funds enhanced enforcement efforts coordinated at Federal, State, and local levels. Nowhere is the need for coordinated enforcement more urgent than in the fight against fraud in nursing homes. Each of our witnesses today plays an essential role in that coordinated strategy, and we welcome their testimony.

At this time, I would like to invite my partner in this effort, Mr. Towns, to make a statement.

Mr. TOWNS. Thank you very much, Mr. Chairman. Let me thank you again for holding this hearing.

One of the concerns that I have repeatedly discussed is the issue of patient records. In preparing for this hearing, I was outraged to learn that, in some instances, nursing home operators make patient records available to equipment suppliers and to outside providers who are not responsible for the direct care of the patient.

These operators and providers target nursing home residents to sell them unnecessary medical supplies and to perform unnecessary medical services, in many instances. This practice is wrong, and it should be illegal. It permits the exploitation of vulnerable nursing home residents and leads directly to fraud within the Medicare and Medicaid programs.

Anyone caught improperly making patient records available should be excluded from the Medicare and Medicaid programs, and should be fined.

Another area of concern is the complicated matter in which Medicare bills are paid. Currently, bills for outpatient and equipment are paid by six different claim processing systems—six, Mr. Chairman. We need a single, consolidated billing system. That is why I was pleased that last week the Health Care Financing Administration awarded a contract for development of a standard system for paying Medicare physicians and other outpatient bills. I am hopeful that this system will permit a more rational Medicare billing process.

Mr. Chairman, we need to develop an accurate Medicare data system as soon as possible. Federal, State, and local agencies must find better ways to share information on nursing home fraud. We need more coordinated Federal and State fraud investigations to make more efficient use of limited enforcement resources.

Finally, we must insist that people convicted of nursing home fraud be punished to the fullest extent of the law, including exclusion from participation in the Medicare and the Medicaid programs. Also, licenses should be revoked and, where appropriate, prison and fines. Without a comprehensive attack on these criminal enterprises, nursing homes will continue to serve as a breeding ground for fraud.

So, Mr. Chairman, again I thank you for holding this hearing, and I look forward to working with you to try to clean up the mess that is out there.

I yield back.

Mr. SHAYS. I thank the gentleman.

Let me get some housekeeping out of the way first. I would ask unanimous consent that all members of the subcommittee be permitted to place any opening statements in the record and the record remain open for 3 days for that purpose. Without objection, so ordered.

I would also ask unanimous consent that all witnesses be permitted to include their written statements in the record. Without objection, so ordered.

At this time, I would like to introduce our first panel. We have four witnesses, from Maryland, Arizona, New York, and Colorado. We know that you come with some effort to be here, and we really thank you for that.

Carolyn McElroy, vice president, National Association of Medicaid Fraud Control Units, and director, Maryland Medicaid Fraud Control Unit; Steven Wiggs, assistant attorney general and director, Arizona Medicaid Fraud Control Unit; Stephen Spahr, deputy attorney general and director, New York Medicaid Fraud Control Unit; and Richard Allen, Medicaid director, Colorado.

We have four excellent witnesses. As I think you were told, we swear in all our witnesses, including Members of Congress.

[Witnesses sworn.]

Mr. SHAYS. For the record, we will note that all witnesses have responded in the affirmative.

We will go just right down the line, and we will start with you, Ms. McElroy.

STATEMENTS OF CAROLYN J. McELROY, VICE PRESIDENT, NATIONAL ASSOCIATION OF MEDICAL FRAUD CONTROL UNITS, AND DIRECTOR, MARYLAND MEDICAID FRAUD CONTROL UNIT; STEVEN WIGGS, ASSISTANT ATTORNEY GENERAL AND DIRECTOR, ARIZONA MEDICAID FRAUD CONTROL UNIT; STEPHEN M. SPAHR, DEPUTY ATTORNEY GENERAL AND DIRECTOR, NEW YORK MEDICAID FRAUD CONTROL UNIT; AND RICHARD ALLEN, MEDICAID DIRECTOR, COLORADO DEPARTMENT OF SOCIAL SERVICES

Ms. McELROY. Thank you. Mr. Chairman, members of the committee, thank you very much for inviting me to be here today.

My name is Carolyn McElroy, and I am the director of the Maryland Medicaid Fraud Control Unit. I am here today representing the National Association of Medicaid Fraud Control Units, of which I am currently serving as the vice president. I have come here today to discuss the role of the States in investigating and prosecuting health care fraud and, specifically, fraud in the delivery of long-term care to Medicare and Medicaid beneficiaries.

When the Medicaid program was established in 1965, its cost to the Federal Government was \$1.5 billion. Today, the cost of the program is more than 100 times as great, \$160 billion, and that is only the cost to the Federal Government. States are responsible for up to 50 percent of the cost of the Medicaid programs, with some of the States devoting to 15 to 20 percent of their total budget to sustain the Medicaid program.

Medicaid Fraud Control Units are presently established in 47 States. We currently have jurisdiction over provider fraud, physical and financial abuse of patients in Medicaid-funded facilities, and fraud in the administration of the program.

There are some holes in the jurisdictional fabric, and the National Association has recently proposed that these loopholes be closed. Specifically, as the States seek lower-cost alternatives to long-term care facilities, we find that they are placing vulnerable adults into domiciliary care or alternative residential settings that were probably unanticipated at the time the Medicaid Fraud Control Units were established.

Although these settings are even more prone to physical and financial abuse than are the more closely watched and regulated nursing homes, the Medicaid Fraud Control Units currently lack the authority to prosecute abuse in these settings. We also find that Medicare fraud which is uncovered during our Medicaid investigations is often not pursued in cases where the Federal authorities deem the amounts uncovered to be too small.

The National Association believes that the proposal to amend the Medicaid Fraud Control Units' jurisdiction to fill in these loopholes, which was originally included in the Kennedy-Kassebaum legislation, would have provided the flexibility we need to more fully prosecute fraud, and we urge you to consider this in future legislative efforts.

The units were established by Congress in the late 1970's, following the discovery that there was rampant fraud and abuse in the Medicaid program. To date, the units have amassed more than 8,000 convictions and recovered millions of dollars which would otherwise have been lost to the programs.

Ironically, the case which spurred the congressional funding of the units was a New York City nursing home case where it was discovered that patient needs were being grossly neglected while the owners diverted millions of dollars intended for patient care to their own personal needs.

We find ourselves here, 20 years later, to talk again about fraud in the nursing home industry. In 1977, when the New York nursing home case was uncovered, Medicaid fraud was relatively unsophisticated and easy to detect. Fraud was rampant mostly because there was no oversight whatsoever. Today, I share the view with my sister States that fraud and abuse are just as prevalent, but that providers are far more sophisticated and able to detect new weaknesses in the system as fast as we shore up our defenses to stop areas of past abuse.

Traditionally, nursing home prosecutions involved the filing of false cost reports, which were proven false because they claimed reimbursement for expenses which were not properly attributed to patient care. In most successful prosecutions, it was shown that the expenses were personal to the owners.

Using only Maryland's cases as an example, we have criminally prosecuted owners and administrators for including in their nursing home cost reports the costs of renovating their personal residences; maintaining the swimming pool; buying shrimp and tenderloin for holiday entertaining, or, in the case of one of our rural facilities, butchering the owner's hogs; including personal maid service and opera tickets on a cost report; paying a salary to a son who was in prison in Texas at the time he was drawing the salary; buying, heating, and fixing up rental properties for the benefit of the owners; and putting together a custom-built monster truck which was owned by the administrator's son.

We have also prosecuted owners who overstated Medicaid's obligations on patient census reports, stole money from patient accounts, failed to report income from a related party contract with a vendor, wrongly authorized Medicaid reimbursed transportation, overstated and upcoded the level of care needed by the patients, and failed to refund amounts which should have been credited for medications that were not actually dispensed to the patients.

That has always seemed to me to be a pretty impressive list of wrongs for a State that has fewer than 250 nursing homes.

Today, we seldom see cases involving this kind of fraud. The State of Maryland audits nearly every nursing home in the State nearly every year. Nursing home owners now know that this kind of fraud will be detected and will be prosecuted. Instead, they concentrate on maximizing profits by analyzing the reimbursement process for weaknesses in the regulations and the oversight of the programs.

Lately, the homes have focused on the gap between the oversight of the Medicare and Medicaid programs. I would like to talk about two specific examples. The first is a gray area where a nursing facility finds it profitable to be a provider or to be related to a provider of ancillary services. This allows them to essentially double-bill for certain items provided in the nursing home care.

The services in Maryland which have proven particularly susceptible to this scheme are therapy of any sort—that includes occupa-

tional, physical and speech therapy—and durable medical equipment. In a nutshell, the problem is that the homes are permitted to include the costs associated with providing the therapy or equipment in their Medicaid cost report, and thereby increase their per diem rate.

The facility is also permitted to bill the services to Medicare Part B. The income which is received from the Medicare reimbursement is not required to be reported as an offset to the Medicaid expenses. Hence, the facility gets paid for the services by Medicaid through a higher per diem rate, and also gets paid directly by Medicare for the same service. It is hard to recover the funds, let alone prosecute a criminal case for this double-dipping, when the regulations of the various programs are not cohesive and do not expressly prohibit this behavior.

The second example is an example of outright fraud. It is exemplified by a case which was indicted by the Washington State Medicaid Fraud Control Unit just 2 weeks ago. As you know, Medicare will cover all or a portion of a patient's care following hospitalization for an acute condition. Since Medicare generally pays more than Medicaid, facilities are encouraged to hospitalize their patient for acute conditions based on eligibility cycles.

Even more egregious, however, is the Washington State case where a nursing home had billed Medicare for the days following a hospitalization, but has also billed the very same care to Medicaid. Hence, the home was literally paid twice for the same days of care, and both times by federally subsidized programs. I would note also that this same fraud has been identified in Texas facilities.

In order to detect and prosecute this kind of fraud, greater cooperation of both State and Federal agencies is needed. Medicaid Fraud Control Units traditionally experience difficulty in getting Medicare payment information regarding nursing homes. This is because nursing homes are permitted to submit their bills to virtually any Medicare fiscal intermediary. So, in the State of Maryland, if I were to go request information on Maryland Medicare beneficiaries in nursing homes, I would have to contact as many as 61 different fiscal intermediaries.

In addition, the information which is reported to us by the fiscal intermediaries is reported in incompatible formats, either with the State's Medicaid data and, frequently, with that of the other fiscal intermediaries. In Texas, for example, information was provided on microfiche and was sorted by beneficiary instead of by facility. If it is not provided in electronic form, it's almost impossible for us to re-sort it.

While this has been a past problem, I am pleased to tell you that we are presently working with the Health Care Financing Administration and other Federal agencies to find solutions. HCFA is working with the Maryland Unit currently to provide electronic data for all nursing homes in the State of Maryland, regardless of what the fiscal intermediary was, and I anticipate that this project will be successful. Washington State, also, as you know, is taking a lead in prosecuting this complex dual eligibility case, and I anticipate that they will also be successful.

All of the Medicaid Fraud Control Units are working toward stronger partnerships with the Federal agencies who are respon-

sible for prosecuting Medicare fraud. We are viewed as having a national leadership role in prosecuting health care fraud and abuse, and we intend to continue to serve in that capacity.

Mr. Chairman, thank you for giving me the opportunity to be heard, and I welcome any questions you have.

[The prepared statement of Ms. McElroy follows:]

Mr. Chairman, Members of the Committee:

I am Carolyn J. McElroy, Director, of the Maryland Medicaid Fraud Control Unit. I am very pleased to appear before you today as the Vice-President of the National Association of Medicaid Fraud Control Units to discuss the role of the states in investigating and prosecuting health care fraud. The skyrocketing costs associated with health care delivery and the continued "graying" of our population have resulted in an increased reliance upon government-sponsored programs such as Medicare and Medicaid to provide much needed health insurance to those who would otherwise go without medical care.

The Medicaid program, which was established to provide health care to indigent patients, has seen its enrollment explode. Nationwide, the Health Care Financing Administration expected to spend more than \$160 billion in FY 1996 to sustain the Medicaid Program. Thirty years ago, when the Program started, Medicaid expenditures were \$1.5 billion. Medicaid recipients increased from about 10 million in 1967 to a projected 37.5 million in FY 96, an increase of 275 percent. State expenditures for Medicaid have doubled in the past five years and in some urban areas, such as Los Angeles, Baltimore and New York, it is not uncommon for one-fourth of the population to rely on the Medicaid program for their basic health needs. Even though Medicaid is generally funded 50% by federal money, several states now spend between 15 to 20% of their general budget to sustain the program.

This nation is expected to spend almost \$1 trillion on health care or 15% of our gross national product this year. Given these figures, it is not surprising that our health care delivery system has proven ripe for fraudulent activity.

The General Accounting Office (GAO) recently estimated that fraud and abuse accounts for 10% of health care costs, currently exceeding \$800 billion, and while there may not be a way to

establish a precise figure, we are certainly talking about many hundreds of millions of dollars of fraud and abuse in the Medicaid program alone. GAO stated further in testimony before the House Subcommittee on Crime and Criminal Justice on February 4, 1993 that only a fraction of health care fraud and abuse is identified and prosecuted. GAO acknowledged that without adequate resources effective investigation and prosecution of health care fraud is not possible.

During the past decade, in particular, we have literally seen a feeding frenzy on the Medicaid Program, a period of unprecedented white collar "wilding" in which wave after wave of multimillion dollar frauds have swept through nursing homes and hospitals, to clinics and pharmacies, durable medical equipment (DME), radiology and labs, and more recently, home health care. Although we do the best we can to put an end to program vulnerabilities, we still have profiteers who search and succeed in finding the next great loophole in the Medicaid system.

STATE MEDICAID FRAUD CONTROL UNITS

While the investigation and prosecution of health care fraud has only recently become a top national law enforcement priority, the states have been combating health care fraud for the past two decades and are viewed as leaders in the detection and prosecution of fraud in the health care industry. Medicaid, established by Congress in 1965 is of course, the primary government health care program for approximately 37.5 million of America's poorest and oldest citizens. For the first decade after Medicaid was created, the system operated with few controls against fraud. Inadequate safeguards combined with multi-billion dollar expenditure levels made a substantial amount of fraud inevitable. The result was an unprecedented theft of government dollars as local prosecutors struggled with the difficult task of prosecuting these highly sophisticated crimes. Congress came to recognize an urgent need to address this loss after much media attention and Congressional hearings highlighted the theft of taxpayer dollars and the harm suffered by Medicaid patients who

were deprived of basic medical care. The result was legislation to establish specialized state-based strike forces to police the Medicaid program.

In 1977, Congress enacted legislation, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, P.L. 95-142 which established the state Medicaid Fraud Control Unit Program. The objective of this legislation was to strengthen the capability to detect, prosecute and punish health care fraud. In addition to investigating and prosecuting providers who defraud the Medicaid program, the mandate to Medicaid Fraud Control Units (MFCUs) specifically includes the authority to prosecute the abuse or neglect of patients in all residential health care facilities which are Medicaid providers. The Units are staffed by professional teams of attorneys, investigators and auditors specifically trained in the complex litigation aspects of health care fraud. The enabling federal legislation emphasizes the necessity of having an integrated multi-disciplinary team in one office in order to successfully prosecute these complex financial crimes. The Units are required to be separate and distinct from the state Medicaid programs and are usually located in the state Attorney General's office, although some Units are located in other state agencies with law enforcement responsibilities such as the state police or the state Bureau of Investigation. The Omnibus Reconciliation Act of 1993 required all states to have a Medicaid Fraud Control Unit by January, 1995, unless a state could demonstrate to the Secretary of the Department of Health and Human Services, (HHS) that it had a minimum amount of Medicaid fraud and that residents of health care facilities that receive Medicaid funding will be protected from abuse and/or neglect.

Since the inception of this pioneering program, 47 federally certified state units have successfully prosecuted over 8,000 corrupt medical providers and vendors and elder abusers -- convictions that would not have occurred without this vital piece of legislation. These 47 Units police most of the nation's Medicaid expenditures with combined staff of approximately 1,166 and

a total federal budget of \$82 million. This amount represents a small fraction of the total Medicaid budget that the Units are responsible for policing. Unit size varies state-by-state and is dictated to some extent by the size of state's Medicaid program. In Maryland, for example, our Medicaid budget is \$2.2 billion and the Unit employs 20 staff. New York is the largest Unit with approximately 280 staff and Wyoming is the smallest with four.

In addition to the criminal consequences of MFCU cases (repayment of restitution, overpayments, state exclusions, incarceration, and often the loss of certifications, the ability to conduct business and professional licenses) the criminal convictions of the Units become the basis for further federal actions. The federal actions that are reported to you by the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) include the underlying state convictions, judgments, forfeitures, civil settlements, federal program exclusions, and civil monetary penalties. In fact, the majority of health care fraud convictions, penalties, and exclusions reported to you are based upon MFCU convictions. The MFCUs are the most efficient and effective law enforcement agencies in the battle against health care fraud and patient abuse.

PATIENT ABUSE AND NEGLECT

While this remarkable success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well known that the Units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect.

Patient abuse can be classified into several categories. For example, providing inadequate medical or custodial care or creating other health care risks may constitute patient neglect. Physical abuse includes acts of violence such as slapping, kicking, hitting or punching a patient and sexual abuse. Financial abuse includes the misappropriation of patients' personal funds such as commingling patient and facility funds or using patient funds to pay for facility operations.

Scores of investigations and years of cumulative experience have made it clear that the abuse, neglect, mistreatment, and economic exploitation of nursing home residents is a problem of far greater magnitude than previously thought. Our national association, in collaboration with the National Association of Attorneys General (NAAG), has therefore promulgated a model patient abuse statute -- already adopted in several states -- that would not only provide the necessary prosecutorial tools and enhanced penal sanctions for combating this type of shocking misconduct, but would also serve as a powerful deterrent to potential patient abusers.

A few examples of the Units' work in this area follows:

- A New York physician was criminally prosecuted for wilful neglect and reckless endangerment of a nursing home patient in his care. He mistook a peritoneal dialysis catheter in the patient's abdomen for a feeding tube, and ordered that she be fed through the catheter. When this error was discovered two days later, he made a conscious decision to do nothing to help the patient despite expert advice that the patient required hospitalization for treatment. Finally, ten hours later, the physician agreed to transfer the patient to the nearby hospital for care.
- In Arizona, a residential care home owner was sentenced to serve 21 years -- the longest sentence for elder abuse in the state's history -- for neglecting and abusing his aged patients. To induce families to place their relatives in his facility, the defendant had lied to them about his licensure status.
- Four nursing home officials in Philadelphia were charged with involuntary manslaughter in the death of two nursing home residents who died from massive and infected bed sores.

- Beverly Enterprises, Inc., the largest nursing home chain in the nation, agreed to pay \$600,000 to improve care at their 17 facilities in the state of Oregon, after an MFCU investigation of a Beverly home found evidence of inadequate staff training and supervision, and other conditions constituting an immediate threat to resident health and safety.
- The third largest nursing home corporation in Texas (the ninth largest in the nation), four corporate officers, and four employees were indicted on charges related to the deaths of two facility residents. One patient allegedly died from neglect, and the other, who suffered from senile dementia, was allowed to wander from the nursing home, became lost, and died of exposure.

And beyond these egregious cases of corporate and management neglect, the Units have also uncovered hundreds of incidents of individual nurses, aides, and orderlies, raping, sodomizing, beating, kicking, and force-feeding the helpless, often incompetent patients in their charge.

Congress enacted P.L. 95-142, not only because of the widespread evidence of fraud in the Medicaid Program, but also because of the horrendous tales of nursing home patient abuse and resident victimization -- and the Units are justly proud of their record in protecting the frail and vulnerable institutionalized elderly.

PROVIDER FRAUD SCHEMES

In the past decade, we have seen a rapid increase both in the number of fraudulent schemes and the degree of sophistication with which they are committed. Although the typical fraud schemes such as billing for services never rendered, double billing, misrepresenting the nature of services provided, providing unnecessary services, false cost reports and kickbacks still regularly occur, new

and often innovative methods of thievery have consistently occurred and are even just beginning to appear.

Medicaid fraud cases run the gamut from a solo practitioner who submits claims for services never rendered to large institutions which exaggerate the level of care provided to their patients and then alters patient records in order to conceal that lack of care. MFCUs have prosecuted psychiatrists who have demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who steal money from residents, and even funeral directors who bill the estates of Medicaid patients for funerals they did not perform.

The following are typical schemes corrupt providers may use to defraud the Medicaid program.

1. *Billing for services not rendered* - A provider bills for services not rendered, x-rays not taken, a nursing home or hospital continues to bill for services for a patient who is no longer at the facility either due to death or transfer, and psychiatrists bill for SSI qualifying exams which do not occur.
2. *Double-billing* - A provider bills both the Medicaid program and a private insurance company (or the recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date.
3. *Substitution of generic drugs* - A pharmacy bills the Medicaid program for a brand name prescription drug, when a low cost generic substitute was supplied to the recipient at a substantially lower cost to the pharmacy.
4. *Failure to refund unit dose prescriptions* - Many nursing home pharmacies dispense drugs using the "unit dose" method, where a month's supply of pills are dispensed in sanitary bubble packs holding individual doses. The prescriptions are billed to Medicaid when

dispensed, usually at a premium because of the extra effort involved in the unit dose packaging. Those medications which are not used should be, but often are not, credited to Medicaid. The percentage of returned medication is high in a nursing home because of the large number of mid-month medication changes, hospitalizations, and "use as needed" medications in the nursing home industry.

5. *Unnecessary services* - A physician performs numerous tests which are medically unnecessary and result in great expense to the insurer. Extreme examples noted in many states include 'gang banging,' where a single optometrist, podiatrist or other specialist will be allowed to treat the entire nursing home population in a day, regardless of whether the service is medically necessary for the particular patient being seen.
6. *Upcoding* - A physician bills for more expensive procedures than were performed, such as a comprehensive procedure when only a limited one was administered, a psychiatrist bills for individual therapy when group therapy was given.
7. *Kickbacks* - A nursing home owner requires another provider, such as a laboratory, ambulance company or pharmacy, to pay the owner a certain portion of the money the second provider receives from rendering services to patients in a nursing home. This practice is particularly costly because we find that it encourages the nursing homes, which act as gatekeepers for the ordered ancillary services, to subscribe to unnecessary ancillary services which are reimbursed by Part B Medicare and Medicaid. Examples of abuse uncovered by state MFCUs include authorizations for ambulance transportation of ambulatory patients, therapy of all disciplines and laboratory services.
8. *False Cost Reports* - A nursing home owner or operator includes inappropriate expenses for Medicaid reimbursement. Examples in cases prosecuted in Maryland alone have included

the cost of shrimp and tenderloin for the owner's holiday entertaining, renovation of the owner's kitchen, opera tickets, the salary for a maid, salary for family members who did no work (including one who was in prison at the time he was being paid) and costs associated with the administrator's 'monster truck'.

9. *False patient census reports* - Nursing home per diem rates are a function of the nursing home's total costs, and the percentage of the nursing home population which is on Medicaid. Overstating the number of Medicaid patients, or understating the Medicare or private paying patients, skews the Medicaid per diem rate. For example, a nursing home owner promised a resident free care for life if she transferred her residence to him. She should have been -- but was not -- reported as a private paying patient. Instead, the owner waited until the transfer of the asset was beyond the eligibility inquiry period, and then placed her on Medicaid.
10. *Overstated facility costs* - Where facility costs are based on historical costs, owners who pay more for the homes get more money from Medicaid. Before it instituted fair market value based reporting, Maryland experienced "musical nursing homes" where the owners literally traded homes at inflated prices in order to increase interest expense and overall book costs on homes. A close corollary is a scheme whereby artificially high administrative costs are paid to management companies who are indirectly related to the home ownership.

NEW SCHEMES AND TRENDS

Over the past few years, these so-called "typical" schemes have given way to more innovative ones. Recently, the Units have identified serious fraud problems in several industries including laboratories, home health care, medical transportation, medical supplies, pharmacies, and imaging centers. The incidence of illegal drug diversion has risen sharply over the years, carrying with it a dramatic financial impact on the Medicaid program.

More and more states are enrolling their Medicaid population into managed care plans. While proponents of the managed care system believe that it is the best method for providing low cost high quality health care to more people, the experience of the fraud units reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans.

Recent global settlements of cases involving multiple state and federal entities have encouraged cooperative federal/state efforts to protect the Medicare/Medicaid programs from health care providers or vendors whose activities know no borders.

FRAUD IN NURSING HOMES

As I stated earlier, the state Medicaid Fraud Control Unit Program was created not only because of the widespread evidence of fraud in the Medicaid program, but because the public and Congress realized that too many nursing home patients were held hostage by the greed of a small number of facility operators and other dishonest health care practitioners who saw fit to use the Medicaid program as their own private "money machine."

The Medicaid program still continues to finance the largest percentage of total costs for nursing homes. In 1995, total Medicaid vendor payments were approximately \$129 billion dollars. Twenty-four percent of this amount went to nursing facility services which includes skilled nursing facilities (SNFs) and all other categories for Intermediate Care Facilities (ICF), other than mentally

retarded (MR) services. The number of skilled nursing facilities has been increasing since the 1970's and by the beginning of 1996 reached 13,444.

Before I discuss dual eligibility, I would like to highlight a few examples of the Units' work in nursing home fraud.

- A Massachusetts nursing home agreed to pay \$40,000 in restitution, to fully comply with all federal and state laws and regulations applicable to the Medicaid program, maintain complete and accurate records, file accurate and true cost reports with the state and continue to provide quality services to its residents after fraudulently billing the Medicaid program for reimbursement of services that were never rendered to its residents.
- South Carolina's first criminal conviction following the Unit's creation in 1995, was a management company that operated a nursing home. The company illegally received almost \$50,000 in Medicaid funds for a patient who had already been discharged.
- The former administrator of a nursing home in Nevada pleaded guilty after the Unit charged him with falsifying reports to the state by reporting nurse staffing hours in excess of the Medicaid regulations minimum requirements, when in fact, the actual hours of direct care were below the minimum levels.
- In Pennsylvania, a nursing home owner and his corporation pleaded guilty to Medicaid fraud for illegally collecting over \$120,000 by claiming reimbursement for personal, family and non-reimbursable business expenses. These expenses included vacation trips, entertainment costs, maintenance and home-improvement expenses for his personal residence and health and life insurance for his family. In addition,

the owner fraudulently inflated reimbursement expenses for the nursing home by submitting in his cost reports operating expenses of two separate personal care boarding homes that he also owns.

- The Bureau of Medi-Cal Fraud obtained a conviction from a former nursing home owner who pleaded guilty to receiving kickbacks from medical supply companies in exchange for ordering incontinence supplies paid for by the Medi-Cal program.
- In Louisiana, a nursing home administrator pleaded guilty to Medicaid fraud for submitting false claims to the Medicaid program when the residents were either deceased or discharged or were hospitalized.

DUAL ELIGIBILITY

In the nursing home setting, there are generally three primary categories of government funded payment, Medicare, Medicaid and those individuals who are dually eligible. In the case of a dually eligible patient, Medicare pays the bulk of the costs for certain periods and Medicaid pays the rest. According to HCFA, there were nearly 6 million dually eligible recipients in 1995. Since there are fifty states and the District of Columbia administering the Medicaid-covered patients, and an even greater number of Medicare intermediaries overseeing the benefits provided to Medicare patients, it is not surprising that there is little effective communication between programs which coincidentally cover the same patients at the same time.

Consider the complexity of the institutional program funding scenario:

In the case of a dually eligible patient who is hospitalized for three or more days, and released to the care of a nursing home, Medicare will cover in full the first twenty days of the post-hospitalization period and a large portion of the following eighty days. Medicaid covers the unpaid portion for days 21 through 100, and everything thereafter. If the patient was in the nursing home

prior to the hospitalization, Medicaid may also pay for a "bed hold" while the patient is in the hospital.

Sixty days after the last Medicare payment, the cycle can be repeated following another hospitalization, without limitation as to the number of cycles.

Nursing homes receive funds from both Medicare and Medicaid, and file cost reports with both the federal and state governments administering these programs. Medicare intermediaries review and audit the Medicare cost reports, while state or state-contract auditors review the Medicaid cost reports. Although it goes almost without saying that, with the exception of the co-pay, these two programs should not be covering the same patient at the same time, there is little or no oversight of the combined program coverage.

The oversight process can be complex and has built in stumbling blocks. In Maryland alone, there are two Medicare intermediaries having both Part A and B patients, and most of the Part A patients are actually handled by a third intermediary in Omaha. Given the scattered liaisons which would be necessary to coordinate audit efforts for these programs, it is little wonder that the Medicare and Medicaid auditors have little knowledge and no natural access to the contents of the other program's cost reports. It has become equally clear that there is much duplicated effort in the dual audit process, while at the same time, an important and effective check and balance has been lost.

Examples include the following:

1) Two weeks ago in Washington State, the MFCU charged a nursing home owner and administrator with billing the Medicaid program for the full cost of patients who were concurrently being billed to Medicare. The allegations involve many hundreds of thousands of dollars in fraud.

A similar complaint is being investigated in Texas, and a sampling of the billings for the provider in question indicate that the same fraudulent scheme which is being prosecuted in Washington State is very likely also a factor in the Texas case.

2) The Texas MFCU has identified problems with hospice providers and nursing home providers receiving payments for the same services. Because the Texas Department of Human Services now periodically (and manually) compares their hospice and their nursing facility patient payment records, they detect and recoup these hospice/ nursing facility duplicate payments. The Texas MFCU has been able to identify several nursing home providers billing and being paid for services which were already billed by and paid to a hospice provider.

3) Another Texas case resulted in the conviction of an owner of the Regency Terrace Nursing Home in Sulphur Springs, Texas. Following a change of ownership audit, it was discovered that AARP, Medicare, and Medicaid were all paying for one resident's care. A more thorough review discovered that there were additional patients whose care was paid by more than one program. At present, the Unit cannot say how widespread the problem is.

4) In Maryland, nursing homes are not prohibited from having related companies provide therapy and durable medical equipment to their patients. The costs of the related entities are incorporated into the Medicaid cost report to prevent profit gouging on the Medicaid side, but many of the vended items and services which are properly included in the Medicaid cost reports may also be billed to Medicare, Part B. There is no requirement that the income from Medicare be offset against the expenses charged through to Medicaid. Hence, the homes "double dip" for these items. Problem areas are identified in Maryland by the rush of nursing homes declaring related ancillary service provider numbers.

5) Finally, we have noted that services which are included in the per diem rate can be unbundled and billed separately to the same or another program. One such example is that nursing homes may be required to provide non-emergency transportation to dialysis centers for their ESRD patients. Some facilities are not providing or paying for this service, but are instead authorizing ambulance transportation which is then billed to Medicare or Medicaid as a separate service as if it were not included in the reimbursement for long term care.

Since Medicaid is the payor of last resort, it is also more likely to be the victim in a dual-eligibility scheme. In order to effectively investigate and prosecute double billing, however, the MFCUs must have access to information from Medicare in a usable format.

MFCUs have traditionally experienced difficulties getting Medicare payment and cost report information. In Maryland, we cannot identify the underlying service for a Medicaid co-pay unless we have the billing information from Medicare. Our requests for Medicare billing information must be cleared by the Office of the Inspector General and then processed by the carrier. It is not unusual for a request to be pending for a year or longer before the information is received, greatly impeding our case investigation and often leading to the decision to exclude Medicare-related recoveries from our cases.

The problem is repeated with minor variations across the country. When the information is received, it is often provided in a cumbersome or unreadable format. Large volumes of information provided on microfiche are often unreadable and difficult to process, and the information is sorted by patient rather than by the facility. Because of co-pays and bed holds, and the possibility that occasional dual payments are mistakes or are properly refunded to Medicaid at a later date, manual review and sampling are ineffective ways to detect fraud. The best method of detecting fraudulent patterns is to engineer an electronic comparison of the Medicare and Medicaid payment histories on

a facility-by-facility basis. Currently, there are many states in which the Medicaid and Medicare record keeping systems are not compatible and will not support the necessary electronic analysis.

Nursing home reimbursement is a complex and intricate process. The reimbursement rates are often a function of average daily costs and may be established on a "market basket" rather than an individual basis. The cost report which is submitted by the nursing home may contain cost centers with individual reimbursement caps and profit and performance incentives, and most are prepared with the assistance of a small and select group of health care accountants who recommend the same profit maximizing ploys to all of their clients. The nursing home industry thinks, as the laboratory industry once did, that if they all inflate their cost reports they will all gain substantially while incurring little individual exposure to criminal or civil fraud prosecution. Additionally, as the result of the uniform rate setting mechanism, an overstated expense on one cost report can result in a higher amount being paid to all facilities.

There has been little success in prosecuting false cost reports on either the state or federal level. The cases are complex, time consuming to investigate, and it is often difficult to show that a false entry increased the amount received by the provider. Annual audits which often fail to challenge a billing practice or inadvertently ratify a provider's position are difficult defenses to overcome. There is, as noted, virtually no collaboration between different programs. This results, ironically, in both duplicated effort and inadequate audit controls. Not surprisingly, prosecutors tend to reject the cases. As a result, the area is wide open for fraud. The Medicaid and Medicare programs are, for all intents and purposes, an "honor" system.

Correcting the problem will not be simple and will require the intervention, attention, and cooperation of both state and federal agencies. Contract auditors for state and federal agencies should have physical and electronic access to the cost report data relating to filings with other

agencies, as well as tax return information, either from the provider or from the IRS.¹

Either HCFA, which has patient-oriented billing information, or the intermediaries, should be encouraged to cooperate with or spearhead the analysis necessary to identify double-dipping. Prosecutors at both the state and federal level should be encouraged to address these complex cases, in spite of the fact that many hours of resources will be needed to secure a conviction. The industry must be made to understand that there is no safety in numbers if all of the numbers are wrong.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS (NAMFCU)

The National Association of Medicaid Fraud Control Units (NAMFCU) was established in 1978 to provide a forum for the nationwide sharing of information concerning the problems of Medicaid fraud control, to foster interstate cooperation on law enforcement and federal issues affecting the MFCUs, to improve the quality of Medicaid fraud investigations and prosecutions by conducting training programs and providing technical assistance for Association members, and to provide the public with information on the MFCU program. All forty-seven MFCUs comprise the Association.

The Association employs a Counsel, located at the National Association of Attorneys General in Washington, D.C. The Association coordinates and disseminates information to the various Units, maintains a library of resource materials, and provides informal advice and assistance to its member Units and to those states considering establishing a Unit. NAMFCU conducts several training conferences each year and is called upon regularly to supply speakers for numerous health care fraud seminars. It has also co-sponsored training programs with the F.B.I. and the American Bar Association, conducts a specialized academy at the Federal Law Enforcement Training Center and

¹ The books and records which are used for tax purposes are often the same as those used for all cost reports. Nursing homes which are engaging in double dipping will most likely be those showing unusually large profits.

is developing a course on investigating and prosecuting institutional fraud. The *Medicaid Fraud Report*, published ten times a year, is the Association's newsletter.

AMENDING MFCU JURISDICTION

In 1994, the National Association of Medicaid Fraud Control Units drafted a legislative proposal to allow the state MFCUs to investigate and prosecute health care fraud in other federally-funded programs and to allow the Units to prosecute patient abuse and neglect in board and care and other alternative residential health care facilities. In an unprecedented historical agreement, the proposal was endorsed by the HHS Office of Inspector General, the United States Department of Justice, the National Association of Attorneys General and the American Association of Retired Persons (AARP).

While this proposal was included in former Senator William Cohen's anti-fraud legislation, it was not included in last year's Kennedy-Kassebaum law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") although it does fit in with recent efforts and initiatives to protect Medicare and Medicaid beneficiaries by closing loopholes that allow fraud and abuse to occur.

MFCUs often uncover evidence of Medicare fraud when investigating a Medicaid provider. A provider that defrauds Medicaid is often defrauding other federally-funded health care programs as well. These ancillary consequences may go unprosecuted in circumstances where either the MFCU funding jurisdiction would prohibit the use of resources to pursue these frauds or where federal authorities (U.S. Attorneys offices) believe the federal program fraud is too small to pursue.

Increasingly, state Medicaid programs are relying on alternative residential settings rather than traditional nursing homes. These alternative residential settings include recipient's own homes, group homes, board and care facilities and adult family homes. Because of the nature of these

alternatives to skilled nursing homes, traditional law enforcement oversight is slight to non-existent. NAMFCU's legislative proposal would allow MFCUs to use their resources to conduct investigations and prosecutions and thereby receive federal grant funding for patient abuse crimes that occur in these residential settings which are being relied on by most states to house their Medicaid population.

The main goal of this proposal is to maintain the jurisdictional flexibility (criminal, civil, administrative) presently available to the MFCUs while building on their experience in combating health care fraud. Many Units have successfully prosecuted cases in state courts in which federal programs have been victimized by the same fraudulent activities of those concurrently convicted of Medicaid fraud. MFCU prosecutors have been able to use both federal and state courts to bring the best possible cases in the most appropriate forum.

In closing, I want to emphasize that the Medicaid Fraud Control Units are viewed as having a national leadership role in detecting and prosecuting fraud and abuse in government funded health care programs. The Units have been successful in serving as a deterrent to health care fraud, in identifying program savings, removing incompetent practitioners from the health care system, and in preventing physical and financial abuse of patients in health care facilities.

Mr. Chairman, I want to thank you for this opportunity to testify today and would welcome any questions you may have.

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Mr. SHAYS. Thank you, Ms. McElroy. Thank you very much.
Mr. Wiggs.

Mr. WIGGS. Mr. Chairman, members of the committee, I am Steven Wiggs, director of the Arizona Medicaid Fraud Control Unit, and I consider it an honor to be here to testify today.

I have been asked to identify some emerging trends of fraud and abuse in the long-term care industry, within the context of dual eligibility and managed care. Let me begin by briefly contrasting the evolution of fraud control within the Medicaid program and the transition toward managed care and its effect on the fraud control efforts, a transition that so fundamentally changes the nature of how and where fraud occurs that it presents distinct and urgent challenges to those of us concerned with program integrity.

In 1977, Congress established the Medicaid Fraud Control Unit program in response to the targeting of Medicaid's soft underbelly of fee-for-service reimbursement by greedy providers. By regulation, the responsibility for fraud control was logically placed where the risk of loss was the greatest and where the location of fraud was most likely to occur. Hence, centralized claim reimbursement or claim-based provider profiling by the Medicaid agencies became the primary method of fraud detection.

The success of the Medicaid Fraud Control Unit program these past two decades is widely recognized, and their evolution as effective Fraud Control Units can be attributed to the fact that that responsibility for detection and referral of fraud logically reflected the system within which they operated.

Such is not the case with managed care. In 1982, Arizona was the last State to join the Medicaid system and, at the same time, the first to deliver indigent health care by way of a managed care model. It has, for the most part, succeeded. However, no thought was initially given to fraud control or program integrity.

As a result, allegations of fraud and mismanagement have shadowed a system once touted as the Nation's managed care model, but have also focused a critical light on what those of us in the fraud control profession have known for a long time: fee-for-service program integrity methods cannot simply be transferred onto a managed care model with any sense of efficacy.

Because of the structural differences and shifting of incentives created by managed care, the nature of fraud changes and its location shifts from the Medicaid agency to the contracting health plans or managed care organizations. The responsibility for fraud control, however, does not likewise shift, and the basis for program integrity, therefore, becomes market-based rather than justice oriented. The net result is that program integrity becomes illusory.

Arizona found itself in this precise predicament and has hit the problem head on by taking several steps in implementing a comprehensive managed care fraud control strategy. Chief among these have been the inclusion of the Medicaid Fraud Control Unit in fraud control development and the clear delineation of responsibility and accountability for program integrity.

I have identified other steps that Arizona has taken in this regard in my written statement prepared for the committee. Suffice it to say, however, current program integrity methods and regula-

tions, having evolved from the fee-for-service experience, are impotent in the managed care model.

This problem is further exacerbated in the long-term care arena where you have both Medicare and Medicaid populations. The amalgamation of dual program eligibility and managed care contracting creates new opportunities for fraud and abuse and leads to further blurring of program integrity responsibilities.

Consider these examples: Dual eligible residents whose Medicare co-payments are included in the Medicaid capitation which is paid to a network provider are routinely placed out of network and seen by non-network vendors, who then discount their services to the nursing home and accept Medicare Part B payment as payment in full.

Not only does Medicare lose out on the reduced fees, but Medicaid does not receive the service it contracted and paid for, and the discount is an illegal kickback between the provider and the nursing facility. Moreover, the patient may be defrauded regarding informed consent by electing to go out of network, and since the nursing facility or non-network provider is required to bill to collect the co-payment, the possibility of sham or duplicate billings increases.

Consider also the managed care organization that awards a competitively bid contract for x-ray services, including coverage for dual eligibles, to a provider-vendor that offers a 20 percent reduction in fee-for-service billings, including those billed to Medicare Part B. The very entity that has program integrity responsibility is benefiting from the potential fraudulent activity.

Consider also the physician in a rural community who has an ownership interest in the managed care organization that administers the capitated long-term care contract covering the very patients that he treats. While allegations of underutilization regarding the capitated patients abound, such as failure to prescribe antibiotics for infections, failing to order necessary x rays, and dispensing leftover or outdated drugs, indications of gang visits and unnecessary services to the dual eligible patients should come as no surprise.

Who is coordinating the data to determine the scope of the problem? Consider also the nursing home administrator that operates a profitable side business involving physical therapy services to nursing home residents, which are billed to Medicare Part B, while allegations of short staffing and underutilization regarding Medicaid patients are widespread.

The complications and blurring of program lines created by dual eligibility is but one example of the emerging and complex issues faced by the Medicaid Fraud Control Units. It is also a good example of how detection and enforcement efforts, which are already compromised by multilayering and decentralization of managed care, become further compromised by the crossover nature of fraud between the two programs. Fraud is no respecter of program boundaries.

Although I am encouraged by the success of such programs like Operation Restore Trust, with its anticipated expansion into more States, in an effort to more fully integrate enforcement activities, I remain concerned that we will continue to play "catch-up" and

“hit-and-miss” regarding fraud because of artificial enforcement boundaries which serve only to limit the Medicaid Fraud Control Units’ continuing success in this new age of health care fraud.

Mr. Chairman, I want to thank you for this opportunity to testify today and would welcome any questions that you or the committee may have.

[The prepared statement of Mr. Wiggs follows:]

Mr. Chairman, members of the Committee, I am Steven Wiggs, Director of the Arizona Medicaid Fraud Control Unit. It is an honor to appear before this Committee today. I have been asked to describe to you our experience in Arizona with managed care and long term-care as it relates to program integrity and, more specifically, to identify some emerging trends of fraud and abuse occurring in the nursing home environment within the context of dual eligibility. Let me begin by briefly describing the evolution of fraud control within the Medicaid program and contrast that with the transition towards managed care and its affect on fraud control efforts - - a transition that so fundamentally changes the nature of how and where fraud occurs, that it presents distinct and urgent challenges to those of us concerned with program integrity.

In 1977, Congress established the Medicaid Fraud Control Unit (MFCU) Program in response to a problem that had gone unchecked for more than a decade. The dramatic upward spiral in program costs was, in large part, directly attributable to the unscrupulous providers who targeted Medicaid's soft 'underbelly' of fee-for-service reimbursement. The system was highly vulnerable to such greed because of the reimbursement incentive to over utilize services and the absence of a fraud control strategy from the inception.

In addition to the MFCU program, Congress implemented a regulatory scheme that required state Medicaid agencies to establish a comprehensive fraud detection, investigation and referral program. This regulatory scheme was based on the fundamental notion that responsibility for fraud control must logically be placed where the risk of loss is greatest and where the location of fraud is most likely. It mandated that each state Medicaid plan establish "methods and criteria for identifying suspected fraud cases" and that "[p]rocedures be

developed...for referring suspected cases to law enforcement.”

Thus, centralized claim-based provider profiling by the Medicaid agency became the primary method of fraud detection. Although many challenges remain with claim-based fraud control, the methods and criteria employed are logically placed, have a rational basis and are quite capable of catching even the most sophisticated scam artists. In short, the history of fee-for-service fraud control entailed the systematic uncovering of various reimbursement schemes concocted in the previous decades of “white collar wilding.” The MFCUs success in this regard is widely recognized and their evolution as independent, effective, and integral fraud control units is due to the fact that responsibility for detection and referral was clearly delineated and logically reflected the system within which they operated. Such is not the case with managed care.

In 1982, Arizona was the last state to join the Medicaid system and at the same time was the first to deliver indigent health care by way of a fully capitated, competitively bid managed care model. Operating as a “demonstration site” under section 1115 of the Social Security Act, Arizona’s managed care program has, for the most part, succeeded in providing cost efficient health care to Arizona’s indigent population. The system has not been without its critics, though. Although highly innovative in the areas of capitation and competitive bid contracting, as with the inception of the Medicaid program, not much thought was initially given to fraud control and program integrity. Managed care, as thought by some, would eliminate fraud as we knew it. Well, in part they were right...fraud ‘as we knew it’ didn’t readily surface in managed care, it came in new forms that we barely recognized. As a result, allegations of fraud and mismanagement have shadowed a system once touted as the nation’s managed care model, but

they have also focused a critical light on what those of us in the fraud control profession have known for a long time: fee-for-service 'program integrity' methods cannot simply be transferred to a managed care model with any expectation of efficacy.

Consider the differences and the fundamental shifting that occurs as a result of competitively bid contracts, capitation payments and risk-based contracting. Managed Care Organizations (MCOs) make their profit based upon how well they manage care. The risk of loss shifts from the third-party payer, in this case the Medicaid agency, to the contracting health plans. As the risk of loss shifts, the incentives regarding patient care are reversed. The threat is no longer exclusively that of over-utilization for maximum reimbursement, but now includes under-utilization for maximum profit. Because of this structural difference and shifting of incentives, the nature and location of fraud also shifts.

Thus, although the major determinants of fraud perpetration (i.e., risk of loss and location of fraud) shift from the Medicaid agency to the contracting MCOs, the responsibility for fraud control does not likewise shift and the basis for program integrity, therefore, becomes market-based rather than justice oriented. The net result is that program integrity becomes illusory. Without methods and criteria for identifying and reporting fraud, referrals from the contracted and sub-contracted health plans are non-existent and referrals from the agency are perennially low. The MCOs have their image, provider network, cost/benefit and civil liability to consider and therefore do not refer cases, while the Medicaid agency, having unofficially delegated the responsibility for fraud control via the managed care contract, can't refer what it can't see. Fraud control simply isn't a priority.

Arizona found itself in this precise predicament and has hit the problem head-on by

taking several first steps in implementing a comprehensive managed care fraud control strategy. Chief among these has been the inclusion of the MFCU in fraud control development and the clear delineation of responsibility and accountability for program integrity. This is accomplished through the contracting process by specifically requiring contracting MCOs to submit a fraud and abuse plan for prior approval and have in place demonstrable methods and criteria for identifying suspected fraud. It has not been without opposition though as no federal rule or regulation currently requires it. (The National Association of Medicaid Fraud Control Units has submitted specific language to the Health Care Financing Administration to amend 42 C.F.R. 455 - Medicaid Program Integrity, to extend the program integrity requirements to MCOs.) In addition, we have proposed that operational and financial 'on-site' reviews of MCOs, which are common in managed care, include a fraud and abuse audit that is designed to determine compliance, uncover irregular practices and assist in further developing fraud control methods. Although Arizona has had somewhat of a head-start, there are many obstacles and challenges that remain. Suffice it to say, current Medicaid program integrity methods and regulations, having evolved from the fee-for-service experience, are impotent in a managed care model.

The problem of delegated, market-based program integrity born out of managed care contracting is further exacerbated in the long-term care arena where you have both Medicare and Medicaid populations. In 1989, Arizona expanded its managed care program to include long-term care services. Like acute care, long-term care is provided primarily through capitation-based risk contracts with various health plans who in turn subcontract with providers and vendors, either through a fee-for-service or capitated arrangements. In many instances nursing

home residents are dually-eligible for Medicare and Medicaid. This amalgamation of dual program eligibility and managed care contracting creates new opportunities for fraud and abuse, and leads to the further blurring of program integrity responsibility. Consider these examples:

- Dual eligible residents, whose Medicare co-payments are included in the Medicaid capitation that is paid to a 'network' provider, are routinely placed out-of-network and seen by non-network vendors who then 'discount' their services to the nursing home and accept Medicare Part B as payment in full. (Not only does Medicare lose out on the reduced fees but Medicaid does not receive the service it contracted and paid for and the 'discount' is an illegal kickback between the provider and the nursing facility. Moreover, the patient may be defrauded regarding informed consent by 'electing' to go out-of-network, and since the nursing facility or non-network provider is required to bill to collect the co-payment, the possibility of sham or duplicate billing increases.)
- A managed care organization that awards a competitively bid contract for x-ray services, including coverage for dual eligibles, to a provider/vendor that offers a 20% reduction in the fee-for-service billings, including those billed to Medicare Part B. (The very entity that has program integrity responsibility also benefits from the potential fraudulent activity.)
- A physician in a rural community who has an ownership interest in the MCO that administers the capitated long-term care contract covering the very patients he treats. While allegations of underutilization regarding the capitated patients abound, such as failing to prescribe antibiotics for infections, failing to order necessary x-rays and dispensing 'left-over' or outdated drugs, indications of 'gang visits' and unnecessary services to the dual eligible patients should come as no surprise. (Who is coordinating the data to determine the scope of the problem?)
- A nursing home administrator that operates a profitable 'side business' involving physical therapy services to nursing home residents which are billed to Medicare Part B, while allegations of short staffing and underutilization regarding Medicaid only patients are widespread.
- An unlicensed portable x-ray vendor that contracts with numerous nursing facilities to provide x-ray services for both populations and simultaneously submits upcoded bills to both programs.

The complications and blurring of program lines created by dual eligibility, through which

fraudulent providers find such smooth sailing, is but one example of the emerging and complex issues faced by the MFCUs. It is also a good example of how detection and enforcement efforts, which are already compromised by the multi-layering and decentralization of managed care, become further compromised by the cross-over nature of fraud between the two programs. Fraud is no respecter of program boundaries. Although I am encouraged by the success of such programs like Operation Restore Trust and its anticipated expansion into more states in an effort to more fully integrate enforcement activities, I remain concerned that we will continue to play 'catch-up' and 'hit-and-miss' regarding fraud because of the artificial boundaries regarding enforcement jurisdiction which serve to limit effective coordination and the MFCUs continuing success in this new-age of health care fraud.

Mr. Chairman, I want to thank you for this opportunity to testify today and would welcome any questions you may have.

Mr. SHAYS. Thank you, Mr. Wiggs. I'm noting that both of you are obviously sharing parts of your testimony, because it's longer than the 5 to 10 minutes that we like, and I appreciate that.

I just want to point out, before our next two witnesses speak, when we passed our Health Care Reform bill last time around, it was going to have two titles. We inserted a third title, actually labeled Title II, which made health care fraud a Federal offense both in the public and private sectors. That whole title came from a hearing like this hearing that we had.

It's our intention—and we have staff on both sides of the aisle here—it's our intention, obviously, to go through your entire statements and continue the dialog we've had, but we're hoping that this hearing will generate some practical legislative changes that can happen in Congress and regulatory changes that we can recommend with the administration. We have a good working relationship with the administration.

I just want you to know that your testimony will, I think, ultimately result in some changes. So that's the attitude I want us to have.

Mr. Spahr.

Mr. SPAHR. Thank you. Good morning, Mr. Chairman, members of the committee.

Mr. SHAYS. Good morning.

Mr. SPAHR. My name is Stephen Spahr. I am the director of the New York State Medicaid Fraud Control Unit.

Mr. SHAYS. Could I ask you, Mr. Spahr, to just move the mike a little closer to you.

Mr. SPAHR. Certainly, sir. Is that better?

Mr. SHAYS. Even a little closer, if that's all right.

Mr. SPAHR. OK.

Mr. SHAYS. Can you still read your testimony?

Mr. SPAHR. Yes, I can.

Mr. SHAYS. OK. Thank you.

Mr. SPAHR. Mr. Chairman, in New York, we have approximately 666 nursing homes in operation.

Mr. SHAYS. What is the number again, please?

Mr. SPAHR. 666, which accounts for an annual expenditure in the last year of \$5.2 billion, out of a total New York State Medicaid expenditure of \$25 billion. That represented a 7 percent increase over the prior year.

In New York State, in recognition of the various problems which have emerged in the nursing home industry in recent years, the Medicaid Fraud Control Unit and the single State agency have engaged in a series of new initiatives, including participation in Operation Restore Trust. The Medicaid Fraud Control Unit has, in the last 3 months, formed a new Special Projects Division to deal specifically with nursing home and cost-based reimbursement issues in New York State.

The problem with dual eligibility: Cases in New York State have suffered, as has been indicated by other witnesses, by a lack of program coordination between the Medicare and the Medicaid programs. The data available from the fiscal intermediaries in the Medicare program has been slow in being available, and has been made available in formats which are difficult to use. In some cases,

it can take up to a year to obtain information relating to Medicare beneficiaries.

Additionally, in New York, most of our nursing homes are reimbursed on a cost basis, which has an all-inclusive rate which includes a number of various therapies and modalities which are included and paid for. We have particularly identified problems in New York where durable medical equipment, physical therapy, psychological services, which are already paid for in a nursing home's rate, are being billed separate by outside vendors, both to the Medicaid system, on a fee-for-service basis, and to the Medicare program, as well.

In a recent survey conducted by the single State agency of 200 durable medical equipment providers under Operation Restore Trust, they identified \$2.5 million in services which had been billed to the Medicare program for durable medical equipment, an additional \$2 million billed to the Medicaid program for DME, all of which were for services already included in the basic rate for those nursing homes.

To date, the single State agency has recovered over \$700,000 of the Medicaid dollars. It has referred over \$1 million for recovery to the Region A carrier, and has referred several cases for investigation to the Medicaid Fraud Control Unit.

A similar difficulty in the unavailability of data from both Medicare and Medicaid, and the coordination of that data, creates the risk that cases which are similar, frauds committed under both programs, may go largely undetected or unprosecuted. And the increased coordination of the availability of data from both those programs will increase the ability of the Medicaid Fraud Control Units and other agencies interested in fraud investigation and prosecution in increasing deterrents and potential punishment for those persons engaged in this activity.

While all of the traditional fraud activities in nursing homes continue in New York, most recently with a Buffalo-based organization which, through cost-based and cost report fraud, cost the program \$1.2 million plus an additional \$300,000 in identified kickbacks between related entities, we have identified a number of new and emerging trends in New York.

First and foremost of those are the durable medical equipment crossover cases which I've just discussed. Additionally, we have identified difficulties with therapy services rendered in nursing homes, such as the so-called "wave therapy," when a therapist will come through a nursing home and wave hello to the patients and then bill both programs whenever possible, as well as billing individual therapies when group therapies are being provided.

Most recently, under the aegis of Operation Restore Trust, we have pending in New York a case involving a physiatrist who billed a total of \$4 million to the Medicare and Medicaid programs for physical therapy evaluations and expensive nerve tests conducted on various nursing home residents.

As Mr. Towns indicated earlier, this provider was able to obtain from five nursing homes, on a monthly basis, lists of residents, including their Medicare and Medicaid billing information, and those patients were billed on a regular basis for therapies which were, in fact, not provided.

Such examples of those therapies included billing for patients who were deceased as of the date of service, billing for four limb nerve conduction tests on patients who were double amputees, and billing for services for patients who were in the hospital as of the date of services that they were alleged to have been rendered.

As stated earlier, the fraudulent provider will no longer recognize the boundaries of a program. The frauds are committed across all programs, both Government and private. The ability of the Medicaid Fraud Control Units to continue to combat fraud across all programs would be greatly assisted by closing the loopholes which Ms. McElroy referred to earlier and permitting the Medicaid Fraud Control Units to go after fraud in whatever Government program it exists.

Mr. Chairman, I thank you for your time and will take any questions.

[The prepared statement of Mr. Spahr follows:]

Statement of

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*Deputy Attorney General
New York State Medicaid Fraud Control Unit*



THE NEW YORK STATE ATTORNEY GENERAL
MEDICAID FRAUD CONTROL UNIT

HISTORICAL BACKGROUND

The New York Attorney General's Medicaid Fraud Control Unit ("MFCU") is the largest state law enforcement agency in the country dedicated exclusively to the investigation and prosecution of health care crime. As the investigative agency primarily responsible for monitoring the more than \$25 billion annually spent on Medicaid in New York State -- nearly 20% of the nation's total -- the 290-member Office has seven regional offices which are located in Albany, Buffalo, Long Island, New York City, Rochester, Syracuse, and Westchester-Rockland. In addition, the Office has 4 specialized Units: the Special Project's Division; the Patient Abuse and Adult Home Unit; the Civil Division; and Counsel's Office. Each Regional Office and Special Unit is directed by a Special Assistant Attorney General-in charge, who in turn reports to the Deputy Attorney General in charge of the MFCU.

The Office was created in 1975 following the revelation of widespread and shocking abuses plaguing the state's nursing home industry. The exposure of these scandals in late 1974 by both the media and the Temporary State Commission on Living Costs and the Economy drew national attention to the problem that millions of Medicaid dollars earmarked for the care of elderly and indigent patients were instead lining the pockets of greedy and politically influential nursing home owners and operators.

In its first two years, the Office, later certified as the State's MFCU, quickly posted some notable successes, including the conviction of two of the State's largest and most notorious nursing home operators -- Bernard Bergman and Eugene Hollander -- and the recovery of millions of dollars in restitution and fines. But as the pace of the MFCU's investigations increased sharply, it became apparent that the crimes of Bergman and Hollander were only the most visible examples of a systemic pattern of fraud that permeated the state's proprietary nursing home industry. Accordingly, the parameters of the MFCU's original mandate had to be expanded to include a sweeping statewide probe of the illicit relationships between all nursing home officials and their suppliers.

A typical Medicaid fraud scheme perpetrated in the late 1970s by corrupt nursing home owners was to include personal expenses on cost reports submitted to, and paid for by, the

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Medicaid program. The following Pennsylvania and North Carolina prosecutions are two more recent examples of inappropriate expenses included in claims to Medicaid.

In Pennsylvania, Beverly J. Turner and her daughter-in-law, Pamela Turner, owners of a 77-bed, family-operated business, were charged with defrauding the State Medicaid program out of more than \$155,000. The personal items charged to the nursing home included costs for remodeling Pamela Turner's home, installation of a furnace, carpeting, household furnishings, utilities, clothing, footwear, and even children's toys.

Following a 13-week trial in Concord, North Carolina, the State MFCU convicted Jo Lene's Nursing Home, Inc., its sole owner, Josephine Weaver, and its administrator, Cherrathce Hager, of multiple counts of medical assistance provider fraud and conspiracy. The investigation revealed that the nursing home, acting through Weaver and Hager, had overstated the facility's expenses and understated its revenues on Medicaid cost reports filed for 3 fiscal years. Among the personal expenses included on the reports were the salary for Hager's son's nanny and the salaries of two maintenance men who spent numerous hours performing work on the personal residences and rental properties of both women. Also included were the salaries of employees who performed duties at a rest home owned by Weaver and Hager which was not eligible for Medicaid reimbursement.

During this period in the 1970's, the New York MFCU received the additional responsibility of identifying fraud and abuse in the operation of the State's private proprietary homes for adults, commonly known as "adult homes", when state authorities began to suspect the possibility of scandal in that weakly regulated industry as well. In 1977, as word spread of New York's advances in the war on nursing home fraud, a nationwide awareness of the potential for Medicaid-Medicare abuse was growing rapidly. One result of this concern was a request by the U.S. Department of Health, Education and Welfare [now Health and Human Services] that the MFCU conduct a similar investigation into the operation of hospitals, thus placing the MFCU in the forefront of government's assault on white-collar health care crime.

In October 1977, as recommended by the U.S. Senate Finance Committee, Congress passed legislation [Section 17 of P.L. 95-142] establishing the State Medicaid Fraud Control Unit Program, thereby authorizing substantial federal funding to all states to "help establish Medicaid Fraud Control units patterned after the successful unit in New York." On May 2, 1978, the Special Prosecutor's Office was officially designated as New York's Medicaid Fraud Control Unit. Thus, the Office's initial jurisdiction over nursing homes and hospitals was expanded to include all Medicaid-funded health care providers - physicians, dentists, labs, clinics, pharmacies, and medical equipment vendors, among others.

During the 1970s and 1980s, the Medicaid Fraud Control Unit's pioneered many innovative breakthroughs in the investigation of fraud and abuse in America's multibillion dollar health care industry. Perhaps most important of these innovations was the implementation of

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the so-called "team concept" of experienced attorneys, auditors, and investigators working side-by-side to solve these highly complex economic crimes. In the MFCU's unique team approach, professionals from the three critical law enforcement disciplines -- invariably confronted by the best of the white-collar, criminal defense bar -- work together from the moment the first allegation surfaces until the jury returns with its verdict.

In addition to prosecuting Medicaid fraud, the MFCU has led the way in utilizing New York State's forfeiture and seizure laws, assisted in the removal of hundreds of unqualified and dishonest medical professionals from the Medicaid system, and actively participated in the reform of numerous Federal and State laws and regulations affecting the quality of patient care and the administration of criminal justice.

Since its inception in January 1975, through December 1996, the New York Attorney General's MFCU's investigations have resulted in the arrest of nearly 2,500 defendants for Medicaid fraud, official misconduct, patient abuse, drug diversion and related crimes, with an overall conviction rate of 92.1 percent. In addition, the Office has instituted the recovery of more than \$200 million in overpayments, fines, and restitution.

IMPROVING HEALTH CARE FOR THE ELDERLY AND DEPENDENT

In addition to prosecuting health care criminals, the Medicaid Fraud Control Unit has continued its long-standing commitment to improving the quality of health care for the elderly and dependent. In 1982, the Office was instrumental in the enactment of a statute -- Section 2805-f(4)(b)(i) of the New York Public Health Law -- that prohibited the solicitation of any gifts, money, or donations as a precondition to admitting or expediting the admission of a Medicaid recipient to a hospital or nursing home.

As a direct result of the law, the Office successfully prosecuted the first cases of their kind in the nation, charging two prominent New York City nursing homes with illegally soliciting supposed 'charitable contributions' from Medicaid patients and their families in return for admission to the homes. Dubbed the *Undercover Granny* case by the media, it became a cause célèbre following the disclosure that a 79-year-old woman had acted as a volunteer undercover agent and played a critical role in the investigation.

In other ways as well, the work of the MFCU has borne fruit beyond the traditional investigation and prosecution of criminals. In its role as advisor to a Queens County Grand Jury impaneled in January 1983 to investigate the "DO NOT RESUSCITATE" (DNR) procedures, also known as 'no-code' orders, at a Queens hospital, the Office supervised the preparation of the notorious 'Purple Dot Report' (aptly named because of the hospital's practice of designating 'no-code' patients by affixing adhesive 'purple dots' to file cards that were kept solely by nurses and then discarded when the patient died or was discharged), which found

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'shocking abuses' in the DNR decision-making process by which the hospital and physicians decided whether to resuscitate terminally ill patients in the event of cardiac arrest.

Following this report, which focused national attention on the problems of DNR and the terminally ill, then-Governor Cuomo formed a blue-ribbon panel -- *The New York State Task Force on Life and the Law* -- to consider various ethical issues in health care policy, including standards for DNR procedures. In April 1986, the Task Force, one of the first of its kind in the country, formally recommended that the State enact legislation, as the Grand Jury report had urged, to establish the rights and obligations of patients, families, and medical professionals in the issuance of DNR orders. The following year New York adopted the nation's first 'Do Not Resuscitate' legislation embodying the essential principles and recommendations of the Grand Jury by allowing hospital patients suffering cardiac and respiratory arrest to decide in advance whether they wish to forgo emergency cardiopulmonary resuscitation.

Most recently, the Attorney General, recognizing the particular vulnerability of institutionalized and homebound elderly, proposed to the State Legislature a model patient abuse statute that would punish as a felony any abuse, mistreatment, or neglect of a "care-dependent" person. The Attorney General's proposed legislation would also require criminal background checks for nursing home employees.

EXAMPLES OF NURSING HOME FRAUD AND CURRENT TRENDS

A recent nursing home review by the New York State Department of Social Services ("DSS"), done in conjunction with its assistance to the HHS IG in Operation Restore Trust, suggests a pervasive billing problem in the manner by which these nursing homes interface with outside providers. DSS reviewed the billings of 200 durable medical equipment ("DME") providers who billed fee-for-service for dual-eligible Medicare/Medicaid nursing home patients for the period 1991-1994. These abuses involved the DME's billing for goods, on a fee-for-services basis, that were already being reimbursed by the nursing homes' rate. DSS identified DME overbillings of \$2.5 million to Medicare and \$2 million to Medicaid. (DSS has recovered, to date, \$700 thousand of the Medicaid money and referred a number of these cases to the MFCU for investigation).

A major difficulty for the MFCU's in investigating these dual eligible cases occurs because of differences in Medicare and Medicaid reimbursement regulations. In a current case, the guardian for a nursing home resident complained that the patient was being charged for an expensive item that he had not requested or authorized. The item turned out to be a seating support system to improve the patients posture while seated in a wheel chair. The item had been billed to the Medicare Program as a "thoracic, humbar, sacral, orthotic anterior-posterior-lateral control body jacket, custom fitted." ("TLSO"). Because the patient was not a Medicaid recipient, the DME had billed the patient's guardian for the co-insurance. The TLSO was

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usually billed at \$1,275; Medicare allowed \$951, and Medicaid was billed and paid \$183 for the co-insurance. The MFCU's expert informed us that the device provided did not qualify as a TLSO and was probably worth \$100 as a seating device for a wheel chair. Medicare does not require prior approval for this item. While Medicaid does require prior approval, Medicaid will pay the 20% co-insurance not covered by Medicare without prior approval. Further, Medicaid will pay the 20% "cross-over" from Medicare even if the item would not have qualified for Medicaid reimbursement in the first instance. The lesser standard imposed by Medicare allows a provider to steal from Medicaid because the latter Program blindly accepts cross-over billings. This will continue to be a particular problem in the nursing home setting where many of these cross-overs exist. Prosecutors are hard-pressed to prove criminal intent when different branches of government offer contradictory requirements.

While many of the abuses seen in the early days of the nursing home investigations have decreased, the DSS review and the following cases suggest that the problems continue with current variations of the schemes of the past.

FENTON PARK NURSING HOME

As principal owner, Anthony Liuzzo became a part of New York's nursing home industry in the year 1965 with the construction of Fenton Park Nursing Home (hereinafter Fenton Park), a skilled nursing facility located in Jamestown, New York. In December of 1973, construction began on a 96-bed addition to Fenton Park, which brought the total bed capacity to 200 beds by March of 1975.

Liuzzo expanded his New York nursing home interests as principal owner when he constructed Fenton Park Health Related Facility, commonly referred to as Greenhurst Health Care Center (hereinafter Greenhurst), a 100-bed facility located near Jamestown, in Greenhurst, New York. Greenhurst was constructed during the years 1981 and 1982, and by November of 1982, the facility opened with 48 beds. The remaining 58 beds became available in April of 1983. The architectural and construction manager services were provided by corporations owned and operated by John Holland. John Holland was a partner with Liuzzo in Crestline Villa, a HUD low-cost housing project. Holland also had been a frequent contractor and architect on other business ventures of Liuzzo.

In September of 1987, the Department of Social Services referred for investigation their preliminary audit findings related to Greenhurst's cost reporting period of July through December 1983. Due to the rate methodology used, costs for this six-month period were used for setting the July 1, 1983, through December 31, 1983, rate and additionally, costs for the six-month period were annualized (doubled) and used for setting the 1984 through 1989 rate. Thus, the six-month costs were reimbursed, for example, eleven times from July 1, 1983, to December 31, 1988. A contract that cost \$20,000 could conceivably be reimbursed at \$220,000 from July 1, 1983, to December 31, 1988. An inflated cost report would surely have

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a tremendous effect on a home's reimbursement rate and subsequent receipts of monies that the home is not entitled to.

The Department of Social Services' review disclosed what appeared to be charges for inflated or unreasonably high expenses for the lease of a computer, which were at least three times the leasing cost of a comparable computer installed in larger nursing homes in the area, and the expenditure of costs for services appearing neither necessary nor prudent, i.e., consultant contracts for nursing, physical therapy and computer services. In addition to these consultant contracts being costly, there was a strong question of whether they were entered into on an arms-length basis with an independent company.

The owner of this facility and his co-conspirators set up businesses in the State of Florida to act as "consultants" to his New York State nursing home. The corporations were designed to have the appearance of an arms-length relationship to the New York nursing home but were in fact controlled by and did business exclusively with the owner of the New York nursing home. Fictitious consulting contracts were drawn up for the provision of data processing equipment and training, staffing consulting, and training and physical therapy consulting. Our investigation showed these contracts were a total sham and no work was ever provided under any of these contracts by the consulting companies. In fact, the work product proffered to our auditors by the nursing home proved to be nothing more than the day-to-day work performed by the employees of the facility in the areas of data processing, staffing patterns, and physical therapy. The owner of the facility developed an elaborate scheme and documentation to conceal the fact that no work was ever performed on any of these contracts.

Additionally, our office performed a construction audit of this newly built facility, which was constructed by an Ohio construction company and construction manager. An audit of the contractor's and construction manager's books and records uncovered an elaborate kickback scheme that funneled \$300,000 to a Florida bank also owned by the owner of the nursing home. In addition to the construction kickbacks, there are numerous other construction charges for fictitious expenses and concealed items which were personal expenses of the owner, i.e., Ferrari automobile lease, personal legal expenses, furnishings and furniture for a mistress, and expenses of other construction projects the nursing home operator and construction manager were co-developing.

New York State reimburses its nursing homes on a cost basis. The net effect of all these fraudulent expenses submitted to New York State on a cost report was in excess of \$1,200,000. All the defendants and corporations have either pled guilty or were convicted after trial with sentences consisting of restitution, five-year probationary terms, removal from the Medicaid program, and forced receivership and sale of the facility to reputable owners.

JOINT MFCU/OPERATION RESTORE TRUST NURSING HOME INVESTIGATION

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The case was opened based on a complaint from a Medicare/Medicaid beneficiary. The patient had visited the defendant physician's office twice, receiving a ten-minute exam by the physician the first time and a kinetic treatment the second time. She subsequently received an Explanation of Medical Benefits Form indicating that the physician had billed Medicaid/Medicare for neurodiagnostic tests amounting to \$2,130.30 that were not ordered or performed.

A preliminary review of billing records revealed that in the past five years, the target physician was paid in excess of \$4 million by the Medicare and Medicaid programs. Although he was paid for a variety of services, most of the procedures that were paid but never performed were studies, EMG (Electromyography), Doppler, NCV (Nerve Conduction Velocity), and Somatosensory tests.

After discovering that in many instances the target physician was billing Medicare for 80 percent of the work (Medicaid was paying the 20 percent co-payment, or in some cases the full amount), we invited the Office of the Inspector General for Health and Human Services to join our investigation with Operation Restore Trust. Thereafter, we worked together and conducted a model/joint federal and state investigation.

A review of the physician's Medicaid/Medicare billings indicated that he had not only serviced patients in his office, but at five nursing homes as well. In each instance, the subject physician gained access into the nursing homes by offering to provide needed physical therapy evaluations (Nursing Home Evaluation - Moderate to High Complexity). The physician indicated to the facilities that he would bill Medicaid/Medicare directly and there would be no out-of-pocket expense to the facilities. This was appealing to the facilities because they were required to perform periodic physical therapy evaluations and were already being paid for physical therapy in their Medicaid rate.

Thus, the physician relied on two factors - - the facility's greed and the inability of elderly patients to recall having such tests done.

At each facility the physician caused a cursory evaluation to be performed on each patient. With this, the physician obtained all information necessary to bill the Medicaid and Medicare programs. He then billed for and back-dated either a test or a series of neurodiagnostic tests that were never performed.

A review of the patient files and interviews of nursing home personnel with respect to the above-mentioned tests revealed the following:

- (a) No primary care physician's orders for such tests (as required by each nursing facility);

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- (c) None of the facilities possessed the necessary equipment to perform the tests;
- (d) The physician was never seen performing the tests or even with the equipment to perform the tests.

Further examination of the patient files revealed 42 instances where patients had been relocated to hospitals at which the target physician had no privileges, prior to the date the tests were allegedly performed, and in eight instances, the patients had passed away prior to the date of the alleged testing.

When the MFCU and HHS requested patient files from the target physician, in most instances he did supply a file with a typed test report. However, a review by our independent expert revealed that the test results were not consistent with the patient profiles. (For example, in some cases, the results indicated elderly infirm nursing home patient profiles consistent with marathon runners).

In one facility it was determined that the cursory patient evaluations were not even performed.

In January of 1997, the physician was indicted and charged with Two Counts of Grand Larceny in the Second Degree (one each for Medicare and Medicaid fraud), One Count of Scheme to Defraud in the First Degree, Twenty-four Counts of Offering a False Instrument for Filing in the First Degree and Twenty-Five Counts of Falsifying Business Records in the First Degree, based upon his billing and being paid for over 13,400 procedures on elderly nursing home patients that he never performed. The billings occurred between 1989 and 1995. In all, the target physician is charged with stealing over \$1 million from both the Medicare and Medicaid Programs.

OTHER SIGNIFICANT CASES

Among the MFCU's more prominent investigations was the infamous Operation Vampire which led to the indictment in August 1988 of 10 individuals and 3 clinical labs for stealing more than \$3.6 million by buying massive quantities of human, often AIDS-infected, blood off the street from drug addicts and other ghetto poor, and then billing the Medicaid Program for hundreds of thousands of expensive, unordered, and unnecessary blood tests. The magazine Time said of the scheme, "The crime was perfect only in its ghoulish symbolism: the perpetrators allegedly drew blood from poor people, paying them as little as fifty cents a vial, then falsely claimed the samples came from Medicaid patients and billed the Government for millions of dollars' worth of bogus laboratory tests."

As the 1980's drew to a close, the New York City weekly, The Village Voice, bestowed the dubious title of "Criminal of the Decade" on the scheme's mastermind, Dr. Surinder Singh Panshi, for having committed one of the most nefarious frauds ever perpetrated

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on this country's health care system -- the illegal trafficking in human blood for millions of dollars in profit.

In a perhaps less depraved, but even more egregious case of massive thievery, Sheldon Weinberg and his two sons, Jay and Ronald, who were convicted, following a five-week jury trial in November 1988, of systematically looting \$16 of the \$32 million their family-run health care center in the Bedford-Stuyvesant section of Brooklyn received from Medicaid for supposedly treating the City's poor over a 7-year period from 1980-1987. It was the largest Medicaid fraud in American history. The Weinbergs' scam involved falsely billing Medicaid for close to 400,000 'phantom' patient visits, first, by paying a clinic dentist on a percentage basis to do nothing but fabricate and file fraudulent Medicaid invoices, and later, by actually programming the center's computer to generate phony claims and backup medical charts for as many as 12,000 fictitious visits a month.

In January 1989, Jay and Ronald Weinberg were sentenced to jail terms of 8 1/3 - 25 years and 5 - 15 years, respectively, for their part in the multimillion-dollar Medicaid theft. Their father, Sheldon, however, disappeared on the eve of sentencing. The subject of a nationwide manhunt, the fugitive health care operator was apprehended four months later in Scottsdale, Arizona, within hours of a specially broadcast first-run segment on NBC-TV's "Unsolved Mysteries", which recreated his crime and flight from justice and brought hundreds of helpful viewer calls.

The MPCU has prosecuted a number of home health care caacs. For example, the unit arrested Kelly Kare, Ltd., a home health agency with offices in Westchester County, its owner and president, Joan C. Kelly, and Susan Filardi, the firm's billing clerk, for stealing more than \$1.1 million between 1987-1990 by fraudulently billing the State for professional nursing services rendered to thousands of homebound Medicaid patients by these unqualified workers. In carrying out their 3-year scheme, the defendants recklessly sent so-called "nurses" -- including illegal aliens from Jamaica and Ireland -- who were not licensed and often had no training whatsoever into the homes of critically ill, care-dependent patients. In one case, for example, the sister of a quadriplegic patient had to train the aides herself on the proper way to care for her brother.

Both defendants were convicted after trial. Joan Kelly was sentenced to 3 - 9 years in prison, and Susan Filardi was sentenced to 1 - 3 years in prison. In addition, Kelly was ordered, together with her company, to make restitution of \$1,100,000 in improperly obtained Medicaid reimbursement. Kelly Kare, Ltd., was also fined \$100,000.

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Lynda Teekah, a social worker and director of Grace Development Services in Manhattan falsely billed the New York State Medicaid Program for 25,000 "phantom" psychotherapy sessions never given to patients. She was actually offering non-medical services such as free food and after-school programs and charging the Medicaid program as if expensive psychotherapy sessions were being provided. She was convicted and sent to state prison.

The MFCU recently convicted Dr. Stanley Wolfson, a Bronx radiologist residing in East Hampton, Long Island, for systematically stealing more than \$1 million between 1988 - 1990 by falsely billing the State for having read and reviewed over 2,700 Medicaid patients' sonograms knowing that the tests were medically unnecessary, often duplications and done solely for the purpose of increasing Medicaid billings - and that the results would not even be furnished to the patients.

On May 19, 1994, Dr. Ross Hamilton, a Manhattan physician who was affiliated with St. Luke's Roosevelt Hospital Center and operated Genesis Medical, P.C. a methadone treatment center in the Bronx was sentenced to 2-6 years in prison for stealing more than \$1.5 million from 1989 - 1993 by fraudulently charging the State for over 25,000 methadone treatments never given to Medicaid recipients. In his illicit 2-year billing scheme, Dr. Hamilton not only used the Medicaid numbers of Genesis patients who had not yet begun the methadone program or had died, but brazenly appropriated the names and ID numbers of St. Luke's Hospital patients who were neither in his care nor even on methadone. Appearing in New York County Supreme Court, Hamilton, who pleaded guilty on March 21, 1994, to the top felony count of grand larceny in the first degree (\$1,000,000+ theft), was also ordered to make restitution of \$1,569,306 in improperly obtained Medicaid reimbursement. He was immediately remanded to prison.

Medicaid fraud is not the province of any particular social strata. Take, for example, the case of Dr. Chester Redhead, Jr., who had formerly operated a dental practice in the Hunts Point and West Farms sections of the Bronx. Born the son of a prominent Manhattan dentist, Redhead and his wife, Lucia Redhead, were accused of running an assembly-line operation in the Bronx that processes upwards of 40 patients* in a 4-hour day and generated nearly \$41.1 million in bogus Medicaid billings over a 2-year period. As part of their scheme, they allegedly paid aides to comb men's shelters and breakfast programs for Medicaid recipients

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who, for \$10 in cash, would come to the dental clinic and submit to a brief oral exam. The dentist hired by the Redheads to man the clinic actually resided in a homeless shelter himself, performed no real dental work, and in fact, had no operating equipment on premises.

Mrs. Redhead allegedly would then bring home shopping bags full of patient charts that her husband would falsify by adding on expensive dental services that had never been performed. Dr. Redhead or his assistant would have had to fill anywhere from 10 - 20 teeth per recipient per visit to amass the amount of Medicaid billings claimed. They were charged in a Bronx County grand jury indictment with stealing more than \$1 million between 1991 - 1993 by repeatedly billing for dental services never given to Medicaid patients.

Other important prosecutions brought by the MFCU over the years include:

* the largest fraud yet uncovered in the nation's home health industry: On February 4, 1992, Creative Care, Inc., a Long Island home health care provider, and four company officials were convicted after trial of a massive scam that not only cheated Medicaid out of \$4.6 million, but recklessly sent hundreds of untrained, unqualified 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 ill and elderly Long Island residents;

* the largest sonogram fraud ever uncovered in the nation's Medicaid Program: On August 14, 1992, Dr. Abraham Sokol, a radiologist with offices in New Rochelle and the Bronx, was sentenced to 3 1/2 - 10 1/2 years in prison for his participation in a scheme to defraud the State Medicaid Program of over \$1.25 million by fraudulently billing for sonogram tests never ordered by physicians;

* the nation's single largest fraud by a Medicaid podiatrist: On August 11, 1989, Dr. Jeffrey Simon, a podiatrist and owner of five orthotic labs in the Westchester-Rockland area, was sentenced to 1 - 3 years in prison for the most sophisticated podiatry fraud ever committed on this nation's Medicaid system, which included recruiting young professionals fresh out of podiatry school to aid him in stealing a record \$1.8 million;

* the U.S.'s largest psychiatry fraud: On December 11, 1991, Dr. Norman Ackerman (a delicensed physician) and Dr. Nathaniel Lehrman, operators of the Lenox Psychiatric Clinic in Harlem, were sentenced to prison terms of 5 - 15 years and 1 - 3 years, respectively, for stealing more than \$1.3 million by fraudulently billing the State for over 50,000 "phantom" psychotherapy sessions never given Medicaid recipients. A third defendant, Robert Cohen, the clinic's office manager and receptionist, was previously sentenced to 4 - 12 years in prison for his participation in the theft;

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* the largest Medicaid fraud ever prosecuted in New York State against a medical equipment vendor: On May 16, 1991, Breathing Therapy Company, Inc., a durable medical equipment supplier on Long Island, its owner Douglas Esposit, and a company employee pleaded guilty to stealing over \$3.8 million by fraudulently billing the State for thousands of high-priced oxygen tanks, masks, regulators and compressors never prescribed or provided to Medicaid patients;

* one of the largest thefts by a Medicaid pharmacist ever prosecuted in New York: On January 31, 1990, Syed Shakeel Uddin, the owner of two Bronx pharmacies, RUB Pharmacy, Inc., and A & J Pharmacy, Inc., was sentenced to 2 - 6 years in prison for stealing \$1 million;

* the largest multimillion-dollar tax fraud by a single individual in New York State history: On March 1, 1989, N.Y.C.-area hospital contractor, Sabino Fogliano, and his company, Sabin Construction Company, Inc., were sentenced on their guilty plea in a record \$8.5 million State tax fraud;

* the first successful prosecution in New York State of a hospital employee for "patient dumping": On October 24, 1989, Barbara Ford, a registered nurse and an assistant director of nursing at Parkway Hospital in Queens, New York, was convicted after trial of refusing emergency care to a nursing home patient;

* one of the first prosecutions under New York's tough new felony laws aimed at halting the rampant prescription of dangerous drugs by pill-pushing physicians now plaguing our city's poorer neighborhoods: In November 1989, Dr. Maria Gentile, a physician working in various Manhattan and Brooklyn Medicaid clinics, was arrested for illegally selling prescriptions for 200 Valium pills for cash to an undercover agent;

* one of the first prosecutions brought under the new State felony tax law: On May 31, 1988, Jay Weinberg, a resident of Trump Tower in Manhattan and the administrator/vice-president of the Bed-Stuy Health Care Corp, in Brooklyn, was convicted after trial of income tax evasion for failing to file New York State tax returns for three years on more than \$190,000 paid to him by his Medicaid clinic. (This prosecution was brought shortly after the enactment of a new statute making the failure to file personal income tax returns for three consecutive years a felony.);

* a joint State-Federal "sting" at a Queens, New York, clinical laboratory that netted 29 "blood traffickers" in a \$7.7 million Medicaid fraud-kickback scam; On November 30, 1990, twenty-nine (29) New York City-area blood salesmen were charged with selling over 100,000 vials of human blood in return for millions of dollars in illegal kickbacks;

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* a "sting" operation at a Long Island lab that uncovered a \$4.3 million Medicaid fraud-kickback scheme: On September 14, 1989, following a one-year undercover operation, 3 N.Y.C. doctors and 22 "blood traffickers" were arrested on various charges -- including selling human blood on a commission basis for useless lab testing and fraudulent billing to the Medicaid Program;

* a joint State-Federal undercover investigation that charged 19 -- including 10 N.Y.C. doctors and M.D. impostors -- in a \$330,000 Medicaid fraud-kickback scam: On November 16, 1989, nineteen individuals were arrested in "sting" operation that revealed a vast black market of clinics, doctors, and assorted middlemen who specialized in the sale of Medicaid prescriptions, at \$100-\$160 apiece, for expensive and utterly unnecessary durable medical equipment never intended for real patients;

* the first successful prosecution of nursing home officials in New York for the illegal "dumping" of Medicaid patients: On June 28, 1991, two officials at Parkshore Manor Health Care Center in Brooklyn, New York, pleaded guilty to participating in a six-year scheme to push Medicaid recipients out of the home in favor of higher paying private patients; and

* the prosecution of 8 in New York, Ohio, and Florida for a \$1.1 million Medicaid theft and cover-up at a Western New York nursing home: On September 7, 1989, 5 individuals and 2 companies were indicted for stealing over \$1.1 million in Medicaid funds by inflating the cost of building and operating the Greengurst (New York) Health Care Center and then creating phony documents, with the assistance of a sixth individual, to hide the fraud from State auditors;

Other cases of note include:

* the prosecution of 7 "drug diverters" for conducting a black market scheme to defraud the Medicaid Program by illegally buying for cash, and then reselling at discount, costly prescription drugs -- including Retrovir (AZT) and Valium -- originally dispensed to Medicaid recipients;

* the arrest of an unlicensed New York City pharmacist for stealing \$60,000 from Medicaid and foisting off dangerous secondhand drugs on unsuspecting AIDS victims;

* the Albany indictment and conviction of Professional Care, Inc. (PCI), once the nation's largest publicly owned home health care company, and certain of its officers and employees for stealing more than \$1.8 million from the Medicaid Program and engaging in a statewide criminal conspiracy to fabricate thousands of company records to deceive auditors and conceal the theft;

(continued)

* the indictment of 2 Long Island contractors for rigging bids on 4 multimillion dollar health facility construction projects and conspiring to rig bids on 6 others.

* the arrest of a Manhattan podiatrist who stole \$660,000 from Medicaid and Medicare, in part, by cavalierly billing in the name and provider number of another podiatrist dying of AIDS;

* the indictment of 4 professors and a former dean at the New York College of Podiatric Medicine for the theft of nearly \$20,000 by billing for high-priced, custom-made orthotics while actually providing Medicaid recipients with cheap stock goods;

* the prosecution of a New Jersey dentist and two construction contractors for placing a 'phantom' provider in the New York Medicaid system in a \$450,000 phony billing scheme;

* the arrest of 34 doctors, druggists, and drugstores doing over \$25 million in Medicaid business in Harlem, Brooklyn, and the Bronx for Medicaid fraud, 'pill pushing', and prescription drug violations;

* the indictment of two brothers and their Brooklyn shoe companies for stealing over \$4.1 million by providing Medicaid recipients with cheap sneakers and high heels but billing the State for expensive orthopedic footwear;

* the indictment of six Buffalo-area taxi companies and their husband-wife owners for stealing \$274,000 by inflating the cost of transporting Medicaid recipients to health care providers; and

FRAUD TRENDS

The capabilities of the MFCUs to detect and to prosecute health care fraud have greatly increased as the tools have become more sophisticated and attempts at sharing information and educational achievements with sister MFCUs and with other law enforcement offices have proven successful. Unfortunately, the opportunity for unjust enrichment has increased equally as fast. The MFCUs have witnessed sophisticated cottage industries springing to life in response to recent legislation increasing federal requirements for certain treatment modalities. Three examples of problems which require immediate regulatory guidance or outright legislative change in order to staunch a hemorrhage of federal and state funds are:

1. The explosive increase in nursing home based contract speech and rehabilitative therapy services rendered sometimes to patients who are medically incapable of benefiting from them; and

(continued)

2. Managed Care which presents a new and difficult area for prosecutors and oversight agencies because of the new nature of provider relationships and billing patterns; and
3. Drug diversion which has become a black market industry paid for by the Medicaid Program.

Although legislative changes in the above areas are being proposed or enacted to deal with the problem, the MFCUs are facing big problems in dealing with an ever-changing health care fraud landscape. It is clear that huge amounts of public dollars are being expended on high-profit services which have little or no value to the patients. To the frustration of both civil auditors and criminal prosecutors who are charged with policing fraud and abuse, there are far too few rules or regulations to constrain these providers' imaginations when it comes to billing ridiculously simple services at outrageous sums.

The rapidity with which a small, unethical segment of the health care industry adapts its infrastructure to new federal legislation is amazing – if not frightening – to those who attempt to prosecute, contain, or stop provider abuse. Unscrupulous providers are increasingly likely to identify and exploit "grey areas" in laws and regulations and fund a powerful health care lobby at State levels which resists implementation of antifraud measures. Aggressive marketing techniques, not traditionally associated with the health care industry, have increased costs by adding marginally necessary or totally unnecessary procedures to health care bills.

An important step in the war against health care fraud is the expansion of the MFCU's jurisdiction beyond the Medicaid Program. As recently proposed, this expansion would allow the MFCUs the ability to investigate the federal health care programs with their considerable experience and resources. Apart from the issue of expanded jurisdiction, the MFCU's have no guaranteed access to Medicare billing information. Therefore, even in cases where fraudulent billing crossovers are being investigated there is no mechanism in place for the state's to have easy access to federal health programs billing records. This is particularly frustrating in light of the current focus on health care fraud.

CONCLUSION

It is clear from the above that no one provider group has the corner on the criminal market. As trends have developed throughout the '80s and '90's, we have seen the frauds evolve and become more sophisticated. Unfortunately, as the Medicaid expenditures have dramatically risen, so has the looting of the Program. Unfortunately despite many years of focus on abuses in nursing homes, new schemes have surfaced. While our abilities at fraud detection have also increased, we are not yet able to stop these new schemes before they have made an impact on the Program. We are best served by vigilance, coordinated administrative and prosecutorial efforts and the resulting deterrence these cause. Although we do the best we can to put an end to program vulnerabilities, we still have profiteers who search and succeed in finding the next great loophole in the health care system.

Mr. SHAYS. Thank you very much, Mr. Spahr.

Mr. Allen. Again, I'm going to ask you to move the mike up and just lower it a bit. If you would lower the mike down. Thank you very much.

Mr. ALLEN. Thank you, Mr. Chairman.

My name is Richard Allen, and I am the Medicaid director for the State of Colorado.

Mr. SHAYS. Since we've had two witnesses tell us Mr. Wiggs, how many nursing homes in Arizona?

Mr. WIGGS. I don't have an exact count for that. I'm sorry. I can provide it.

Mr. SHAYS. OK. That's all right.

Mr. ALLEN. We have 105 nursing homes in Colorado participating in the Medicaid program, out of a total of about 192.

Mr. SHAYS. I realize that it also depends on the number of beds, and so on, but I'm just curious. Thank you.

Mr. ALLEN. Just another statistic that I think you might find interesting is that in the State of Colorado, like most States, Medicaid pays for about 65 percent of all days of care in a nursing facility. Medicare pays for about 5 to 6 percent. And then, finally, the balance is paid for by patient payment.

I have been involved with the Medicaid program for a long, long time, especially in the long-term care area. I have been working in this area for 17 years. While I certainly don't have direct knowledge of fraud and abuse type issues like the people to my right, what I do see is that we do have a systematic problem, and that is, the Medicaid world and the Medicare world, we live in two different worlds, and we don't work together very much at all.

We have different incentives for the way we conduct our business, and that is probably a tragedy. The reason why I say that is that both of us are making significant amounts of money payment for the same services, for the same clients, and because we don't coordinate, we are setting up situations which are imperfectly understood by either payment system. We are setting up systems that perhaps invite abuse and perhaps even fraud. I think that's what you heard from some of the testimony here earlier.

Medicaid sets up its payment system one way; Medicare sets up its payment system yet another way. And the provider, the vendor who is working in the middle, figures out how to maximize the reimbursement from the two systems. What I would like to share with you are some problems that we see with the Medicaid hospice benefit.

The Medicaid hospice benefit is an optional benefit, and it came on line in 1986, and Colorado took advantage of the program in 1992. The reason why we got involved with the hospice program is due directly to the AIDS epidemic, and we knew that many persons suffering from AIDS needed to have a hospice type benefit. However, we were disappointed in the restrictions that were placed on the program by the Federal Government in the administration of the program.

The hospice benefit is, indeed, also paid for by Medicare. Medicare pays to the nursing facility about \$105 a day in my State for what we call routine care. That is the payment from Medicare. In addition to that payment, the Medicaid program will make another

\$85 payment, coupled with the patient payment, to the same hospice agency. The combined payment is about \$195 a day.

Just to put that in perspective, the average rate that I'm paying in my State for a full day of nursing home care is about \$98.50. What you can see there is that, between Medicare and Medicaid, we've made a payment of \$190, when, in fact, for most types of care in nursing facilities, I can get the job paid for by \$98 a day.

What this clearly represents, in my mind anyway, is a very lucrative payment system for hospice people, who have also Medicare and Medicaid, and then they are put into a nursing facility. This lucrative payment, in my opinion, has resulted in the hospice benefit in Medicaid, in Colorado, being now primarily an institutional benefit. Seventy percent of all the people who are on our Medicaid hospice benefit are in nursing facilities. And the reason why we think that is happening is because of the lucrative payment system that has been designed.

Again, both of these requirements are Federal requirements. The Federal Government does issue this payment under the Medicare system for \$105, and we also have to make this other \$85 payment. By "have to" I mean that it is a Federal mandate that we have to pay the nursing home hospice 95 percent of our usual rate that we pay for a nursing home, even though that nursing home and the hospice have received another \$105 from another payment source.

If the States had flexibility, the States, I think, may choose two different things. The first thing that they may do is decide that, if they are going to pursue a hospice benefit, they would only use it in the home-based situation. Most States have realized the wisdom of using long-term care in the home situation rather than using nursing homes.

The second thing that we would also ask for flexibility on is, let the State design the rate structure that it wants to pay for the hospice person who is in a nursing home. I would think that our rate, instead of being \$85 a day, would be somewhere around \$20 a day, to pay for what is loosely defined as room and board cost.

The other issue I would point out is that there are very interesting incentives that exist between the Medicare and the Medicaid systems. Those, generally speaking, are that Medicare has an incentive to put people into nursing facilities, and the Medicaid program has an incentive to try to put people back into hospitals.

What is happening to the client is that they are not getting coordinated care. We think that the long-term response to that is to allow the Federal Government to issue waivers to the Medicaid agencies to put long-term care services for both the Medicare and the Medicaid systems into an HMO, managed care environment, where you would have a private sector HMO trying to coordinate the money and the care for the people who are being served by both programs.

They would have an interest in coordinating not only the money but even the care. Medicare, generally speaking, pays for the acute care benefit; Medicaid pays for the long-term care benefit. If you had one entity trying to coordinate the care, we believe we would see improvements in care and also doing it for less cost.

We are seeking a waiver from the Federal Government. We have been seeking that waiver since September 1995; it is still not ap-

proved. We hope that it will be approved soon, but even that waiver is on a small scale. It would only be in a county of about 150,000 people and would only cover 1,000 people.

What we believe can happen here is that the coordination that is so sorely missing between the Medicare and Medicaid programs can, in fact, be accomplished through the use of managed care principles through private entities such as HMOs and other similar entities.

Thank you, Mr. Chairman. I am available for any questions.
[The prepared statement of Mr. Allen follows:]

I am Richard Allen, Medicaid Director in Colorado. I appreciate the opportunity to appear before the Committee this morning to discuss the special problems created, including the potential for fraud and abuse, when an individual is covered by both the Medicare and Medicaid programs. I believe there are numerous areas in the financing of the care of the dual eligible population where greater economies and efficiencies could be implemented that would save a significant amount of money on a national basis.

Before assuming the position of Colorado Medicaid Director in 1994, I worked in the area of the agency that was responsible primarily for overseeing the reimbursement system for nursing facilities. I have been engaged in this endeavor in one position or another for about 17 years. Today, as has been true throughout these years, the Medicare and Medicaid programs work in two different worlds, rarely speaking or coordinating with the other. This leads to inefficiencies and works to the detriment of all parties involved, including the beneficiaries we all want to serve. I will offer some possible solutions to this problem.

The Medicaid hospice benefit

Congress authorized Medicaid programs to offer hospice care as an optional benefit in 1986. As of 1994, 37 states were offering the benefit. It is patterned on the Medicare hospice benefit, and is governed by all the Medicare statutory and regulatory requirements. The hospice benefit is available to persons whom a physician certifies as terminally ill and have a prognosis of no more than six months to live. It emphasizes palliative care to relieve pain and control symptoms rather than attempt to cure.

Medicaid beneficiaries can receive hospice benefits while residing in nursing facilities. In those cases, the state Medicaid agency must pay the hospice at least 95% of the nursing facility's per diem, and the hospice reimburses the facility for what is loosely defined as "room and board" costs. The hospice is responsible for the professional management of care for the individual's terminal illness.

Most people assume hospice care is provided to patients in their own homes. In fact, by allowing hospice care to be provided also in the nursing facility, the locus of care is frequently the nursing home. In Colorado, 70% of the users of the Medicaid hospice benefit are in nursing facilities. The result, in my view, is unduly expensive.

When a Medicaid hospice client is in a nursing facility, the hospice receives a Medicare payment of \$105 per day, and a Medicaid payment of \$87 per day (that mandatory 95% of the Medicaid rate of \$91.50 per day), for a combined payment of \$192 per day. In Colorado, a Medicaid rate which just covered room and board would be approximately \$20 a day, not \$87. Arguably the federal 95% rule results in an overpayment of \$67 a day!

The current federal statute and regulations governing hospice care should be changed to give states more flexibility. First, the states should be allowed the option to provide the hospice benefit only in the home. Second, states should be permitted to set the Medicaid rate for hospice care in the nursing facility setting, and not be required to continue the current 95% of Medicaid rate policy.

Integrating Care for Dual Eligible Clients

For persons who are covered by both Medicare and Medicaid (dual eligibles) the existing fragmented system presents formidable obstacles to receiving rational, efficient health care. "Rather than working together for the maximum benefit of consumers, each part of the system is motivated to guard its resources jealously, shifting patients and their costs to the other part of the system rather than managing those costs." (Paul Saucier and Trish Riley, Managing Care for Older Beneficiaries of Medicaid and Medicare: Prospects and Pitfalls, National Academy for State Health Policy, Portland, Maine, 1995, p. 7)

The conflict of interest is most apparent for elderly and disabled persons, who tend to move back and forth between the acute and long term care systems. Currently the acute care and long-term care service systems are not well coordinated, and have different benefit packages with different eligibility rules. There can be incentives to over-serve, as well as to shift costs between Medicaid and Medicare. Further problems include gaps and duplication in services. Additionally, the interests of the two program can be in conflict with each other. For example, the Medicare DRG reimbursement system provides financial motivation to discharge individuals quickly from hospital settings. As discharges to nursing facilities are easier and quicker to arrange than are discharges to community settings, Medicare beneficiaries may be commonly discharged to nursing facilities. However, the Medicaid program prefers to have beneficiaries discharged directly to the community setting from the hospital. It is easier to divert someone from a nursing facility than to move them once admitted.

On the other hand, Medicaid reduces its costs when a Medicaid-funded nursing facility patient is re-hospitalized, for the hospital is paid by Medicare. Nursing facilities have a financial incentive to send clients to the hospital for an acute episode, because their costs decrease. Some states even pay for medical leave days in such situations. As a result, Medicare is saddled with higher expenditures because of the fractured incentives caused by public program boundaries.

Currently, services are typically provided based upon what the payment source will reimburse, rather than what the individual client needs. For example, many dually eligible clients who are discharged from a hospital to recuperate at home need skilled nursing services for only a short period of time, but also need personal care and homemaker services. Under Medicare, they cannot get the personal care and homemaker services, which might prevent future hospitalizations. In addition, if they are not actually homebound, they do not qualify for in-home services. Under Medicaid in Colorado, unless they meet the nursing home level of need requirement under the home and

community-based services waiver program, they cannot get their personal care and homemaker services either. The preventive care elements of each program are stifled.

Under the current system states see limited value in managing the long term care portion of the system because they are not given the opportunity to coordinate care early enough to be effective and efficient. The benefits of avoiding hospitalizations largely accrue to the Medicare program, while the state Medicaid program is increasing its costs. To remedy this, Colorado is seeking federal approval of the necessary waivers to implement an integrated care Medicare/Medicaid demonstration project.

Colorado's Integrated Care and Financing Project (ICFP) would bring funding and responsibility for primary, acute and long term care services into one managed care entity, Rocky Mountain HMO. The Project will not change any of the present Medicaid eligibility requirements. However, it will eliminate many of the existing rigid, pre-defined service restrictions. As a result, services can be individually tailored and provided based on a beneficiary's needs, rather than what the payment source permits. Each beneficiary will have a single plan of care with the HMO afford the necessary flexibility to carry it out.

Colorado submitted its request for the necessary waivers under section 1115 and 1395(b) of the Social Security Act to the Health Care Financing Administration on September 28, 1995. We are expecting approval of the waiver request in the near future. More authority in federal law to pursue such demonstration projects for dually eligible clients may help expedite similar projects in the future.

I would be pleased to answer any questions about my suggestions or on nursing home financing issues.

Mr. SHAYS. Thank you very much.

I was just asking my staff why we couldn't step in and try to help you with your seeking to get a waiver. Now, I understand the issue is that your program would be mandatory rather than voluntary, in terms of participation in managed care?

Mr. ALLEN. That's not true. Actually, we have voluntary participation.

Mr. SHAYS. I don't know if that's wrong or not. I'm not saying having mandatory is wrong, I'm just saying, what are you hearing is the challenge? Because we're going to have HCFA before us later, not today, but later, just to help us understand their thought processes.

Mr. ALLEN. We believe that HCFA has real reluctance to move the elders into managed care. They have done their own studies, and they are not quite sure if the programs are cost-effective. The elders are also a very strong constituency and nervous about managed care, and things of that nature.

We submitted our waiver in September 1995. We got our first questions from HCFA in May 1996, and when we got the questions, there were 80 questions for what we thought was a fairly simple, direct, forward sort of concept. And it's a pilot; it's just an experiment. Coupled on that, they wanted 5 years worth of payment data, you know, for the program that we're trying to set up in a small county called Mesa County in Colorado.

Mr. SHAYS. So this would have been a pilot in one county; this would not have been Statewide.

Mr. ALLEN. Exactly right.

Mr. SHAYS. Interesting.

I'm going to first acknowledge that some of what has been discussed, I'm not fully grasping it, so I'm going to tell you, I'm going to be asking some ignorant questions, and I'm going to try to put it in a way that I can understand. Some of this is just trying to remember what I knew 2 years ago and have just forgotten.

It strikes me that one of the challenges we're dealing with is, "legal but wrong." It's legal; it's just dumb the way the Government allows things to happen. Another way I look at it is, it's illegal, but it's hard to stop because of lack of coordination, and so on.

I want each of you to tell me what you think is legal but just wrong. What is happening now that is legal, but it's just wrong, dumb, stupid, just unacceptable. We'll just go down the line.

Ms. McELROY. Well, Mr. Chairman, I think the example that I gave regarding the ability of a nursing home and a related ancillary service provider to bill for therapy services to Medicare, as well as including that in its cost base for its cost report to Medicaid.

Mr. SHAYS. OK. I want to interrupt you. When you say "ancillary," we're just talking about any service provider—physician, psychiatrist, whatever?

Ms. McELROY. Yes. Here's how we know what's happening in Maryland. When all of the nursing homes declare that they have, as a related party, a durable medical equipment provider, we know there's a reason for it. When this happens, it happens—literally 80 to 90 percent of the nursing homes at the same time will do the

same thing, and the other 10 percent are the ones that we believe are out of the loop.

Mr. SHAYS. Give me some kind of examples with real numbers.

Ms. MCELROY. I'm afraid I can't do that, in terms of how much money.

Mr. SHAYS. No, just give me an example of what—I'm just trying to understand how they put it in the base. I'm just not seeing how the system works. You can make up numbers.

Or if someone else wants to give me an example, because this is a common problem with all four of you; correct? We're talking about ancillary services being put in the base and, in a sense, double billing, but legal.

Ms. MCELROY. Yes.

Mr. SHAYS. But legal, not illegal.

Ms. MCELROY. Not illegal. Not prohibited.

Mr. SHAYS. Not prohibited. OK.

Ms. MCELROY. A nursing home is required to screen its patients for therapy needs and to provide any therapy that the patient needs. If the nursing home determines that a patient needs, for instance, physical therapy, the nursing home hires a therapist. The therapist provides the therapy to the patient, and the cost of the therapist's salary would go on the nursing home's cost report.

If the nursing home were to set up a related entity, say ABC Therapy, and it was owned by the same persons as owned the nursing home, they would be required to include the costs and the expenses of that company on their cost report because it's a related entity. They are all owned by the same people.

Mr. SHAYS. Right.

Ms. MCELROY. But if they set up that related entity and they put the costs of that entity on their cost report, they are going to get a higher per diem rate. So if they pay the therapist \$20,000 a year, they will put \$20,000 a year on their cost report, and Medicaid will increase their per diem rate accordingly.

Mr. SHAYS. Medicaid?

Ms. MCELROY. Medicaid.

Mr. SHAYS. But Medicare would be paying?

Ms. MCELROY. But if they have a related entity—all right, it's not the nursing home itself; it's just this related entity—ABC Therapy can bill Medicare Part B and be paid for providing the therapy which is needed by the Medicare beneficiary in that home.

Mr. SHAYS. Now, when you see that, are you able to have them stop, or they can continue doing it because it's not illegal?

Ms. MCELROY. It is not illegal, but if our State contract auditors are advised to attempt to back out that cost from the Medicaid cost report, they will try to do it. They will be in appeals; they will be fighting.

Mr. SHAYS. Something may not be illegal, therefore, they can attempt to do it and some can get away with it. You might say, this is crazy. Someone couldn't look you square in the eyes and say this is right. And you could basically say, stop. Some might fight you, and some might not. But the one thing is, they know they can do it.

The bottom line is that you're telling me it's not illegal, and therefore someone can attempt to do it. If they are found out, you

might attempt to stop them, and you may succeed or may not succeed.

Ms. MCELROY. And if we do succeed, it will take several years to do it. By the time we do succeed in backing it out, they will be doing durable medical equipment instead of therapy.

Mr. SHAYS. OK. And that would fit my definition of legal but wrong.

Ms. MCELROY. Correct.

Mr. SHAYS. It is just really dumb that Government would allow this to happen.

Would you all agree that this is one type of an example that's legal but wrong?

Mr. WIGGS. I would also suggest—I would concur with that. When you have owners and operators of nursing homes or physicians that have an ownership in either the managed care organization to which they are providing care—you know, they have an ownership in the managed care organization that has the patients, so they are effectively treating their own patients, and you can see those trends. But also in the nursing homes where you maybe have a side business, and you're using that business to bill.

Mr. SHAYS. In some areas of medical care, that's illegal.

Mr. WIGGS. Correct.

Mr. SHAYS. Or just not allowed.

Mr. WIGGS. Right. And it would be illegal if it—you know, kind of a violation of self-referral type of—anti-kickback.

Mr. SHAYS. Right.

Mr. WIGGS. Another area that's of concern to me, frankly.

Mr. SHAYS. Still on the issue of legal, but wrong.

Mr. WIGGS. Legal but wrong.

Mr. SHAYS. OK.

Mr. WIGGS. Or legal but leads to areas where it could go wrong very quickly.

Mr. SHAYS. OK.

Mr. WIGGS. Would be in the context of managed care contract for long-term care services, such as the mobile x-ray type of industry, where you have a network provider who has contracted, is capitated, who has gone through the bidding process, has shown that he's legitimate, and is providing those services under a capitation rate.

Your current rules allow nursing facilities to choose any willing provider for the dual eligibles. For example, if it's a Medicare primary patient, and then the secondary coverage is picked up by Medicaid, they can choose whoever they want to come in there and do those x rays. What we're seeing is a trend of them choosing non-network or noncontracted vendors. That's perfectly legal, although the capitation has already paid for their coverage.

The dilemma comes in, how is the co-pay getting billed? Who is billing? Is the vendor billing the nursing home, and then the nursing home turns around and, through their Part A cost report, showing it as a bad debt, perhaps, because it's uncollectible from the indigent or the managed care agency?

The picture I'm trying to paint here is, it gets terribly complex, in terms of, gee, what's really happening here? Does the program end up paying more, both programs? And then how do you create

a trail sufficient to say it's fraud or it's not fraud, without expending an inordinate amount of resources?

Mr. SHAYS. But is it illegal for two people to submit the same bill? You're implying that it may not be illegal. I mean, two different entities.

Mr. WIGGS. Well, what's being submitted is, the coverage is already there under a capitation arrangement.

Mr. SHAYS. It's already paid for.

Mr. WIGGS. It's already paid for through a Medicaid arrangement.

Mr. SHAYS. Right.

Mr. WIGGS. It's legal for the nursing facility to go out of network, basically choose any willing provider to do noncapitated x rays for dual eligibles. So you pull a non-network vendor in there to do the x rays.

Mr. SHAYS. So, basically, it was covered under Medicaid.

Mr. WIGGS. It's covered under Medicare and Medicaid, but then it's billed out to Medicare for the Medicare portion. And you're supposed to bill out that co-pay, but that's already covered by capitation. So the non-network vendor is—there's kind of a benefit there.

Mr. SHAYS. Let me be clear. Is Medicare paying twice, or is it an issue between Medicaid and Medicare both paying?

Mr. WIGGS. They are both not getting the benefit of the bargain of a discounted service. Medicare would not be getting the bargain from a 20 percent reduction in the discounted service by the non-vendor; Medicaid has already paid for that. So both programs—it's double coverage, if you will. Medicaid has already paid for that through capitation. The capitation rates are set based upon, you know, how many people and what services, and so forth. So it's already there.

There's nothing illegal about a nursing facility choosing any willing provider for the dual eligibles. It just gets terribly complex to try to sort it out.

Mr. SHAYS. But the bottom line is, the taxpayer pays more.

Mr. WIGGS. Exactly. And it makes it terribly difficult, in terms of investigation and prosecution, as has been alluded to. Where do we get the information? Who is monitoring it? Does it really boil down to a kickback or just a bad practice?

Mr. SHAYS. OK. Well, I'd like you all to be thinking, ultimately, how we try to address that issue in statutory language.

Mr. Snowbarger, I'm going to call on you in just a second. I'm not going to get to my "illegal but hard to stop." I want to keep going just with "legal but wrong."

Mr. Spahr.

Mr. SPAHR. Mr. Chairman, let me identify another issue for you that has to do with the dual eligibility and the crossover payments. Under New York's Medicaid program, DME equipment requires prior approval for most items, durable medical equipment.

Mr. SHAYS. DME being?

Mr. SPAHR. DME—durable medical equipment.

Mr. SHAYS. Right.

Mr. SPAHR. When Medicare is the primary payor on items which are then billed for a 20 percent co-payment to Medicaid, no prior approval is required by Medicare. In a recent example that arose

in our Syracuse office, there were multiple bills being submitted for nursing home residents.

Mr. SHAYS. I'm going to ask you to slow down just a little bit. I'm just trying to keep up with you.

Mr. SPAHR. Sure.

Mr. SHAYS. You're saying Medicaid had a co-payment?

Mr. SPAHR. Yes.

Mr. SHAYS. I thought you said Medicaid, and I thought you should have said Medicare.

Mr. SPAHR. If Medicare is primarily responsible for payment for the patient services, the 20 percent co-payment for a dual eligible patient is then billed to Medicaid.

Mr. SHAYS. OK.

Mr. SPAHR. In this particular circumstance, a company was billing for a very expensive item, which I won't give you the long name of, it's basically a custom-fitted body jacket, for which Medicare would pay \$1,231. Medicaid, because it was only paying the 20 percent co-pay, was not permitted to enter into a prior approval review of the material, and paid the 20 percent on Medicaid's approved rate of \$951, without having the opportunity to examine either the medical necessity or the physical invoice for the material that was being provided.

In that case, upon referral and examination by experts, it was determined that the actual device being provided was a \$100 seat adjustment, which Medicaid would have totally denied payment for, had it had the opportunity to do so.

As a result of that, the U.S. attorney's office, I believe, in New Jersey, entered into a civil settlement, because Medicare decided that it constituted one device, at a reduced rate, and settled the case civilly. Whereas, New York State's Medicaid, had it had the opportunity to do a prior approval on these items, would have saved over \$80,000 by not having paid the co-payments on those items, as well.

And in terms of a lack of coordination, I would also point out that, when the settlement was entered into by the Federal office, it was done without attempting to collect the State's Medicaid share, as well. So that case is pending to try to recover that civilly. That's a case that was correct, to the extent that the difference in the regulations between the programs permitted a primary bill to Medicare without prior approval.

Mr. SHAYS. What I'm having trouble understanding is—that sounds illegal.

Mr. SPAHR. Well, what was illegal was the question of what the actual device was.

Mr. SHAYS. OK. What was legal but wrong?

Mr. SPAHR. What was legal was the ability to bill any device to the Medicare program without prior approval, without their being any medical review as to either the necessity or the quality of the material being provided, under the State regulations.

Mr. SHAYS. Thank you.

Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman. I guess, in the area of legal but wrong, I think the issue that you're hearing from the others around the nursing home getting paid from Medicare for a day

of care, or they get paid from Medicare for what we call a Part B service, and then they are able to take that same cost and place it on the Medicaid cost report.

What that does is, it causes the cost report to overstate the cost of treating the average person in a nursing facility. By doing that, Medicaid is paying out more than it should, at least in my State. This is what we have just recently discovered in our State. We went in, we examined it, we have found it, and now we're in the process of taking corrective action on the problem.

I would not declare it to be an illegal situation; it's just an issue where, again, because Medicare does its thing, and Medicaid does its thing, we're slow to coordinate on these issues. In my State, what we've done is, we've put some caps on some rate growth, and we're also trying to get away from the use of the cost report and go to what we call a "case mix" reimbursement system.

I would also add that, in my experience, this is a relatively new phenomenon. I think it started seriously about 5 years ago, when, for whatever reason, Medicare started paying a lot more long-term care services than ever before. I've seen some HCFA publications that their expenses for long-term care-related Medicare costs have increased something like 1,000 percent over the last 5 or 6 years. I could be wrong with that statistic, but it was a remarkably large percentage increase.

With that change and pattern of payment out of Medicare, the effect is to drive up the cost in an unrelated area such as the Medicaid cost report. There are things the States can do, perhaps like moving to a case mix reimbursement system or moving away from a cost report system.

I cannot say that this system exists in the same way in every other State as it existed in my State. For instance, we did offset Part B revenues, but that's just an accounting thing. But we have found it also to be true in our State.

The other thing that's legal, but dumb, is the whole issue of the hospice benefit. Medicare makes a \$105 payment; we make an \$85 payment. The person is still inside a nursing facility. And I think the answer there is to allow the State some flexibility to administer their own Medicaid hospice program, in conjunction with Federal oversight, but certainly give us some flexibility. We're the ones in the field. We see it day to day, and we suspect we can come up with some better responses to make sure the job is done right.

Mr. SHAYS. Well, I would say that one of our attempts, 2 years ago, was to just allow States a lot more flexibility, clearly, with Medicaid, and to bring in the private sector in competition in Medicare.

I appreciate Mr. Snowbarger's patience here. When you just have two Members, you can get a little more followup here, which is nice.

What I'm having trouble reconciling is, Maryland probably has five Members of Congress right now. I'm just trying to think of your size.

Ms. MCELROY. Six, at least.

Mr. SHAYS. What is your population in Maryland?

Ms. MCELROY. About 2 million.

Mr. SHAYS. These are not trick questions, honestly.

Ms. MCELROY. Yes, but they're the ones I can't answer.

Mr. SHAYS. Let me just tell you what I'm wrestling with. I'm not going to ask—you know, I feel like I just did something very dirty pool-like. You know, if you asked me who the President was of a particular country, and I might get flushed or not be able to tell you. And then you say, he's a Member of Congress, good grief.

What I'm trying to reconcile is, if I heard you, Mr. Spahr, you said there were only 666 nursing homes?

Mr. SPAHR. That's correct. Serving a population of about 117,000 right now.

Mr. SHAYS. You have, in your State of New York; correct?

Mr. SPAHR. Correct.

Mr. SHAYS. In the entire State there are how many nursing homes?

Mr. SPAHR. 666 Medicaid-certified skilled nursing facilities.

Mr. SHAYS. But there are lots more nursing homes. I'm comparing apples to oranges here. You were talking just total nursing homes.

Ms. MCELROY. 243 nursing homes, 30,000 beds in Maryland.

Mr. SHAYS. But we're not comparing apples to apples here, are we? Yes or no? How many skilled?

Mr. SPAHR. Skilled nursing facilities, Medicaid-funded, 666.

Mr. SHAYS. And how many in Maryland, do you know?

Ms. MCELROY. How many of those beds are skilled, I don't know. Most of our facilities have some skilled beds and some intermediate beds.

Mr. SHAYS. I'm just trying to see the difference, because it would seem to me your difference would be one to eight, or something. That seems so close. It's just surprising to me.

Mr. Snowbarger.

Mr. SNOWBARGER. Mr. Chairman, first of all, let me apologize to the panel and to you for being late.

Mr. SHAYS. You never need to apologize. You have 100 different meetings.

Mr. SNOWBARGER. Well, I will. I'll apologize anyway.

Mr. SHAYS. I'm not going to do it when I'm late.

Mr. SNOWBARGER. The other thing is, I know that you're on a tight timeframe, and I think it might be the best use of our time if I would yield back to you and let you continue.

Mr. SHAYS. If you don't mind.

Mr. SNOWBARGER. That's fine.

Mr. SHAYS. If I could just have you go through "illegal but hard to stop."

Ms. MCELROY. Mr. Chairman, I think probably the thing that concerns me a great deal is that anytime you get into a situation with a nursing home contracting for a service or allowing another vendor to come in and provide a service, you have the potential for a kickback. And the kickbacks that we would like to see, as criminal prosecutors, are a situation where, if I am allowed to sell \$100 worth of my wound care kits in your nursing home, I will give you \$10. We don't see that at all.

You are far more likely to see, if I'm allowed to sell \$100 worth of wound care kits in your office, I will allow you to come to the sky box at the Orioles, at Camden Yards, with me. And then, if I'm

allowed to sell 200 or 500, then, you know, we'll go to the Caribbean and play golf.

These are extraordinarily difficult situations for us to investigate and prosecute, and yet there is very little doubt that there is a lot of quid pro quo when it comes to being permitted to provide services.

To go back to the situation of therapy in nursing homes, both mental health therapy, occupational, physical, what have you, if you look at the increase in the therapy services over the past 5 years, any kind of therapy, you're going to find that it has doubled and tripled, as an item provided to Medicare and Medicaid patients in nursing homes, sometimes to the point where the therapy services billed to Medicaid and Medicare, together, cost more than the programs are paying for the long-term care.

In some instances, therapy services are required. People must be screened for them. You get an outside contract agency to come in. The people who are doing the screening are the ones who ultimately are going to be providing the service. Well, guess what they recommend? They recommend that this person could benefit from therapy.

You have frequent cases where people with Alzheimer's and diseases that will just not be corrected by any type of therapy being treated and, at a great cost to both programs, receiving virtually useless mental health therapy and counseling or occupational therapy.

This kind of situation, when we look at it, we do not believe that it does not come with a kickback. If the kickback is, "I will refer these people to you, if you will refer these people to me," it becomes extraordinarily difficult for us to prosecute that in a court of law.

Mr. SHAYS. I'm trying to understand, though, what the cost to the taxpayers is. In other words, are we overpaying for these services? Are these services you wouldn't have otherwise?

Ms. MCELROY. Frequently, we're overpaying. If you bring in an outside contract service, you do not have that cost included on the cost report; it's billed separately. And if the company decides to bill it at \$100 an hour, and Medicare is going to pay \$100 an hour, but they pay the therapist only \$5 an hour, then there's a \$95 profit figure in there. If it were included on the Medicaid cost report, they would not be able to take the \$95 profit figure. So, yes, it does cost more to bring an outside company in.

You also have the cost that's associated with the incentive to provide a service that is not necessary and is not beneficial. And you have virtually no checks or controls. You have the therapy company itself screening the patient for necessity. You may even have a doctor that is affiliated with the therapy company, or really not very involved with a particular patient, signing off on that.

And you have a therapist who probably is trained to go in and market the therapy services at the nursing home, to market to the families: "This might help. This might help. It can't hurt, and you don't have to pay for it." So you wind up, in the end, paying for a service which, even if you get it, has not helped either the patient or the program or the cause.

Mr. SHAYS. So, in some cases, it's legal but wrong, and in other cases, it's simply illegal.

Ms. MCELROY. If there's a kickback of any type involved, it is illegal, but it is hard to prove.

Mr. SHAYS. OK. As a general rule, any kickback is illegal?

Ms. MCELROY. Yes.

Mr. SHAYS. OK. And we define "kickback" by all the different ways you described it: some financial gain.

Ms. MCELROY. Yes.

Mr. SHAYS. OK. Mr. Wiggs.

Mr. WIGGS. I think it's simple.

Mr. SHAYS. We're talking about "illegal but hard to stop."

Mr. WIGGS. I think it's a two-part answer. One is, I think it's as simple as a dual billing might be, where you have a billing to the Medicaid program and a duplicate billing to the Medicare program, certainly illegal, certainly hard to stop because of the lack of coordination between the two programs. That's a very simplistic level that's just pretty much always going to be there as long as you have the different methods of payment, et cetera.

Mr. SHAYS. But there could be a solution to that.

Mr. WIGGS. Sure. I think what concerns me, once again, in the managed care context, in addition to kickbacks that will be hidden because of the capitation contracting from the managed care organization to the various vendors. I think you're going to have concerns that rise naturally with managed care because of underutilization potential, and ownership interest, et cetera. I can't blame that on dual program eligibility, necessarily, but that's very difficult to sift through and get to the information.

If you had access to that information, you could compare Medicare services to Medicaid services and start to get a picture of what this physician—what are his or her practice patterns relative to the long-term care patients. In an underutilization case, it's going to be hard to show anyway. We're further handcuffed because we can't really gather all the data and say, here's the complete picture.

I'm trying to think of other examples.

Mr. SHAYS. We've covered one. That's all right. We can just go on to Mr. Spahr. In other words, you would agree with Ms. McElroy's example, as well.

Mr. WIGGS. Certainly, the kickback arrangements, they are there, and it's a matter of sifting through the data to get the information that it's there, No. 1, and then being able to build your case based upon all the information available, to carry it forward to a prosecution.

Mr. SHAYS. Thank you. Mr. Spahr.

Mr. SPAHR. First, I would agree with what Ms. McElroy said with respect to the existence of the kickbacks in these ancillary services being provided in the nursing homes. An additional problem is, to establish, in a criminal case, whether those ancillary services have, in fact, even been provided to the residents of the nursing homes is extremely difficult to prove.

You're dealing with a population that is vulnerable, often ill, almost exclusively unable to testify whether or not a particular service was ever received. In many cases, even where we are able to establish the existence of criminal activity, we cannot establish the full extent of the criminal activity because the dollars stolen can only be established circumstantially.

I am reminded of a recent case where, in establishing the existence of a scheme to bill for services not rendered, a doctor, on some occasions, attached copies of test studies which had been xeroxed out of a textbook for a marathon runner and were being offered up as proof of services rendered to a 96-year-old nursing home resident. But where that doesn't exist for all of the residents in that nursing home, you cannot conclusively or circumstantially establish that every single bill was fraudulent.

So those types of activities, where there has already been a financial incentive to bring an ancillary service into the home, and a greedy provider can further enhance his profitability by simply not rendering the service at all, it becomes difficult to prove not only the existence of the crime but the extent of the crime.

Mr. SHAYS. Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman.

I'm not the head of a Medicaid Fraud Control Unit, so I'm a little bit out of my league; that's for sure. What I have heard and what staff have told me about is a situation where you've got the nursing home owned by the same entity that also controls something called the management company. And the management company then has a contract with the nursing facility to say, we will provide various consultant services, and what have you, and so a fee is paid.

The issue is, have services ever been rendered, or are they rendered in the full amount. That's very difficult to prove, simply because, in both entities, they are both controlled by the same party. So, in an arms length arrangement, if I paid someone for service and the vendor did not show up, you terminate the contract, or you don't make the payment. But when you have owner-related situations, you don't have that normal check that you have in the marketplace.

Mr. SHAYS. OK. I'm struck by the fact, as you were talking, that it would be very difficult to know if you have just someone who is doing therapy with a patient, who is just pretty much coming in and asking how they feel, and in the end you don't know how long they spent. So I would think your task would be very difficult, in some ways, really determining clearly if a service had been rendered or not.

You have to prove it wasn't rendered; they don't have to prove it was rendered. Correct? In a criminal case, is that accurate?

Ms. MCELROY. That's correct. Not only that, sir, but they bill in units, so they have perhaps a minimum, one unit being 15 minutes. But if a service actually only takes 5, they are permitted to bill the one unit, or 15 minutes. So you can look at a case where a therapist has billed a 12-hour day and worked 8.5 hours, and still have something that you could not prove beyond a reasonable doubt in a court of law, was a service not rendered.

Mr. SHAYS. Very interesting.

Mr. Towns.

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

Let me begin with Ms. McElroy. We do have some problems. There's no question about it. I want to get clear in my mind—you indicated that most facilities are audited. Were you talking about the State of Maryland, or were you speaking nationally, at the time?

Ms. MCELROY. I speak only for the State of Maryland on that. We have a contract agency which does at least a desk audit, and most times an onsite audit at the major facilities, every year.

Mr. TOWNS. Mr. Spahr, what legislative changes would you propose to deal with the problems of therapy services, managed care, and drug diversions that you have outlined in your testimony. What recommendations or suggestions would you make?

Mr. SPAHR. With respect to managed care, there are a group of model statutes which Ms. McElroy, I hope, has with her, on behalf of the National Association of Medicaid Fraud Control Units. They have been introduced in various State legislatures.

They have been introduced, in one form, in New York's legislature this year by Attorney General Vacco, which will seek to provide the tools which prosecutors will need to address the oncoming frauds in managed care. Arizona has had long experience with it. New York has been seeking an 1115 waiver to mandate managed care for its 2.6 million recipients, I think since 1995.

With respect to the problems of drug diversion, again, New York, in November 1995, enacted or adopted the first noncontrolled drug diversion statute in the United States, at the State level, which made it a crime up to a 5- to 15-year C felony to sell noncontrolled substances outside the normal course of business.

Several weeks ago, in Manhattan, the Medicaid Fraud Unit had the occasion to seize, during the execution of a search warrant, over \$350,000 in cash from the back room of an apartment, along with numerous drugs that had been diverted from the legitimate marketplace, most of which or much of which is paid for by the Medicaid program, not only once, but on some occasions two and three times, because the drugs are paid for by the Medicaid program, resold back into pharmacies, and paid for by the Medicaid program again.

Before the New York legislature this year is a proposal to criminalize the possession of those diverted drugs, which was not included in the original statutory package in 1995, which will make it a crime up to a B felony to possess in excess of a million dollars worth of drugs.

Since January 1997, the New York Medicaid Fraud Unit has taken over a million dollars worth of drugs from various locations, including, on one occasion, over 30,000 capsules of AZT contained in garbage bags, in an apartment in the Bronx.

So that's a continuing problem, and legislation concerning possession and diversion of drugs at the Federal level would be appropriate, as we have seen more and more occasions where those drugs are crossing State lines or, in fact, being diverted out of the country.

What was the third? Managed care, drug diversion?

Mr. TOWNS. Managed care, drug diversion and, of course, the other one was therapy services.

Mr. SPAHR. With respect to therapy services, the ability of the Medicaid Fraud Control Units to examine, investigate, and prosecute instance of dual eligibility, and prosecute the Medicare sides of the cases on a regular basis, would allow us to address that problem substantially.

Also, the further coordination or the mandated availability of information from the Medicare and Medicaid programs to each other, so that they can coordinate what services are being rendered, would go a long way toward alleviating that problem, as well.

Mr. TOWNS. Let me raise the issue here. Mr. Chairman, I think that it's something I want to talk further with you about as we move along. But I think that we have some experts here, and I would like to get their opinions on this issue.

I'm concerned about the uniformity of recordkeeping. The fact that, in some States, if a facility closes, nobody is responsible for the records. They can throw them out the window; they can do anything they want to do with them. Now, in your area, in terms of those of you who have the burden of going to look and see, whether somebody has done something illegally, if those records are gone, I think it makes it very difficult for you to be able to establish a case.

What suggestions or recommendations do you have that we might—I must say, Mr. Spahr, New York State has been taken care of. We've done that. But the point is, in other States, we do not have that. So what suggestions do you have for us here that we might be able to do that, because I think this ties in to the whole thing of fraud.

We're talking about downsizing, in terms of hospitals, you know. We're saying that the stay is no longer needed. A lot of things now can be treated on an ambulatory basis rather than in a hospital setting, which means that some hospitals are going to close. Some facilities are going to close, and when they close, nobody has jurisdiction over those records.

I even take it a step further, Mr. Chairman, that even when physicians die now, nobody is taking over their practices. In the past, it would become a part of the estate, and somebody would come in and they would buy it. But now all of a sudden, there is no interest. In many areas of this country, if a physician's office closes, it just stays closed; nobody takes over, which means that those records become the property of no one.

I would like to get your input on that while you are here. I really would like to hear, because I'm looking very seriously at that issue.

Mr. WIGGS. That problem arises also in a managed care type of setting where we've recently seen, in a particular case, where you might be investigating some particular organization who has closed shop, so to speak, for whatever reasons might attend to that, but the records disappear.

So it's not only a problem for ongoing treatment of those patients, in terms of whoever takes over the care, but it's certainly a problem if you're trying to establish any kind of paper trail, what was provided, what wasn't provided, regarding a criminal prosecution or any kind of civil restitution that may be warranted.

I don't think we've adequately dealt with the necessity to have some type of sanctions for, you know, making sure that those records are where they should be. Certainly, we have fraud laws and forgery laws that we can deal with it if they are altered, which is frequently the case. But in terms of where they are retained, I don't think we've dealt with this sufficiently.

Ms. MCELROY. I'm going to get in trouble for making this point, but I'm going to do it anyway.

When we have Medicare intermediaries change or when we have Medicaid data holders change, we can't even get the records from the Medicare intermediaries that have stopped being paid by Medicare. So it is, indeed, a problem. But from criminal prosecution standpoint, we have more problems getting records from defunct fiscal intermediaries than anywhere else.

Mr. TOWNS. Mr. Allen.

Mr. ALLEN. I really wouldn't have much to add to that. It's been my experience that, when a nursing facility changes hands, the medical records stay with the facility, for continuity purposes. I would share what you have seen about physicians. In the old days, it used to be that, when a physician passed on or got out of the business, they would sell the practice, and with the practice would come the medical records.

I have seen, just in the last few years, that no longer is the case. Physicians are getting out of the business, and they are not selling their practices, which leaves a care coordination issue for us in the Medicaid program, trying to pick up a new physician for the client. But I've not really seen that in the nursing home area, to any extent.

The only thing I would add is that there is something called the minimum data set. All the nursing homes are supposed to use the same sort of a client evaluation system, nationwide. And it's pretty much a computerized-looking form, which is a good thing. Unfortunately, it's still not automated, and that was the original intent. They are still piloting it and experimenting with it.

This requirement was done in, I believe, 1987, and we're still not automated on a nationwide basis, which is really unfortunate, because then you could have data to make comparisons across the States, which would help with operating the programs better.

Mr. TOWNS. Mr. Spahr.

Mr. SPAHR. If I may just add to the size of the problem for you, if you may recall, in New York, the nursing homes were reimbursed on a 1983 cost year, which was trended forward. New York State's regulations require that all the records underlying the cost reports be maintained for a period of 6 years.

In 1989, it became suddenly apparent that all of the nursing homes were going to be in a position to destroy all the records underlying their cost reports, and an emergency regulation was passed which required that they be kept 6 years past the last year in which that cost year is maintained.

But there are other problems. When conducting a fraud audit with respect to a cost report, you are not only going to look at the records in the possession of the nursing home, you are looking at the records of the vendors, who may have done the construction, or provided the food services, or provided various equipment.

Those vendors are not bound by any of the regulations requiring them to maintain records beyond whatever the IRS would require for tax purposes. So, when looking at older cost years, it is often difficult to establish a case because those records of vendors are no longer in existence.

Mr. TOWNS. That's interesting. Let me throw this one out, then I will yield back, Mr. Chairman.

Are we devoting sufficient resources to combat Medicaid and Medicare fraud? We're talking a lot of stuff, but do we really have the resources out there to deal with it effectively? I don't want to put anybody on the spot, but I sure want to get some information.

Ms. MCELROY. We would certainly like to have more money. You know, quite frankly, as you know, the Medicaid Fraud Control Units are 75 percent federally funded. And the problem that I have is not in getting the 75 percent Federal money, it is getting the 25 percent State money from my own State.

The States are extraordinarily strapped at this point, and coming up with that first quarter, as little as it is, is sometimes very difficult. So my unit has lost investigators, lawyers, staff attorneys, over the past 3 or 4 years, and the people I have working for me are leaving to go to other jobs because they haven't had a raise in 4 years.

So I am dealing with a personal problem, and it's affecting what we do, but I don't know that it's a problem that the Federal Government can solve under the current funding structure.

Mr. WIGGS. We have the same dilemma. I revert money back from our Federal grant every year because we can't use it, because we don't have the adequate State match from which to use those funds. So I'm a bit chagrined when I send money back that I think that I could use in other ways.

For example, we see a lot of areas that we could perhaps become more proactively involved, that would require some detailed auditing, inspection-type activity, but there's no way that I'm really going to seriously consider it when I'm short-staffed in the area that we are.

Again, not to beat the managed care drum too loudly, but it does increase the level of sophistication and the degree to which crime hides and fraud hides, that you do need to throw those resources into it just to get the picture and to be able to do the detailed runs that you need to, in a managed care setting.

So I, too, would like to see more resources, but more importantly, I would like to see more of a coordinated effort with the resources that are there, to hit head on the problems that we identify. If I think those resources could be used strategically, I think we'd see more effect.

Mr. TOWNS. Mr. Spahr.

Mr. SPAHR. I have to agree with both my colleagues that the resource question is a problem. It's primarily a question at the State level. In 1978, when the New York State Medicaid Fraud Control Unit was first certified, it had a staff which was 40 percent larger than it does now. And in that time, since 1978, New York State's Medicaid budget has gone up 90 percent. So we are policing a Medicaid program that is almost 10 times as large, and doing it with nearly half the staff at this point in time.

I would also point out that, in Kennedy-Kassebaum last year, the Federal Government dedicated large amounts of resources to combat health care fraud and to coordinate the Federal, State, and local investigations into health care fraud. But as I look at it, that fund which was created dedicates the resources primarily to Fed-

eral agencies and doesn't make any of that funding available to assist either the State or local agencies in the battle that they have been fighting for the last 20 years.

Mr. ALLEN. It's a sad tale. States don't have enough resources to do the jobs that need to happen. I would like see some innovation, because getting a State legislature to see the wisdom of investment is one of the harder things to do.

But one thing that we're doing in our State is that we've just entered into a contract with a private legal firm, on a contingency basis, so they may look into taking on those cases which the Medicaid Fraud Control Unit has determined that it would be very difficult to prove fraud.

They would go in under another statute which is called, I think, the Civil Claim Penalty Act, and they would come in on that side. They would work on a contingency basis so that there's Federal fund or general fund obligation to pay those folks, but they would take up the case if they thought it was worthwhile.

The other thing, I think, that could be done is—you've heard people here, from four different States, all find the same problem on their own around the inclusion of costs on the Medicaid cost report. Four separate jurisdictions had to find that problem on their own.

It's interesting that the Federal Government, who has jurisdiction over it all, has not found the problem yet. And I wonder if we shouldn't be bringing more coordinated resources together, especially at the national level, maybe to bring more experts in and to examine the whole Medicare/Medicaid payment relationship.

You do have a lot of resources out there now. Take advantage of what you have and spread the information, and it can go a lot further.

Thank you.

Mr. TOWNS. Thank you very, very much. Let me thank all of you. I really think you've been extremely helpful.

I yield back, Mr. Chairman.

Mr. SNOWBARGER [presiding]. Thank you, Mr. Towns.

I'm going to ask what I think are some fairly simple and short answer questions. I've found before that what I think should be short answers never come out that way.

In your investigations, do you find that you're focused and finding more in the nursing home operations or in the vendor side of things?

Ms. MCELROY. The vendor side of things.

Mr. WIGGS. Vendor.

Mr. ALLEN. Quite frankly, I'm finding, in our experience, it's home health agencies that we really need to worry about. And transportation is also very troublesome. But especially home health. It's a growing part of the industry, and what we've got is a lot of claims being submitted that no care was behind it, or we have what we typically refer to as "procedure creep," things of that nature.

Mr. SNOWBARGER. OK. Let's go to a short answer on kickbacks. I believe, Ms. McElroy, you were the one that mentioned the sky box tickets or the trip to the Caribbean. All of those are pretty obvious examples of kickbacks. Why are those so difficult to track and to prove that there has been a kickback?

Ms. MCELROY. In order to prove that you have a kickback, you have to show that the benefit that was received had, as one of its material purposes, the intention that it would induce a referral for an item that was going to be paid out of the Federal or the State program.

The defense to the tickets to the Orioles is, well, you know, I got to know this gentleman through my business dealings with him, and I genuinely liked him, and I wanted to take him to the Orioles, and that is the only reason why I took him to the Orioles game. And that is a very difficult defense.

Again, keep in mind, we are dealing with a standard. All the Medicaid Fraud Control Units are primarily criminal prosecution units. We deal with the "beyond a reasonable doubt standard." If you are unable to show a pattern that is an exact quid pro quo, it gets to be a little bit more difficult to prove that the purpose was for the obtaining of a referral, or a vendor contract, or another benefit.

Mr. SNOWBARGER. Are there changes in law that would help that by loosening the standard? You know, the general public doesn't have any problem indicting me if I accept those things and they can't show a quid pro quo. We have ethics reform at least every 2 years, even numbered years, for some strange reason. So I don't quite understand the difficulty. I'm going to act like the general public does toward politicians. It sure seems to me like there's a quid pro quo, if that kind of thing is happening.

Are there changes in law that we might be able to enact that would make that an easier thing to prove?

Ms. MCELROY. Certainly, thinking along the lines—any provision that prohibited conflict of interest between vendors and nursing home owners and administrators would be something that would be welcomed by someone seeking to prosecute a kickback case. Whether or not something like that would be feasible, I would not venture to say.

Mr. SNOWBARGER. Problem in defining conflict of interest?

Ms. MCELROY. Yes.

Mr. SNOWBARGER. Most of these facilities, I presume, not only provide services to Medicaid and Medicare patients, but also to other patients?

Ms. MCELROY. Correct.

Mr. SNOWBARGER. Private pay, either individually or through other plans, I presume. I presume there are no prohibitions for private pay or for private insurance companies on these kickbacks. Is that a fair statement?

Ms. MCELROY. The answer is going to be found on a State by State basis. As to Maryland, the answer is yes, there is no prohibition against private.

Mr. SNOWBARGER. The answer is no.

Ms. MCELROY. In Maryland, there is no prohibition against any kickback that relates to anything other than Medicaid.

Mr. SNOWBARGER. What about the other States?

Mr. WIGGS. In Arizona, we have an anti-kickback statute, but there has to be a nexus to the Medicaid program. You can usually establish a nexus to the Medicaid program simply because a facility delivers services. But the difficulty lies in that the statute is so

convoluted, really, on how it defines what the quid pro quo that it is of no value, frankly, for staunch enforcement efforts.

Mr. SPAHR. In New York, the answer is, it depends on the service that's being rendered. We have a kickback statute similar to Arizona's that makes it a felony to pay a kickback of over \$7,000 in connection with the Medicaid program. However, it's only a crime for a medical provider to do so, because of the way the statute was originally drafted; whereas, the Federal law makes it a crime for any person to do so.

There has been introduced in our legislature this year a felony all-payor kickback statute. But also on the books, it is a crime under our public health law to make a self-referral or a kickback with respect to certain types of services, which would include laboratory services, radiation therapy, x ray, things of that type. So while it doesn't cover all services under that case, it does cover certain services.

Mr. SNOWBARGER. Let me go to a little different issue, and that's on the dual eligible population. Do I understand from all of you that one of the major problems there is that—well, maybe I need to ask an initial question.

What tools and methods do you normally use to investigate these potential fraud situations? In connection with that, I note that you just don't have access to the Medicare side of things. So how do you get a handle on the dual eligible fraud issue?

Does that look for a simple answer?

Ms. MCELROY. Well, there's a simple answer, and the answer is, it's very difficult to do. We go beyond that. I think Stephen Spahr mentioned this, as well. When the Medicaid program pays a co-pay, we can't even tell what the underlying service was unless we go back to the Medicare intermediary and get a copy of the claim.

So, we don't even know what this money is paid for. We would be unable to tell whether or not a therapy service that was billed to Medicaid had also been billed 100 percent to Medicare, because we would not know what the Medicare billings were. So that becomes extraordinarily difficult.

We don't have jurisdiction, currently, to investigate and prosecute any Medicare fraud. That lies with the U.S. attorney's office in Maryland. So we don't have any incentive to look at it, and we actually really probably should not look at it. So it becomes difficult.

The situation we're talking about here, where Medicaid and Medicare are paying for a patient, for the same day, in a nursing home, really is a Medicaid issue, because Medicaid, as the payor of last resort, is the program that I would see as the one primarily harmed by such a scheme.

In order to get that information, I have gone to HCFA and asked them to provide the information for all of the Maryland nursing home residents to me, and they have indicated that this is possible.

Mr. SNOWBARGER. That it is possible?

Ms. MCELROY. It is possible. In fact, I don't believe it's going to be very difficult.

Mr. SNOWBARGER. OK. So this has just been a matter of asking for that information, and you will be able to coordinate?

Ms. MCELROY. Well, I will say it took me 2 years trying to figure out where to go to get it, but yes, the answer is just asking, executing a Memorandum of Understanding, which is similar to that which HCFA has with the Federal Bureau of Investigation.

Mr. SNOWBARGER. It may get back to Mr. Allen's comment that 50 States shouldn't have to figure this out, that HCFA should figure it out and be able to offer it.

Mr. ALLEN. In collaboration with the Medicaid States. If one State gets a bright idea, it should quickly get spread to the other 50 States, and HCFA would be the obvious vehicle to do that.

If I could just add, there is a wonderful instrument out there, and that is the Medicare nursing home-cost report. It is a stepped-down cost report. What that means is, it isolates the costs associated with the Medicare client, the Medicaid client, and other payors, which is pretty much the business.

I say it's a wonderful instrument because it's much more sophisticated a tool than what most States are using for their own cost reporting mechanisms. The way that we were able to identify our problem was, it came out of the Medicare cost report. The only problem with the Medicare cost report is that it's slow to be audited. So oftentimes you, in the State, are dealing with a 1996 or 1997 cost basis, but the Medicare cost report perhaps is reflecting costs in 1994.

So it makes it hard for the comparison to be done, but it can tell a big part of the story. And like I said, it's a wonderful instrument, and all States should be encouraged to secure the Medicare cost report in their States, and analyze it and put it on spreadsheets. What will come from it is very valued and good information.

Quite frankly, in my State, I require the nursing facilities to submit their latest Medicare cost report when they submit their Medicaid cost reports, just so I can do this comparison. And it's interesting, the nursing homes get a little grumpy in handing over the Medicare cost report. They will do it, but they complain about it. I think one of the reasons why they complain about it is, they know we're doing these comparisons and things of that nature.

Mr. SNOWBARGER. Yes.

Mr. WIGGS. I might add that, typically, we will be called into a facility, for example, because of a patient abuse type of case that opens the door to investigation of resident abuse, physical abuse.

We will often see that there may be some allegations that some staff may want to say about, you know, billing patterns, et cetera. But usually we will have to just carve out maybe the abuse allegations and separate them from the fraud allegations; whereas, we would really prefer to be able to put those together.

Because not only do you have crossover between the two programs, but, typically, in a patient abuse type of investigation, we may want to look at how these services are being billed, or is that part of the problem. But we end up referring those types of cases to the Office of Inspector General, appropriately so, but they may not have the inclination nor the interest nor the resources focused, at that time, on that particular case.

So a lot of it is energy-driven, which is determined by, if you have an investigative unit that's in there, that's looking, and has the energy to go forward with the prosecution, why not bring all

components together and be able to deal with it that way, rather than carving it out.

Mr. SNOWBARGER. This is a very elementary, basic question: what are the consequences for the perpetrator of the fraud?

Ms. MCELROY. In Maryland, 5 years in jail and a \$10,000 fine.

Mr. SNOWBARGER. OK.

Mr. WIGGS. In Arizona, it depends on the class of felony. If it's a fraud scheme, class 2 felony, it depends on how many prior convictions, et cetera, but you're looking at up to 10, 15 years, potentially. Typically, though, white collar crime, you know, first offense, is not viewed as abhorrent, if you will, as some kind of blue collar crime, if you will. So probation or something like that usually occurs.

Mr. SNOWBARGER. What is the range of the fines? I'm sorry. Was it \$5,000? \$10,000.

Ms. MCELROY. \$10,000 in Maryland, currently. We have just passed a new statute which would increase that up to \$250,000, in the case of a corporate provider.

Mr. WIGGS. Up to \$150,000, for an individual, for Arizona.

Mr. SPAHR. In New York, if, say, it's a larceny of over \$1 million, it would be mandatory State prison up to a period of 25 years, with a fine equal to double the gain.

Mr. ALLEN. I certainly don't know the provisions for criminal misconduct, but one of the biggest deterrents would be, you kick the vendor out of the program. Right now, there are some limits over how long it goes on, but that will get especially a national corporation's attention, which is, you're not only out in Colorado, but you're out in all the other States that you do business in, as well. That's a major deterrent.

Mr. SNOWBARGER. Now, is that nationwide? I mean, if you find something in Maryland with a national vendor, they can no longer be a Medicaid vendor. Is that by Federal law?

Ms. MCELROY. It's Federal law. If there is a criminal conviction, there is a mandatory exclusion of a minimum of 5 years for a health care related offense.

Mr. SNOWBARGER. Corporate offenders, up to \$250,000. What constitutes a corporate offender, if you're incorporated?

Ms. MCELROY. Anyone who is not an individual.

Mr. SNOWBARGER. OK.

Ms. MCELROY. Again, we patterned that on the Federal statute.

Mr. SNOWBARGER. OK. Is that enough deterrence? I mean, if you're talking about multimillions of dollars. Now, in New York, I understand, where you've got a multiple of the benefit that was gained, I see that. In other States, I'm concerned that \$10,000 is certainly worth the risk; \$250,000 may be worth the risk. Was it \$150,000? I don't remember.

But are the penalties stiff enough, or is this a risk of doing business that most vendors are willing to take their chances on?

Ms. MCELROY. In cases where there is no real probability of exclusion, I think it's a risk of doing business that the vendors will accept.

Mr. WIGGS. I think all criminals, to whatever degree of sophistication, do some form of cost-benefit analysis, in terms of the likelihood of getting caught, to getting prosecuted, to getting signifi-

cant jail time. To the extent that you have aggressive prosecution, you're going to create that deterrent effect.

Mr. SNOWBARGER. Do these penalties get to the owners of the business? In other words, it's pretty easy for a corporation, particularly if they are just doing business in one State, to go out of business. Like we mentioned before, you lose the records at that point. Are there penalties, though, for the business owners, if you find the fraud?

Mr. SPAHR. If the fraud can be traced directly back to the individuals, it is a policy, with our unit, to prosecute both the individuals responsible for the acts as well as the corporate entities. And yes, they would trace directly back.

I would also just point out, in terms of the deterrent effect, the difference between a single State's attempt to collect, civilly, dollars, as opposed to the effect of a criminal deterrence. In a recent case, we had a subject of an investigation who, being threatened with a civil audit by a single State agency, made the statement, "Who cares if we get audited; we've already made millions." If that becomes the threat of criminal prosecution and a permanent or a long-term exclusion, it becomes a significant deterrent to the future activity.

Mr. SNOWBARGER. Let me throw out one more topic and get a response from all four of you, just real quickly, if I could. Could you assess for us what you would see as the value or not of consolidated billing by nursing homes? In other words, where nursing homes are billing for the other providers, so that you're not getting flooded from all different directions, I suppose.

Ms. McELROY. To be perfectly honest, I'd have to see how it worked before I could answer that. It sounds like a good idea, but I don't know whether it would be feasible.

Mr. SNOWBARGER. And I'm thinking particularly on the dual eligibles.

Mr. WIGGS. I think, in theory, the better you are able to consolidate where the information is going to be to determine fraud, the more likelihood you're going to be able to have effective program integrity. But, again, it depends on how it takes place.

Mr. SPAHR. I am in general agreement. I would just be concerned that, by creating a billing umbrella in one location, you would permit criminal activity which may go on around the services done for the nursing home that would then never hit the information data bases that the Government programs maintain. Either the names of the vendors or the services that they are billing would never appear anywhere except under the name of a facility.

Mr. SNOWBARGER. So it would depend on how the program is set up.

Mr. ALLEN. I really can't comment on whether a consolidated billing process would solve the problem. You may have other difficulties, which is then the nursing home is responsible for the pharmacy billing, and all the rest of it, and I'm not sure you would necessarily want that.

It does seem to me that you should allow the States to experiment with more managed care type operations in long-term care, for the dual eligibles, which is, all the billing information now goes to one HMO that has to pay all the Medicare and the Medicaid

bills, with all that information being centralized, plus the financial responsibility. You've brought marketplace dynamics onto the problem, which is, why do I want to pay for this; I think I already paid for this somewhere else.

Mr. SNOWBARGER. Thank you very much.

Mr. Towns.

Mr. TOWNS. Thank you.

I just wanted to explore something that was raised earlier. Now, I understand, in terms of if a person is convicted in one State, then they can't practice in that State, but I'm not sure, in terms of whether or not we are able to do this nationally. If a company is doing business in more than one State, do we really have the information to prevent them from doing business elsewhere?

Ms. MCELROY. Yes, we do. The Medicaid Fraud Control Units are required to report their convictions to the Federal Government. The Office of Inspector General regularly publishes, and it is on the Internet, a list of all of the providers that are barred from doing business. If Maryland convicts someone, the Federal Government will bar that provider from participating in the Medicare program and in any other State Medicaid program.

Mr. TOWNS. The same?

Mr. ALLEN. Yes. Indeed, the information is well shared. So, indeed, if something happened in New York, we do learn about it in Colorado. We get those just about on a monthly basis.

The only thing I would throw out for consideration is, is 5 years long enough? We've seen in Colorado where a nursing home owner was found guilty of fraud. They waited their 5 years, and they came back. And it was quite disturbing to me, because I thought we had seen the last of them. So I'm not sure if 5 years is long enough. In a business cycle, it's not really very long.

Mr. TOWNS. Let me ask a question along those lines. Let me make sure, because this is a part where we've had a lot of problems, in terms of dealing with various pharmacists, in particular, in terms of doing business in different States. Shut them down in one State; they do in the next State.

Let me ask, in terms of the extent of that, that means, if it's a husband, can a wife take over the business? What are we really talking about here? Or is it the fact that, one brother is convicted, then the other one now takes over and is able to do business?

I just want to get as close to this as we can, because I just feel that there is a big problem in terms of fraud. So you grab me, and, of course, my younger brother now takes over and still continues to do business. He might even change the name for a minute, and then 5 years later we change it back. Is that a problem?

Mr. SPAHR. It's a problem. It's also a problem of proof, in many respects. In New York, I believe it's an unacceptable practice for any Medicaid provider to employ a person who has been debarred from any State or Federal program, or to have them have an ownership, I believe, of more than 5 percent.

But proving the existence of the relationship between yourself and your brother, that you actually have an interest or that you are actually performing a service for that company, can be extremely difficult. We have done it, on occasion. Where we have been able to prove that a debarred provider is out acting as a sales-

man for a company, we have been able to put the additional company out of business or put them out of the system. It's a difficult question to prove.

Mr. WIGGS. I would say there's nothing stopping that individual from closing down their shop, incorporating under a new name, and having a new board of directors, their brother, or something like that, and continuing on in the practice. I don't see how that's going to be—as Steve says, it's going to be hard to establish the relationship, the link there, to be able to say that that falls under the exclusion categories. I think your concern is well-founded.

Mr. ALLEN. The only thing I would add is that I've seen the same dodge that you're describing. You do get the brother, and then you find a sister comes in to operate the company, things of that nature, or the wife, or what have you. We've seen that very same thing, and it is, from what I can tell from our Medicaid Fraud Control people, very hard to stop it.

Mr. TOWNS. It's a tough situation, I tell you. But thank you very, very much.

Mr. Chairman, I yield back.

Mr. SNOWBARGER. Thank you.

Thank you to the panel members. I think that will conclude the questioning of this panel, and we will move on to the next.

Mr. Grob and Ms. Aronovitz, if you will come forward, we will swear you in and get started on the next round. I should have caught both of you before you sat down. If you would both stand up, we've made a practice of swearing in those who are going to testify before us. So if you would raise your right hand.

[Witnesses sworn.]

Mr. SNOWBARGER. Mr. Grob, if you want to lead.

Mr. GROB. Mr. Chairman, would you mind if Ms. Aronovitz goes first?

Mr. SNOWBARGER. That's fine with me. I have no problem with that.

Ms. Aronovitz.

STATEMENTS OF LESLIE ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND SYSTEMS ISSUES/HEHS, GENERAL ACCOUNTING OFFICE; AND GEORGE GROB, DEPUTY INSPECTOR GENERAL FOR EVALUATIONS AND INSPECTIONS, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. ARONOVITZ. Members of the subcommittee, I am pleased to be here today to discuss the challenges that exist in combating fraud and abuse in the nursing facility environment. While the Medicaid program, as you heard, is the largest payor for nursing facility care, Medicare does pay a substantial portion of the health care costs of nursing facility residents.

For the opportunistic provider, a nursing home represents a vulnerable elderly population in a single location, and the opportunity for multiple billings. That is why it is so important for nursing facilities to be aware of and oversee the services and supplies that are being billed on residents' behalf.

While most providers abide by the rules, some providers of supplies and services have used the nursing facility setting as a target of opportunity. This has occurred for two main reasons: First, the

complexities of the reimbursement process invite exploitation. And second, insufficient control over Medicare claims has reduced the likelihood that inappropriate claims will be denied.

First, I would like to briefly address the complexities of the reimbursement system. Ancillary services and items for Medicare beneficiaries in nursing facilities can be provided by the nursing facility itself, a company wholly or partially owned by the nursing facility, or an independent supplier or practitioner. As a matter of fact, our work has shown that independent providers and suppliers can bill directly for services or supplies without confirmation from the nursing facility that the care or items were necessary or delivered as claimed.

Billing for therapy service is even more complicated. Reimbursement rates and procedures vary according to the patients circumstances, who provides the services, and who submits the bills to Medicare. These factors also affect the type of contractor which reviews and processes the claims, and whether the claim is paid from Part A or Part B.

Until recently, HCFA had not established salary guidelines, which are needed to define reasonable costs for occupational or speech therapy. Even for physical therapy, for which salary guidelines do exist, the Medicare established limits don't apply if the therapy company bills Medicare directly.

In regard to HCFA's lax oversight, we have long been critical of the unstable funding support HCFA's contractors have to carry out program integrity activities. While Medicare contractors do employ a number of effective automated controls to prevent some inappropriate payments, our 1996 report on 70 fraud and abuse cases showed that atypical charges or very large reimbursements routinely escape those controls and typically went unquestioned.

Initiatives on various fronts are now under way to address fraud and abuse that we are talking about today. To address the root cause of the problems, the administration has announced an initiative to change the way Medicare reimburses for services and supplies in skilled nursing facilities. They are calling this consolidated billing.

This proposal will require skilled nursing facilities to bill Medicare for all services provided to their beneficiary residents, except for physician and some other practitioner services. We support this proposal. A consolidated billing requirement would make it easier to control payments for these services and give nursing facilities the incentive to monitor them.

In regard to therapy services, after a lengthy administrative process, HCFA proposed salary guidelines last month for occupational and speech therapists, and revised current guideline amounts for physical and respiratory therapists who furnish care to beneficiaries under a contractual arrangement with a nursing facility. The administration estimates these changes will result in savings to Medicare of \$1.7 million between now and the year 2001.

On the legislative front, the Health Insurance Portability and Accountability Act established the Medicare Integrity Program, which ensures that the program safeguard activities function is funded separately from other processing activities. The act also included

provisions on administrative simplification, and there is also a requirement that HCFA send out explanations of Medicare benefits for all services billed, not just where co-payments or deductibles are involved.

We are encouraged by these recent efforts to combat fraud and abuse. As more details concerning these or other proposals become available, we will be glad to work with the subcommittee and others to sort out their potential implications.

This concludes my prepared remarks, and I would be happy to answer any questions.

[The prepared statement of Ms. Aronovitz follows:]

Statement of Leslie G. Aronovitz, Associate Director
Health Financing and Systems Issues
Health, Education, and Human Services Division

Mr. Chairman and Members of the Subcommittee,

I am pleased to be here today to discuss the challenges that exist in combatting fraud and abuse in the nursing facility environment. While the Medicaid program is the largest single payer for nursing facility care, Medicare, the national health insurance program for the elderly and certain disabled people, pays a substantial proportion of the health care costs of nursing facility residents. For the opportunistic provider, a nursing home represents a vulnerable elderly population in a single location and the opportunity for multiple billings. Many nursing home patients are cognitively impaired, and their care is controlled by the nursing facility. Because these patients would probably not realize what items or special services were billed on their behalf, some providers may take advantage of the situation by submitting fraudulent claims.

My comments will draw heavily from reports we have recently issued that focused on cost growth and fraudulent and abusive billings for ancillary services and supplies for nursing facility residents.¹ I will describe how providers have exploited the Medicare program, why they were able to do so, and what steps have been taken to protect the program from the recurrence of such reimbursement schemes. I will also describe the special vulnerabilities associated with individuals who are eligible for both Medicare and Medicaid. They are poor and are less likely to have family members in the community to represent their interests.

In summary, while most providers abide by the rules, some unscrupulous providers of supplies and services have used the nursing facility setting as a target of opportunity. This has occurred for several reasons:

- the complexities of the reimbursement process invite exploitation and
- insufficient control over Medicare claims has reduced the likelihood that inappropriate claims will be denied.

We are encouraged by a number of recent efforts to combat fraud and abuse—the pending implementation of provisions in the Health Insurance Portability and Accountability Act (HIPAA) and a legislative proposal made by the administration. While these efforts should make a difference in controlling fraud and abuse in nursing homes, it is too early to tell whether these efforts will be sufficient.

BACKGROUND

Medicare falls within the administrative jurisdiction of the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS). HCFA

¹See the list of related GAO products at the end of this testimony.

establishes regulations and guidance for the program and contracts with about 72 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 are handled, for the most part, by contractors, and they are the primary referral parties to law enforcement agencies for suspected fraud.

Medicare's basic nursing home benefit covers up to 100 days of certain posthospital stays in a skilled nursing facility.² Skilled nursing facilities submit bills for which they receive interim payment; final payments are based on costs within a cost-limit cap. This benefit is paid under part A, Hospital Insurance, which also pays for hospital stays and care provided by home health agencies and hospices.

Even if Medicare beneficiaries do not meet the conditions for Medicare coverage of a skilled nursing facility stay, they are still eligible for the full range of part B benefits. Although Medicaid or the resident may be paying for the nursing home, Medicare will pay for ancillary services and items such as physical and other types of therapy, prosthetics, and surgical dressings. Part B is voluntary part of the Medicare program that beneficiaries may elect and for which they pay monthly premiums. Part B also pays for physician care and diagnostic testing.

About 6 million people have both Medicare and Medicaid coverage, and, of these, over 4.8 million represent state "buy-ins" for Medicare coverage.³ Dually eligible beneficiaries are among the most vulnerable Medicare beneficiaries. They are generally poor; have a greater incidence of serious and chronic conditions, and are much more likely to be institutionalized. As a matter of fact, about 1.4 million reside in institutions, while only 600,000 of the approximately 31 million Medicare beneficiaries without Medicaid coverage are in institutions. Over half of all dually eligible patients over 85 reside in nursing facilities.

When a copayment is required, a Medicare beneficiary or a representative designated by the beneficiary, receives an "Explanation of Medicare Benefits" (EOMB), which specifies the services billed on behalf of the individual. The EOMB is an important document because beneficiaries and their families can use it to verify that the services were actually performed. The dually eligible population, however, often does not have a representative in the community to receive and review this document. In fact, many nursing home patients actually have the nursing home itself receive the EOMBs on their behalf.

²Under the Medicare part A nursing home benefit, skilled nursing facilities are nursing homes that maintain a full-time staff of medical professionals who provide daily care for patients with complex medical or rehabilitative needs.

³States frequently pay the premium for part B coverage for Medicaid recipients.

MULTIPLE BILLING METHODS FOR SERVICES IN NURSING FACILITIES LEAVE MEDICARE VULNERABLE

In 1996, Medicare spent \$11.3 billion on skilled nursing facility benefits and an undetermined amount on part B ancillary services and items. The providers of these services and items can bill Medicare in a variety of ways. With this variety comes the opportunity to blur the transactions that actually took place and inflate charges for services rendered.

Ancillary services and items for Medicare beneficiaries in nursing facilities can be provided by the nursing facility itself, a company wholly or partially owned by the nursing facility, or an independent supplier or practitioner. Our work has shown that

- independent providers and suppliers can bill Medicare directly for services or supplies without the knowledge of the beneficiary or the facility and
- companies that provide therapy are able to inflate their billings.

Outside Providers and Suppliers Bill Medicare Directly

Nursing facilities often do not have the in-house capability to provide all the services and supplies that patients need. Accordingly, outside providers market their services and supplies to nursing facilities to meet the needs of the facilities' patients. HCFA's reimbursement system allows these providers to bill Medicare directly without confirmation from the nursing facility or a physician that the care or items were necessary or delivered as claimed. As a result, the program is vulnerable to exploitation.

According to the HHS Inspector General, provider representatives typically enter nursing facilities and offer to handle the entire transaction—from reviewing medical records to identify those patients their products or services can help, to billing Medicare—with no involvement by nursing facility staff. Some of these facilities allow providers or their representatives to review patient medical records despite federal regulatory standards prohibiting such unauthorized review. These representatives gain access to records not because they have any responsibility for the direct care of these patients, but solely to market their services or supplies. From these records, unscrupulous providers can obtain all the information necessary to order, bill, and be reimbursed by Medicare for services and supplies that are in many instances not necessary or even provided. In 1996, we reported the following examples:⁴

⁴Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

- A group optometric practice performed routine eye examinations on nursing facility patients, a service not covered by Medicare. The optometrist was always preceded by a sales person who targeted the nursing facility's director of nursing or its social worker and claimed the group was offering eye examinations at no cost to the facility or the patient. The nursing facility gave the sales person access to patients' records, and this person then obtained the information necessary to file claims. Nursing staff would obtain physicians' orders for the "free" examinations, and an optometrist would later arrive to conduct the examinations. The billings to Medicare, however, were for services other than eye examinations—services that were never furnished or were unnecessary.
- The owner of a medical supply company approached nursing facility administrators in several states and offered to provide supplies for Medicare patients at no cost to the facility. After reviewing nursing facility records, this company identified Medicare beneficiaries, obtained their Medicare numbers, developed lists of supplies on the basis of diagnoses, identified attending physicians, and made copies of signed physician orders in the files. The supplier then billed Medicare for items it actually delivered but also submitted 4,000 fraudulent claims for items never delivered. As part of the 1994 judgment, the owner forfeited \$328,000 and was imprisoned and ordered to make restitution of \$971,000 to Medicare and \$60,000 to Medicaid.
- A supplier obtained a list of Medicare patients and their Medicare numbers from another supplier who had access to this information. The first supplier billed Medicare for large quantities of supplies that were never provided to these patients, and both suppliers shared in the approximately \$814,000 in reimbursements.

We found that nursing home staff's giving providers or their representatives inappropriate access to patient medical records was a major contributing cause to the fraud and abuse cases we reviewed.

Reimbursement for Therapy Services
Is Complicated and Vulnerable to Waste and Abuse

Many nursing facilities rely on specialized rehabilitation agencies—also termed outpatient therapy agencies—to provide therapy services. These agencies can be multilayered, interconnected organizations—each layer adding costs to the basic therapy charge—that use outside billing services, which can also add to the cost. In those situations in which the nursing facility contracts and pays for occupational and speech therapy services for a Medicare-eligible stay, Medicare might pay the nursing facility what it was charged because of the limited amount of review conducted by claims processing contractors. In practice, however, because of the difficulty in determining what are

reasonable costs and the limited resources available for auditing provider cost reports, there is little assurance that inflated charges are not actually being billed and paid.⁵

Until recently, HCFA had not established salary guidelines, which are needed to define reasonable costs for occupational or speech therapy. Without such benchmarks, it is difficult for Medicare contractors to judge whether therapy providers overstate their costs. Even for physical therapy, for which salary guidelines do exist, the Medicare-established limits do not apply if the therapy company bills Medicare directly.

This is why Medicare has been charged \$150 for 15 minutes of therapy when surveys show that average statewide salaries for therapists employed by hospitals and nursing facilities range from \$12 to \$25 per hour. Our analysis of a sample drawn from a survey of five contractors found that over half of the claims they received for occupational and speech therapy from 1988 to 1993 exceeded \$172 in charges per service. Assuming this was the charge for 15 minutes of treatment—which industry representatives described as the standard billing unit—the hourly rate charged for these claims would have been more than \$688. It should be noted that neither HCFA nor its contractors could accurately tell us what Medicare actually paid the providers in response to these claims. The amount Medicare actually pays is not known until long after the service is rendered and the claim processed. Although aggregate payments are eventually determinable, existing databases do not provide actual payment data for any individual claim.

**LAX OVERSIGHT PROVIDES LITTLE CHANCE OF TIMELY
DETECTION OF EXCESSIVE MEDICARE REIMBURSEMENTS**

HCFA pays contractors to process claims and to identify and investigate potentially fraudulent or abusive claims. We have long been critical of the unstable funding support HCFA's contractors have to carry out these program integrity activities. We recently reported that funding for Medicare contractor program safeguard activities declined from 74 cents to 48 cents per claim between 1989 and 1996. During that same period, the number of Medicare claims climbed 70 percent to 822 million.⁶ Such budgetary constraints have placed HCFA and its contractors in the untenable position of needing to review more claims with fewer resources.

While Medicare contractors do employ a number of effective automated controls to prevent some inappropriate payments, such as suspending claims that do not meet certain conditions for payment for further review, our 1996 report on 70 fraud and abuse cases showed that atypical charges or very large reimbursements routinely escaped those

⁵Medicare reimbursement in these instances is supposed to be based on the providers' "reasonable costs."

⁶High Risk Series: Medicare (GAO/HR-97-10, Feb. 1997).

controls and typically went unquestioned.⁷ The contractors we reviewed had not put any "triggers" in place that would halt payments when cumulative claims exceeded reasonable thresholds. Consequently, Medicare reimbursed providers, who were subsequently found guilty of fraud or billing abuses, large sums of money over a short period without the contractor's becoming suspicious. The following examples highlight the problem:

- A supplier submitted claims to a Medicare contractor for surgical dressings furnished to nursing facility patients. In the fourth quarter of 1992, the contractor paid the supplier \$211,900 for surgical dressing claims. For the same quarter a year later, the contractor paid this same supplier more than \$6 million without becoming suspicious, despite the 2,800-percent increase in the amount paid.
- A contractor paid claims for a supplier's body jackets⁸ that averaged about \$2,300 per quarter for five consecutive quarters and then jumped to \$32,000, \$95,000, \$235,000, and \$889,000 over the next four quarters, with no questions asked.

In other instances, we found that providers that were subsequently investigated for wrongdoing billed and were paid for quantities of services or supplies that were unnecessary or could not possibly have been furnished:

- A contractor reimbursed a clinical psychology group practice for individual psychotherapy visits lasting 45 to 50 minutes when the top three billing psychologists in the group were allegedly seeing from 17 to 42 nursing facility patients per day. On many days, the leading biller of this group would have had to work more than 24 uninterrupted hours to provide the services he claimed.
- A contractor paid a podiatrist \$143,580 for performing surgical procedures on at least 4,400 nursing facility patients during a 6-month period. For these services to be legitimate, the podiatrist would have had to serve at least 34 patients a day, 5 days a week.

The Medicare contractors in these two cases did not become suspicious until they received complaints from family members, beneficiaries, or competing providers. The EOMB was critical in identifying the specific items and services being billed to Medicare. Although EOMBs have in the past only been required when the beneficiary had a deductible or copayment, HIPAA now requires HCFA to provide an explanation of Medicare benefits for each item or service for which payment may be made, without regard to whether a deductible or coinsurance may be imposed. This provision is still of

⁷GAO/HEHS-96-18, Jan. 24, 1996.

⁸A body jacket is a custom-fitted spinal brace made of a rigid plastic material that conforms to the body and largely immobilizes it.

limited value, however, for nursing home residents who designate the nursing home to receive the EOMBs—which is more common for the dually eligible population.

In other cases, contractors initiated their investigations because of their analysis of paid claims (a practice referred to as "postpayment medical review"), which focused on those providers that appeared to be billing more than their peers for specific procedures. One contractor, for instance, reimbursed a laboratory \$2.7 million in 1991 and \$8.2 million in 1992 for heart monitoring services allegedly provided to nursing facility patients. The contractor was first alerted in January 1993 through its postpayment review efforts when it noted that this laboratory's claims for monitoring services exceeded the norm for its peers.

In all these cases, we believe the large increases in reimbursements over a short period or the improbable cumulative services claimed for a single day should have alerted the contractors to the possibility that something unusual was happening and prompted an earlier review. People do not usually work 20-hour days, and billings by a provider for a single procedure do not typically jump 13-fold from one quarter to the next or progressively double every quarter.

INITIATIVES NOW UNDER WAY TO ADDRESS LONG-STANDING PROBLEMS

Initiatives on various fronts are now under way to address fraud and abuse issues we have discussed here today. Several of these initiatives, however, are in their early stages, and it is too soon to assess whether they will, in fact, prevent fraud and abuse in the nursing facilities environment.

HHS Initiatives

Last year, we recommended that HCFA establish computerized prepayment controls that would suspend the most aberrant claims. HCFA has since strengthened its instructions to its contractors, directing them to implement prepayment screens to prevent payment of billings for egregious amounts or patterns of medically unnecessary services or items. HCFA also authorized its contractors to deny automatically the entire line item for any services that exceed the egregious service limits.

In regard to therapy services, after a lengthy administrative process, HCFA proposed salary guidelines last month for physical, occupational, speech, and respiratory therapists who furnish care to beneficiaries under a contractual arrangement with a skilled nursing facility. The administration estimates these changes will result in savings to Medicare of \$1.7 billion between now and the year 2001, and \$3.9 billion between now and the year 2006. The proposed rule would revise the current guideline amounts for physical and

respiratory therapies and introduce, for the first time, guideline amounts for occupational therapy and speech/language pathology services.

In March 1995, the Secretary of HHS launched Operation Restore Trust (ORT), a 2-year interagency, intergovernmental initiative to combat Medicare and Medicaid fraud and abuse. ORT targeted its resources on three health care areas susceptible to exploitation, including nursing facility care in five states (California, Florida, Illinois, New York, and Texas) with high Medicare and Medicaid enrollment and rapid growth in billed services.

To address the root cause of the problems cited here today, the administration has also announced an initiative to change the way Medicare reimburses for services and supplies in skilled nursing facilities: consolidated billing. More specifically, the administration has announced that it will propose requiring skilled nursing facilities to bill Medicare for all services provided to their beneficiary residents except for physician and some other practitioner services. We support this proposal. We and the HHS Inspector General have reported on problems, such as overutilization of supplies, that can arise when suppliers bill separately for services for nursing home residents.

A consolidated billing requirement would make it easier to control payments for these services and give nursing facilities the incentive to monitor them. The requirement would also help prevent duplicate billings and billings for services and items not actually provided. In effect, outside suppliers would have to make arrangements with skilled nursing facilities so that they would bill for suppliers' services and would be financially liable and medically responsible for the care.

Legislative Initiatives

HIPAA established the Medicare Integrity Program, which ensures that the program safeguard activities function is funded separately from other claims processing activities. HIPAA also included provisions on "administrative simplification." A lack of uniformity in data among the Medicare program, Medicaid state plans, and private health entities often makes it difficult to compare programs, measure the true effect of changes in health care financing, and coordinate payments for dually eligible patients. For example, HIPAA requires, for the first time, that each provider be given a unique provider number to be used in billing all insurers, including Medicare and Medicaid.

The new provisions also require the Secretary of HHS to promulgate standards for all electronic health care transactions; the data sets used in those transactions; and unique identifiers for patients, employers, providers, insurers, and plans. These standards will be binding on all health care providers, insurers, plans, and clearinghouses.

CONCLUSION

The multiple ways that providers and suppliers can bill for services to nursing home patients and the lax oversight of this process contribute to the vulnerability of payments for the health care of this population. As a result, excessive or fraudulent billings may go undetected. We are encouraged, however, by the administration's recent proposal for consolidated billing, which we believe will put more responsibility on nursing home staff to oversee the services and items being billed on behalf of residents. As more details concerning these or other proposals become available, we will be glad to work with the Subcommittee and others to help sort out their potential implications.

This concludes my prepared remarks. I will be happy to answer any questions.

For more information on this testimony, please call Leslie G. Aronovitz on (312) 220-7600 or Donald B. Hunter on (617) 565-7464. Lianne Bradley also contributed to this statement.

Mr. SNOWBARGER. Thank you.

Mr. Grob.

Mr. GROB. Mr. Chairman and Mr. Towns, all of my colleagues on both panels have given numerous examples of fraud, waste, and abuse in the nursing home setting. I have a set of my own, but I thought that it might be more useful if I would just take a few minutes to try to explain at least the backbone of the complicated reimbursement system that currently exists in the Medicare and Medicaid programs.

I can't explain it in all of its complexity, but at least I can outline the major features of it. Even at the highest level of aggregation, I think you will see that it is, indeed, a very complex system. It reminds me of Gordian's knot, for which there was a promise that, if it was untied, the untier could conquer the world. No one ever untied it, although Alexander the Great came up with a solution which I will refer to at the end of my presentation.

The system is outlined on the charts that you see before you. First of all, it is good to remember that we are talking about several different financing sources for nursing homes. The first one is Medicare Part A, about \$9 billion in 1995. What we're talking about there is the basic payment that is made to a Medicare beneficiary who is in a nursing home to receive skilled nursing care after a hospital stay. I will call this a Medicare Part A stay, and we are talking about basically being in the nursing home, with some services, collateral services, related to that.

Medicaid, \$33 billion in 1995, would be for poor individuals who receive care under the Medicaid program to be in a nursing home. This could include skilled care, or it could also include long-term care. I have included in that \$33 billion the money spent for both kinds of nursing homes, not just the skilled nursing homes.

Now, the reason that I put Medicare Part B last instead of putting it right into Part A, where most people think it belongs, is because the payments made under Part B would be for other services, physician services, for example, or some of the other services people have mentioned. I will refer to some of them later. Those payments can be made for a Medicare beneficiary in a nursing home, no matter which nursing home that beneficiary is in.

So, for example, if a Medicare beneficiary is in a Medicare Part A paid stay, the physician's payment will be made out of Medicare Part B. But if that Medicare patient is also poor and is in a Medicaid nursing home, Medicare Part B will still pay the physician's payment for that resident, and that's logical enough. But it also provides other services, as well, some of which might duplicate payments made under Part A or in the Medicaid program.

Now, on the other chart, we can see clearly what the structure of the payment is. Under the Medicare Part A program, the payment is divided into three parts: a per diem, which is basically room and board and related services that all nursing patients receive; the so-called "ancillary services," primarily therapy services, but also things like portable x rays; and capital payments: the beds, the facility itself, and things of that nature.

Medicaid is paid for in a variety of ways, because every State sets up its own system for paying for Medicaid programs. There you see just a listing of some of the different systems that are used

in the Medicaid nursing home. And then Medicare Part B pays for supplies and services for Medicare beneficiaries who are in nursing homes.

With all these different payment mechanisms, it would be easy to see why a decision that a biller might make would be to bill for the service on the line item that would pay the greatest amount. That, basically, is what will often happen for the sophisticated biller. Again, it falls into the categories that Mr. Shays referred earlier as legal but troublesome, perhaps.

I would like to now just give a few examples. Some of them you have heard before, but I would like to relate them to that payment system, because I think that will help in understanding the possible ways to fix it.

On my left, we see here a pole for a nursing bed. Now, traditionally, in Medicare, we don't pay separately for that pole. That pole is covered under the capital expenses. It is just a cost item. It is well placed in that category because it gives the nursing home the incentive to economize in the purchasing of equipment like that. They don't bill for the pole.

However, recently, starting in 1994, enteral nutrition services were regarded as a billable service under Medicare Part B. Now, since the nutrient is covered under Medicare Part B, someone thought, well, the pole ought to be, as well. So starting in 1994, we started receiving billings for the pole. In 2 years, we've worked our way up to \$3.5 million. That was at the end of 1995.

I think we're seeing the beginning of one of those rocket ship curves that we see so often in the billing practices, where we're going to see something take off, because as people begin to understand that they can bill for these, they will.

Also, the incentives change. If you were, under Medicare Part A, receiving reimbursement for that pole under capital expenses, you would try to bulk purchase them. And if you did, you could get them for about \$33 each. But if you bill Medicare Part B, you can get \$110 for that pole. This is an example of where the billing mechanism does provide incentives for things that could be very inefficient.

Mr. Chairman, I see that I've used up my 5 minutes on one example. I could give a few more. If you have a preference, I will end my testimony here. If you would like me to give a few more, I would be happy to do so. Whatever your choice is.

Mr. SNOWBARGER. We have normally allowed people to go beyond their 5 minutes, so if you want to continue with a couple more, we have the time. We're going on the second round. Why don't you go ahead.

Mr. GROB. OK. So we showed with the pole the thing that can occur, primarily resulting in a loss of economy.

Now, let me give you another couple examples. The example of the pole that I just gave would fit Mr. Shays' earlier example of legal but dumb, perfectly legal. In fact, if you were a nursing home operator, you would probably be chastised by your company if you didn't bill that way.

Let me give some examples now that I would call outright fraud. We found in a study we did that incontinence supplies billed to Medicare patients, most of whom were in nursing homes, were

falsely billed. Bills were made for services not rendered; they were billed for supplies that Medicare doesn't cover; they were billed for excessive use, to the tune of about \$100 million a year.

This is flat-out fraud. The rules were clear. The billers knew they were violating the rules. We just put someone in jail for 10 years who admitted to billing Medicare for \$70 million of incontinence supplies, and he received \$45 million of that, all illegal billings.

A couple years ago we looked at wound care supplies under Part B for people in nursing homes. Again, about \$100 million that probably should not have been billed, given the guidelines that were in effect in those days. One of them was for 12 miles worth of bandages and dressings for one patient and 5 gallons of gel for the wounds. Now, we are sure that patient didn't get that amount; it was probably stored in the nursing home for the other patients.

The famous orthotic body jackets that virtually every speaker has mentioned in their testimony was something that we found. That was a jacket that Medicare pays about \$1,000 for, if you need the lumbar support for critical injury of your back, but we were finding that people were billing for seat cushions to keep people in their wheelchairs. But they were billing for the \$1,000 instead of the \$50 or \$100 worth.

Mr. SHAYS [presiding]. That's clearly illegal.

Mr. GROB. That's clearly illegal. They were falsely billing for the item that clearly was not covered by the Medicare program. We found that 95 percent of the billings for that item were illegal billings. We started out paying \$1 million a year for that item, and it suddenly shot up to \$14 million year, and 95 percent of that we found to be illegal.

Sad to say, we recently did a study where we looked at mental health services for people in nursing homes, and we found that one-fourth of the billings that we looked at were not properly billed. These were for services that were inappropriate. The previous speakers mentioned examples of these: people with Alzheimer's disease, incapable of understanding, were given therapy sessions; or people giving coffee klatches charged for group therapy, things of this nature.

These are examples of where you have outright fraud. And, of course, the fraud is possible because, as people have mentioned, it is the supplier billing for this without any coordination necessarily with the nursing home owner. For some of these supplies, the biller could go to the nursing home operator and say, "Look, let me take care of things for you. I'll check your patients out. I'll make sure they get everything they need. And, don't worry, it won't cost you a penny; I will bill Medicare directly." And they bill Medicare directly for that.

Consolidated billing is meant to overcome that kind of problem of lack of supervision. I might mention that this creates a serious problem of quality of care for the patient, as well, since the nursing home is not now necessarily supervising the care. As Mr. Towns previously made reference to, we have a problem of access to patients' records and a violation of the privacy of records, if suppliers go into those nursing homes and look at the records to see how much services can be billed for these patients.

To show you that every aspect of the system can be “gamed,” if you will, and again, perhaps legitimately, I will go back to a case of “legal but dumb.” We would be going back to the ancillary services. Several people have mentioned this. If you bill for a service such as therapies or portable x rays under ancillary services instead of under Part B, there is no Part B limit. It’s based on reasonable charge. So we may end up paying considerably more, even several times more, for the same item under the ancillary service portion of the payment than we do under Part B.

In fact, to make matters worse, if the payment is made under arrangement, there may be additional overhead and business expenses that are added on, and sometimes those can be higher if there is some collaboration between the nursing home operator and the nursing home supplier.

Finally, I would like to mention something that’s not quite on a chart, that an earlier speaker mentioned. We are also concerned about hospice services for people in nursing homes. There is, indeed, a double payment for that. There are questions being raised about the level of service provided for the hospice services and the legitimacy of the payments. We have that under study right now, and we will be hoping to provide you some information about that very soon.

With regard to solutions for this problem, I believe the knot cannot be untied. I believe we should take the approach Alexander the Great did, which was to simply cut the knot and then proceed to take over the world. And I believe what we need to do here is to simply cut the whole thing. If the problem is complexity, I think the solution is simplicity.

So the idea, first, of a prospective payment system under the Medicare Part A program is probably a pretty reasonable one where a flat payment could cover all the services. This has been proposed by the administration, and if it were adopted, our strong recommendation would be that you would put as many of the services as possible under that prospective payment rate, so that they would not be separately billed under Part B, for example, as separate services.

In my opinion, this would certainly include enteral nutrition, which is basically food for people who need special help with nutrition, which is one of the reasons why they go to the nursing home. It could include all the incontinent supplies, and probably should include much of the wound care, as well.

For the parts that don’t belong under that prospective payment, we strongly support the idea of consolidated billing. We recognize that this creates additional billing problems; we are well aware of that. Perhaps there would even be some inefficiencies. But we believe that the nursing home would now have responsibility to supervise the care that is being given in a nursing home, and we believe that would be a step up, as far as quality of care is concerned, and also provide a better handle on where to look for problems as they occur.

If those broad kinds of actions cannot be taken, we would recommend some fixes such as more limits on what we pay, limiting the amount we pay to what a prudent purchaser might pay, for example, per capita payments, and finally, correcting that discrep-

ancy between the ancillary and the Part B services that I mentioned earlier.

So that's my explanation. I hope that you find it useful. We're happy to answer questions.

[The prepared statement of Mr. Grob follows:]

TESTIMONY BEFORE THE HOUSE
GOVERNMENT REFORM AND OVERSIGHT COMMITTEE
SUBCOMMITTEE ON HUMAN RESOURCES
April 16, 1997

George F. Grob
Deputy Inspector General,
Evaluation and Inspections
Department of Health and Human Services

INTRODUCTION

Good Morning, Mr. Chairman. I am George Grob, Deputy Inspector General for Evaluation and Inspections of the Department of Health and Human Services. I am here today to discuss fraud, waste, and abuse in nursing homes. My testimony focuses on the "gaming" of billings by some nursing home owners and by suppliers of medical services and supplies. This gaming ultimately takes the form of unnecessary services, excessive prices, and fraudulent billings; and it results in a loss of quality of care for the nursing home residents. It will take aggressive administrative action and legislation to eliminate these problems.

The abuses that I will discuss involve the so called "dually eligible"--low income elderly or disabled individuals who are entitled to receive benefits under both the Medicare and Medicaid programs. In the context of nursing homes, these are residents whose nursing home stay is financed by Medicaid but who are also receiving medical services and supplies paid for by Medicare Part B.

However, these same problems occur when the nursing home stay is financed under Medicare Part A or even under private insurance. The interplay of all these various payment sources is complex. In fact, it is this complexity which is the source of most of the vulnerabilities which I will describe.

The material included in this testimony is derived from intensive work under an initiative called Operation Restore Trust. This was a two year demonstration of innovative ways to fight fraud, waste, and abuse in the Medicare program. It focused on problems with home health, nursing homes, hospices, and durable medical equipment in five States--New York, Florida, Illinois, Texas, and California. It involved concerted and coordinated action by the Office of Inspector General, the Health Care Financing Administration, the Administration on Aging, the Department of Justice, and other law enforcement agencies. The initiative is now being expanded beyond the initial five States and to cover additional programmatic areas within the Medicare and Medicaid programs.

MEDICARE AND MEDICAID FUNDING OF NURSING HOME SERVICES

In 1996, almost 3 million persons were in nursing homes whose stay was paid for by either the Medicare or Medicaid program. Nursing home care includes a wide variety of services that range from skilled nursing and therapy services to assistance with such personal care functions as bathing, dressing, and eating. It also includes room and board.

The Medicare and Medicaid programs together paid \$46 billion for nursing care of all kinds in 1995. This included \$42 billion in payments to nursing homes (\$9 billion under Medicare Part A and \$33 billion under Medicaid), and \$4 billion (under Medicare Part B) in payments to various providers of medical supplies and services for Medicare beneficiaries residing in nursing homes.

Medicare Part A. Medicare Part A provides up to 100 days of coverage after hospitalization for stays in a skilled nursing home. After 20 days, a daily co-payment of \$95 must be paid by the nursing home resident. The amount it pays has three separate components--the per diem, ancillary costs, and capital costs.

Per Diem: The per diem, or routine service costs such as nursing, room and board, and administrative and other overhead costs of the facility. These costs are subject to a limit.

Ancillary Services: Ancillary costs include laboratory, radiology, drugs, therapy, and other items and services. These are paid on the basis of reasonable costs, but are not subject to a limit as such.

Capital: Capital is also reimbursed on the basis of cost and is not subject to a limit as such.

A deeper look at the Part A payment methods will reveal additional details about how the per diem limit is established and how payments vary depending on whether a nursing home is free standing or hospital based. Certain nursing homes, under certain conditions, are also allowed to elect to be paid on the basis of a prospective payment rate.

Medicare Part A payments to nursing homes have more than doubled, from \$3.7 billion in FY 1992 to \$9 billion in FY 1995. The number of beneficiaries in covered nursing home stays increased from 779,000 in 1992 to an estimated 1.2 million in 1996. Along with home health services, this is one of the fastest growing parts of the Medicare program.

Medicaid. Medicaid covers nursing home care for low income families and individuals. Eligibility requirements vary by State. Medicaid will only pay for nursing home care provided in Medicaid-certified facilities. Most of these are skilled nursing facilities which also satisfy Medicare certification requirements. But while Medicare pays only for post-hospitalization skilled care, Medicaid pays for both skilled and long term care. It also covers care in

intermediate care facilities. An estimated 1.7 million individuals received Medicaid paid nursing home stays in 1996.

States employ different payment methodologies. These include prospective, flat rate, and cost based systems, some of which may involve ceilings, case-mix adjustments, and efficiency incentives.

Medicare Part B. Medicare beneficiaries who are residents of nursing homes, including but not limited to Medicaid and Medicare Part A covered stays, may be eligible for Medicare Part B covered medical supplies and services for which they would be eligible whether or not they are in a nursing home. A good example would be physician services. Other examples include psychotherapy, lab services, wound care, etc.

Medicare Part B generally pays 80 percent of the approved amount based on a fee schedule, reasonable charge, or reasonable cost, for covered services in excess of a \$100 annual deductible. The remaining 20 percent is paid by the beneficiary, or by Medicaid if the beneficiary does not have the ability to pay.

Medicare payments for Part B services for both Medicare and Medicaid nursing home residents in 1995 were \$4 billion.

VULNERABILITIES

Nursing home residents are accessible and can be vulnerable, providing a unique opportunity for fraud, waste, and abuse. Unless protected by concerned family or friends, the attending physician, or enlightened policies and practices of the nursing home, nursing home residents may be subjected to health care practices in which decisions on care are governed as much by financial incentives as medical necessity.

Some services can be reimbursed under more than one payment category. This weakens the oversight of expenditures and services, providing opportunities for outright fraud and abuse, reducing incentives to economize, and diluting the responsibility for the overall care of nursing home residents.

Fraud and Abuse Under Medicare Part B. We have particular concern regarding Part B supplies and services when they are furnished in a nursing facility setting because they are frequently furnished and billed by an outside entity, not the nursing home. The nursing home may have very little to do with authorizing or overseeing the quantity or quality of such services. Without appropriate oversight, the opportunity and incentive exist for aggressive marketing as well as excessive and unnecessary utilization. Following are examples of the problems we have found.

Wound Care: We found that questionable payments of wound care supplies may have accounted for as much as two-thirds of the \$98 million in Medicare allowances from June 1994 through February 1995. In the more egregious cases:

- One beneficiary was charged \$5,290 for tape over a 6-month period, almost \$5,000 of which appears excessive. Medicare paid for, but the beneficiary probably did not receive, 66,000 feet or 12.5 miles of one-inch tape.
- Another beneficiary was charged with \$11,880 in hydrogel wound filler, \$11,533 of which may be unnecessary. This beneficiary's record showed payments for 120 units of one-ounce hydrogel wound filler each month for 6 consecutive months, or over 5 gallons.

We also assessed the marketing of wound care supplies. We found that nursing homes and physicians generally determine which patients need supplies, but some suppliers determine the amount provided. We also found that 13 percent of nursing homes have been offered inducements in exchange for allowing suppliers to provide wound care products to patients in their facility.

Incontinence Supplies: We found that questionable billing practices may have accounted for almost half of incontinence allowances in 1993. In addition, information obtained from nursing facilities and beneficiaries indicates that some suppliers engage in questionable marketing practices.

Orthotic Body Jackets: We reported that 95 percent of claims paid by Medicare (\$14 million in 1992) for custom fitted orthotic body jackets were for non-legitimate devices. These non-legitimate devices are more properly categorized as seat cushions rather than body jackets. In addition, we found that suppliers, rather than physicians, initiated orders for the non-legitimate body jackets, and that physicians provided only limited controls for preventing the sale of non-legitimate devices.

Mental Health Services: We conducted a review of the medical necessity of mental health services furnished in nursing homes and found that in 32 percent of the records we reviewed Medicare paid for unnecessary services. This amounted to \$17 million or 24 percent of all 1993 Medicare payments. In an additional 16 percent of the records, representing \$10 million, the services were highly questionable.

Excessive Cost of Medicare Part A Ancillary Services. As noted earlier, ancillary services are not subject to the limit imposed on per diem. Also, since they are reimbursed under Part A, they are not subject to the limits imposed on services reimbursed under Part B. This can lead to excessive costs which are difficult to control.

For example, we recently completed 16 joint HCFA-directed surveys of Florida nursing homes which were undertaken to evaluate the medical necessity of the care and services provided and the reasonableness of the charges and reimbursements made to these facilities. These 16 surveys of 1-year periods, questioned charges of about \$2.5 million for selected beneficiaries residing in these facilities. Most of the questioned costs related to physical, occupational, and speech therapy services. We recommended that these overpayments be collected and that the fiscal intermediaries conduct a focused review of all rehabilitation therapies at most of these facilities.

We are now studying the cost of portable x-rays provided to nursing home patients. We are finding that Medicare pays considerably more for these services under the Part A ancillary cost category than it would if reimbursed under Part B.

Lost Economies. We found that in 1992 Medicare Part B paid about \$368 million in enteral nutrition equipment and supplies; \$514 million in rehabilitation therapy; and \$84 million for surgical dressings, incontinence supplies, catheters, and similar items for Medicare beneficiaries in nursing homes. We believe that these services are more appropriately paid as part of the per diem under Part A of the program. One reason is that payment under Medicare Part B reduces the incentive for nursing homes to economize. Some recent studies provide evidence to this effect.

Enteral Nutrition: Some nursing homes include their enteral supplies in their per diem rate. We found that nursing homes and hospitals who purchase enteral nutrition supplies in bulk are able to get them on average 30 percent below what Medicare allows for them. We also found that other third party payers are able to purchase enteral products at rates 17 to 48 percent less than Medicare allows.

I-V Poles: We found that I-V poles can be purchased in bulk by nursing homes for as little as \$33. Generally, the cost of these poles is included in the nursing home per diem rate, and Medicare benefits from the incentives that nursing homes have to keep their costs down, and from the limit placed on per diem payments. However, current payment rules allow these poles to be reimbursed under Part B if they are used for enteral feeding services. The purchase costs on the Medicare fee schedule exceed \$110.

Hospice Services. Recently we have become concerned about Medicare payments for hospice services provided to nursing home patients. As many as one in five hospice patients who live in nursing homes may be erroneously enrolled. In audits we have conducted of hospice patients, two thirds of those whom we found to have been ineligible were nursing home patients. We are finding that they are receiving fewer services from hospices than at-home patients and that most of the services would have been available to them from the nursing home without the assistance of the hospice.

We are very concerned about these patients. The Medicare hospice program provides an extraordinarily important service to patients who are facing death. They receive relief from their

pain, counseling, and help in meeting their daily needs during their final days. Their families also receive counseling to help them through the dying of their loved one. However, as a condition of eligibility for Medicare hospice care, the beneficiaries must forego their rights to Medicare payment for curative care. This is appropriate for someone who is near death and has decided to seek help in facing it in peace. But a patient who is improperly enrolled may be receiving inappropriate services while not receiving those he or she really needs.

Both Medicare and Medicaid pay for hospice care for these nursing home patients. The States' Medicaid programs pay 95 percent of the daily nursing home rate to the hospice, and Medicare pays the hospice the same daily rate it pays for at-home patients. The hospice then is primarily responsible for patient care but usually returns to the nursing home the amount it would have received from the State under the Medicaid program to cover room and board costs. This is another example of the complicated financial arrangements that arise in the Medicare and Medicaid program for nursing home patients. Inappropriate incentives can easily crop up under such circumstances.

We are continuing to study this situation and hope to provide new insights and recommendations shortly.

REMEDIES

Administrative. I am pleased to report that in addition to discovering problems we are also developing new and effective ways to deal with them. Some of these techniques have come from Operation Restore Trust.

One good example is the problem with incontinence supplies which I mentioned above. Our exposure of these billing abuses, coupled with a coordinated nationwide investigation involving more than 20 separate cases and a concerted effort by the Health Care Financing Administration's durable medical equipment carriers has turned the escalating reimbursements downward. By the end of FY 1995, the abusive practices we identified had all but disappeared and Medicare is now saving more than \$104 million per year as a result. In addition, approximately \$45 million has been seized from or imposed on abusive providers in the form of penalties or restitutions.

Through Operation Restore Trust, we have also learned to make effective use of collateral resources in fighting fraud, waste and abuse. One example is the long term care ombudsman program funded by the Administration on Aging. The ombudsmen, who visit nursing homes and conduct other activities to protect patients from abuse, have learned to spot symptoms of fraud and waste as well. They have referred suspicious problems for further investigation or review. Examples include over-utilization of "ambulettes," questionable prescription of eye glasses, unauthorized rehabilitation therapy, and fraudulent provision of the orthotic body jackets such as those mentioned previously.

Concerted action by all agencies involved in overseeing nursing home care under the Medicare and Medicaid programs can eliminate some of the other abuses I have discussed in my testimony. Under Operation Restore Trust, the Office of Inspector General and the Health Care Financing Administration have been developing improved tactics involving State Survey and Certification teams and Medicaid Fraud Control Units, as well as Department of Justice and State attorneys and law enforcement officials.

Legislative. Unfortunately, administrative action is not sufficient to address all the vulnerabilities associated with nursing homes and related services. It is important to get at the underlying systems which leave Medicare and Medicaid so vulnerable to abuse. Therefore, we believe it is necessary to restructure the way these programs pay for services to nursing home patients.

A consensus seems to be emerging for a prospective payment system. This is now being advocated for payments to skilled nursing homes covered by Medicare Part A. Some States already use this approach in making Medicaid payments to nursing homes. We support the idea of prospective payments for Medicare Part A and would advocate that this approach be more widely used by States under their Medicaid programs as well.

As the above examples show, however, it is important to simplify the categories of payment. Otherwise we will continue to experience excessive prices and utilization from unbundling services and skirting the various payment limits. We therefore recommend that any proposal for a prospective payment system capture as many services as possible into the prospective payment rate. This should probably include most payments for enteral nutrition, incontinence supplies, and wound care.

Services which are not included in the prospective payment rate should be consolidated into a single bill to be submitted by the nursing home. The President's budget includes a proposal to do this for services provided to patients in nursing home stays covered under Medicare Part A. We believe consideration should be given to extending this idea to Medicaid paid stays as well.

Other approaches that could be considered would be to limit Medicare payments under both Parts A and B to no more than a prudent nursing home would pay through competitive bidding or bulk purchasing arrangements; or to make capitation payments to nursing homes for services provided to residents.

In any case, Medicare Part A payments for ancillary services should be limited to the amount that would be paid under Part B.

Each of these strategies attempts to take advantage of the ability of nursing facilities to more economically provide services and supplies to their patients with the cost savings passed on to Medicare.

It is just as important to ensure quality of care as it is to control costs. Most of the proposals described above--prospective payments, rebundling of routine services into the per diem rate, and consolidated billing--recognize the importance of the nursing facility in overseeing the quality of their residents' care. Since nursing facilities are significantly involved in the planning and provision of patient care, they arguably are the most appropriate entity to scrutinize providers and determine the most cost effective methods of obtaining and utilizing the services and supplies needed to meet the medical needs of their patients.

Prospective payment systems will bring their own incentives, some of which may provide a risk to quality of care through premature discharge or refusal to accept patients with complicated conditions. Therefore, it may be necessary to include higher payments for outlier cases with excessively long stays and anti-dumping provisions similar to those under Medicare's hospital prospective payment system. Stepped up vigilance by long term care ombudsmen, State survey and certification teams, and Medicaid Fraud Control Units will also help protect the quality of care for nursing home patients.

CONCLUSION

I appreciate the opportunity to appear before you today and share with you the results of our work, especially the insights we have gained under Operation Restore Trust. We have made all of our reports available to the Subcommittee. I hope this information will be useful to you in formulating legislation to deal with pervasive problems afflicting the elderly residing in nursing homes. I would be happy to respond to any questions you may have.

Nursing Homes

PAYING THE BILL

Medicare Part A

- Per diem
- Ancillary services
- Capital

Medicaid

- Various systems
 - prospective
 - flat rate
 - cost based
 - ceilings
 - incentives

Medicare Part B

- Supplies
- Services

Nursing Homes

PAYING THE BILL

1995 Data

Medicare Part A

➤ \$9 billion

Medicaid

➤ \$33 billion

Medicare Part B

➤ \$4 billion



Mr. SHAYS. I will ask questions last. Do you want to start, Mr. Snowbarger?

Mr. SNOWBARGER. Let me ask a couple real quickly.

One, I still don't quite understand about the pole here. I mean, it wasn't difficult for you to figure out that it was being paid for under Part A and then being paid for again under Part B. When you said that somebody figured out that, because it's part of the delivery system for the nutrition, they decided to include it, who is "they"?

Mr. GROB. The decision to allow the billing for that came from HCFA. It was an interpretation, because enteral nutrition is a covered service under Part B. So it was an interpretation. I understand now that they may be reconsidering that decision.

Mr. SNOWBARGER. Why are they just billing for a pole? Why don't they bill for an employee to stand there and hold it? Wouldn't they get more money that way?

Mr. SHAYS. Don't give them any ideas.

Mr. SNOWBARGER. Well, I understand. I shouldn't have given them the idea. But it's just that ridiculous. It seems to me, you've already paid for that pole once; why are we paying for it a second time? You and I both saw that pretty clearly. What was wrong with HCFA?

Mr. GROB. Well, again, we've called the problem to the attention of HCFA in a report that we've issued, and they have agreed that this needs looking at, and hopefully, they will fix it real soon.

It actually is much more complicated than that. If you hang a cancer drug bag on that pole, then it's not covered. But if you hang an enteral nutrition bag on that pole, it is covered, because it's the enteral nutrition that is paid for, not the pole. The pole is part of capital, and should be.

Mr. SNOWBARGER. Well, I'm not going to pursue that line of questioning, because it would presume rational thought on the part of somebody, and there doesn't seem to be any.

Mr. GROB. It is complicated.

Mr. SNOWBARGER. This is a question that I really probably should have asked the panel before, but it goes back to the whole overall payment system. Somebody had mentioned in that panel that there is a requirement, when a person goes into the nursing home, that there be some assessment about their needs and what services need to be provided. And they were talking about that, in essence, being a conflict, because it's normally the nursing home that does that assessment.

Is that a correct assessment of that?

Mr. GROB. Yes.

Mr. SNOWBARGER. I agree; that is a conflict. Do you know why we have it set up that way? It had seemed to me that, in dealing with this at the State level in Medicaid, we had required the assessment to be done. For instance, if it was a patient that was coming out of a hospital into a nursing home, it was done by a social worker, or whomever, at the hospital, as opposed to the nursing home, to try to get around that conflict.

Does it vary by State?

Mr. GROB. Well, Mr. Snowbarger, in that case, I would have to say that it probably was a great advancement in medical care that

that requirement was put in place. That stems from the reforms of the nursing home care that were the result of several years of study that occurred around the late 1980's and the early 1990's.

The problem that they were addressing there was the conditions in the nursing homes where patients would languish a long time in nursing homes, perhaps, without having the kind of care that they needed. So that was really trying to make sure that the needs of the patient were assessed during their stay in a nursing home.

Ms. ARONOVITZ. One thing I should mention is that we are in no way advocating that services that are medically necessary do be provided. I mean, clearly, in 1987 and after that, there was some indication that nursing home patients were not receiving all the services that they needed.

Nursing home patients are very, very vulnerable. Half of them probably have dementia. They don't have a family support system in the community. They do rely on the nursing home itself to make sure that they get the services they need.

The nursing home itself already has a significant role in planning and providing patient care. They are the closest. They are the people who are responsibility for the care of that patient. This is not a hotel; it's not a boarding house.

So, therefore, it makes a lot of sense, in our minds, that because the nursing home is responsible for coordinating and helping establish a comprehensive assessment of that patient's medical, nursing, mental, and psychosocial needs, that it would also then be responsible for assuring that the proper services and items that are being delivered on behalf of that patient in fact are delivered.

So it's just a little bit of an extension beyond what we think is a rational approach to what the responsibility of a nursing home is anyway.

Mr. SNOWBARGER. I can tell you that it's not only the patients that rely on that, but it's the families of the patients.

Ms. ARONOVITZ. Yes, that's true.

Mr. SNOWBARGER. Because those families don't know any better. Maybe we've got a little better handle on things and watch for services that we don't see a need for, but we, as a family, don't particularly have the incentive to keep them from doing something extra. If someone says your mother really needs this, then you think, well, OK then, she must really need that.

Ms. ARONOVITZ. You're exactly right. And very often family members don't always know all the services that are being provided. And you're right, there's a real sense that family members are happy that their parents or the people they care about the most are being looked after.

Mr. SNOWBARGER. Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

Ms. Aronovitz, on page 5 of the "Early Resolution of Overcharges for Therapy in Nursing Homes"—do you have that document?

Ms. ARONOVITZ. Yes.

Mr. SHAYS. Walk me through this chart. Physical therapy, is that a capped expenditure?

Ms. ARONOVITZ. I'm sorry. I'm not sure what you're referring to. Oh, I see. That's something else.

Mr. SHAYS. It's "Early Resolution of Overcharges for Therapy in Nursing Homes Is Unlikely," August 1996.

Ms. ARONOVITZ. OK.

Mr. SHAYS. What I'm wrestling with, are all of them uncapped expenditures?

Ms. ARONOVITZ. No. It gets very, very complicated. This is pertaining to therapy services. How the therapy services are billed has a lot to say about whether the amount is capped or not.

If a nursing home contracts with a therapy company and pays that therapy company, and then puts that amount in its cost report, that amount is capped, if it was physical therapy. There were also salary guidelines for respiratory therapy. So later, when that nursing home would get audited, there would be a limit on how much the nursing home could have reimbursed a physical therapy company. And that's called an arrangement, where the nursing home reimburses the therapy company.

If, on the other hand, the nursing home agrees or has an agreement with a rehabilitation company to come in and provide that same service to the same beneficiary, and the nursing home doesn't actually reimburse the therapy company but the therapy company bills Medicare directly, then there is no limit. It's not capped, in terms of how much they could charge. And that's one of the reasons why you see these exorbitant amounts that are charged, because they are billed directly.

Mr. SHAYS. So you're not saying that physical therapy was capped and the others. All of these could be capped or noncapped, depending on how they are billed?

Ms. ARONOVITZ. Right.

Mr. SHAYS. And all of them went up significantly.

Ms. ARONOVITZ. Right. What we're advocating, though, is that, at least in the sense where you have an arrangement between a nursing home and a therapy company, you do want to make sure—right now, speech and occupational therapy don't even have any salary guidelines.

So for those two services, even if the nursing home reimburses the therapy company and then puts it in the cost report, in that case, Medicare will probably pay the whole amount, because there aren't any salary guidelines for those two types of therapies. Medicare can come back to the nursing home and say, you've overstated in your cost report how much, or you paid this therapy company way too much money, based on salary guidelines.

Mr. SHAYS. I'm not clear on that. I'm not clear. There has to be some limit that they can't charge. A certain amount per hour, a certain amount per episode; something.

Ms. ARONOVITZ. I know you seem surprised. We were very surprised also. But, in fact, when you have a therapy company which is billing directly to Medicare, it would get what is considered to be their reasonable cost. And if it could show that these were its reasonable costs, whatever these costs are, it would get those reimbursed.

Or if it was reimbursed by a nursing home for speech or occupational therapy, it could actually bill the nursing home—we found some examples where they could bill the nursing home for \$100 a unit, and that would go into the nursing home's cost report.

Now, another complication—and I certainly don't mean to over-complicate this more than it already is—but there is no real good definition of what a unit of billing is either. Typically, or in the industry lingo, a unit could be 15 minutes. So if you're billing \$100 to a nursing home for a unit of service, that's \$400 for an hour. If there is no salary guideline, which there is not for speech or occupational—although HCFA is in the process of trying to establish those guidelines—then the nursing home reimburses you.

The nursing home could reimburse you \$400 for an hour, and it has an incentive to do that, because it goes in their cost report and ultimately it would get paid a certain amount of administrative reimbursement for having paid the therapy company and put it in its cost report. So it has an incentive to let the therapy company charge it whatever the therapy company wants to.

Mr. SHAYS. In a rational world, particularly in a business environment, this would be an absurdity.

Ms. ARONOVITZ. We think it borders on absurdity, in certain cases.

Mr. SHAYS. No, it is an absurdity. I look at this, and I realize that we may—because Lord knows we do it—have mandated nursing homes do certain things and certain services, and all these services are important services. But to see, in a period of about 6 years, a 646 percent increase in—that's utilization.

Ms. ARONOVITZ. That's correct.

Mr. SHAYS. For physical therapy. A 1,270 percent increase in occupational therapy—excuse me, in speech therapy. And a 1,968 percent increase in occupational therapy, for the last one. It just boggles the mind.

Ms. ARONOVITZ. That's correct. It is outrageous. I should say one thing, though, and that is that this chart does show charges. In all due respect, we can't determine for sure that all the amounts, the complete amount that was billed was actually paid. However, in most cases, you have to wait for the cost report and get audited later on, and most of that would get paid.

Mr. SHAYS. But the issue is, the billings went up by those percentages.

Ms. ARONOVITZ. Exactly.

Mr. SHAYS. It's an example of, you give people what they pay for, not what they need.

Ms. ARONOVITZ. Exactly. I think this is a clear indication that people realized that this was a benefit, that this was a way to really take advantage of the Medicare program.

Mr. SHAYS. Let me back up and say, I have no trouble whatsoever arguing that Medicaid for health care for the poor be managed care, because my view is that most of the recipients didn't pay into the tax stream, but they are getting a benefit which they are not forced to take, which they would be fools not to take. So I feel very comfortable mandating managed care, frankly, for the poor.

I have argued in my own mind that managed care for the elderly in Medicare should be discretionary, given that they put into a fund. But I would also probably have to admit that some of it is political, as well. They have argued they put into the fund for all these years, they also are primary taxpayers, as well, so they can make that argument.

But I have made it optional, in the work that I was doing 2 years ago, but believe that, ultimately, managed care, because of all the waste and the fraud and the games in the system, could actually capture a lot of volunteers under managed care. They could promise eye care, dental care, pay the entire premium, pay the co-payment, and do a lot of things that say you would be foolish not to consider them. And then we would let them go out, if they didn't like the system.

But what I'm wondering is, what kind of mechanism could you have for Medicaid-paid nursing care cost? What would be the mechanism for having managed care in a nursing home? Just basically saying, you get a lump sum, and whatever you save, you save; whatever your costs are, so be it.

Ms. ARONOVITZ. Actually, George, you might want to address the whole idea of PPS, because that's getting at that exactly, but not per episode, but for per diem.

Mr. SHAYS. I'm not talking Medicare; I'm talking Medicaid.

Mr. GROB. Yes, and I think that's a point well worth making. The administration has now proposed a prospective payment system.

Mr. SHAYS. I'm going to have you speak a little more slowly.

Mr. GROB. OK.

Mr. SHAYS. Some of this, you know, you're using acronyms, and so on, and I'm just a little behind here.

Mr. GROB. The administration has proposed to adopt a prospective payment system for the Medicare Part A nursing homes. Some of us believe that it would be equally reasonable to use a system like that for all Medicaid stays, as well. Some States already have prospective payment systems.

Now, the prospective payment system is perhaps the nursing home version of what you're talking about. You would pay so much for the patient to stay or so much per day, a simple flat rate. There are various ways to construct it. And it could depend upon the patient's condition, for example, if you could structure a way to classify the patient's needs.

So there are a lot of details to work out about it, but still you could make a simple payment, basically, rather than having many different billings.

Mr. SHAYS. Could you have an insurance company basically assume the responsibility and manage the health of individuals, and then place them in nursing homes and negotiate, with the nursing home, fees?

Mr. GROB. To be honest with you, I haven't thought my way through the relationships with the insurance companies. I know that the long-term care insurance business has not come to be the protection that everyone wished that it would be, perhaps because it's so discretionary.

Mr. SHAYS. Help me sort out how we can combine under one—my simple view is, basically, Medicare is a Federal program; Medicaid is a partnership, federally matched. But I keep in my office the big yellow manual, which, ultimately, we wanted to dump in a waste paper basket.

One of the more exciting parts of what we did 2 years ago was to get people in the health field, and we'd say, we want to slow the

growth of Medicare and Medicaid from 10 to 7 percent, and they'd say, you can't do it. We'd say, why not? And they would tell us all these reasons why, and basically, they were Federal rules and regulations.

Then we'd say, we're not going to do that. And they would look at us, what do you mean? What right do you have to say we're not going to do it? And we'd say, well, we're Congress, and we're going to change the law; we're going to change the law governing the regulations.

Then we'd say, what happens if we do this? They would say, we can't do this because of this. And finally, we couldn't get in their minds that we were going to literally take this yellow book and dump it in the waste paper basket. But if we could, we would allow so much flexibility.

I don't think the Federal Government has the ability to properly regulate. And it's not disrespect toward the Federal Government, or HCFA, or whomever; it's that we can't keep up with the times. We basically have a floor that becomes a ceiling. This "one-size-fits-all" particularly bothers me.

We want to keep it simple. If we keep it simple, frankly, there are more ways to "game" the system, in some ways. In complexity you can hide yourself, but the simplicity means that you can do certain things because you haven't put rules and regulations that say you can't.

So, you make it too complex, people will hide in the system; you make it too simple, there are 100 different ways to abuse it. So either way, people can abuse it. And that's why I begin to think that maybe we shouldn't be in the business, and we should let the private sector sort it out and just give them lump sums.

Now, do you think it is possible to write the laws in a way that simplifies and reduces the abuses? If so, tell me the biggest area—sorry, I've taken a long time to come to this question—tell me the biggest payback, the least difficult thing to do with the biggest payback, the least difficult change with the biggest payback.

Mr. GROB. In the nursing home area?

Mr. SHAYS. Yes.

Mr. GROB. I do believe that it would be some kind of a flat payment or prospective payment system. For people in nursing homes, that would capture as many as possible of the services into one payment.

Mr. SHAYS. Including Medicare services?

Mr. GROB. Yes.

Ms. ARONOVITZ. Especially Medicare services.

Mr. SHAYS. Especially.

Mr. GROB. Medicare Part B services. Some of those could not be. The professional services, like physician services, you know, someone needs heart surgery, you're not going to put that in the nursing home payment. But the nonprofessional services, as many of those as possible, to put in that flat payment.

And those that you just couldn't tolerate that even, I would use the consolidated billing as the way to try to exercise some control over it.

Ms. ARONOVITZ. At least, if you use consolidated billing, there would be one entity, which would be the nursing home itself, that

would be responsible for overseeing all the services that were ordered and delivered for a particular patient in that facility. Right now, because you could bill directly for Medicare ancillary services under Part B, very often the nursing home should but doesn't, or claims it doesn't, or it, in fact, doesn't know all the services that are being provided.

Now, there are quite a few nursing homes in this country which do a wonderful job at becoming very involved with the needs and the services provided to their nursing home residents. This is not an outrageous request that nursing homes do this. It's done every day, and it's done very well.

We think that there needs to be some accountability in one place, so that therapy companies know, and the nursing home would say to a therapy company, I'm sorry, you can't bill \$400 for this therapy. This person doesn't even need it; we didn't ask for it, and so on.

Mr. SHAYS. My best sources for abuses in the medical profession are from nurses, male and female nurses who tend to be paid on an hourly rate, and who will describe various services that are provided that they just feel are an absolute outrage. We know we've got a big problem.

I'm wondering if staff, on either side, has a question. Do you have any questions?

Ms. SAYER. Yes, I wanted to ask a question.

Mr. SHAYS. Identify your name, please.

Ms. SAYER. Marcia Sayer.

I want to ask a question on the consolidated billing that you've talked about, and you've indicated that it is a possible solution. If the industry takes the position that, indeed, consolidated billing is good but they would need some additional revenues or reimbursement in order to take on this additional responsibility, what would be your reaction to that? Are they already reimbursed for that function? Would they need additional resources in order to take on the consolidated billing concept?

Ms. ARONOVITZ. When the nursing home provides or coordinates or conducts a plan of care, and makes sure that it knows all the services that are needed on behalf of a resident, it needs to update that plan of care every 3 months and reflect that in the plan of care. It is very involved on the quality side already.

Admittedly, nursing facilities are not as involved right now in monitoring all the services from outside entities, and they don't do the billing for these entities. So there is a little bit more work there. We believe that it would not be an inordinate cost, although we haven't studied it in depth, and we need to study it more.

But any type of administrative services or administrative costs that are involved with patient care can be put into the cost report. So if we're talking about very efficient nursing homes that are currently under the Medicare ceiling on their cost reports, they will be able to add those costs to their cost report and get reimbursed for it. It's really the less efficient nursing homes that are at or above the Medicare ceiling, that would be hurt.

Congress has tried very hard to encourage nursing homes to become more efficient, and this would be along those lines.

Mr. GROB. Also, in that sense, I believe that it's conceivable that the nursing homes would need to cover that cost of billing, but, of course, there are economies in the billing process in a nursing home.

I would like to point out, as well, that by having those services bundled in a nursing home, I believe the nursing home might well be looking for opportunities to gain the economies and the efficiencies in the procurement of the services.

We did a study where we looked at enteral nutrition, for example, and we found that nursing homes that bulk purchased the enteral nutrition for the patients, that Medicare was paying 40 percent more for the enteral nutrition under Part B than was being paid for by the nursing homes that were bulk purchasing it for the patients. So we think there's lots of room in there to economize, and that the forces of economy would come into play to perhaps offset some of those administrative costs.

Mr. SHAYS. We have a vote now. If we only have one vote, then we will start in about 15 minutes with the next panel.

I have a few minutes more. I'm just interested to know if there is any question you wished had been asked, that we should have asked you, something that you feel needs to be put on the table?

Mr. GROB. Mr. Shays, if I could mention one thing.

Mr. SHAYS. Sure.

Mr. GROB. I'll try to be very brief about it.

Mr. SHAYS. Let me also say, if there was any question we asked the previous witnesses that you wished we had asked you.

Mr. GROB. Could I take the opportunity to elaborate slightly on the earlier question about the kind of reform that would be needed?

Mr. SHAYS. Yes.

Mr. GROB. Considering those extra payments under Medicare Part B, if you could briefly think of them this way. Get in your mind a kind of continuum here.

On the one end, think of things that everyone would think of as things that should be part of the daily rate. Nutrition might be a good example, the pole, whatever, it's part of going to the nursing home, nutrition, wound care. At the other end of it, put heart surgery, physician payment.

Clearly, we would not want to include the heart surgery in the nursing home payment. Many people would think that the nutrition should be in. You could run the gamut, and you would find things in the middle. Let me give an example: mental health care, psychotherapy services, group counseling, whatever, some of those therapies.

I think that honest people would disagree where to draw those lines. So I see three categories: The first category are things that obviously belong to the daily stay; they just belong to going to a nursing home. Then there are things you clearly would exclude. Then the things that are in the middle, and I think it's probably just a process of people coming to an agreement, perhaps even an arbitrary one, that would be the subject of the consolidated billing.

So perhaps that will help explain the categories that we're talking about here. I hope that helps.

Mr. SHAYS. OK. Thank you very much.

Do you have any last comment?

Ms. ARONOVITZ. There are probably two things that are worth mentioning, and they are probably not the most critical, but they certainly would help with these problems.

One of them has to do with something that—and the legislation has already passed, in the Health Portability and Accountability Act, and that's making sure that EOMBs, explanations of Medicare benefits, go to beneficiaries for every service, not just ones where there's a co-payment or a deductible involved. I think that will help a lot in just making sure that the families, to the extent that they get these, are aware of the services that are being provided.

One other thing that was very frustrating for us and has continued to be is that it's very hard to get a handle, with HCFA data, on the services or the money spent on behalf of nursing home recipients, because nursing homes are not a unit a analysis.

Mr. SHAYS. Yes, I hear you.

Ms. ARONOVITZ. In other words, the place of service block on the Medicare form is either unreliable or incomplete. And the reason for that is, it's not a billing item; it's not necessary to get reimbursed. If that block could be more reliable, and if we could assure that we could do more analyses based on that, I think we'd have a chance to try to get in front of the problem.

Mr. SHAYS. Are you suggesting, in a way, that if you were in a nursing home, being billed by Medicare, that the bill might have to go to the nursing home? I'm just wondering why you couldn't do it that way. In other words, what I'm hearing you saying is, if my mother were in a nursing home, she would be billed as if she were living in my house.

Ms. ARONOVITZ. Right. Very often, it's impossible to tell whether your mother is in a nursing home or not.

Mr. SHAYS. Which tells me you don't even know the problem then.

Ms. ARONOVITZ. We don't know the extent of the problem, especially on the Part B side.

Mr. SHAYS. You don't even begin to know it.

Ms. ARONOVITZ. That's correct.

Mr. SHAYS. How would you know it?

Ms. ARONOVITZ. That's correct.

Mr. SHAYS. I'm really happy you made that point.

Mr. GROB. Mr. Shays, the \$4 billion on our chart there for Part B, we had to conduct a random sample of cases and go backward and get the data. It took quite a bit of work to find that number.

Mr. SHAYS. This begs a lot more questions. I've never missed a vote yet, and I have 4 minutes left. So I'm going recess, and we're going to take the next panel.

Thank you. And I would like staff to followup on just this whole point. Thank you. We will be about 15, 20 minutes.

[Recess.]

Mr. SHAYS. I call this hearing to order and thank our third panel: Paul Willging and Suzanne Weiss.

Paul Willging is executive vice president of American Health Care Association, and Suzanne Weiss is vice president and counsel, Public Policy, American Association of Homes and Services for the Aging.

Thank you for remaining standing. I will swear you in, if you would raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. Let me say that one of the disadvantages of the third panel is, you have to be here from the beginning, in some cases. But the advantage is that you can hear the questions and you have comments. So you get the last word, which is an advantage.

So I would welcome you to deliver your testimony, part of your testimony—certainly, you’ve been here, and you deserve to be able to do that—but also welcome you to just comment on what you’ve heard. You can ask yourself the questions that we asked and answer them, if they are questions you want to answer.

We will start with you, Mr. Willging.

STATEMENTS OF PAUL WILLGING, EXECUTIVE VICE PRESIDENT, AMERICAN HEALTH CARE ASSOCIATION; AND SUZANNE WEISS, VICE PRESIDENT AND COUNSEL, PUBLIC POLICY, AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING

Mr. WILLGING. Thank you, Mr. Chairman. I thought our being last was more a reference to Biblical studies and the wedding feast at Cana, the best wine was saved until last.

Mr. SHAYS. This is true.

Mr. WILLGING. So I have no problem whatsoever with that.

Mr. SHAYS. And the first shall be last.

Mr. WILLGING. I actually am pleased to be here, pleased for a variety of reasons. One of them is that we share a common goal, which is the eradication of fraud and abuse, either in America’s nursing homes or on the part of those who provide services to America’s nursing homes.

That mission becomes even more critical when one deals with a population that’s frail.

Mr. SHAYS. I have to give fair advertising here. I misrepresented. I said you’d get the last word, but I will say to you—I’m sorry to interrupt—but anyone from the first and second panel who stayed will be able to have some dialog with you, as well.

I’m going to let you start over, but I just want to say that you can say whatever you want. I’m going to stay as long as it takes, but I will also invite anyone who stayed, if they want to, just at the end, dialog, have a little question and a good exchange.

I’m sorry to interrupt you.

Mr. WILLGING. You might find that fairly dull, though, because this may surprise you, Mr. Chairman, as it turns out we probably agree with a great number of the solutions that the previous panels have put on the table.

Mr. SHAYS. Right.

Mr. WILLGING. I’ve been in Washington some 30 years, and I’m not sure I’ve ever agreed with the Inspector General’s Office before. But this time I can’t disagree with most of their proposals.

As I said in my initial comment, it is because I think we share a common goal, which is the eradication of fraud and abuse. And I think we probably share a zero-tolerance level, as far as fraud and abuse are concerned.

I understood, from your opening statement, Mr. Chairman, that we may agree on a third point, which is, let us make sure we know what is fraud and abuse and what is simply confusion. You referred to the labyrinth of confusing, sometimes conflicting, Federal and State regulations.

I think we want to make sure that we apply the harshest possible penalties to those who are truly defrauding the programs, and engage the ultimate in education for those who are simply confused. And I didn't sense any disagreement there either.

I think the key is, what do we want to do about the problems? I don't feel the necessity today to quibble about whether it's a huge problem, a minor problem. If we're both at zero-tolerance, it really doesn't make any difference how big it is. How do we get rid of it, is the critical issue.

It was interesting, as I suggested, to hear much of what was proposed by some of the previous panels. We, as an industry, as an association representing 70 percent of all nursing facilities in the country, essentially, we're in lock step, as far as those solutions are concerned.

What I would like to suggest, in just the couple of minutes I want to take in my opening comments, however, is whether the solutions should be focused on the symptoms of the problem or whether we ought to try to get a sense of what the underlying root causes are.

As it turns out, we support consolidated billing. We certainly support consolidated billing for the Part B services provided to Part A patients. That has been a long part of our congressional testimony over the years.

Mr. SHAYS. Would you define "consolidated billing," as you understand it?

Mr. WILLGING. Essentially, as you have heard from some of the preceding panelists, for Part B services, the vendor of the service can bill, under certain circumstances, the Medicare program directly. That bill may never be seen at the facility.

Mr. SHAYS. Right.

Mr. WILLGING. One of the reasons I think we have to look carefully.

Mr. SHAYS. OK. Keep defining the consolidated billing.

Mr. WILLGING. Consolidated billing essentially means that the bills go through, are consolidated at the point of the facility itself. In other words, the therapy company, the pharmacy company, everything goes through the facility.

Mr. SHAYS. Everything goes through.

Mr. WILLGING. Now, there are different ways of managing that. One can, in effect, say only the facility may actually bill, and they are ultimately responsible. One can say simply that they have to flow through the facility, so that the facility is familiar with what's being billed. And the devil is in the details, obviously.

Mr. SHAYS. Yes.

Mr. WILLGING. But the concept is an important one. The reason the concept is important, back in 1987, this Congress enacted the Nursing Home Reform Law. That law made it unequivocally clear that it was the nursing facility responsible for the totality of services provided to the residents in that facility.

Mr. SHAYS. And that was 1987?

Mr. WILLGING. That was 1987, in the Omnibus Budget Reconciliation Act of 1987, a major provision, a watershed provision for our industry, which, in effect, said, we bear, ultimately, the responsibility for the services. You can't blame it on all those other suppliers; the nursing home is responsible. If we are responsible, then perhaps we ought to see who is billing under that area of responsibility.

But that's just an immediate and, I think, an interim step. You don't even have to worry about consolidated billing if you take the next step, which was referenced by at least two or three panelists, prospective reimbursement. Why do we want to have multiple bills and multiple payments for what is essentially one service? We should have one bill and one payment.

Now, the big debate: Should we do it on a per diem basis, or should we do it on an episodic basis? We actually prefer an episodic basis, but nobody has yet been able to figure out exactly how you do that. It's analogous to the DRG program in hospitals, but it was much easier to group patients in the hospital setting. It becomes very difficult to do it in the nursing facility setting. But we still support that.

If you have prospective reimbursement, a lot of these issues we've been talking about fall by the wayside; they really do. If you have a price which accurately reflects what the payor, be it Medicare or Medicaid, should be paying for that service, and you have at the same time the regulations—and we would not propose eliminating all regulations.

The regulation that says we are responsible, as an industry, to maintain the highest practicable level of physical, mental, and psychosocial wellbeing, that provides a balance. It keeps us from taking that single payment for a service and trying to skim, because we have this other requirement that says we have to provide the highest practicable.

So I think prospective reimbursement takes care of a lot of the problems. But here's where I really want to color outside the lines. It doesn't take care of the problem.

Mr. SHAYS. You want to what? I'm sorry.

Mr. WILLGING. Color outside the lines. It's one of these cliches I throw out every so often. Be innovative.

Mr. SHAYS. Where did you grow up?

Mr. WILLGING. I grew up in St. Paul, MN.

Mr. SHAYS. OK.

Mr. WILLGING. I had hoped to grow up in Connecticut, but, unfortunately, my parents weren't there at the time.

None of what we've talked about really deals with the issue of Medicare and Medicaid, and the potential for "gaming." And everyone games. States game; the Federal Government games. Do providers game? Of course not. But, hypothetically, I'll say we do.

How do you deal with that? Well, if the problem is we're not coordinating effectively, why don't we coordinate effectively? And here's where I'm going to be a little bit off the wall.

The long-term care part of Medicaid, Mr. Chairman, was never intended, by the enactors of that bill, Title XIX. They thought that Medicaid was going to be basically acute care and ambulatory serv-

ices for the traditional welfare population, the AFDC population. Nobody thought a whole new program was going to grow up within the program, which was elder care in nursing facilities.

Mr. SHAYS. I'm a very impressionable person, and I will say this to someone else, and they will say I'm crazy. So you have to be very careful what you're telling me. You're saying to me that nursing care was never part of the original Medicaid bill?

Mr. WILLGING. I'm saying that the growth, the size that nursing home care became was never envisioned by those who enacted it.

Mr. SHAYS. We didn't envision any of the health care programs to be that size. So I don't know why that would be any more significant with nursing homes.

Mr. WILLGING. Because of something called "spend-down," Mr. Chairman. There is a provision in Medicaid that is referred to as "spend-down."

Mr. SHAYS. OK. Right. Yes.

Mr. WILLGING. That is, if you deplete all of your resources, and essentially you have no resources, assets, or income, you are then deemed to have spent down to Medicaid eligibility.

And basically, the vast majority of those people on Medicaid in nursing facility are not your traditional welfare population. They are, as I put it, mom and dad; my mom, your dad. These are tax-paying, middle class, American citizens who, except for the unfortunate circumstance of having gotten old, having gotten sick, had to pay so much in bills to nursing home care that they spent down to eligibility.

Mr. SHAYS. I understand that issue.

Mr. WILLGING. That, I don't think, was ever envisioned, the growth, the size. So what we have here is, at the State level, run by 50-some separate jurisdictions, a program for elder care which almost begs to be controversial when it comes up against Medicare, the other major program designed for the elderly.

What we are suggesting is, pull them both together. Give the welfare part of Medicaid to the States, lock, stock, and little green apples—it ties into the devolution of responsibility this Congress had already enacted as far as the welfare program is concerned—and coordinate. And do it all in a budget neutral fashion. I think it can be done.

Bring the elder care part of Medicaid, nursing homes being primary, up to the Federal level, where you can, finally, with one basic program, coordinate these two funding streams. At the same time, I would certainly take your suggestion, move as much of that out into the marketplace as you can, and let the marketplace do a lot of the regulating.

Mr. SHAYS. What's interesting is, you are going totally contrary to the trend of Congress last year. I mean, we were going to have Medicaid be a block grant to States, and we were looking to give the States a lot more flexibility. You are saying the component that is health care for the poor stay with the States, and nursing care for the elderly come to the Federal Government.

Mr. WILLGING. Because you already have, at the Federal level, the two major support mechanisms for the elderly: Social Security and Medicare.

Mr. SHAYS. That's interesting. I'd like to think about that.

Mr. WILLGING. It will ultimately resolve all the issues we've talked about, in terms of these conflicts between the Medicare and the Medicaid programs.

Mr. SHAYS. It's interesting.

Mr. WILLGING. And I think it can be done in a budget neutral fashion. You've got to do some switching and swapping, obviously.

Mr. SHAYS. It's very provocative.

Mr. WILLGING. Well, that's the point at which I will then close my testimony.

[The prepared statement of Mr. Willging follows:]

Chairman Shays and Members of the Committee, I am Paul Willging, Executive Vice President of the American Health Care Association (AHCA). AHCA is a federation of 50 affiliated associations representing over 11,000 non-profit and for-profit assisted living, nursing facility, and subacute providers nationally. We serve over one million residents in our member facilities. On behalf of AHCA's members, thank you for the opportunity to speak on health care fraud and abuse and what we can do to combat it.

There are three major points I would like to emphasize:

- First, Federal laws and rules need to be as clear, consistent and simple as possible. Otherwise legitimate disagreements over permissible reimbursement payments may be mistaken as intentional fraud and abuse.
- Second, AHCA has zero tolerance of any fraud and abuse. That is why we have launched legislative initiatives and legal and educational programs to combat it within our industry. AHCA pledges to continue to work with the federal government in its effort to combat fraud and abuse. We are proud to play a role in such a cooperative approach.
- Third, since the enactment of OBRA '87, freestanding SNFs have made great progress in improving quality and in providing lower cost alternatives to hospitalization. We are taking a leadership role in working to close reimbursement loopholes and eliminate waste costing Medicare billions of dollars each year!

Complexity in the Federal Laws

Let me first turn to the need for clear, consistent and simple federal laws rules. As everyone here knows, the Medicare and Medicaid programs are extremely complex. The benefits and reimbursement policies for skilled nursing and home care have evolved over several decades. The result is a system that reimburses in different ways to different providers by different payors for different patients with different legal and regulatory requirements. This is why legitimate differences over permissible reimbursement payments often are mistaken as intentional fraud and abuse.

We see this confusion occurring with Medicare and Medicaid dual eligibles. What you can bill Medicare Part A, Medicare Part B and Medicaid for the same patient is confusing and may overlap, yet these are the current programs that provide residents of nursing homes the care they need. For example, a Medicare patient must be in a hospital for three days prior to obtaining a 100 day Part A skilled nursing facility (SNF) benefit. Under some circumstances, during this Part A (SNF) stay, Medicare requires certain ancillary or non-routine services to be billed to Part B. After 100 days and if care is still needed, either Medicaid or the patient pays. If it is Medicaid, each state covers the stay in a different way. And to further complicate the issue, beneficiaries may still receive certain Part B benefits as long as the premium is paid.

As a result, some believe that suppliers of nursing home services, nursing homes and Medicaid payors may game the system. For example, some of the GAO and OIG reports have stated that some providers of contract services have overcharged the federal government or billed for services not actually provided. The OIG and GAO conclude that the rules are not clear and that HCFA, the Congress and providers must work to clarify the rules. AHCA believes the system must be changed as it may invite the type of problems that have been identified.

The solution is not to spend more money and time to try and sort out this vague and inefficient system. Rather AHCA supports Congress's efforts to replace the present eligibility, coverage and reimbursement rules with a streamlined and simplified system. True reform of our elder care system cannot happen if we insist on maintaining multiple funding sources aimed at the same client.

While the system won't change overnight, we do support some immediate changes.

Consolidated Billing

A good first step is to consolidate billing for all SNF services to Part A patients. This change creates a single payor for these defined services. We are continuing to review our position on the complexity and administrative burdens of proposals to require us to bill for Part B services once the Part A benefit is concluded. Payment and oversight of the medical necessity documentation for Part B benefits are generally conducted by carriers. Over the past several years, carriers have instituted strict documentation and medical necessity requirements. We do not yet know the specific details of the Administration's consolidated billing requirements and urge you to explore in greater detail these issues with the supplier and provider community. AHCA does believe that when bills are submitted for services provided by an outside supplier to a SNF resident, all nursing homes should have copies of the information submitted for payment. This is essential for us to be able to verify charges and that billed services were actually delivered.

Access to Medical Records by Outside Suppliers

The skilled nursing home is a unique provider of services. We are authorized, under federal law, to either provide services directly or to contract for certain medical services. This authority permits the nursing home provider to cost-effectively purchase services only when they are medically necessary. We do not have to maintain certain supplies or employ professional services that may be underutilized. This flexibility has assisted the skilled nursing home provider to treat higher acuity patients in our lower cost setting. We act as partners in providing services to these residents with the suppliers and providers having access to medical records. However, this authority has also created a need for greater scrutiny to ensure that providers and suppliers are complying with federal laws on coverage and reimbursement for skilled nursing home services. Again, we have zero tolerance for reported tactics of sharing patient records to increase the marketing of services and supplies. These should only be provided when they are medically necessary and in accordance with the right to privacy of our patients. .

Transfer and Discharge

Another proposal Congress may consider this year may provide incentives for fraudulent behavior. We oppose a provision in the Administration's FY 1998 budget proposal redefining discharges from hospitals to PPS exempt entities. This will incentivize acute care providers to hold on to their patients longer to obtain the full hospital DRG payment before moving patients into related PPS exempt services and receiving a second payment. Many refer to this as "double dipping."

The more appropriate solution to address this problem is best summed up by Dr. Uwe, Reinhart of Princeton University, in a January 31, 1997 letter to me where he stated, "What is needed is a recalibration of the DRGs to reflect the modern potential of subacute care, and then a system of open, competitive bids for Medicare's subacute care business, without any differential between hospitals and freestanding SNFs."

At the very least, Congress should enact a provision to eliminate double dipping by those facilities related to or controlled by the acute care referring organization.

Enactment of a Prospective Payment System

The next step to help simplify the reimbursement rules is the adoption of a Medicare Prospective Payment System (PPS) for SNFs. This system essentially will incorporate all SNF services into one payment stream, reducing the ability of providers to manipulate reimbursement. Although we are very concerned about the level of proposed reductions incorporated into the Administration's PPS proposal, along with several other important details, we want the PPS system to begin in FY1998 and support much of what is proposed in the Administration's FY 1998 budget proposal for SNFs.

SecureCare

As important as Prospective Payment is to Medicare, we also need to reform Medicaid. AHCA is developing a legislative proposal we call SecureCare. Once the vast majority of Medicare providers are on prospective payment system, perhaps government can finally evolve toward becoming a funding source for comprehensive health solutions chosen by beneficiaries in a competitive marketplace. This is not the forum to go into details, but Secure Care will stop reliance on a system that steers people toward impoverishment to obtain long term care through Medicaid. Its four goals are 1) to transform long term care from welfare to healthcare 2) coordinate long term care private resources with Medicare and Social Security 3) encourage personal and family responsibility, and 4) maximize quality and control costs through market competition and consumer choice. The consolidation of all payments for services provided to the elderly and disabled would greatly simplify and streamline current policies and reduce the possibility of fraud and abuse.

Retention of Expanded Fraud and Abuse Laws

There are some other efforts that should be considered. We support the use of criminal background checks for nursing facility employees. However, we oppose the Administration's attempt to repeal many of last years fraud and abuse provisions. These include advisory opinions for providers, protections against unfair civil monetary penalty authority and a provision prohibiting "intentional" transfers of assets from wealthy or above-average income individuals to qualify for Medicaid.

While this latter provision was poorly drafted, it should be repaired, not repealed. We believe that if wealthier Americans wish to transfer significant assets out of their estates, they should be required to purchase long-term care insurance as a precondition of any future Medicaid eligibility.

Let me now turn to my second point. AHCA is proud of our voluntary efforts to combat fraud and abuse. Let describe some of our efforts.

Ongoing Information Activities

We undertake substantial efforts as an association to educate our members regarding compliance and legal issues critical to avoiding fraud and abuse. We offer seminars, produce publications and distribute educational materials which help our members better understand fraud and abuse issues. We frequently prepare legal briefs and memos on how to avoid potential problems and comply with the law.

We try hard to keep our membership informed of the latest Office of Inspector General (OIG) activities in uncovering fraud. For many years we have distributed the OIG's fraud alerts to all our members. We encourage all members to forward fraud and abuse information to AHCA as soon as they are notified of such schemes by HCFA's regional office, Medicare intermediary fraud units, or Medicaid fraud units.

AHCA also recognizes that fraud and abuse must be combated throughout the entire health care industry. That is why we are member of the Coalition of Health Associations United Against Fraud and Abuse. We recognize that anytime a single provider is caught in fraudulent or abusive activities it reflects on the entire industry. We worked closely with Health Subcommittee Chairman Bill Thomas and Senate Aging Committee Chairman Bill Cohen in the 104th Congress to enact tougher penalties against fraud while providing guidance and protections for innocent providers.

AHCA encourages our members, employees or anyone suspecting fraud and abuse to call the OIG's toll free hot line. We have and will continue to support the government's efforts to combat fraud and abuse. We have also supported the expansion of federal criminal penalties in the fraud and abuse area. Strong and swift enforcement of the law is always the best deterrent.

But we must never forget that we need to continue government efforts to better educate providers. Informed providers are less likely to unintentionally cross the line. Not only is good information crucial with such complex programs, educational efforts save money and compare favorably with the cost of finding and litigating fraud and abuse cases.

I truly believe AHCA's voluntary efforts coupled with our activities with the government have made a difference. When we look at the 5 state pilot program called "Operation Restore Trust", there are no major fraud and abuse settlements by SNF providers. Although we take no solace in the fact that other types of providers have been involved in huge settlements recently, we can be proud of our industry's improving record.

Conclusion

My final point is that SNFs have come a long way since the enactment of OBRA '87. Our federal, state and local oversight is stringent. Our quality has improved. We can provide cost-effective medical and skilled services to nursing home residents as an alternative to higher cost hospitalization. Most importantly, our legislative initiatives on fraud and abuse, consolidated billing, criminal background checks and prospective payment clearly show we are working hard to reform the system and to weed out fraud and abuse. We look forward to working with you in this regard. Thank you.

Mr. SHAYS. I thought you said you were going to be boring.

Mr. WILLGING. Only in the sense that I'm not going to be disagreeing a lot with my colleagues from the GAO or the Inspector General's Office.

Mr. SHAYS. You're just trying to set a good example for Congress.

Ms. Weiss.

Ms. WEISS. Thank you, sir.

May I begin, Mr. Chairman, by clarifying some of the remarks and some of the questions that came up a little earlier?

Mr. SHAYS. Sure.

Ms. WEISS. I would specifically like to address an issue raised by Mr. Towns, and that is the issue of confidentiality of records. He is absolutely correct about that.

Mr. SHAYS. Could I just—just so I have it—define to me how you both have similar responsibilities and different responsibilities. Do you represent certain nursing home associations? Where is your perspective?

Ms. WEISS. Our perspective is from a continuum of care, Mr. Chairman. We represent only 501(c)(3) organizations. They must be not-for-profit. They represent freestanding nursing facilities, retirement communities, senior housing or apartments, assisted living, and home and community-based services.

Mr. SHAYS. And you tend to have a smaller constituency. Do you sometimes have the same organizations?

Mr. WILLGING. We sometimes even have the same members, Mr. Chairman.

Mr. SHAYS. That's what I meant.

Mr. WILLGING. What the American Association of Homes and Services for the Aging does is, indeed, the entire continuum, including housing.

Mr. SHAYS. I've got it.

Mr. WILLGING. Total non-health care. We do not represent any housing. We do represent the entire array of facility-based long-term care: subacute, assisted living, and nursing facilities.

Mr. SHAYS. You have nursing facilities, but you have other activities, as well.

Ms. WEISS. That's correct.

Mr. SHAYS. Thank you.

Ms. WEISS. May I just address Mr. Towns' remark on the confidentiality of records?

Mr. SHAYS. Sure.

Ms. WEISS. We want to emphasize that he is correct, that nobody should have access to resident records in a nursing facility except bona fide clinicians who need to see that record for the purpose of treatment planning. I am unaware that our members are making those records available to vendors so that they can copy beneficiary numbers and use those for fraudulent purposes. But we will caution our members again and try to alleviate some of his concern.

The other question I wanted to address is the issue of dual eligibles and the interaction between Medicaid and Medicare. I think a lot of the people from the first panel described that as "legal but ridiculous." I'm not sure it's legal. I think the tendency there was to equate the term "legal" or "illegal" with "criminal."

It is against the regulations to be paid from both sources. Medicaid is always the last payment resort, always the last, which means there can only be one that's the last. So what they should do, and what many States do, is to first look at the Medicaid coverage.

Some States cover it very differently. Wisconsin, for instance, takes the therapies out of the Medicaid rate, and they are always billed separately. New York combines therapies in their Medicaid rate. Texas combines it in their Medicaid rate.

So what should happen is that, if Medicare Part B is paying for that therapy, there should be some kind of carve-out from that Medicaid payment that represents that payment was made from another source. In the case of Wisconsin, for instance, where they have separate billing for therapies, then it's not an issue, because Medicaid wouldn't be paying for that anyway, within the daily rate.

So there is not a criminal penalty for that kind of thing, but there is a source of recovery. And the problem, probably, is that when you do a Part B payment, billing for these therapies, and so on, to Medicare, what you're dealing with is Medicare carriers, the contractors who pay those claims on behalf of Medicare.

They often cover claims from a several-State area, and it's very doubtful that they would understand how every State Medicaid system is set up to cover therapy costs. So they probably pay it, not realizing that the therapies may be in that Medicaid rate. So that would be the issue to be concerned with there.

All right. The other thing I would like to talk a little bit about is the consolidated billing issue that wasn't raised. You asked if it would require added reimbursement on the part of providers. I think the GAO's response was that they hadn't really studied the issue, but there would be tradeoffs, and so on.

We haven't done an exhaustive study either, but we did call some of our members who do Part B billing now, on a voluntary basis. What they told us is, eventually, over a long period of time, you can recover those costs in many ways. There are benefits. But the startup costs are enormous for this kind of thing.

If you've got the volume so that you do Medicare Part B billing, consolidated billing, in your facility, you have a dedicated staff member who does nothing for a living but Part B billing. A miserable life, but some people choose to have it. OK.

The other thing is that you need a computer system to do that, and it's not the same system that you use to check your census data every day, which separates Medicaid billings, Medicare billings, private pay billings. So that's a separate, parallel system. You also need training. We've been talking about how badly the therapists handle their billing when they do it themselves, well that's because it's very complicated.

So all those things together mean resources. And they may not mean resources for 20 years, but they are going to need resources initially.

That said, I would like to move on to a point that I don't think has been made in front of the committee today, Mr. Chairman, and that is the issue of what we fear is the looming conflict between nursing home regulatory provisions and the False Claims Act.

The False Claims Act is part of the Medicare fraud and abuse regulatory scheme. It's probably the oldest part. It goes way back to the Civil War, when suppliers were giving rotten food and blind mules and ammunition made with sawdust to the Union Army. And they passed this law so that they could go after those suppliers. That has carried forward to this day and is now a major component of the Fraud and Abuse Act.

I'm surprised that so far nobody on these panels has mentioned a nursing home case that we call "Geri-Med," the official name being *U.S. v. GMS Management and Tucker House*. Mr. Chairman, that was a terrible, terrible nursing home situation, in 1996. What it involved was residents who had gotten such poor nutrition in the nursing home that they developed decubitus ulcers, the video of which made people leave the room. It was a very bad situation.

Somehow that was not picked up in the normal regulatory scheme. So what happened is that the Inspector General took that case and applied the False Claims Act in a way that it had never been applied before. What they said was—the argument went like this: We gave you a certain amount of money—this being Medicaid—to provide care to this resident. The condition of this resident shows that you could not have used the money that way. Therefore, submitting the claim for reimbursement was a false claim.

The case never went to court, so we don't know if it's a good theory, it's a bad theory, or whatever, but it was an impressive enough theory and threat to the facility that the case was settled the day the complaint was filed, for \$600,000. Now, that's a penalty facilities almost never would see under the normal survey and certification process.

Mr. SHAYS. Was she one of many patients?

Ms. WEISS. It was a "he," and he was one of three patients who were in that condition. There were three named in the complaint. That's correct.

All right. Nobody in our field, whether this is a good theory or not, nobody in our field would ever attempt to defend or even explain the facts of Geri-Med. It just should never have happened. Those residents, the bottom line is, they didn't get what they needed. OK.

At the other side of the extreme, the other extreme case, we have been informed by the OIG's fraud alerts and other anecdotes that we have occupational therapists now in facilities, giving OT to comatose residents; the other extreme, another false claim unnecessary service, and something we don't condone.

But what we see happening is that between these two extremes there is a vast difference and a vast middle ground where things are not as clear as they were in these cases. In thinking this through, we have to remember what Mr. Willging said, that nursing homes are the only entities that, as a matter of law, are mandated to guarantee certain outcomes. As he said, those outcomes are lumped together, collectively, under the highest practicable level of care for each resident.

In effect, the highest practicable level is a "failure to thrive" standard for the nursing home population, the vast majority of whom are over 80, with multiple chronic conditions. The term "fail-

ure to thrive,” too, is very differently applied and very newly applied in long-term care.

This is what we use in the criminal law to look at child abuse, that standard. We look at what the measurements are for a normal child developing at a certain stage. We look at the child before us, and we see if that child has unexplainable failures to reach the averages.

We aren’t sure what this standard yet means, in terms of nursing home residents, and HCFA is very ready to admit that. We won’t know, in terms of benchmarks, for several years. But because of this standard, even before we have benchmarks, nursing homes are required to work as aggressively as possible to assure improvement whenever possible, not the status quo. That is not enough. We have to keep trying until we go as far as we can to get improvement.

The irony of this to us is that, in the current fraud and abuse climate, the harder we work to meet that standard, and the closer we get to the goal, the more likely it is that some of these services are going to be considered unnecessary.

So, from our point of view, the world looks like this now: If we’re bad, that’s fraud. If we’re really good, that’s fraud. So the most practicable standard for us is mediocre, and then we will surely be cited for noncompliance by the State licensure agency, and we should be, because that means that we didn’t live with OBRA. That’s not what OBRA is about, and frankly, that’s not what we are about.

Mr. SHAYS. Well, it is interesting. I mean, I think that’s a very interesting analysis. But I was thinking, before you were talking about this, we want nursing care patients to be getting very good health care.

Ms. WEISS. Right.

Mr. SHAYS. I’m just thinking, do we want it to be fair, do we want it to be good, or do we want it to be excellent. I’m not sure. In my judgment, it would be good to excellent, somewhere in that range. But we don’t want it to be fair.

Ms. WEISS. Right.

Mr. SHAYS. And I realize we would have to define that. But kids in school, I mean, we have two different standards. For kids under special education, they have to get “the best.” And the best may mean that you take in special ed someone out of a school system and send them 300 miles away to get “the best.” But we don’t mandate “the best” for the vast majority of students there, because “the best” would be unaffordable.

So we’re not saying “the best.” If we are, then we have created a circumstance that we would go bankrupt.

Ms. WEISS. And some people feel that that’s where we’re going, and that’s one of the problems. Think of it in terms of the regulatory structure. HCFA’s standards area is saying “the best,” that’s what the law says. The payment agency is saying, “the best,” but we can’t pay for it or we will be bankrupt.

Mr. SHAYS. Right.

Ms. WEISS. And the IG’s Office is saying, “the best,” and maybe it’s a crime. I mean, literally, that’s where we find ourselves.

Mr. SHAYS. "The best" may be having a nurse in every room. It can get carried away. Reading to the patient. Your point is valid. I'm not discounting your point. I'm just thinking that we have to look at that. As I was saying that, I was thinking, "My God, I hope there's not a reporter here saying I don't want the best care for people in nursing homes."

Ms. WEISS. The problem is, we all want the best care, because someday it's going to be our parent. But the problem is how we accomplish that within the resources we have available.

Mr. SHAYS. I would want very good health care for my mother. And to me that would be very good. And I would want it for me.

Mr. WILLGING. If I could, in one of the previous panels, Suzanne, there was a suggestion that there was something perhaps "iffy" about the provision of occupational therapy to Alzheimer's patients. Well, I suggest, Mr. Chairman, if you had the head of the Alzheimer's Association here, they would demand that same kind of highest practicable care.

It is a definitional issue. Unfortunately, this word in the law, and it is in the Nursing Home Reform provisions of OBRA 1987, it does say our responsibility is to bring the resident up to and maintain the resident at—and I'm quoting exactly from the law—the highest practicable level.

Mr. SHAYS. No, you left out "practical." "Practical" is good. I like that.

Mr. WILLGING. And that's what they haven't defined yet. That is our dilemma.

Mr. SHAYS. OK. But, no, that satisfies me. I want the highest practical, most excellent care we can give.

Mr. WILLGING. And we would all like to be able to define it before it gets to the courts, I suspect.

Mr. SHAYS. Right. Yes.

Ms. WEISS. May I just build on his reference to the Alzheimer's case, Mr. Chairman?

Mr. SHAYS. Yes.

Ms. WEISS. That is quite real. What you heard today is actually, we fear, becoming Government payment policy. Today, one of our members in Oregon is meeting with a fiscal intermediary, the contractor that pays Medicare Part A claims, because that fiscal intermediary has said to that member that Medicare should no longer be paying for any therapies for people with Alzheimer's.

What that is going to result in is people who could be up and on their own, are people bedfast, with contractures, limbs that have contorted from lack of exercise, feeding tubes, and, at worst, pressure sores. We will be right back to the Geri-Med case.

Mr. SHAYS. Right. I hear you.

Ms. WEISS. Thank you, Mr. Chairman. We really look forward to working with you.

[The prepared statement of Ms. Weiss follows:]

SUZANNE M. WEISS
VICE PRESIDENT AND COUNSEL, PUBLIC POLICY
AMERICAN ASSOCIATION OF HOMES AND SERVICES
FOR THE AGING

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, on behalf of the American Association of Homes and Services for the Aging (AAHSA), I appreciate the opportunity to appear before the Subcommittee on Human Resources of the Committee on Government Reform and Oversight and to share with you AAHSA's perspective on the problems of fraud and abuse in the Federal Health Programs.

AAHSA is a national nonprofit organization representing over 5,000 not-for-profit long-term care providers who serve over one million individuals every day. More than half of AAHSA's membership is affiliated with religious organizations; the remaining members are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups. Our members include not only nursing facilities, but also affordable elderly housing, continuing care retirement communities (CCRCs), assisted living, and providers of home health care, adult day care, respite care, meals on wheels and other community-based services. Our members have long-standing relationships with the communities in which they operate. For the past thirty-six years, the Association has been an advocate for the elderly themselves and for a long-term care delivery system that assures all those in need of quality services and quality of life.

In response to the Committee's request, we will address fraud and abuse problems in nursing homes, including those identified by the Government Accounting Office in several recent reports. We also will describe some of AAHSA's initiatives to alert its members to fraud and abuse issues. In closing, we will make some recommendations for continued efforts to reduce fraud and abuse in state and federal health programs, including a recommendation for ending a major example of beneficiary fraud that we believe is pervasive.

OVERALL FRAMEWORK FOR FRAUD AND ABUSE DISCUSSION

Control of fraud and abuse in health care has evolved considerably over the 30+ years since the Medicare and Medicaid programs were established. When the Medicare program began in 1965, the only prohibition against fraud contained within the Social Security Act related to the making of false statements in applications for benefits. The law did not provide a means for penalizing practitioners or other health care providers who engaged in fraudulent activities.

In 1972, the Social Security Act was amended to prohibit the payment of kickbacks in exchange for the referral of Medicare and Medicaid patients and to permit the exclusion from future participation in the programs of those who filed false or excessive claims or provided substandard or unnecessary care.

Amendments in 1977 expanded the anti-kickback statute to preclude any remuneration, including kickbacks, bribes or rebates. Violations were made punishable by a \$25,000 fine and/or five years imprisonment. These changes responded to widely publicized abuses against both Medicare and Medicaid.

Further amendments to the fraud and abuse provision occurred in 1981 and 1987. In 1981, Congress authorized the administrative imposition of civil monetary penalties against health care providers who submit false or otherwise improper claims for Medicare and Medicaid reimbursement. In 1987, the Medicare and Medicaid Patient and Program Protection Act (MMPPPA) substantially increased the grounds upon which a health care provider can be banned from all participation in Medicare and Medicaid. In that same year, the Omnibus Budget Reconciliation Act added a long list of technical violations concerning Medicare billings. Under these provisions, employers such as nursing facilities and other long-term care providers are held strictly liable for the billing errors of their staff, regardless of whether they knew or had any reason to know that false claims were being filed. Violations can result in substantial civil monetary penalties and exclusions.

With the Omnibus Budget Reconciliation Act of 1989, Congress passed the Ethics in Patient Referrals Act ("Stark I"), which prohibits physician referrals of clinical laboratory tests to an entity with which a physician has a financial relationship. The Act was effective January 1, 1992. Stark I was expanded in 1993 to prohibit physicians from referring Medicare and Medicaid patients to an entity furnishing one or more of the "designated health services" listed in the Act. Among the services listed are home health, physical and occupational therapy, and durable medical equipment.

The last round of amendments occurred on 1996 with passage of the Health Insurance Portability and Accountability Act. Major changes included provisions to develop a coordinated fraud and abuse program; expand the Medicare and Medicaid anti-kickback statute to other federal health programs; increase civil monetary penalties; tighten the intent standard for the imposition of CMPs; and create a health care fraud criminal sanction; establish a fraud and abuse control account; create an exception to the anti-kickback statute for risk-sharing arrangements; and mandate advisory opinions.

The results of 30 years of legislation, augmented by regulations, administrative rulings and judicial opinions is an implementation and enforcement scheme designed to protect both Medicare and Medicaid and other health programs; safeguard the welfare of beneficiaries; and save money. All the goals are admirable; however, the statutory and regulatory framework for meeting those goals achieve a level of complexity that only lawyers and accountants can love.

This statutory and regulatory structure may be divided into four categories of prohibited conduct; first, making, or causing to be made, false statements with

respect to claims or otherwise causing improper claims to be filed; second, making false statements with respect to conditions of participation in the Medicare or Medicaid programs; third, submitting claims for excessive charges or unnecessary services or providing service of a quality which fails to meet professionally recognized standards of health care; and fourth, paying, receiving, offering or soliciting any remuneration, including kickbacks, bribes or rebates in exchange for referrals.

For long-term care we note that the first and third categories are areas in which increasing activity and emphasis have been placed during the past two years. Federal authorities have expanded the scope of investigations into the provision of medically unnecessary services, services substantially in excess of an individual's needs and those of a quality that fail to meet professionally recognized standards of health care. Investigators also have used the False Claims Act to prosecute providers who neglect residents.

The Committee has requested that AAHSA focus its testimony on three recent reports on fraud, waste and abuse in the field of long-term care. Although the reports note that nursing homes are not blameless, to a large extent, all of the reports highlight the vulnerability of nursing homes as *settings* for the fraudulent activities of others. Several solutions are underway which will help alleviate the problems cited.

I. The General Accounting Office Reports

A. "Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities". GAO, January, 1996.

The GAO's January 1996 report on fraud and abuse in nursing facilities did not accuse nursing facilities themselves of fraud, but instead recommended ways for facilities to help prevent outside providers from taking advantage of their residents. The report identified two situations that enabled unscrupulous outside providers to obtain payment for services and supplies that were never provided to nursing facility residents. One common problem involved outside providers' unauthorized access to the medical records of nursing facility residents, which enabled the providers to obtain Medicare numbers and information on diagnoses that they then used to file fraudulent claims. The other common thread was Medicare carriers' failure to discern and immediately follow up on clearly excessive amounts claimed by outside providers for services and supplies provided to nursing home residents.

AAHSA recognizes that nursing facilities have a responsibility to ensure that residents' records are kept confidential and that no outside providers of services or supplies have access to these records. We agree with the GAO that nursing facilities should be held accountable for unauthorized disclosure of residents'

records, with the proviso that clinical situations may occur in which nursing staff must consult with therapists and other providers on appropriate care for a resident's condition.

B. "Medicare: Tighter Roles Needed to Curtail Overcharges for Therapy in Nursing Homes", GAO, March, 1995.

Medicare pays for therapy benefits in nursing homes as long as the need is indicated in the resident's assessment and as long as the resident's condition continues to improve as a result of the therapy. One of the criteria for receiving the Medicare skilled nursing facility benefit is that the resident be able to benefit from rehabilitation, so it is reasonable to expect a high level of therapies for this group. In every case, however, the extent of the Medicare SNF stay would be bound by the 100-day coverage limit of the SNF benefit.

The 1995 Government Accounting Office report on therapies pointed out that the 1990 implementation of the Nursing Home Reform provisions of OBRA '87 resulted in dramatically higher Medicare spending on therapy services delivered in nursing homes. The report acknowledged the link between the increase in services and the law's requirement that nursing facilities assess and provide for their residents needs for various kinds of therapy.

The report also highlighted dramatic increases in costs for nursing home therapies, costs that exceeded what the government would have expected just by the increased volume. Two primary reasons were identified for the increased costs for therapy services: (1) HCFA placed no absolute dollar limits on Medicare reimbursement for occupational and speech therapy; and (2) charges for therapy services were not linked through billing codes to the amount of time spent with the resident or to the specific treatment provided. The GAO suggested two solutions. The first was for HCFA to develop salary guidelines that set explicit limits on the amount Medicare will pay for occupational and speech therapy. The second was to require that bills for these services specify time spent with residents. GAO's follow-up report in 1996, *Medicare: Early Resolution of Overcharges for Therapy in Nursing Homes is Unlikely*, GAO/HEHS-96-145, pointed out the difficulty of addressing both problems.

Since the 1996 report, however, HCFA has made progress on both fronts.

Salary Equivalency Guidelines. The Health Care Financing Administration has issued a proposed rule for the Medicare and Medicaid Programs concerning Salary Equivalency Guidelines for Physical Therapy, Respiratory Therapy, Speech Language Pathology, and Occupational Therapy Services. HCFA's proposal is an attempt to develop a better methodology based on more up-to-date data to cover all four categories of therapies.

Consolidated Billing. The Administration's budget proposes to have nursing homes bill for all services a resident receives, other than services provided by a physician, certified nurse midwife, qualified psychologist services, hospice and services of a certified registered nurse anesthetist. Durable medical equipment and enteral feeding supplies are included. It appears that nursing facilities would be responsible for both Part A and Part B billing. Part B billing would be required even if the residents are not receiving Part A reimbursement.

AAHSA agrees that consolidated billing is likely to avoid some of the fraud and abuse issues presented when therapists bill separately for either Part A or Part B services. Although we are still evaluating the total impact of the Administration's proposal on our members, one conclusion is obvious: while the federal government is perfectly willing to use nursing homes to solve one of its major problems, there has been no mention of helping nursing homes with the administrative burdens imposed by this solution. Billing for non-routine services is technical and can be very complicated. Many, if not most, skilled nursing facilities will need training and computer support to take over this function. Sufficient lead time also will be needed. The President's Budget would require implementation six months after the budget is passed, or July 1, 1998, whichever is later. Neither date provides sufficient time. There is no provision for reimbursing homes for the administrative costs.

Prospective Payment System. If consolidated billing is a short-term "solution" to over-billing, prospective payment is probably the long-range plan. We recognize that reform of the current retrospective, cost-based reimbursement system is inevitable and that some form of prospective payment is likely. The current Medicare PPS for low-volume skilled nursing facilities is a start that has been working fairly smoothly, but it is only a first step. A well designed PPS could promote management efficiencies and create some savings for the Medicare program. It also could address fraud and abuse concerns such as unnecessary services.

It is very important, however, that the system be set up with sufficient rates to interest providers in participating in Medicare, as well as that it be based on the proper incentives to ensure it meet the government's goals, within the context of what is good for beneficiaries and manageable by providers. For example, a poorly constructed system, such as one based on episodes of care, could result in underservice or early discharge. This sets up a pattern of re-hospitalization and greater expenditures by other post-acute providers.

We have seen from the implementation of the hospital PPS that the health care industry is very complex and can react in unexpected ways to PPS incentives. For example, the reduced hospital length of stay was an anticipated and desired result of PPS implementation. With hindsight, the growth of subacute care based in hospitals seems a natural result, but it was not as clearly expected at

the time of implementation. Prior experience would argue for implementation of a PPS very gradually and with careful evaluation of its implementation and impacts.

C. "Part B Services in Nursing Homes - An Overview", OIG, March, 1996.

As part of the Operation Restore Trust (ORT) anti-fraud initiative the OIG reviewed Part B services in Medicare. Part B covers a wide range of medical services and supplies for beneficiaries, including beneficiaries in nursing homes. These services include physician services, outpatient hospital services, diagnostic laboratory tests, imaging, ambulance services, and a wide range of medical equipment and supplies. The OIG report identifies three main areas of vulnerabilities: duplicate payments, lack of oversight and questionable supplier or physician practices. According to the report there is often confusion about whether Medicare or Medicaid is required to pay for a nursing home service; consequently, both programs may be billed. We believe GAO currently is studying this further. This is no easy task in that there are more than 50 ways of looking at the problem. Medicare Part B carriers also often lack the information needed to adequately ensure appropriate billing for nursing home residents. In addition the report found that Medicare is subject to questionable supplier and physician practices in ordering equipment such as incontinence supplies, wound care, and orthotic supplies for nursing home patients.

Two initiatives by HCFA already address the potential abuses. The Medicare Transaction System and the President's FY98 budget proposal for consolidated billing both should help reduce the frequency of duplicate payments. The Medicare Transaction System integrates Medicare Part A, Part B and managed care data. The MTS is an automated, standard, integrated information system that will also coordinate insurance benefits, assist in the detection of program fraud and provide Medicare beneficiaries and providers with a single point of contact to resolve all program inquiries. Under consolidated billing, as explained in more detail above, outside suppliers would have to make arrangements with SNFs so that the nursing homes would bill for suppliers' services and would be financially liable and medically responsible for the care.

II. Fraud and Abuse as Part of Nursing Facilities' Regulatory Scheme

Few non-health care businesses are subject to as many regulatory authorities as nursing homes. Currently, nursing facilities must comply with regulations promulgated by the Health Care Financing Administration (HCFA), the Food and Drug Administration (FDA), the Occupational Safety and Health Administration (OSHA), the Department of Justice (DOJ), the Environmental Protection Agency (EPA), the Department of Labor (DOL), the Office of Civil Rights (OCR), the Federal Communication Commission (FCC), and State Licensure and Medicaid agencies. Nursing facilities are challenged daily to strike the balance that will

allow them to achieve and maintain compliance with the requirements issued by these varied regulatory agencies while simultaneously ensuring optimal well-being for residents ranging in extremes across age, acuity level, physical independence, and cognitive ability.

These “many masters” often interact to put nursing homes in regulatory jeopardy. The fraud and abuse regulations are no exception, and the False Claims Act (FCA) provides examples of conflicting governmental judgments in determining the needs of nursing home residents.

A. Interaction of OBRA '87 and Determinations of Overutilization/Unnecessary Services.

One of the most important legislative initiatives that affected the provision of services in long term care facilities was the passage of the quality reforms found in OBRA '87. The distinguished ranking member of this Committee, Mr. Waxman, is quite familiar with this legislation. I think it is safe to say that he was the principal architect of this landmark law, which enacted the most sweeping changes to nursing facility operations since the passage of Medicare and Medicaid.

A major provision of OBRA puts it potentially at odds with fraud and abuse statutes. Nursing home residents must receive the necessary care and services to attain or maintain the *highest practicable physical, mental and psychosocial well-being, in accordance with the resident's comprehensive assessment and care plan* (42 CFR 483.25). Federal regulations restate this provision in several behavioral goals. For example, there will be

- no diminution in activities of daily living, unless a clinical condition makes this unavoidable; residents receive appropriate treatment or services to maintain or improve activities of daily living (ADLs), and residents unable to maintain ADLs receive good nutrition, grooming and personal and oral hygiene;
- no new, avoidable pressure sores after entering the facility; new sores must receive necessary treatment;
- no new need for indwelling catheterization unless it is required by a clinical condition; residents must receive appropriate bladder training to avoid infection and restore function;
- no reduction in range of motion, unless it is unavoidable due to a clinical condition; residents must receive appropriate treatment to increase ROM and/or prevent ROM reduction;
- mental and psychosocial treatment to address adjustment difficulties; residents without a pattern of such difficulty do not display a pattern of

decreased social interaction and/or increased withdrawal or angry or depressive behaviors, unless these are unavoidable due to a clinical condition;

- ability on the part of residents to eat independently or with assistance but without a naso-gastric tube unless a tube is unavoidable due to a clinical condition; residents with NG tubes receive services and treatment to prevent aspiration, pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers and to restore eating skills.

All of the examples listed imply that some sort of therapy--physical, occupational, psychological, speech-- and a certain level of other services will be available and provided to help residents stay at their maximum level of functioning.

This is a wonderful goal for residents and one AAHSA supports. Moving toward this end, though, may result in several more years of "close calls" with regard to what is or is not a necessary therapy or other service. This concerns us because so far the FCA has addressed only the extremes of these cases.

B. Unnecessary Services. The GAO report on overcharges for therapies in nursing homes cited the strong possibility that unnecessary therapies were provided either by nursing homes, themselves, or by rehabilitation companies providing services to nursing home residents. Subsequent OIG Fraud Alerts, e.g., *Fraud and Abuse in the Provision of Services in Nursing Facilities* (May 1996) and *Fraud and Abuse in the Provision of Medical Supplies to Nursing Facilities* (August 1995), have provided additional evidence of unnecessary services or supplies. An examples cited by the OIG included unneeded hearing exams. Aside from the OIG Fraud Alerts, AAHSA staff have heard government investigators at national conferences cite cases such as occupational therapists giving treatments to comatose residents.

Certainly we cannot condone this type of behavior. There is, however, a vast "gray area" in meeting the provisions of one law's requirements of reaching the "highest practicable" level of care, and the recommendations of the GAO to curb unnecessary services. At which point do services become unnecessary? And who makes this determination?

C. Failure to Provide Services. The other extreme of the situation is presented by *U.S. v. GMS Management-Tucker, Inc., et al. ("Geri-Med")*. The Geri-Med case was settled in 1996, after the Department of Justice filed an innovative civil complaint against the not-for-profit nursing facility and its former for-profit management company for inadequate nutrition and wound care to three residents. The complaint was prompted by the hospitalization of a resident whose overall condition, including horrendous decubitus ulcers, was beyond description. The theory used by the DOJ was that the provider had submitted claims for reimbursement for all three residents in

the case. However, the condition of the three residents was such that the nursing home could not possibly have used the reimbursement to provide the care represented by the claims; therefore, the claim must have been false.

Defense attorneys can debate as much as they want about whether the False Claims Act should be used this way. In cases such as Geri-Med, it's hard to argue over the solution when the problem is so bad. We do feel, however, that in closer cases, where facilities reasonably decide that services are unnecessary, they may face the same jeopardy from the Justice Department or other oversight agencies that facilities face if the agencies decide that too many services were provided.

Dilemmas Presented for Nursing Homes

In effect, federal regulations have established a "failure to thrive" standard for nursing home residents, most of whom are well over 80 years of age. This standard exists without the research to establish benchmarks for the "average" elderly nursing home resident. Considering the consequences under OBRA '87 of not complying with the regulations (e.g., civil monetary penalties, temporary managers, suspension of payments, suspension of new admissions, closure), providers can hardly be faulted for occasionally erring on the side of somewhat more therapy than may be needed in the eyes of the Inspector General. Good assessment and care planning will minimize these mistakes but are unlikely to completely eliminate them. We should note that HCFA is working on computerization of the resident assessment system, which will help gather the data to make benchmarking possible.

In addition to our concern about the uncertainty of routine therapy and other services generally, we are disturbed by recent statements by a fraud and abuse enforcement representative to the effect that some kinds of therapy for terminally ill residents and persons with Alzheimer's Disease is a waste. I do not know what therapies the individual was referring to, and I do not know whether that was the official statement of a fraud control unit or a state's attorney giving a personal view. Either way, the statement gives credibility to our view that quality of care decisions belong with individuals trained to make them.

Certainly nobody wants to spend the last hours or days of his or her life on a treadmill or learning how to swallow again. But the difficulty of defining terminal illness (as evidenced by recent stories about hospice care and the debate about physician-assisted suicide) makes it risky to say that as a class, and without qualification, the "terminally ill" should not be receiving certain therapies, particularly those associated with mental health. We are very concerned about what will happen if and when states are permitted to pursue statutes legalizing physician-assisted suicide and those statutes require not only medical second opinions but also psychiatric consultations and batteries of psychological tests.

AAHSA also is bothered about the possibility that fraud and abuse authorities might systematically limit certain kinds of therapy for persons with Alzheimer's Disease or other forms of dementia. We understand that there have cases of inappropriate therapy for these individuals, such as having a therapist give complex instructions to afflicted person and then expecting the individual to follow through independently with a series of exercises. This IS a waste. But there are valuable forms of therapy for persons with dementia, including physical therapy to maintain mobility, and speech therapy to maintain swallowing ability. Keeping residents with dementia free of contractures, out of wheelchairs, and off of feeding tubes not only enhances their quality of life but dramatically cuts the cost of their care.

We urge the government to consider that just because a person does not remember his or her therapy does not mean that the person cannot benefit from the therapy's effects. As this Committee continues its deliberations, we strongly urge you to dialogue with organizations such as the Alzheimer's Association, whose recommendations for quality care we take very seriously.

In addition, when we consider quality of life with respect to therapies and other services, it is important to recall that residents have federally mandated rights which may not always be clear to agencies that do not work with residents regularly.

III. AAHSA Initiatives/Educational Activities

Committee staff have asked us to comment on some of the initiatives our Association has taken to combat fraud and abuse.

A. Helping members recognize fraud and abuse. Knowing what fraud and abuse looks like is not simple; lawyers are making careers out of trying to tell the difference between right and wrong in this field. Moreover, providers who are trying to maximize quality of life for residents and others in the facility on tight budgets have had to come to grips with the fact that some of the applications of the fraud and abuse statutes seem contrary to common sense. For example, we became aware that some of our members were receiving birthday cakes from suppliers for residents. We had to counsel them to stop this practice because it met the technical definition of a kickback. AAHSA has publicized examples of what fraud and abuse look like as these stories come to our attention. We also have worked with the association's Legal Committee to collect examples that the attorneys see in their practices.

B. Helping members identify competent counsel. Unlike hospital systems or large nursing home chains which have in-house counsel, most of our members are free-standing providers who use local counsel for their legal needs; many are located in rural or small city areas where health law counsel are not readily available. AAHSA has tried to identify attorneys who not only can represent the facilities when they have questions but who also can participate in the educational programs of our state

associations, which members attend. In addition, AAHSA invites attorneys who represent our state associations to meet in Washington every year, as well as at the site of our annual convention. These meetings educate counsel about national developments in fraud and abuse among other topics and enable them to reach out to our individual members more effectively.

C. Technical Assistance Guides. For several years, our Association has been publishing Technical Assistance Briefs to our members. These "how to" papers are intended to provide practical guidance on issues of concern to not-for-profit nursing homes, continuing care retirement communities, senior housing facilities and community service organizations.

Technical assistance briefs provide useful instruction on how to comply with applicable laws, offer guidance on management issues and address pertinent topics for our members. These briefs attempt to provide clear interpretations and suggestions for compliance or implementation of Federal laws and regulations.

Four years ago, with the assistance of outside council, AAHSA published a TA brief entitled "Complying with Medicaid and Medicare Fraud and Abuse Provisions." This brief covered a wide range of topics and was designed to serve as an important primer for our long-term care facilities.

Three new guides are currently underway and will cover fraud and abuse issues involving medical directors; home health issues in senior housing; and home health issues in retirement housing. Technical assistance briefs are distributed free to all AAHSA members.

D. Publications. Fraud and abuse cases, programs and initiatives, including Operation Restore Trust, are publicized in three regular AAHSA publications: *Currents*, a monthly newsletter with a circulation that includes all AAHSA members and numerous outside organizations; *Washington Reports*, which covers legislative and regulatory developments for our members every two weeks; and *Legal Memo*, a summary of pertinent cases for attorney and member subscribers, six times a year.

E. Educational Sessions. Virtually all AAHSA annual meetings and spring conferences have offered seminars on fraud and abuse topics for years. Examples include fraud and abuse enforcement activities; Operation Restore Trust; the implications of fraud and abuse on tax-exempt facilities; anti-kickback statute; safe harbors, and many others.

F. Corporate Compliance Plans. Corporate compliance plans are internal systems which help providers monitor their compliance with federal and state statutes governing Medicare, Medicaid, and other government health programs. They are not mandatory, but all settlements between fraud and abuse enforcement agencies have required the plans as a means of future compliance with the law. Operation Restore Trust has particularly emphasized corporate compliance plans as an integral part of providers' internal monitoring systems.

A corporate compliance plan, if done for an individual facility by an attorney can cost well in excess of \$100,000. It is extremely labor intensive and time-consuming. This comes at a time when the government is reducing overall spending for Medicare and Medicaid.

Currently the OIG is developing model compliance plans for health care providers. The model for clinical laboratories was published in the Federal Register recently. Models for hospitals and HMOs will be prepared next. Because nursing homes are farther down the line, AAHSA's staff and Legal Committee are working on what we feel would be the most appropriate components of a model for nursing facilities. Hopefully, this will be acceptable to the OIG when it is completed.

V. Recommendations

AAHSA has several suggestions for continued efforts to eliminate fraud and abuse. Some have already been stated in the body of this testimony but bear repeating.

A. Fraud Alerts. The Fraud Alerts published by the Office of the Inspector General have been a valuable mechanism to educate our members about suspect practices. We would hope that the OIG would continue to update the Alerts as the results of their investigations warrant.

B. Advisory Opinions. The legal and provider communities both recognize the complexity of fraud and abuse law, and the difficulty of entering many kinds of arrangements with any assurance that they would survive OIG scrutiny. The provision in last year's Health Insurance Portability and Accountability Act requiring the IG to prepare advisory opinions about the legality of certain transactions was welcome news to all.

Unfortunately, the Administration's budget proposes to repeal that provision, even though the IRS and FTC have managed to prepare similar kinds of opinions for many years. We ask the Committee's help to preserve the ability of good people to do the right thing by keeping the advisory opinion mandate.

C. Consolidated billing. HCFA and long-term care providers must work together to develop a reasonable system for consolidated billing through nursing facilities if providers are to assume this additional responsibility to help eliminate fraud and abuse. Part of the system must include some reimbursement for additional administrative costs to skilled nursing facilities. In addition, providers must receive support for training, computerization of their billing systems, and sufficient phase-in time.

D. Prospective Payment System. A well-designed PPS has considerable potential to simplify Medicare billing and to eliminate some of the fraud and abuse identified in the GAO reports. In order to avoid repeating the unforeseen

and expensive consequences of the hospital DRG system, however, we recommend that HCFA invest an additional period of time on the front end of the design. This time should be spent developing the data necessary to support the rate-setting (cutting) and to relate patient acuity levels to an all-inclusive payment. AAHSA also advocates the refinement of quality assurance systems based on outcomes monitoring to protect against negative impacts on residents of payment system changes and reductions. An adequate phase-in period must be allowed, and implementation must include a program to monitor trouble spots early on.

E. Unnecessary services. We would like to see dialogue between HCFA, the OIG and provider and consumer groups on the issue of unnecessary services. We believe recent cases and actions by government agencies demonstrate a need to determine how the need to meet the highest practicable level of care should be interpreted to avoid citation of inadequate service by HCFA and unnecessary service by the Inspector General.

F. Asset Divestiture. This hearing has focused on fraud and abuse by nursing homes and others. As a final note, we would like to ask the Committee to remember the abuse being perpetrated ON nursing homes, as well as the Medicare and Medicaid programs, by beneficiaries.

Medicaid estate planning is a growing practice whereby individuals shelter their assets in order to qualify for Medicaid coverage while preserving their own financial resources for relatives and heirs. Common practices include transferring countable assets into exempt assets; sheltering assets in trusts, annuities, and other financial vehicles that are deemed unavailable to the Medicaid beneficiary; transferring assets through joint bank accounts and other property held in joint tenancy; and manipulating spousal impoverishment rules to divert income and assets to a community spouse. In New York alone, these assets are reported to cost the Medicaid system \$28 million annually.

AAHSA believes that public assistance should be provided to the truly needy, not to individuals who are financially capable of paying for their own care. The use of estate planning gimmicks to qualify for Medicaid coverage of long-term care drives up the cost of the Medicaid program to both the federal and state governments. We believe it is unfair to the thousands of needy Americans of all ages who have no health insurance or Medicaid coverage to have public dollars used to pay for care for those who could well pay their own way. This abuse of the Medicaid program is unfair to long-term care providers, who must accept the generally inadequate Medicaid payment rates and subsidize care for Medicaid abusers out of their endowments. It is also unfair to those nursing facility residents who are paying for their own care, since facilities often must charge them higher rates in order to make up for the shortfall in payments from Medicare and Medicaid.

Congress has made several attempts to curb the practice of asset divestiture. In 1993, a stronger look-back provision was enacted, disqualifying individuals from Medicaid if they had transferred assets within the previous 36 months. Last year's Health Insurance Portability and Accountability Act contained tax incentives for the purchase of long-term care insurance. AAHSA had advocated these incentives for many years, since we feel that the availability of private insurance to cover the cost of long-term care will lessen the asset divestiture problem. HIPAA also included criminal penalties to be imposed on individuals who transfer their assets during the three-year look-back period for Medicaid eligibility. We understand that there may be problems with this provision, since few people really expect that an elderly nursing home resident would be taken off to jail, and asset transfers that were not criminal at the time they were made might later become criminal if the transferor entered a nursing facility. Legislation to repeal the criminal penalties provision has been introduced.

AAHSA concurs that the "Granny Goes to Jail" scenario is not what we need, and we do not advocate retaining a criminal penalty for the nursing home resident. We do hope, however, that Congress will continue to discourage divestiture. At the very least, we need some reliable research to measure the dimensions of the problem. Congressman LaTourette's bill to repeal Section 217 of the Health Insurance Portability and Accountability Act seems, on the surface, to be a politically correct approach. We do, however, have serious reservations about sending a signal to the growing legion of elder law attorneys that Medicaid divestiture is an acceptable practice. Congress should move very cautiously in this area.

VI. Conclusion

The elimination of fraud and abuse in the health care system is a shared responsibility. To achieve it, we need a clear law, solid regulations, and good faith on the part of all the players. The bottom line of the GAO reports is that none of these exist.

It is hard to believe there will ever be a clear law on fraud and abuse, without starting over. That is why advisory opinions are so important. But there can be solid regulations, and the GAO reports point out several areas where regulations are needed. The GAO also cites the need for these regulations to be based on data-driven decisions, e.g., salary surveys.

Regulations based on data, fairly implemented and uniformly enforced, will do much to inspire good faith on the part of health care providers.

Mr. SHAYS. Well, you will have a chance at that.

Do you want to just speak directly to it now? I would be happy to have you, if you want to make a comment.

Mr. GROB. If I could.

Mr. SHAYS. Just state, for the recorder, your name again.

Mr. GROB. Mr. Chairman, just to address the concerns.

Mr. SHAYS. No, for the record, since you're joining the panel, your name.

Mr. GROB. It's George Grob, and I'm with the Office of Inspector General.

I just would like to address some of the concerns that were raised here about the Office of Inspector General. I think that any police force, in any place, can be abused. And I think it is incumbent upon all the people who govern that in the country to be very wary of that ever happening.

I think that if we did reach a situation where the Inspector General's Office was bringing cases against people for providing legitimate services, I think that everyone should, in fact, make sure, through the political process or whatever, that that doesn't happen.

I certainly hope that we're not there right now. I think the cases that were brought up were rather extreme. In the case of Tucker House, as I understand it—and I hope you will correct me here, if I'm wrong about the detail—criminal charges were brought by the State against that nursing home.

Mr. SHAYS. Which nursing home are we talking about?

Mr. GROB. The Tucker House nursing home that was mentioned.

Mr. SHAYS. Right.

Mr. GROB. I believe several people died there as a result of malnutrition.

Mr. SHAYS. But I don't think your testimony was that there shouldn't have been this case.

Ms. WEISS. No.

Mr. SHAYS. No. I don't think she was—correct me if I'm wrong, but, Ms. Weiss, I think you were just giving us a spectrum on the kinds of cases.

Ms. WEISS. That's correct.

Mr. GROB. I think the concern was that there was a creative use of an authority here to deal with that, and probably properly used in this case.

Mr. SHAYS. And that's the point. In this case, properly, but just think, that could be carried to an extreme.

Mr. GROB. It could be.

Mr. SHAYS. Correct? Is that your point?

Ms. WEISS. That's correct.

Mr. SHAYS. In this case, you weren't making that claim?

Ms. WEISS. No.

Mr. SHAYS. Yes.

Mr. GROB. Again, I just wanted to emphasize that it was a pretty extreme case, and that doesn't necessarily mean that the Inspector General's Office is out there looking for the marginal.

Mr. SHAYS. Don't be too sensitive. I think we're doing pretty well.

Mr. GROB. That's good. OK.

Mr. WILLGING. When have I ever agreed with you this much?

Mr. GROB. No.

Mr. WILLGING. Somebody once said, when you've sold the car, get off the lot.

Mr. GROB. The other one I'd like to mention had to do with the Alzheimer's patients and the therapies. The reference was to occupation therapy. I don't remember that reference. My reference, in my testimony, was to mental health services. And the reviewers that looked at those cases did not reject, out of hand, any mental health therapy for anybody with Alzheimer's. They looked at the record to see whether those particular individuals could benefit from the treatment or needed it.

So, again, I would agree with you about the concern for making sure that Alzheimer's patients receive all the services they need.

Ms. WEISS. And we would have no objection to individual reviews made by qualified people. My concern at this point is the fiscal intermediary's position that Medicare should not pay for any therapies, and there were no qualifications.

Mr. SHAYS. We bring different experiences to the table, but as a State legislator, I remember there was a very old facility—it almost had the feeling of a house to it—but patients didn't have certain activities, but they loved that place. They loved being out on the porch; they loved the flowers and the lawn.

But our local paper went after them because of one or two things they didn't do. And you could come and take pictures of this place and make it look a certain way, and they shut it down. I would have submitted that the people at that nursing home were far happier—they had a really family feel to it—than some of the new ones with everything according to Government regulations, the hallways just the right size, and so on.

It's a difficulty when we, in Government, just try to regulate to fit some kind of view of what we want. We don't always accomplish that. So I have a lot of sympathy for nursing home facilities, in terms of you have to not only do it right, you have to look right, as well.

But I do know we have tremendous abuses, and you all know that, as well. You all know that, given the amount of money we're talking about, 10 percent, or 5 percent, whatever it is, I would just say to you, I do think that we're talking billions of dollars of problem, not millions or not even hundreds of millions.

Mr. WILLGING. Regardless, Mr. Chairman, it should be eradicated.

Mr. SHAYS. But, see, I'm going to go—you said "regardless." No, it always should, and I think that's the view, whenever you have your legalities, and so on. But I'm just saying to you, in this one, it conks us over the head to do it quickly and to save the taxpayers a lot of money.

Mr. WILLGING. But I think what we're also saying, and I repeat what you said, is, let's make sure we know what is a result of confusing interpretations of regulations and what is indeed fraud. And let's go after the fraud vigorously.

Mr. SHAYS. Ms. Weiss, I will call on you in just a second.

This staff is eager to work with all three panels, not just the first two. You are partners in this effort. I would defend anyone, if they said you weren't involved in this process, to say, who better to be involved than people who have to deal with it every day.

What did you want to say?

Ms. WEISS. The only thing I wanted to say was that I agree with Paul, that it should be zero-tolerance and that we should get it under control. Where I don't agree with him is that it doesn't matter what the source is. It does matter what the source is, because the "fixes" are very different, and the resources should be directed differently.

If we have criminal behavior, then resources should be put there. But if we have misunderstanding and bad reimbursement policy, which is what an awful lot of this is about, then we ought to give HCFA the resources to put in a couple of GS-14s and work on this problem. They could save a lot more money by curing that problem than they would save just by cutting the HCFA staff.

Mr. SHAYS. I have a feeling, though, we have the biggest chunk in the middle. And the biggest chunk in the middle are the people who know it's probably wrong and criminal, but it's confusing enough to give them cover. I suspect we have a large chunk right in that area.

Ms. WEISS. We are providing them with a lot of loopholes that could be closed.

Mr. SHAYS. True, true. Other comments you all want to make? Any questions that we had asked earlier?

Does Colorado want to respond in any way? You have such a nice smile, I was thinking, what is he thinking?

Mr. ALLEN. If I may, Mr. Chairman.

Mr. SHAYS. Sure. Just state your name and title.

Mr. ALLEN. Richard Allen, Colorado Medicaid program.

Mr. SHAYS. We have New York here, too, if New York wants to respond.

Mr. ALLEN. Just a few comments. In the area of the best, let's make sure we do the best, and how we ever are going to afford it, the big problem we have in long-term care is that it's financed through the Medicaid program. The Medicaid program is a welfare program. It's not an actuarially sound program at all. There is no money being put aside like you typically see in insurance, getting ready for the day where you need something like long-term care insurance, just like car insurance, or life insurance, or something like that.

There is a new product on the market; it is called long-term care insurance. My department believes that that is a prudent new policy that should really be pursued by both the Federal and the State level. Several years back, there was something called asset protection, which is that if an elder bought a long-term care insurance policy, the State then would promise to protect their assets as they went through the spend-down process, or what have you. We think that was a very good model.

The real thing we need to do is to get the entire long-term care industry, if you will, set up on an actuarially sound basis, which is some sort of insurance program other than the Medicaid insurance program, where we're really cutting ourselves all short, in the long run. It's only 20 years from now that many of us will, indeed, be looking at the same situation, and do you really want it to be the Medicaid program that's going to come in and pay for your

care, especially with the baby boomer situation out there? The clock is ticking, and we've got a real problem.

In terms of this sharing back and forth on the Medicaid program, States, you take the acute care program, and the Federal Government will take over the long-term care program, it is an intriguing idea. As a Medicaid director, I get to do long-term care and acute care, and I think it would be a wonderful bargain for the Federal Government, because the acute care side, which would remain with the State, is the larger portion of the Medicaid program right now.

Mr. SHAYS. Let me just tell you, in my judgment, what I recall, using more of the averages, is that one-third of the patients are nursing care, and they take two-thirds of the money. And the two-thirds that are AFDC recipients under Medicaid health, they get one-third of the money. I think the national statistic is close to that.

Mr. WILLGING. That is correct. There's no question that the smaller percentage of beneficiaries, the elderly, take the disproportionate amount, because they are in nursing facilities, to a considerable extent, and at the end of life.

Mr. SHAYS. Exactly. I was trying to think of the reasons why we didn't think of this idea, because Congressmen are always brighter, obviously, you know, than everyone else. Why didn't we think of this idea?

Mr. WILLGING. We, unfortunately, just were not articulate enough at the time.

Mr. SHAYS. To make us think it was our idea.

Mr. WILLGING. That's right.

Mr. SHAYS. Yes.

Mr. WILLGING. You pointed out the reason. If you don't look behind that proposal, it does appear to run against the grain, in terms of what this town—and I don't think just Republicans, Mr. Chairman—what this town has generally been moving toward, which is a devolution of more authority to the States, not something coming back up to the feds.

But you make this swap. Actually, one of your colleagues on the Republican side in the Senate, Nancy Kassebaum, a former colleague, had, in effect, broached this idea, oh, 3, 4, 5 years ago.

Mr. SHAYS. I knew it was a Member of Congress.

Mr. WILLGING. Oh, it was. Just took me a while to think of it.

Mr. SHAYS. Yes. Right. Well, the other reason may be, and this would be sad, but those who are on one committee, Ways and Means, or, in this case, Commerce, may not want to give that authority to Ways and Means, because it would become a Ways and Means responsibility.

Mr. WILLGING. But for the greater good of the American people.

Mr. SHAYS. No, I'm just being very candid with you. I'm not saying that's good; I'm just saying that this is one of the things that has been very disturbing to me. Why do you have 48 percent of all education programs only in the Department of Education, and 52 percent outside the Department of Education?

The reason is, when you check it, some Member of Congress had an idea, and they put it through their committee, and they wanted their jurisdiction. I mean, the Agriculture Department has all rural housing. That's not in HUD. Don't get me started here.

But, anyway, you had an intriguing idea. I will claim it as my own, if I like it, and I will go on to better things because of it.

Mr. WILLGING. And we will give you all the credit.

Mr. SHAYS. May I ask if anybody else has any last comment here?

[No response.]

Mr. SHAYS. If not, let me say this has been a very interesting hearing. I think you will see its impact in legislation, if not this year, sometime next year, but maybe this year. We don't begin to know what that is, but we're getting a sense of the problem.

With that, I would like to thank Marcia Sayer and Jared Carpenter, on the majority side of the staff, and Ron Stroman and Ashan Detok, on the minority side, and Donna Ferguson, who was our transcriber. Thank you very much, as well.

And I thank all of our witnesses. You have provided this committee a tremendous amount of helpful information. We thank you for being here.

Mr. WILLGING. Thank you, Mr. Chairman.

Mr. SHAYS. This meeting is closed.

[Whereupon, at 1:45 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

Statement of the National Association for the Support of Long Term Care
Before the
Human Resources and Intergovernmental Relations Subcommittee
of the
House Government Reform and Oversight Committee

April 18, 1997

The National Association for the Support of Long Term Care (NASL) was founded in 1989 to address legislative and regulatory matters regarding the professional services and supplies provided to beneficiaries in a skilled nursing facility (SNF).

NASL is pleased to provide this statement to the Subcommittee on Human Resources outlining recommendations for reducing the level of fraud, abuse, and waste in connection with Medicare and Medicaid payment for skilled nursing services.

Background

NASL recognizes the need for strong federal and state action to identify and eliminate fraud and abuse in the Medicare and Medicaid systems. The Association also recognizes the need to eliminate waste and other unnecessary program costs which add to federal and state outlays without providing commensurate benefits to program participants. The challenge is to find a way to accomplish these objectives efficiently and effectively without sacrificing quality or access to medically-necessary care.

Most Medicare and Medicaid providers and suppliers of ancillary services to SNFs are trying to comply with program rules and regulations. Unfortunately, the complexity of some of these rules and their uneven application can lead to confusion and billing errors. While this cannot excuse genuine fraud and abuse of the program where unnecessary services are provided or costs are deliberately inflated, it suggests the need for a more sophisticated approach than simply adding more resources to law enforcement or increasing the severity of penalties for violations of payment rules.

Accordingly, NASL urges the Congress to give serious consideration to two additional areas:

- the enactment of legislation to reform the current SNF payment system by improving the coordination of payments under Parts A and B of the Medicare program and establishing a prospective payment system for SNF services; and
- the encouragement of a partnership between the industry and government in developing pro-active compliance programs modeled after the program for clinical laboratories which was recently announced by the HHS Inspector General.

If implemented, these recommendations would go a long way toward reducing the incentives and opportunities for fraud and abuse to occur in the SNF setting while

giving providers and suppliers who are committed to compliance with the program rules and regulations, more effective tools to police their own operations.

Coordination of Part A/Part B Payments

SNF's have three options in providing ancillary services to SNF patients: 1) hire staff to deliver the service, 2) enter into an "under arrangement" contract with a supplier or provider and bill for the services through the facility; or 3) enter into an "under agreement" contract with a supplier or provider and let the supplier or provider bill the program for the services.

While nearly 13,000 nursing facilities participate in the Medicare program, fewer than 2,000 facilities account for 50% of Medicare reimbursed days of care and less than 5,000 facilities account for 90% of the Medicare reimbursed days of care. Facilities admitting more than 10-20 new admissions per month may sustain a patient flow sufficient to justify a broad array of medical professional services. However, most facilities experience a significantly lower turn-over of residents and, therefore, offer a more narrow scope of core services. These facilities, under arrangement or under agreement, deliver specialized services on an as-needed basis.

The demand for professional medical services is based upon patient need. Unless a facility has a relatively high volume of admission and discharges, demand will fluctuate. Where there is fluctuating demand for ancillary services, it is often less costly to contact with an outside provider or supplier. Even for higher volume

ancillary services, such as therapy services, market studies have affirmed lower per unit cost of delivery in contracting relationships. There are savings to Medicare when services are purchased only when they are needed.

The decision to secure products or services either under arrangement and/or under agreement depends upon demand, focus, and availability. From a facility standpoint, the current cost-based reimbursement system provides an incentive to hire staff or secure services or products under arrangement. Medicare pays the lower of reasonable costs or charges. Whatever approach used by the facility, it still has the responsibility for the clinical management and services provided in the facility.

In any reform of post-acute services, Part A should be billed for Part A services and Part B should be billed for Part B services. In calculating what Part A reimbursement should be, there is need to make appropriate adjustments to compensate for services currently billed under Part B. This is essential to ensure that future Part A reimbursement will accurately reflect how post-acute care services and products are presently being delivered. We do not have the data nor do many SNF's have the experience to justify applying these consolidated billing principles immediately to Part B services that are provided after Part A eligibility is exhausted.

Implementation of a Prospective Payment System

Statutes and regulations have not kept pace with market changes, and in some instances act as barriers in providing low cost, high quality services. There are conflicting rules and outdated provisions.

NASL urges the Congress to replace the existing cost-based reimbursement system for the Part A benefit. A number of technical changes clarifying the existing Part A benefit can be done through regulation, but some may need Congressional action.

A prospective payment system for the Part A benefit should 1) recognize legitimate differences in factors that affect cost, 2) encourage appropriate access to care for Medicare beneficiaries, 3) encourage the provision of high quality care, and 4) provide incentives for efficient use of resources.

The development of a prospective payment system also must reflect patient need. The accuracy of the data used to identify patient needs in constructing the PPS system is crucial. It must include a patient assessment tool that accurately reflects all that is involved in patient care. It should also encourage quality outcomes, offer ease of administration, and establish reasonable payment levels. It is important to establish objectives that can be implemented in a realistic time frame.

Safeguards should be written to require that services reach beneficiaries, that suppliers and providers will receive timely payment, and that quality will be

maintained. A realistic SNF prospective payment system for Part A services will focus attention on the need for consolidated reporting and coding of services for Part A patients across care settings. Such information will help in evaluating the appropriateness of services. Usable, uniformed measures for clinical outcomes should be developed as the current system relies too heavily on factors which add costs, but do not necessarily ensure meaningful results.

Likewise, any prospective payment system must enable the dynamic health care market to continue to progress and not lock-in the status-quo. The reimbursement system should encourage medical and therapeutic innovation and permit services to evolve to meet changing patient needs.

Government/Industry Partnership

It is NASL's strong belief that effective progress in addressing the problem of fraud and abuse in the health care industry will require greater cooperation among provider groups and federal and state government agencies. The recent "Open Letter" to health care providers from HHS Inspector General June Brown echoed this sentiment. She noted the "through cooperative efforts we can best ensure the success of initiatives to identify and penalize the relatively few dishonest providers whose fraudulent activities are eroding the solvency of the Federal health programs and undermining public confidence in the health care industry".

Inspector General Brown described the work being done by her staff in cooperation with representatives of various provider groups to fashion model compliance programs for health care providers in specific industry sectors. The first such program for clinical laboratories was announced last month. It builds upon the general compliance principles which have been developed by the U.S. Sentencing Commission and the OIG with specific reference to the issues and vulnerabilities of the clinical laboratory industry. NASL applauds Inspector General Brown for this initiative and looks forward to the development of similar guidance relating to other health care sectors.

Conclusion

Health care fraud and abuse is a serious problem which requires serious action at all levels of government. However, NASL urges the Subcommittee to recognize that an effective response must include more than prosecutions and penalties. Antiquated payment systems must be modernized to reflect the rapidly changing forms of health care delivery. New approaches such as prospective payment should be put into place quickly in order to reduce the incentives and opportunity for fraud and abuse. Finally, the type of genuine partnership outlined by Inspector General Brown should be encouraged between the government and health care providers who are committed to self-policing.

In the long run, working cooperatively with providers on sensible payment systems and standards for internal compliance programs will yield the highest benefit in combating fraud, waste, and abuse in the Medicare and Medicaid programs.

Statement of the
Health Industry Distributors Association

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The following statement is submitted to the House of Representatives Committee on Governmental Reform and Oversight, Subcommittee on Human Resources on behalf of the Health Industry Distributors Association (HIDA). HIDA is the national trade association of home care companies and medical products distribution firms. Created in 1902, HIDA represents more than 700 companies with approximately 2000 locations nationwide. HIDA members provide value-added services to virtually every hospital, physician office, nursing home, clinic, and other health care sites in the country, and to a growing number of home care patients. As the intermediary between medical products manufacturers and Medicare providers, HIDA Members are able to provide unique "ground level" recommendations to aid efforts to combat fraud and abuse in the Medicare Program.

As a professional trade association, HIDA wholeheartedly supports the rigorous enforcement of laws that ensure that Medicare pays reasonable reimbursement amounts for medically necessary items and services on behalf of Medicare beneficiaries. HIDA has long advocated the responsible administration of the Medicare program, and has repeatedly identified specific abusive or illegal practices occurring in the marketplace to assist the government's anti-fraud efforts. HIDA has also assisted in the development of additional targeted policies designed to aid the government in the administration of the Medicare program. This statement will focus on two such policies, Medicare supplier standards and nursing facility consolidated billing.

POLICY RECOMMENDATION NUMBER ONE:
SUPPLIER STANDARDS

To help rid the industry of the few illegitimate players which jeopardize patient care, tarnish the industry, and unfairly distort the market for medical products, HIDA urges the Health Care Financing Administration (HCFA) and Congress to require that all Part B suppliers comply with standards that will assure Medicare beneficiaries receive a consistent quality of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) services. The following recommended supplier standards result from a fundamental belief that the current Medicare Supplier Standards (42 CFR 424.57 et. seq.) are simply insufficient. Importantly, it is not just the de minimus nature of the standards that is deficient, but also the process Medicare uses to determine whether a provider actually meets those standards. The following recommended standards therefore would inject some substantive meaning into the notion of being a Medicare provider of DMEPOS services.

These new standards are intended to build upon those currently administered through the Medicare National Supplier Clearinghouse (NSC). These standards would therefore apply to all firms that have or apply for a Medicare Part B supplier number in order to provide DMEPOS services and bill Medicare on behalf of beneficiaries (including those who reside in nursing facilities). They reflect the consensus of a wide array industry leaders, national associations, state associations, HIDA Members, and other constituent interests.

If the NSC adopts the recommended standards and changes the process by which it determines whether a provider actually meets the standards, Medicare will realize an immediate benefit by ensuring that beneficiaries receive DMEPOS items and services only from legitimate firms. If an effective screening process is used, unscrupulous firms will never have an opportunity to engage in abusive behavior because they will never be able to bill the Medicare program on behalf of beneficiaries. Consequently, the standards will significantly contribute to reducing fraud and abuse in the Medicare program. For these reasons alone, Congress should require HCFA to adopt these Supplier Standards.

ORGANIZATION OF STANDARDS:

1. Basic Business Standards—would apply to all firms applying for a Medicare Part B Supplier/Provider number and any firm that currently has a Part B supplier number issued by the National Supplier Clearinghouse.
2. Standards for Providers of Respiratory Products—would apply to all firms providing respiratory products and services to Medicare beneficiaries, and billing Part B for those products.

3. Standards for Providers of Home Infusion Therapy—would apply to all providers of home infusion therapy, and billing Medicare Part B for these products.

4. Supplier Enrollment/Application Procedures and Verification—describes a new process by which suppliers would receive a Medicare Part B supplier/provider number. The process includes verification of information submitted to Medicare, and an on-site visit to the firm.

NOTE ON TERMS:

Please note that the following terms are used interchangeably:

- patient, consumer, client
- supplier, provider

BASIC BUSINESS STANDARDS FOR PART B SUPPLIERS

The Basis Business Standards would apply to all providers/suppliers that apply for a Medicare Supplier number, and that are in the business of providing medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to Medicare beneficiaries either in their home or in a nursing facility.

STANDARD BB-1:

AS PART OF THE APPLICATION PROCESS, THE PROVIDER/SUPPLIER MUST PROVIDE BASIC INFORMATION, INCLUDING:

1. Name
 - A. Registration/business license
 - B. D/B/A ("doing business as")
2. Tax identification number
3. Address verification
4. Proof of insurance
 - A. General product liability insurance
 - B. Professional liability insurance (if company has health care professionals as employee(s))

STANDARD BB-2:

Provider/supplier must comply with all federal, state and local regulatory requirements (e.g., licensure), and show proof of compliance when applicable.

Standard BB-3:

Provider/supplier must provide evidence of financial soundness. May be demonstrated in many different ways, for example by:

- A. Bank references
- B. Insurance—property, liability
- C. Trade credit references
- D. Etc. (Dun & Bradstreet or other credit reports)

STANDARD BB-4:

Provider/supplier must have policies and procedures to cover basic scope of services for appropriate product lines.

STANDARD BB-5:

Provider/supplier must maintain all professional and business licenses and certifications, and show proof when applicable.

STANDARD BB-6:

Provider/supplier must have 24-hour a day, 7 day a week service availability for appropriate products and response to emergency situations.

STANDARD BB-7:

Provider/supplier routinely monitors the quality and appropriateness of services, equipment and supplies provided.

STANDARD BB-8:

Provider/supplier has a corporate compliance program.

Standard BB-9

Provider/suppliers (owners and officers) shall not have been convicted of violations of Medicare and/or Medicaid rules and regulations.

Standard BB-10:

Provider/supplier attests that it is knowledgeable of the Medicare laws, regulations and policies pertaining to the billing of the applicable services, equipment and supplies provided.

Standard BB-11:

Provider/supplier has the capability (either directly or through contractual arrangements with other entities) to service customer locations, as evidenced by product inventory, distribution systems, and emergency backup systems.

Standard BB-12:

Provider/supplier provides its customers with educational resources relative to the products and services provided such as assistance with understanding Medicare regulations, provision of Medicare's toll free beneficiary help line, equipment inservices (if applicable), and product information.

Standard BB-13:

Provider/supplier has policies and procedure to document and resolve customer complaints and inquiries.

Standard BB-14:

Provider/supplier maintains regular business hours.

Standard BB-15:

Provider/supplier maintains a physical business location with its business name evidently displayed.

Standard BB-16:

Provider/supplier has procedures to document maintenance and repair programs for equipment as applicable.

Standard BB-17

The patient/caregiver must be informed of the provider's compliance with all applicable HME Federal and State laws, regulations and Standards.

Standard BB-18

The provider/supplier must assure that all the necessary and appropriate patient/caregiver education has been provided or arranged for with respect to the services, equipment, and supplies provided.

Standard BB-19

The provider/supplier must provide patient/caregiver training in the safe and proper use of equipment, with a follow-up demonstration.

Standard BB-20

The provider/supplier must inform, in general terms, the patient/caregiver of his/her financial responsibilities.

Standard BB-21

The provider/supplier will assure that environmental considerations are addressed such that the continuing needs of the patient/caregiver are met in the safest possible manner.

Standard BB-22

The provider/supplier only uses equipment and supplies that conform to generally accepted industry manufacturing standards.

Standard BB-23

The provider must have a valid, current and accurate prescription for all equipment and supplies provided.

Standard BB-24

The provider/supplier must notify the prescribing physician of apparent patient non-compliance.

SUPPLIER STANDARDS FOR PROVIDERS OF RESPIRATORY PRODUCTS

These provider standards would apply to providers of respiratory products (in addition to the Basis Business Standards described above).

STANDARD RESP-1:

All patient/caregiver information must be kept in confidence (except when required to be released, for example, by JCAHO; and provider will first obtain client's permission).

Standard Resp-2:

Providers may only provide respiratory therapy equipment for which it is an authorized dealer.

Standard Resp-3:

The provider must perform and document scheduled in-home routine preventative maintenance of provider-owned (i.e., rental, loaner) equipment.

Standard Resp-4:

Either directly or through contracting with another entity, the provider must perform and document manufacturers' scheduled maintenance of provider-owned (i.e., rental, loaner) equipment.

Standard Resp-5:

Provider cleans, stores, and transports respiratory therapy equipment in accordance with the manufacturer's recommendations and all applicable Federal and local laws and regulations.

Standard Resp-6:

The provider must have a valid, current and accurate prescription for all respiratory therapy equipment dispensed.

Standard Resp-7:

The provider must secure physician approval, either through a change in the prescription or through physician-approved protocols, before respiratory therapy equipment modality substitutions are made.

Standard Resp-8:

The provider only utilizes the services of personnel who are appropriately trained, qualified, and competent for their scope of services.

Standard Resp-9:

The provider utilizes services of health care professionals that adhere to all Federal and State laws, rules, and regulations.

Standard Resp-10:

Providers providing life supporting or life sustaining respiratory therapy equipment assume the responsibility to directly provide or arrange for the services of a respiratory therapist or equivalent.

SUPPLIER STANDARDS FOR PROVIDERS OF HOME INFUSION THERAPY

These provider standards would apply to providers of home infusion products (in addition to the Basis Business Standards described above).

PERFORMANCE STANDARDS**Standard IV-1**

Provider has competent staff:

- A. Provider has trained, competent technical staff
- B. Provider has access to qualified health professionals

Standard IV-2

Provider performs client assessments, which includes:

- A. Appropriateness of therapy
- B. Safety of home environment
- C. Development of plan of care to establish product and service needs

Standard IV-3

Provider coordinates client care with other providers and practitioners:

- A. Communication and interaction with other providers and practitioners
 - a. Patient assessment/service plan
 - b. Changes in patient's needs
 - c. Changes in patient's care regimen

Standard IV-4

Provider has a valid, current and accurate prescription for all products dispensed.

Standard IV-5

Provider schedules activities, including

- A. Who does what and when

Standard IV-6

Provider performs patient/caregiver training which includes:

- A. Indication for therapy
- B. Administration of medications or formula
- C. Operation and maintenance of pump
- D. Inventory storage and management
- E. Self-monitoring
- F. Emergency response

Standard IV-7

Provider delivers, sets up and pickup equipment and supplies.

Standard IV-8

Provider performs ongoing monitoring and follow-up, including:

- A. Assess response
- B. Assess functioning of therapy delivery system
- C. Assess product utilization, patient compliance
- D. Assess continuing need for therapy (with others)
- E. Equipment tracking, cleaning, maintenance and repair

Standard IV-9

Provider provides access to emergency response services

- A. Services are available 24 hours a day, 365 days a year
- B. Provider responds within reasonable time

- C. Provider provides intervention as indicated.
 - a. Technical
 - b. Clinical—provide instruction, visit or contact other provider

INFORMATION MANAGEMENT

Standard IV-10

Provider manages the following information related to the client:

- A. Maintain clinical records
- B. Patient satisfaction/grievances
- C. Complications
- D. Unscheduled deliveries and visits
- E. Utilization data by service, by patient
- F. Goals of therapy, patient needs

APPLICATION PROCESS -- FOR A MEDICARE PART B SUPPLIER NUMBER

The verification that a provider/supplier meets the Medicare supplier standards is vitally important to the provider/supplier industry, beneficiaries, and the Medicare Program to ensure that only viable providers/suppliers provide medically necessary DMEPOS items and services to Medicare beneficiaries.

HIDA recommends that non-governmental independent organizations verify that providers/suppliers comply with the Medicare supplier standards, both initially and on an ongoing basis. This recommendation is similar to the structure used world wide by the International Standards Organization (ISO). This process would be simple, minimize bureaucracy and paperwork, and most importantly, ensure the suppliers comply with the standards.

1. National Supplier Clearinghouse (NSC) would certify organizations that wish to verify suppliers meet the Medicare supplier standards.
2. These organizations would verify compliance based solely on the Medicare supplier standards. Verification would include:
 - A complete review of the application,
 - Written follow-up on questionable areas
 - On-site visit to verify/check remaining questionable areas
3. There would be a time limit to complete the review process (no more than 90 days)
4. The provider/supplier pays the fee to the verification organization (a portion of which may go to the NSC to cover administrative costs).
5. There would be a three year cycle for renewal of Medicare supplier number to ensure ongoing compliance with the Medicare supplier standards. The fee would cover the three year cycle.

Note: HIDA supports a reasonable application fee to cover costs of verification. The recommendation is made with the understanding that these verification procedures will actually weed out the "bad actors;" non-legitimate companies would not be able to get a Medicare supplier number because of the rigorous screening of all applicants.

POLICY RECOMMENDATION NUMBER TWO: **NURSING FACILITY CONSOLIDATED BILLING**

The Administration's FY 1998 budget package contains a legislative proposal prohibiting any entity other than a nursing facility from billing Medicare for the medical supplies and services

provided to nursing facility residents. This “consolidated billing proposal” does not distinguish between reimbursements for services covered by Medicare Part A vs. Part B.

HIDA supports consolidated billing for nursing facility residents who are covered by Medicare Part A. We understand that Part A consolidated billing is needed to gather the information that the Health Care Financing Administration (HCFA) needs to develop the nursing facility prospective payment system. However, HIDA believes that nursing facilities should retain their ability to use outside suppliers of medically necessary Part B services when the resident is not covered under the 100-day Part A stay. This choice is more efficient and economical for many nursing facilities.

Outside suppliers provide nursing facilities with a number of services that promote positive health outcomes. Value-added services provided by medical suppliers including storage, inventory management, clinical services (e.g., respiratory therapy, nutritional assessments, support for wound care protocols), billing and collection, and outcomes support.

Many facilities do not have administrative staffing, physical space, or other resources to ensure that adequate quantities of the appropriate products are available to meet each patient’s needs, especially since some patients require products on an emergency basis or have frequently changing needs. As a result, beneficiaries could be denied access to the wide range of high quality, medically necessary products that are currently available. For example, on average no more than five percent of a nursing facility’s residents require enteral therapy. It is simply not cost-efficient for many facilities to bill Medicare for these products. However, economies of scale allow suppliers to offer a broad range of high quality products in a cost-effective manner.

In addition, an experienced supplier understands coverage guidelines and billing procedures, and can ensure that all required documentation is obtained for medically necessary supplies, consistent with coverage and utilization guidelines. Inexperience and misunderstandings regarding coverage can lead to unnecessary delays or interruptions in the provision of medical supplies and nursing facility reimbursements.

In addition, HIDA opposes consolidated billing for nursing facility residents who are not covered by Medicare Part A because:

Concerns Relating To Fraudulent Billing Are Not Applicable After The 100 Day Part A Stay: It is argued that consolidated billing is needed to eliminate the opportunity for fraudulent “double billing” of Medicare Part A and Part B. These concerns can be addressed through Part A consolidated billing - simultaneous billing of Part A and Part B is not feasible for residents who are not covered by Part A. In addition, the new Durable Medical Equipment Regional Carriers (DMERCs) have instituted tight controls over the Part B benefit. With full time Medical Directors developing and implementing strict guidelines defining medical necessity and utilization of medical supplies, the DMERCs have been highly effective in combating fraudulent billing practices. Therefore, irregularities in the Part B billings of outside suppliers providing services to nursing facility residents are readily apparent under the current system.

Consolidated Billing Would Impose New Cost Burdens On Nursing Facilities: By requiring fully consolidated billing, even when beneficiaries are not under a Part A stay, many nursing facilities that previously utilized outside suppliers to provide their residents with medically necessary supplies and services would be required to provide these services themselves, to directly bill for these supplies and services, and to assume other responsibilities that are currently fulfilled by outside suppliers. These services would add significant costs to a nursing facility. Importantly, current law allows a nursing facility to act as a Part B supplier; presumably those facilities who choose to do so now would continue this practice in the future if it is their best option.

Consolidated Billing Is, At Best, Budget Neutral: The proposed legislative prohibition against the use of outside suppliers is considered revenue neutral, as it is characterized by the Congressional Budget Office as a billing requirement. In reality, fully consolidated billing would likely increase costs to the health care system, since the supplier community provides valuable billing expertise, inventory control, staff education and clinical services which the facilities will need to replace.

Consolidated Billing Is Not Necessary For Prospective Payment: It is argued that consolidated billing is necessary to collect the data needed to construct a prospective payment system for nursing facilities. However, there is no prospective payment proposal for the Part B benefit, which will continue to exist unless Congress specifically eliminates it.

In fact, the Prospective Payment Assessment Commission (ProPAC), an organization founded by Congress to provide policy recommendations on improvements to the Medicare Program, supports consolidated billing for Part A only. In their March 1, 1997 *Report and Recommendations to the Congress*, ProPAC states that, "the Secretary should require consolidated billing for all services furnished to beneficiaries during a Part A stay." ProPAC does not recommend consolidated billing for Part B items and services supplied to residents who are not covered by Part A. HIDA supports the ProPAC recommendation because it, too, would allow nursing facilities to maintain their ability to utilize outside suppliers of Part B items and services for residents who are not under a Part A stay.

CONCLUSION

HIDA appreciates the opportunity to submit these recommendations to the Subcommittee. We urge Congress and HCFA to strengthen the Medicare program by implementing rigorous supplier standards and requiring nursing facility consolidated billing during the 100-day Part A benefit. These two recommendations will aid in the ongoing effort to combat Medicare fraud and abuse while promoting the provision of consistent, high quality services to Medicare beneficiaries.

