

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**Implementation of the
Administration on Aging's
Health Care Fraud and Abuse Programs**



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EXECUTIVE SUMMARY

PURPOSE

To describe the implementation of the Administration on Aging's (AoA) two health care fraud and abuse control programs and to identify common problems and effective practices.

BACKGROUND

The AoA asked the Office of Inspector General (OIG) to assess the implementation and performance of its two health care fraud and abuse control programs: the Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program and the Health Insurance Portability and Accountability Act (HIPAA)-funded Program. The AoA will use this information to develop guidance for current and future projects and to inform Congress and others about the programs' performance.

Both of these programs aim to educate beneficiaries about health care fraud, waste, and abuse but operate somewhat differently. The community volunteer program received \$2 million and provided grants to 12 organizations to recruit and train retired professionals to educate Medicare beneficiaries about health care fraud, waste, and abuse. This program has recently been expanded to \$7 million. The second program received \$1.4 million in funding under the Health Insurance Portability and Accountability Act of 1996 and provided grants to 18 State units on aging. The goal of this program is to train aging network staff and volunteers to educate Medicare beneficiaries about health care fraud, waste, and abuse as part of their ongoing activities.

In response to AoA's request, the OIG developed two reports. The following report describes the implementation of the two anti-fraud and abuse programs including problems projects encountered and practices they developed to overcome these barriers. A companion report entitled, *The Administration on Aging's Health Care Fraud and Abuse Programs: 18-Month Outcomes* OEI-02-99-00110, presents 18-month performance data for the two programs.

FINDINGS

Organization

Projects in the two programs followed somewhat different approaches, although overlap was evident. The community volunteer projects generally implemented a train-the-trainer approach. All but one project recruited retired seniors who were new volunteers to the aging network. These projects trained seniors who then conducted group presentations to educate

Medicare beneficiaries and others about health care fraud and abuse. In addition, all of the community volunteer projects also trained staff and volunteers in the existing aging network.

In contrast, the HIPAA-funded projects primarily trained staff and volunteers in the existing aging network. These individuals typically met with Medicare beneficiaries and their family members one-on-one and educated them about fraud and abuse as part of their ongoing responsibilities. In addition, about a quarter of the HIPAA-funded projects also recruited and trained new retired seniors who conducted group sessions to educate Medicare beneficiaries.

Projects in both programs utilized existing aging network resources. All but one project built on existing aging programs. They most commonly used Area Agencies on Aging (AAAs) and insurance counseling programs in their States. To a lesser extent, they utilized senior centers and ombudsman programs. About a third of the projects built on two or more of these aging network resources.

Partnering

Projects partnered with a variety of organizations to support project goals. Programs used partnerships to establish and operate their projects. Projects commonly formed partnerships with aging network programs, fraud and abuse agencies, health care organizations, and senior advocacy organizations. Partners helped projects recruit and train beneficiaries and handle and track complaints.

Training Trainers

Training for trainers appeared comprehensive, although its intensity differed across projects. Training typically included an overview of Medicare and Medicaid and a discussion of how to detect and report instances of health care waste, fraud, and abuse. Projects conducted this training differently, however. In some projects, staff were responsible for conducting the training, whereas in others, Medicare carriers and other investigative agencies led the training. In general, the training provided by the community volunteer projects was more intensive than that provided by the HIPAA-funded projects.

Complaint-Handling

Projects had different strategies to handle complaints. The majority of the projects were affiliated with or operated a State or local hotline that Medicare beneficiaries could call to report a suspected instance of health care fraud or abuse. Some projects took complaints directly from the beneficiary and sent them to the appropriate investigative agency. Other projects instructed beneficiaries to call their Medicare carrier or the OIG Hotline directly.

Tracking

Most projects did not routinely track complaint outcomes. The majority of projects did not systematically track outcomes of complaints. Several projects had some type of tracking system in place, however. Most of these projects developed partnerships with key agencies and discussed the status of complaints with them. One project was in the process of developing a tracking system on the Internet. Two other projects trained staff at the carrier's customer service hotline to better track complaints resulting from their efforts.

Almost all projects received little or no feedback about complaint outcomes. Not getting feedback about complaints was the most common problem cited among projects. Many projects stressed that they routinely referred complaints to the Medicare carrier or the appropriate investigative agency, but received little or no information about their status.

CONCLUSION

The HIPAA-funded and community volunteer projects have conducted a wide array of activities to help fight health care fraud, waste, and abuse. Despite these differences, it appears that well-structured projects address several common programmatic elements. These elements include organizing and start-up, partnering, recruiting trainers, training trainers, educating beneficiaries, community outreach, complaint handling, and tracking.

At this stage, it appears that a number of different approaches can be successful and that there is not one way to operate a project. This report therefore highlights the varied strategies and practices implemented by the individual projects. This information will give projects the opportunity to learn from one another. It will also give AoA the ability to provide guidance to new projects that will enable them to get off to a running start and avoid delays.

Additionally, as part of their ongoing implementation efforts we encourage AoA, through their regional offices, to:

- ▶ Make sure that all projects address the key programmatic elements and provide guidance to projects in the areas that they have not yet developed.
- ▶ Pay closer attention to tracking. Specifically, AoA needs to impress upon the individual projects the importance of tracking outcomes. It also needs to identify and disseminate effective ways to track trainers' activities and complaint outcomes so that projects can better document the outcomes of their efforts.
- ▶ Provide guidance about ways to improve retention of trainers and about working with minority communities and with providers to expand projects' efforts.

COMMENTS

We received comments from AoA. They agreed with the major conclusions and are working with their grantees and OIG to replicate effective practices. The full text of these comments can be found in Appendix B.

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INTRODUCTION

PURPOSE

To describe the implementation of the Administration on Aging's (AoA) two health care fraud and abuse control programs and to identify common problems and effective practices.

BACKGROUND

The AoA asked the Office of Inspector General (OIG) to assess the implementation and performance of its two health care fraud and abuse control programs: the Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program and the Health Insurance Portability and Accountability Act (HIPAA)-funded Program. The AoA will use this information to develop guidance for current and future projects and to inform Congress and others about the programs' performance.

The AoA asked the OIG to evaluate the implementation and performance of its anti-fraud initiatives for several reasons. First, this information is a continuation of other work conducted by the OIG. At AoA's request, the OIG helped develop performance measures for the community volunteer program and agreed to collect these data on an ongoing basis. Second, the results of the report that presented first year performance data entitled, *Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program: First Year Outcomes* OEI-02-97-00522, generated interest in implementation issues. This report found that first year performance varied widely among the 12 projects, suggesting that the projects implemented the program differently or that some had slower starts than others. Third, Congress recently expanded the community volunteer program and AoA is currently selecting new grantees. As a result of these factors, AoA believed that it was an important time to look at these issues.

To meet these objectives, the OIG developed two reports. The following report describes the implementation of the two anti-fraud and abuse programs including problems projects encountered and practices they developed to overcome these barriers. A companion report entitled, *The Administration on Aging's Health Care Fraud and Abuse Programs: 18-Month Outcomes* OEI-02-99-00110, presents 18-month performance data for the two programs.

Operation Restore Trust

In 1995, AoA became a partner in a OIG-led demonstration project to fight fraud, waste, and abuse in the Medicare and Medicaid programs called Operation Restore Trust (ORT). This two-

year demonstration program focused on combating health care fraud, waste, and abuse in five States. This initiative showed that Medicare beneficiaries and others could play an important role in curbing losses to the Medicare and Medicaid programs by becoming better educated about how to identify and report suspected instances of fraud and abuse. The results of the demonstration program encouraged AoA to continue and to expand its efforts.

Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program

Congress authorized the Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Demonstration Program in the Omnibus Consolidated Appropriation Act of 1997 (P.L. 104-208) to further reduce fraud and abuse in the Medicare and Medicaid programs. At that time, the Senate Committee believed that thousands of retired accountants, health professionals, investigators, teachers, and others could serve as community volunteers in this effort. More specifically, these retired professionals, with appropriate training, could serve as Medicare educators and as expert resources to assist Medicare beneficiaries and others to detect and report fraud, waste, and abuse. Because the language for this program was introduced by Senator Tom Harkin of Iowa, these grants are commonly known as “Harkin Projects.” For this inspection, they are referred to as the community volunteer projects.

To fund this program, the Senate Report (104-368) directed that \$2 million be transferred to AoA from the Health Care Financing Administration’s (HCFA) research and demonstration budget. In July of 1997, AoA awarded grants to 12 organizations including two area agencies on aging, six State units on aging, and four private aging organizations. This report is based on these 12 projects.

As of October 1998, the program was expanded. Under Title IV of the Older Americans Act in the FY1999 Omnibus Appropriations Act, funding for the program was increased to \$7 million, significantly extending the scope of the program. The AoA is currently reviewing applications and selecting grantees for this new round of funding. These projects will be called the Senior Medicare Patrol Projects.

HIPAA-Funded Program

The AoA developed a second set of projects that are funded under the Health Insurance Portability and Accountability Act of 1996. The goal of these projects is to combat health care fraud, waste, and abuse by training aging network staff and volunteers to educate Medicare beneficiaries. In August 1997, AoA awarded grants to 15 State units on aging. In March 1998, the program was expanded to include three additional States. The program received a total of \$3.8 million for the first three fiscal years. In FY 99, \$1.4 million in funding was provided. About \$900,000 of these funds was granted to State units on aging. The remaining funds were used by AoA for training and technical assistance for the grantees, for facilitating the exchange of resources, for identifying best practices, for convening national and regional partnership conferences, and for developing and disseminating informational materials.

It is important to note that the two programs differ in several ways. First, the HIPAA-funded projects primarily train aging network staff and volunteers who educate Medicare beneficiaries as part of their ongoing activities. In contrast, the community volunteer projects recruit and train retired seniors who conduct group sessions to educate Medicare beneficiaries. Second, the HIPAA-funded projects are run solely by State agencies, whereas the community volunteer projects are operated by State, local, or non-profit agencies. Third, the HIPAA-funded projects receive less funding than the community volunteer projects. Specifically, AoA awarded \$50,000 annually to HIPAA-funded projects and between \$100,000 and \$188,000 per year to community volunteer projects.

Performance Measures

With the assistance of AoA and the 12 projects, OIG developed a set of performance measures for the community volunteer projects. (See *Health Care Anti-Fraud Volunteer Project Performance Measures* OEI-02-97-00520.) To provide ongoing information about the program, the OIG asked each of the projects to provide data on these agreed upon performance measures on the 12, 18, 24, and 30 month anniversary of the initial grant. As mentioned earlier, first year outcomes are presented in the OIG report entitled, *Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Program: First Year Outcomes* OEI-02-97-00522.

Westat, Inc. a private research corporation under contract with AoA, developed performance measures for the HIPAA-funded projects. Westat, Inc. collected preliminary outcome data for the first year and is currently conducting a longer-term evaluation of both fraud and abuse control programs. This evaluation will provide a more in-depth analysis of the implementation and impact of the two programs.

METHODOLOGY

This inspection was conducted in several phases. First, OIG staff collected performance data from the 12 community volunteer projects and 17 HIPAA-funded projects for the first 18 months of the programs. See Appendix A for a list of all projects. Note that the New York State Unit on Aging which received funding from both programs is considered a community volunteer project for the purposes of this report.

Second, we asked AoA for the projects' most recent semi-annual report that they submitted as part of AoA's reporting requirements. Whenever possible, we compared these reports to their performance data to check for consistency.

Third, we interviewed staff from each project. We conducted interviews with staff members from selected projects on-site and interviewed the others by telephone. We asked project staff about their experiences with implementing the program and about problems that they have had. We also

asked them to identify practices that have been effective, particularly in tracking outcomes.

This report is primarily based on data from the staff interviews and reflects the first 18 months of most programs. (Three projects, LA, NJ, and OR, are included that have been in operation for only one year.) Data from the other sources were also analyzed to validate the interview data and to further identify problems and effective practices. As mentioned, the performance data are discussed in detail in our companion report entitled, *The Administration on Aging's Health Care Fraud and Abuse Programs: 18 Month Outcomes* OEI-02-99-00110.

Limitations

There are several limitations of this inspection. First, the performance data used in this report are self-reported and were not independently verified. Second, certain projects may be used as examples for specific activities but may not necessarily represent an exhaustive list of all projects that conduct such activities. Third, the methodology used to identify effective practices does not guarantee that a particular practice can be replicated and that it will work as well in a different setting. Lastly, the methodology cannot sufficiently determine whether a successful practice is the result of a particular activity or of the characteristics of the practitioners.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President's Council on Integrity and Efficiency.

FINDINGS

Organization and Start-up

Projects in the two programs followed somewhat different approaches, although overlap was evident.

The community volunteer projects generally implemented a train-the-trainer approach. All but one project recruited retired seniors who were new volunteers to the aging network. These projects trained these seniors who then conducted group presentations to educate Medicare beneficiaries and others about health care fraud and abuse. In addition, all of the community volunteer projects also trained staff and volunteers in the existing aging network. These individuals included State and local long-term care ombudsmen, health insurance counselors, senior center volunteers, and others who worked directly with seniors.

The HIPAA-funded projects focused their efforts somewhat differently. These projects primarily trained staff and volunteers in the existing aging network. These individuals typically met with Medicare beneficiaries and their family members one-on-one, and educated them about fraud and abuse as part of their ongoing responsibilities. In addition, about a quarter of the HIPAA-funded projects also recruited and trained new retired seniors who conducted group sessions to educate Medicare beneficiaries.

Projects in both programs utilized existing aging network resources.

All but one project built on existing aging programs. In general, the projects in both programs utilized similar aging network resources. They most commonly used area agencies on aging (AAAs) and insurance counseling programs in their States. To a lesser extent, they utilized senior centers and ombudsman programs. About a third of the projects built on two or more of these aging network resources.

As noted, the community volunteer program funded different types of organizations to test various approaches to educating seniors. The grantees that received funding included six State units on aging, four private agencies for seniors, and two local AAAs. There was no relationship between the type of organization of the project and the type of program that the project chose to work with.

Projects faced several challenges in starting up their programs.

One of the most common problems for projects in both programs was staffing. At least seven projects had difficulty hiring project staff or had problems with staff turnover which caused slow starts or delays in implementation. Additionally, a few of the HIPAA-funded projects stressed that their resources were limited, particularly as they tried to develop their program statewide.

A few projects struggled with the logistics of coordinating a statewide project. Projects seemed to approach this problem in two ways. The HIPAA-funded project in Pennsylvania, for example, tested the program in a few counties before starting to implement it statewide. In contrast, the New York project chose to operate the program in a larger area from the start.

A few projects also had difficulty in gaining the support of the provider community. Providers initially believed that the program was out to get them. This issue also affected projects' attempts to create partnerships. In one State, for example, the AAAs were reluctant to cooperate with the project because they did not want to alienate providers in their area. In response to this situation and to similar incidences, a few projects took the time to develop a more balanced message that addressed providers' concerns.

Some projects commented that planning was extremely important to overcoming several start-up problems. Clearly defining the roles of staff and volunteers helped projects operate more smoothly. It was also helpful for projects to plan how they were going to handle and track complaints and to clearly map out the flow of information before they started implementing their efforts.

Partnering

Projects partnered with a variety of organizations.

Partnerships were an important tool that projects used to establish and operate their programs. As mentioned, projects in both programs partnered or built on existing aging network resources including local AAAs and health insurance counseling programs. Projects also contracted with or used the ombudsman programs and senior centers to administer their programs.

Projects in both programs formed partnerships with other organizations as well to help fight health care fraud, waste, and abuse. These organizations commonly included fraud and abuse agencies such as the OIG, the Department of Justice (DOJ), the Federal Bureau of Investigations (FBI), the U.S. Attorney General, and health care organizations such as Medicare carriers, intermediaries, Durable Medical Equipment Regional Carriers (DMERC), and State Medicaid Fraud Units. Projects also reached out to other types of organizations, namely, the American Association of Retired Persons (AARP), senior advocacy groups, and the Retired Senior Volunteer Program (RSVP). A few projects collaborated with State agencies, provider groups,

or consumer rights organizations such as the Office of Consumer Affairs and the Better Business Bureau.

Partnerships helped expand project resources and support project goals.

Partners helped projects in various ways. Several projects created advisory boards, steering committees, or joined existing task forces that included many of their partners. In this capacity, partners provided guidance and expertise to projects, helping them plan and implement their efforts. Partners also introduced staff to agencies responsible for fraud and abuse and for health care, a key step towards building a State infrastructure to address these issues.

In addition, partners played an important role in the operation of programs. They often helped projects recruit seniors. They developed and reviewed training and other project materials, including brochures and pamphlets that were disseminated to the public. In some projects, partners were directly responsible for training volunteers. They also helped develop complaint handling and tracking systems and iron out problems in these areas. Some projects used the contacts they developed to follow-up on and track complaints that they referred to the different agencies. Lastly, partners kept projects abreast of current issues in Medicare as well as new trends and fraud scams in health care.

Some projects had difficulty establishing partnerships and getting diverse agencies to agree on key issues. One project noted that it was challenging to merely get the different agencies to cooperate and make fraud and abuse a priority. Projects particularly had difficulties with partners in developing their complaint handling and tracking systems. Despite these issues, several projects highlighted the importance of forming partnerships. These projects often made substantial investments in establishing and maintaining these relationships, but generally believed their efforts were well worth it.

Recruiting Trainers

Projects looked to the aging network and to other organizations for trainers.

As noted, many of the projects, particularly in the HIPAA-funded program, recruited and trained existing aging network staff and volunteers to be trainers. These individuals were typically from local AAAs, senior centers, ombudsmen programs, and health insurance counseling programs. Projects that recruited new retired seniors commonly looked to senior centers and organizations that recruited or had existing volunteers. Projects also advertised on the radio and in newspapers for trainers. Additionally, some seniors heard about the program from other trainers and from the projects' other outreach activities.

Many projects had difficulty recruiting trainers, particularly in the beginning stages of their program. In a few cases, trainers believed projects were recruiting them to be Medicare cops or

fraud busters. Volunteers, particularly those in the existing aging network, were sometimes reluctant to participate in the program for this reason. Other projects had difficulty with finding trainers who were dedicated and willing to do presentations.

Projects offered several suggestions about how to overcome these barriers and effectively recruit trainers. Projects had success with working with agencies that had existing sources of senior volunteers. Specifically, the three projects, Iowa, Pennsylvania, and Virginia, partnered with RSVP which recruited and placed volunteers in different agencies throughout the community. Some projects worked with AARP or used lists from the National Association of Retired Federal Employees or the Retired Teacher's Union to recruit trainers. In addition, projects from both programs stressed the importance of tapping into the aging network for trainers to capitalize on volunteers' experience working with seniors and expertise in health care issues. Several projects also noted that it was critical to recruit trainers from diverse backgrounds in order to reach different audiences in their communities.

Most projects had requirements to become a trainer.

Volunteers and staff who were already part of the aging network had to meet certain criteria in order to be selected for those programs. Generally, they were not allowed to have worked in the insurance industry or have any conflict of interest relating to the goals of the program.

Most projects also screened new retired seniors who wanted to become trainers. Five projects required them to have good communication skills. A few projects preferred seniors who already had some knowledge of health care. Among the community volunteer projects, only four required their trainers to be retired professionals i.e. teachers, accountants, investigators and health professionals. The remainder of the projects welcomed all retired seniors, indicating that they did not believe it was appropriate to limit their program in this manner. One project noted that having requirements for trainers gave the program a certain prestige and ensured that trainers were competent.

Training Trainers

Training for trainers appeared comprehensive.

Training for trainers seemed fairly extensive in most projects. Training for retired seniors new to the aging network typically included an overview of Medicare and Medicaid and a discussion of health care fraud and abuse. The training also explained how to detect and report inconsistencies and suspected instances of fraud, waste, or abuse. In some cases, the training also covered issues relating to durable medical equipment and home health services. A few projects instructed trainers and provided helpful hints about how to give presentations. In some projects, training for existing aging network volunteers was more focused and specifically addressed how to identify and report health care fraud and abuse.

Projects conducted training somewhat differently.

In general, the training provided by the community volunteer projects was more intensive than that provided by the HIPAA-funded projects. Training conducted by the community volunteer projects ranged from 4 to 32 hours, with a median of 16 hours. In contrast, training conducted by the HIPAA-funded projects ranged from 1 to 36 hours, with a median of 6 hours.

Projects also organized their training somewhat differently. In 12 projects, project staff were responsible for conducting the training. In eight projects, outside agencies led the training sessions. These agencies commonly included representatives from the Medicare carriers, intermediaries, DMERCs, the HCFA and OIG Regional Offices, Peer Review Organizations, the FBI, the U.S. Attorney General's Office, and local law enforcement agencies. In the remaining projects, staff led sessions but invited individuals from these agencies to assist them.

Several projects stated that having partners participate in the training had many advantages. One project commented that having the FBI provide training gave their program more weight and made their trainers feel important. Partners also provided projects with experts in their related fields as well as helpful training aids such as overheads and brochures.

Projects came up with a number of innovative practices for training trainers. Many projects produced extensive manuals that trainers used as references and as presentation aids. Two projects used experienced trainers to help train newer recruits. Another project administered a pre and post test to assess trainers' knowledge of the program. The project used these results to focus their training and to make sure trainers were getting the intended message.

Projects provided somewhat limited support for trainers.

Many projects provided only minimal support for trainers. Most commonly, they provided materials for them to present. Less than half of the projects, however, reported having a coordinator, supervisor, or a telephone number available for trainers to call for assistance.

Some of the community volunteer projects provided additional support for trainers. These projects offered follow-up training or refresher courses. They also sent out newsletters or mailings or conducted meetings to update volunteers on new statistics and changes in regulations and laws. Four community volunteer projects arranged presentations for their trainers or advertised that speakers were available to talk about fraud and abuse. In addition, the community volunteer project in Pennsylvania provided a small stipend to its trainers. The Illinois project, as well as the HIPAA-funded project in Florida, reimbursed trainers for their travel expenses.

Recognition of trainers' efforts differed significantly between the two programs. Almost all of the community volunteer projects provided some incentives or recognition for their trainers. Most commonly, they featured trainers in their newsletters, invited them to project-related events, and gave them certificates or small gifts of appreciation. Most of the HIPAA-funded projects did not specifically recognize trainers' achievements, but some suggested that local aging programs did so

as part of their other activities.

Retention of trainers appeared to be a significant problem.

Not all trainers conducted activities after they were trained. As discussed in the companion report, the performance data indicated that projects in both programs had difficulty keeping trainers involved in the project. Specifically, half of the community volunteer projects reported that less than one-quarter of trained volunteers had ever conducted activities to educate others. At least six of the HIPAA-funded projects also had difficulty retaining trainers.

At the same time, few projects had suggestions about how to improve retention. Moreover, our analysis showed that retention of trainers in the community volunteer projects was not associated with the intensity of the training provided nor was it related to the level of support projects provided to trainers. Additionally, in both programs, retention was not related to whether projects had any incentives or forms of recognition for their trainers.

Educating Beneficiaries

Projects reached Medicare beneficiaries through various channels.

One of the primary goals of both programs was to educate beneficiaries about health care fraud and abuse. As mentioned, projects informed beneficiaries who were participating in or receiving other aging services. They also conducted larger informational sessions to educate beneficiaries.

Projects used different strategies to recruit beneficiaries and family members to attend sessions about health care fraud and abuse. Most commonly, they approached senior centers, senior residences, nutrition sites, aging advocacy groups such as AARP, senior clubs, retiree organizations such as the Retired Teachers Association, church groups, and care-giver support groups. In some projects, volunteers were responsible for recruiting beneficiaries.

Projects also used the media to recruit beneficiaries. (These same methods were used to attract volunteers.) Projects aired public service announcements, conducted mass media events, and wrote articles about the program in newsletters and other publications. Some projects conducted mass mailings targeted towards the aging population that invited beneficiaries to informational sessions. Many of the projects also relied on contacts their partners had already established in their communities.

Most projects conducted group and one-on-one sessions to educate Medicare beneficiaries.

The majority of projects used both types of sessions to educate beneficiaries and their family members about health care fraud and abuse. The community volunteer projects were more likely to conduct both types of sessions than the HIPAA-funded projects.

Group Sessions: In general, group sessions covered the same topics as the training that was provided to the trainers, although they tended to be shorter and more interactive. A typical session consisted of a brief overview of the Medicare and Medicaid programs. Trainers then showed beneficiaries how to read their Explanation of Medicare Benefits (EOMB) or Medicare Summary Notices (MSN), and how to report any inconsistencies. Specifically, trainers taught beneficiaries to look for instances of double billing, upgrading, or billing for services not provided. Trainers either presented this information alone or as part of a larger session that included other topics relevant to seniors. Depending upon these factors, sessions usually ranged from 20 minutes to over an hour.

Trainers often tried to get beneficiaries to participate in these sessions. To do this, they described common scenarios and asked about beneficiaries' own experiences. Several projects showed a video to highlight key points and to help get the project's message across. Additionally, trainers often took questions and answers, or offered one-on-one assistance following their presentation.

One-on-one Assistance: Trainers who were often health insurance counselors or ombudsmen typically met with beneficiaries one-on-one for a variety of reasons. During these sessions, trainers answered questions about Medicare and often showed beneficiaries and family members how to identify and report suspected instances of fraud, waste, and abuse. They also helped beneficiaries resolve problems or concerns by either taking their complaints directly or by directing the beneficiary to the appropriate authority. In addition, trainers were on the lookout for inconsistencies and problems as they went about their other responsibilities.

Projects stressed the importance of tailoring the message to the audience.

Projects offered a number of suggestions for educating beneficiaries. As mentioned earlier, several projects highlighted the importance of recruiting trainers from different backgrounds as a way to reach diverse groups in their communities. The community volunteer project in Pennsylvania capitalized on this idea; they recruited a diverse group of trainers and encouraged them to develop their own presentations and to draw on their own style and personal experiences. Some projects also highlighted the need to make presentations easy to follow and relevant to the interests of the audience.

Additionally, several projects suggested that using specific examples was an effective way to get the message across. They noted that anecdotes tended to hold people's interest. Projects also incorporated role playing exercises, and discussed common scenarios and cases in the media to get people's attention and to promote audience participation. Some projects recommended using a video, whereas others had success with providing handouts or brochures.

Individual projects had several other innovative ideas. The Arizona project brought in counselors after group presentations for beneficiaries to speak to one-on-one. The New York project distributed medical records booklets for seniors to record and track their medical services. The Ohio project distributed a similar tracking envelope to beneficiaries. A few projects focused specifically on improving trainers' presentations. To do this, trainers in the community volunteer projects in California and Illinois surveyed beneficiaries after each session and used their comments to refine their presentations. In the Pennsylvania community volunteer project, trainers gave each other feedback about their presentations.

Projects that educated the largest number of beneficiaries differed.

According to performance data, the community volunteer projects in California, Illinois, New York, and Pennsylvania reported educating more beneficiaries than any of the other projects. Each educated more than 6,000 beneficiaries in the first 18 months of the program. These projects had few similarities, however. They were organized differently in that they represented various types of organizations, and built on different aging network programs. These projects also had different approaches as to whom they trained to be trainers. The California project primarily trained aging network staff. The Illinois and Pennsylvania project mainly trained new retired seniors and the New York project trained both types of trainers. Despite these differences, all of these projects conducted a large number of group sessions to educate beneficiaries.

Community Outreach

Projects conducted a wide range of outreach activities.

Most projects conducted different types of media events for the general public. Most commonly, projects conducted public service announcements or TV and radio interviews and commercials. They also wrote articles, placed ads in local newspapers, and produced brochures and other publications to raise public awareness about Medicare fraud, waste, and abuse. To do this, several projects established relationships with reporters and the local media. Projects also issued press releases, conducted kick-off events and rallies, and publicized cases that had recouped large sums of money to generate interest in the project. In several projects, the individual AAAs conducted additional activities aimed at local media.

Most projects also conducted community education activities. These activities typically included operating informational booths at health fairs and community festivals, and distributing pamphlets to libraries, senior centers, and providers. Some projects organized community events with other agencies for increased exposure. A few projects spoke to community groups such as professional associations and church and civic groups. The project in Rhode Island took another approach. It conducted a workshop on health care fraud and abuse for residential coordinators who then shared this information with their clients. This project also set up information booths at local supermarkets.

Some projects worked with minority and provider communities to get the word out.

A number of projects encountered problems reaching out to minority populations. At the same time, a few projects had some success in this area. These projects, notably the HIPAA-funded project in California, created flyers, pamphlets, and brochures in several languages to spread the word about their project. Additionally, in the Florida project, trainers worked with the media to specifically target the Hispanic community. Commenting on the overall approach, one project recommended establishing a relationship with a contact person in each community to help open up the channels of communication.

As mentioned earlier, several projects experienced some resistance from providers in their areas. Some of the projects tried to allay providers' concerns by sharing information with them. The community volunteer project in Missouri, for example, conducted training seminars especially for providers. In Ohio, home care providers objected to the program. In response, the project created a consumer booklet for them about how to select home care services. In New York, the project worked with their Medicare carrier to distribute 25,000 copies of their training manual to providers throughout the State. Five projects also reported partnering with provider groups as part of a larger steering committee or task force.

Other projects developed presentations that took into account providers' concerns. One project specifically trained volunteers to present a balanced message that highlighted that not all providers committed fraud. Another approach, taken by the Virginia project, was to enlist providers to make presentations which also gave them an opportunity to show that they were concerned about these issues.

Almost all projects believed that outreach activities were effective in educating Medicare beneficiaries and others.

The majority of projects believed their outreach activities were either "very effective" or "somewhat effective" in educating beneficiaries and others to identify fraud and abuse. In general, projects believed that outreach activities raised community awareness and were an effective way to get the message across. A common response was that these efforts helped to educate people who were not previously aware of health care fraud and abuse. A few projects also noted that outreach helped strengthen a projects' presence in the community. As one project commented, "the media gives the project legitimacy and credibility." One project pointed out, however, that these activities "would not be effective on their own without the trainers and their sessions."

Complaint-Handling

Most projects relied on a hotline, although its purpose differed across projects.

The majority of the projects were affiliated with or operated a State or local hotline that Medicare beneficiaries could call to report a suspected instance of health care fraud or abuse. The type of hotline that projects relied on differed, however. Most projects, particularly in the HIPAA-funded program, used a general hotline that handled a wide variety of issues concerning seniors. These hotlines were operated by the State Department of Aging or health insurance counseling programs. In other projects, the AAAs operated local hotlines for beneficiaries to call if they had any type of problem. Only a few community volunteer projects operated their own hotline that was dedicated solely to the project and to the reporting of health care fraud, waste, and abuse.

Several projects advocated using an existing local hotline. One project that used a local hotline operated by benefit counselors stressed that the operators were well-trained in diffusing the emotional part of the problem and in getting to the issue. “They are good complaint handlers.” Several projects also noted that beneficiaries preferred to talk to someone who was local. The advantage of having a separate hotline operated by project staff, however, was that it made it easier to track complaints that resulted from the project’s efforts.

Projects developed different strategies to handle complaints.

Some projects took complaints directly from the beneficiary. Most commonly, they took complaints after a group session, during a one-on-one session, or over the telephone. At this time, staff and volunteers usually filled out a form that included detailed information about the complaint. In some cases, they also asked the beneficiary to sign a release form. The project then sent the complaint to the appropriate investigative agency for action.

Other projects instructed beneficiaries to call their Medicare carrier, the OIG Hotline, or another agency directly. Several of these projects saw their role in this part of the process as more limited. One project, for example, explained, “We see our job as a referral agent. We let others do the investigating and tracking. We do the training and the detecting of fraud and abuse.”

Finally, a few projects used a combination of these two approaches. The Maryland project often conducted three-way calls with the Medicare carrier, the beneficiary, and the project coordinator to assist the beneficiary in making a complaint. Other projects encouraged the beneficiary to make the complaint directly but would also assist the individual if he or she needed help.

Projects referred complaints to the appropriate investigative agency, although some referred only to the Medicare carrier.

Many projects referred complaints to a number of different agencies including Medicare carriers, intermediaries, the Regional Inspector General’s office, the Regional HCFA office, and the OIG Hotline. They typically referred Medicaid complaints to the Attorney General’s Office or to the

State Medicaid Fraud Units. In some cases, they directed other types of complaints to insurance counseling programs or ombudsman programs. One project believed that “shopping the case,” or giving the complaint to the agency that was most likely to act on it, was effective. A few projects, however, had agreements with or referred all complaints to the Medicare carrier. The carrier then triaged the complaints and sent them to other agencies if necessary.

Most projects instructed beneficiaries to use some form of the 1-2-3 approach.

Projects almost universally instructed beneficiaries to follow some version of the 1-2-3 approach, that is to call their provider, followed by the appropriate Medicare contractor, and then the OIG or local hotline. The national campaign to fight fraud and abuse also advocated this approach and encouraged beneficiaries to call the OIG Hotline. Several projects agreed that this approach was effective in getting beneficiaries to check and report any discrepancies on their Medicare statements. One project was somewhat concerned that beneficiaries may get confused about whether to call the OIG Hotline or a local hotline.

Tracking

Most projects did not routinely track complaint outcomes.

The majority of projects did not systematically track outcomes of complaints. The HIPAA-funded projects were less likely to track outcomes than community volunteer projects. A typical response was that their purpose was to educate and train beneficiaries and not to track them. In some of these projects, tracking was inconsistent. For example, one project relied on beneficiaries to call the project about the outcome of their complaint.

Several projects developed informal tracking systems. These projects typically developed relationships or informal partnerships with key agencies or they had advisory committees that included agencies such as Medicare carriers, the HCFA, and the Attorney General. These groups met regularly to discuss the project or fraud and abuse issues more generally. During these meetings, projects also discussed outcomes of individual complaints.

Tracking was difficult because there were many ways to report fraud and abuse. Although some projects recognized that it was important to track outcomes, they also stressed that it was almost impossible to follow all complaints that resulted from projects’ efforts. Most projects, for example, had no way of tracking how many beneficiaries and others called the Medicare carrier or the OIG Hotline directly as a result of their efforts. A few projects noted that for these reasons, their outcomes were under-reported and the impact of the program was therefore underestimated.

Several projects had some type of system in place to track complaints.

Some projects developed more formal mechanisms to track, often in addition to forming

partnerships. Some of these projects kept a list of the complaints that they had referred and periodically called the carrier or other agencies to inquire about their outcomes. Two projects maintained a tickler file to follow up on complaints. The Pennsylvania HIPAA-funded project experimented with tracking complaints in some areas by asking beneficiaries to ask the carrier to send the letter about the status of their complaint to the AAA, rather than to them. This process also helped maintain confidentiality which was particularly important when the person was residing in a nursing home.

Two projects were experimenting with other methods of tracking. The Ohio project was in the process of developing a tracking system on the Internet that allowed different agencies to report electronically about what happened to a complaint. The California HIPAA-funded project integrated measures into the National Ombudsman Reporting System (NORS) to track the type of fraud and abuse complaints that they received.

Other innovative approaches included efforts by the Pennsylvania HIPAA-funded project and the New York project to train staff at the carrier's customer service hotline. These projects asked staff to collect information about the source of the complaint so that they could more accurately track the number of complaints that could be attributed to their efforts.

Most projects received little or no feedback about complaint outcomes.

Not getting feedback about complaints was the most common problem cited among projects. Many projects stressed that they routinely referred complaints to the Medicare carrier or the appropriate investigative agency, but received little or no information about their status.

There were a few exceptions, however. The New York project which had several years to develop the project under ORT, forged a strong relationship with the carrier. As a result, the carrier agreed to inform the project about the status of complaints and any money that was recouped, including overpayments, that resulted from complaints referred by the project. The Minnesota project developed a specific contact person or division in each carrier that reported back to the project on a quarterly basis. A few other projects reported receiving some feedback from carriers and others about complaints they referred.

Some projects noted that the lack of feedback was partly due to issues of confidentiality. In some cases, carriers, as well as other agencies, maintained that information provided by beneficiaries was confidential and that projects were not privy to it. In response, a few projects asked beneficiaries to fill out a release form which allowed the project to follow up on the complaint. Two projects found that working with HCFA helped them gain access to complaint information from the carriers. Lack of feedback may have also been due to the lengthy investigative process. As a few projects noted, establishing that actual fraud or abuse was committed could take months or years.

Projects also tracked trainers' and outreach activities.

Most projects collected key information about trainers' activities. Community volunteer projects, however, were somewhat more likely to track this information than HIPAA-funded projects. Projects typically collected the number of presentations or contacts that volunteers made, and the number of people who attended these sessions. To do this, volunteers were usually asked to fill out a report form that they then sent to project staff. In some projects, AAA staff or health insurance counselors added this information to monthly reports that they were already required to submit. In addition, a few projects developed an evaluation form for beneficiaries to complete about the session which was also used to track trainers' activities.

Fewer projects routinely tracked outreach activities. Many of these projects tracked the number of activities and the number of people who attended these activities. Some projects also asked people who called the hotline about how they heard about the project. None of the projects was able to determine the impact of these activities; they could only provide anecdotal evidence.

AoA's Guidance

Guidance from AoA was helpful, particularly in promoting communication.

The majority of projects in both programs reported that AoA's guidance had been helpful to the program. Most notably, AoA was instrumental in promoting communication between the grantees. The agency created a newsletter and a website and also arranged regional meetings and two national conferences for grantees to meet each other and exchange ideas. As a result of these efforts, many projects reported they communicated with other grantees by telephone or e-mail. Some projects also expressed satisfaction with the national conference and were interested in having this forum continue.

At the same time, projects offered several suggestions to strengthen AoA's efforts. A few projects stressed the need for more feedback from AoA, particularly during the start-up phase. Projects specifically asked for more assistance with training volunteers and with tracking outcomes. One project advocated that AoA support a few grantees to develop a system to report and track complaints that other projects could use as a model. In addition, a few projects commented that knowing the performance measures earlier in the process would have given them a better idea about what to record and track. Lastly, a few projects requested that AoA coordinate additional regional meetings, noting that AoA was in the best position to bring the grantees together.

CONCLUSION

The HIPAA-funded and community volunteer projects have conducted a wide array of activities to help fight health care fraud, waste, and abuse. Despite these differences, it appears that well-structured projects address several common programmatic elements. These elements include organizing and start-up, partnering, recruiting trainers, training trainers, educating beneficiaries, community outreach, complaint handling, and tracking.

Our analysis of specific practices in these areas, however, shows that none was strongly associated with key outcome measures. This result may be due to the fact that many projects had difficulty tracking outcomes and that the projects are relatively new. These factors also suggest that it may be too early to do a systematic analysis to distinguish which practices are most effective.

Rather, at this stage, it appears that a number of different approaches can be successful and that there is not one way to operate a project. This report therefore highlights the varied strategies and practices implemented by the individual projects. This information will give projects the opportunity to learn from one another. It will also give AoA the ability to provide guidance to new projects that will enable them to get off to a running start and avoid delays.

Additionally, as part of their ongoing implementation efforts we encourage AoA, through their regional offices, to:

- ▶ Make sure that all projects address the key programmatic elements and provide guidance to projects in the areas that they have not yet developed.
- ▶ Pay closer attention to tracking. Specifically, AoA needs to impress upon the individual projects the importance of tracking outcomes. It also needs to identify and disseminate effective ways to track trainers' activities and complaint outcomes so that projects can better document the outcomes of their efforts.
- ▶ Provide guidance about ways to improve retention of trainers and about working with minority communities and with providers to expand projects' efforts.

COMMENTS

We received comments from AoA. They agreed with the major conclusions and are working with their grantees and OIG to replicate effective practices. The full text of these comments can be found in Appendix B.

The Health Care Fraud and Abuse Programs

Community Volunteer Projects

State Units on Aging

Hawaii
Iowa
Maryland
Minnesota
New Hampshire
New York*

Area Agencies on Aging

District III AAA, Missouri
Suburban AAA, Illinois

Private Aging Organizations

Aging 2000, Rhode Island
California Health Insurance
Counseling Advocacy Programs
Coalition of Advocates for the Rights
of the Infirm Elderly, Pennsylvania
Coalition of Wisconsin Aging Groups

HIPAA-Funded Projects

State Units on Aging

Arizona
California
Colorado
Florida
Georgia
Illinois
Louisiana+
Massachusetts
Missouri
New Jersey+
New York*
Ohio
Oregon+
Pennsylvania
Tennessee
Texas
Virginia
Washington

* Note: The New York State Unit on Aging receives both types of grants. For the purposes of this report, it is considered a community volunteer project.

+ Note: Louisiana, New Jersey, and Oregon were incorporated at a later date and have only received funding for one year.

Comments



JUL 19 1999

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for Aging

| | |
|--------|-------|
| IG | _____ |
| EAIG | _____ |
| SAIG | _____ |
| PDIG | _____ |
| DIG-AS | _____ |
| DIG-EC | _____ |
| DIG-FI | _____ |
| DIG-PI | _____ |
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| AG-LC | _____ |
| CSERG | _____ |
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7/20/99

SUBJECT: Comments on the Draft OIG Report OEI-02-99-00111, entitled, *Implementation of the Administration on Aging's Health Care Fraud and Abuse Programs.*

I am writing to provide comments on the draft report of the Office of Inspector General (OIG) entitled, *Implementation of the Administration on Aging's Health Care Fraud and Abuse Programs.*

The Administration on Aging is very appreciative of your office's ongoing assistance in gathering and providing information on effective best practices pertaining to our two sets of projects designed to combat and prevent health care waste, fraud, and abuse. While the projects operate differently and have different purposes, it is important to note that several common elements are necessary for their success, including strategies for: organization and start-up; partnering; recruiting, training, maintaining volunteers; educating beneficiaries; community outreach; complaint handling; and tracking performance outcomes.

The projects were permitted to use somewhat different approaches in their activities to train aging network staff or retired professionals so they can adapt to state and local needs and test which strategies are most effective. We agree with the major conclusions of the report. We are working with your agency and with our partners to identify and replicate effective tracking systems, develop effective strategies for retaining volunteers, expand outreach to minority and isolated elders, and continue to develop partnerships with the vast majority of health care professionals who are honest and are working to provide quality care.

We believe the information contained in this report will help new projects throughout the country avoid common problems and utilize effective implementation strategies from the beginning of their operations.

We have enjoyed the close working relationship with the staff of the OIG and look forward to continuing to build an effective partnership to combat waste, fraud, and abuse.


Jeanette C. Takamura