

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**OPERATION RESTORE TRUST
ACTIVITIES**



JUNE GIBBS BROWN
Inspector General

NOVEMBER 1995
ORT-12-96-00020

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INTRODUCTION

At the Department of Health and Human Services (HHS), the Office of Inspector General (OIG) has undertaken a number of initiatives to ensure that its resources are deployed in the most efficient and cost-effective way and that its work products continue to be of the highest quality. One of the OIG's major thrusts has been an intensified effort to combat fraud, waste and abuse in the Medicare and Medicaid programs. While the health care industry has always been vulnerable to fraud and abuse, recent years have seen a surge in complex schemes which often span several States and implicate millions of health care dollars. In an effort to respond to this growing problem most effectively, the OIG has shifted its organizational culture toward an added emphasis on interdisciplinary teamwork. The OIG's auditors are working even more closely with its investigators when audit findings suggest criminal fraud; and OIG evaluators are using their analyses to identify program vulnerabilities, giving auditors and investigators targets for further development as well as case-specific data for existing investigations which may result in civil and administrative sanctions.

The benefits of greater collaboration and sharing of resources also have been realized in the OIG's relationships with other Federal and State law enforcement and regulatory agencies. Using this expanded team concept, the OIG is working jointly with the Health Care Financing Administration (HCFA) and the Administration on Aging (AoA) on a project designed to prevent and detect fraud and abuse in three rapidly growing sectors of the health care industry: home health agencies, nursing facilities and durable medical equipment suppliers. Operation Restore Trust (ORT), announced by the President on May 3, 1995, is a 2-year partnership of Federal and State agencies working together to protect the health care trust funds more effectively through shared intelligence and coordinated enforcement, and to enhance the quality of care for the programs' beneficiaries. The project has initially targeted five States which together account for 40 percent of the Nations' Medicare and Medicaid beneficiaries.

As the project's coordinator, the OIG has assembled teams that include investigators from its Office of Investigations and the State Medicaid Fraud Control Units; auditors and evaluators from both the OIG and HCFA; quality assurance specialists from the State surveyors and durable medical equipment regional coordinators; State long-term care ombudsmen through AoA; and prosecutors from the Department of Justice and the Offices of the United States Attorneys General. These teams are conducting financial audits of providers, performing criminal investigations and making referrals to Federal and State prosecutors. Civil and administrative sanctions and recovery actions have been enacted, and surveys and inspections of nursing facilities are also underway. The collective experience of these teams also will be used to recommend to HCFA and the Congress program adjustments to prevent future fraud and to reduce waste and abuse.

The OIG is also enlisting the support and participation of the public and the industries that the initiative targets. A hot line (1-800-HHS-TIPS) has been established to receive allegations of fraud and abuse on a confidential basis. To further assist health care

providers, the OIG will continue its practice of issuing Special Fraud Alerts to identify and describe fraudulent and abusive health care practices. Moreover, a voluntary disclosure program has been initiated on a pilot basis under the auspices of ORT. Through this pilot program, the OIG and the Department of Justice have established procedures by which home health and nursing facility suppliers and providers in the five States may come forward with full disclosure of potential fraud and abuse. By doing so, self-disclosing providers may minimize the cost and disruption of an investigation, negotiate a monetary settlement in lieu of prosecution, and when appropriate avoid exclusion from Medicare and Medicaid program participation.

The ORT project will take 2 years for completion and evaluation. If it proves to be both effective and efficient, other areas may be singled out for similar treatment. Employing these and other initiatives, the OIG is working to ensure the integrity and efficiency of the Medicare and Medicaid programs and to protect the beneficiaries of those programs.

HOME HEALTH REVIEWS

COMPLETED AUDITS AND EVALUATIONS

Review of Claims by One Home Health Agency

Review of Home Office General and Administrative Costs Claimed by One Home Health Agency

Periodic Interim Payments (PIP) to Home Health Agencies

Home Health Agencies: Alternative Coverage and Payment Policies

The Physician's Role in Home Health Care

Results of the Audit of Medicare Home Health Services in Florida

Variation Among Home Health Agencies in Medicare Payments for Home Health Services

Geographical Variation in Visits Provided by Home Health Agencies

Medicare Beneficiary Satisfaction with and Understanding of Home Health Services

ONGOING AUDITS AND EVALUATIONS

High Cost Home Health Agencies

Home Health in Health Maintenance Organizations

Home Health Eligibility Reviews

HHA Cost Report Reviews

PLANNED AUDITS AND EVALUATIONS

The Physician's Role in Home Health Care: A Follow-Up

HOME HEALTH REVIEWS: PROJECT DESCRIPTIONS

COMPLETED AUDITS AND EVALUATIONS

Review of Claims by One Home Health Agency (A-04-94-02078)

This report involves claims for home health agency visits that did not meet Medicare guidelines. These claims involved visits that were not rendered and visits that were made to individuals that were not eligible for home health benefits. Of the \$45.4 million claimed by this home health agency during FY 1993, we estimated that \$25.9 million did not meet reimbursement guidelines. We recommended that HCFA recover the overpayment. HCFA initiated recovery action. The agency filed for bankruptcy in August 1993.

Final Report February 1995

Review of Home Office General and Administrative Costs Claimed by One Home Health Agency (A-04-93-02067)

This report involves unallowable general and administrative costs claimed by this HHA on its FY 1992 Medicare cost report. This agency claimed \$14.6 million of unallowable computer software, salaries, owner's compensation, entertainment, marketing and promotional activities, lobbying, and other costs. Subsequent to issuing the final audit report, we initiated exclusion proceedings. The agency is currently appealing the proposed exclusion action.

Final Report March 1995

Periodic Interim Payments (PIP) to Home Health Agencies (A-14-95-00396)

This report shows that HHAs which receive bi-weekly prepayment of claims based on an estimate of annual visits creates an environment that fosters excessive overpayments. Our review shows that HHAs on PIP account for an average of 41.4 percent of the total HHA overpayments to the Medicare program. We recommended that PIP method of reimbursement to HHAs should be strictly enforced or eliminated. The HCFA concurred with our recommendation and included elimination of PIP in its 1997 legislative package.

Final Report March 1995

Home Health Agencies: Alternative Coverage and Payment Policies (OEI-12-94-00180)

This inspection describes policies of payers other than Medicare regarding coverage, limitations, and quality and utilization controls. Surveyed entities included national health maintenance organizations, Medicaid programs, the Department of Veteran's

Affairs, private insurers, and foreign governments. We found that while home health benefits in other health plans are structured similarly, they tend to use a variety of different approaches to control home health expenditures. Other payers may place limits or caps on the number of services, target home health programs to special needs populations, require copayments, issue explanations of benefits, or more intensely use case management services.

Final Report May 1995

The Physician's Role in Home Health Care (OEI-02-94-00170)

This review examines the current role of the physician in home health care. We found that physicians are most involved in referring patients, approving plans of care, and monitoring the progress of complex patients. They are less involved in coordinating services, visiting patients at home, and participating in interdisciplinary conferences. Both agencies and physicians identify some obstacles related to the physician role including: communications, paperwork, physician awareness and education, and the overall intensity of physician involvement. We recommended that HCFA continue its efforts to change the plan of care to ensure it conveys only critical information and relieves unnecessary burden. We also recommended that HCFA strengthen its efforts to educate agencies and physicians about its policies regarding the physician's role in home health care.

Final Report June 1995

Results of the Audit of Medicare Home Health Services in Florida (A-04-94-02087)

This involves a review of claims paid to a sample of HHAs in Florida. We found that 26 percent of the claims approved for payment did not meet Medicare reimbursement requirements because: visits were made to beneficiaries who were not homebound, unnecessary services were provided, and visits were not documented or not rendered. We estimated that during the month of February 1993, the intermediaries approved unallowable claims with charges totaling \$16.6 million out of a universe of \$78 million.

Final Report June 1995

Variation Among Home Health Agencies in Medicare Payments for Home Health Services (OEI-04-93-00260)

This inspection report describes the variation in average reimbursement per beneficiary for 6,803 HHAs in 1993 and possible reasons for this variation. We found that the variation was significant and seemed to be explained by the wide variation in the average number of visits per beneficiary. Proprietary, for-profit, non-affiliated agencies tended to receive higher reimbursement. These higher reimbursed agencies provided seven times more home health aide visits than lower reimbursed agencies. Differences in quality or beneficiary characteristics did not appear to explain the variation. We recommended

that HCFA explore ways to address excessive utilization and inappropriate variation in reimbursement among HHAs. In addition, we recommended that HCFA continue to work on improving the home health benefit and to control fraud, waste, and abuse.

Final Report July 1995

Geographical Variation in Visits Provided by Home Health Agencies (OEI-04-93-00262)

This report analyzes differences among States in visits by home health agencies. Nineteen States had a larger concentration of home health agencies with a high average number of visits per beneficiary than other States. Home health agencies in four Southeastern States averaged significantly higher average number of visits than all other States.

Final Report September 1995

Medicare Beneficiary Satisfaction with and Understanding of Home Health Services (OEI-04-93-00143)

As part of the OIG's recurring nationwide Medicare beneficiary satisfaction survey, we included questions in the 1994 survey about satisfaction and understanding of home health services. We found that a high percentage of beneficiaries were satisfied with the home health services they received. However, only half of the beneficiaries thought it was clear what Medicare paid for. We recommended that HCFA pursue methods to increase beneficiary understanding of what home health services Medicare pays for on their behalf. HCFA has been experimenting with various methods to do so.

Final Report November 1995

ONGOING AUDITS AND EVALUATIONS

High Cost Home Health Agencies (OEI-04-93-00261)

This study will provide an analysis of differences in quality assurance, utilization controls, and patient management between high cost and low cost home health agencies. We have defined as high cost those agencies with significantly higher average per beneficiary costs, and as low cost those with significantly lower average per beneficiary costs. This study is a follow up to previous work in which we found wide variation in per beneficiary costs without apparent explanation for such variation.

Draft Target December 1995

Home Health in Health Maintenance Organizations (OEI-04-95-00080)

This study will assess how home health services are provided and managed in health

maintenance organizations, how home health is delivered and provided in managed care versus fee for service, and what lessons Medicare can draw from managed care environments.

Draft Target December 1995

Home Health Eligibility Reviews

The objective of these reviews at approximately 10 providers is to determine whether home health visits claimed by selected HHAs meet Medicare guidelines. During these audits, we will determine if home health visits were made to beneficiaries who were not homebound; visits provided services that were considered unreasonable and unnecessary; and visits were billed but not made.

Draft Targets 1995 and 1996

HHA Cost Report Reviews

We are conducting joint HHA cost report audits with Medicare contractors in New York and Texas. The audits will examine the allowability of HHA administrative costs claimed by the selected HHAs. We also plan to conduct HHA cost report audits through the use of contracting services.

Draft Targets May 1996

PLANNED AUDITS AND EVALUATIONS

The Physician's Role in Home Health Care: A Follow-Up (OEI-02-95-00270)

We will examine whether physicians are providing case management services as required when billing for oversight of home health plans of care. Effective January 1, 1995, Medicare will provide separate payment for physician care plan oversight of beneficiaries who are receiving Medicare covered home health services.

Expected Issue Date: FY 1996

NURSING FACILITIES REVIEWS

COMPLETED AUDITS AND EVALUATIONS

Medicare Payments for NonProfessional Services in Skilled Nursing Facilities
Review of Improper Payments Made to Hospitals and Skilled Nursing Facilities for Beneficiaries Electing Hospice Benefits
Review of Hospice Beneficiary Eligibility at Hospicio Del Oeste, Inc., San German, Puerto Rico
Review of Hospice Beneficiary Eligibility at Hospicio En El Hogar De Manati, Manati, Puerto Rico
Medicare Services Provided to Residents of Skilled Nursing Facilities

ONGOING AUDITS AND EVALUATIONS

Part B Services in Nursing Homes: An Overview
Mental Health Services in Nursing Homes
Review of Hospice Beneficiary Eligibility in Puerto Rico
Review of Hospice Eligibility
Services Provided to Medicare and Medicaid Beneficiaries in Nursing Homes: A Joint Project

PLANNED AUDITS AND EVALUATIONS

Further Review of Improper Payments to Hospitals and SNFs for Beneficiaries Electing Hospice Benefits
Hospital Use of Subacute Nursing Facility Care to Maximize Reimbursement
Three-Day Hospital Stay
Medicare/Medicaid Duplicate Payments in Nursing Facilities
Imaging in Nursing Homes
Nail Debridement
Medicare Ambulance Transportation for Nursing Home Residents
Hospice Services Provided to Patients in Nursing Homes
Overview of Hospice Services

NURSING FACILITY REVIEWS: PROJECT DESCRIPTIONS

COMPLETED AUDITS AND EVALUATIONS

Medicare Payments for NonProfessional Services in Skilled Nursing Facilities (OEI-06-92-00864)

This report examines the appropriateness of allowing Part B payment for non-professional services during SNF stays. The report focuses on enteral nutrients, incontinence items, and surgical dressings and finds that over \$70 million were allowed by Part B for these services in 1992. The report recommends that HCFA take action to require SNFs to provide these services within the Part A payment rate.

Final Report June 1995

Review of Improper Payments Made to Hospitals and Skilled Nursing Facilities for Beneficiaries Electing Hospice Benefits (A-02-93-01029)

This report described situations in which both hospitals or skilled nursing facilities (SNF) and hospices submitted claims for payment for services related to a beneficiary's terminal illness. In a nationwide audit, we determined that, during the period 1988 through 1992, approximately \$21.6 million was improperly paid to hospitals and SNFs for services related to a beneficiary's terminal illness. Under the hospice program, if a hospice beneficiary is hospitalized/institutionalized for a condition related to his/her terminal illness, the hospital/SNF should not bill Medicare for the admission or any services rendered but should receive payment from the hospice. The hospice receives its appropriate per diem payment from Medicare for the period of time the hospice beneficiary is confined. We recommended recovery of the improper payments and HCFA agreed with our recommendation.

Final Report June 1995

Review of Hospice Beneficiary Eligibility at Hospicio Del Oeste, Inc., San German, Puerto Rico (A-02-94-01029)

This audit assessed the accuracy of beneficiary eligibility determinations made by Hospicio Del Oeste, Inc., San German, Puerto Rico. We found that incorrect eligibility determinations were made in approximately 77 percent of the cases reviewed at this hospice. This resulted in improper Medicare payments to Hospicio Del Oeste of \$1.1 million. Based on our findings, investigations are being conducted to determine possible criminal charges against the owners/operators of the hospices reviewed.

Final Report June 1995

Review of Hospice Beneficiary Eligibility at Hospicio En El Hogar De Manati, Manati, Puerto Rico (A-02-94-01030)

This audit assessed the accuracy of beneficiary eligibility determinations made by Hospicio En El Hogar De Manati. We found that incorrect eligibility determinations were made in approximately 70 percent of the cases reviewed at this hospice. This resulted in improper Medicare payments to Hospicio En El Hogar De Manati of \$1.6 million. Based on our findings, investigations are being conducted to determine possible criminal charges against the owners/operators of the hospices reviewed.

Final Report June 1995

Medicare Services Provided to Residents of Skilled Nursing Facilities (OEI-06-92-00863)

This report, released in conjunction with our report entitled "Payment for DME Billed During Skilled Nursing Facility Stays," provides an overview of payments made under Medicare Part B for beneficiaries in a Medicare covered SNF stay, and identifies issues needing further analysis. We found that there were \$930 million in Part B charges for Medicare beneficiaries residing in SNFs. Utilization of Part B services varied considerably among States. This report represents the first of a series of products resulting from the OIG's initiative to examine services and supplies provided to Medicare beneficiaries residing in nursing homes.

Final Report October 1994

ONGOING AUDITS AND EVALUATIONS

Part B Services in Nursing Homes: An Overview (OEI-06-92-00865)

This report, released in conjunction with our reports entitled "Enteral Nutrient Payments in Nursing Homes" and "Durable Medical Equipment Payments in Nursing Homes" provides information on the range and nature of over \$2.7 billion in Part B payments made on behalf of Medicare beneficiaries in nursing homes. We found that most money was spent on physician services, followed by medical equipment and supplies. The Part B average daily charge varies significantly among States and nursing homes. Vulnerabilities include cost shifting, lack of oversight, and questionable physician and supplier practices.

Draft October 1995 Final Target November 1995

Mental Health Services in Nursing Homes (OEI-02-91-00860)

This study assesses the nature and appropriateness of mental health services delivered to Medicare beneficiaries in nursing homes. This study will identify possible vulnerabilities to the Medicare program resulting from the expanded provision of mental health services

to nursing facility residents. As a result of this expansion, Medicare reimbursement for all outpatient mental health services increased 57 percent between 1991 and 1993. By comparison, reimbursement for mental health services in nursing homes has increased by 244 percent for the same time period.

Draft Target November 1995

Review of Hospice Beneficiary Eligibility in Puerto Rico (A-02-94-01035)

This audit expanded our review of eligibility determinations to include all hospices in Puerto Rico. Our original review had been conducted at two facilities. Preliminary indications are that during the period 1987 through 1994 as much as \$19.7 million was improperly paid to hospice providers in Puerto Rico on behalf of ineligible beneficiaries.

Draft Target December 1995

Review of Hospice Eligibility

We plan to review the eligibility determinations at approximately 13 hospice providers to assure that care was provided for in accordance with applicable Medicare guidelines.

Draft Targets 1995 and 1996

Services Provided to Medicare and Medicaid Beneficiaries in Nursing Homes: A Joint Project (OEI-06-95-00220)

This inspection, involving a joint OIG-HCFA team, will develop data on services rendered to and paid by Medicare and Medicaid to beneficiaries in nursing homes in Texas and Louisiana. We are undertaking work in Texas first.

Draft Target (Texas) April 1996

PLANNED AUDITS AND EVALUATIONS

Further Review of Improper Payments to Hospitals and SNFs for Beneficiaries Electing Hospice Benefits

We plan to expand our previous review of these duplicate payments made to hospitals and SNFs to include payments made during the years 1993 and 1994 and into 1995, if information is available. We are currently in the process of extracting data from computer tapes of payments made to these providers and will extrapolate the results to determine if the situation previously found continues to exist. We will also determine if

there are providers that display aberrant patterns in terms of duplicate payment situations and assess the need for further review of these providers.

Expected Issue Date: FY 1996

Hospital Use of Subacute Nursing Facility Care to Maximize Reimbursement
(A-09-95-00089)

There is a perception that hospitals are maximizing reimbursement by prematurely discharging some Medicare patients covered under the prospective payment system to their own hospital-based nursing facilities that are reimbursed on a cost basis. We intend to compare average length-of-stays (ALOS) for selected diagnosis related groups (DRGs) that have subacute units with those hospitals that do not have such units. Besides reviewing the ALOS for several different DRGs, we will perform a more detailed cost analysis on a statistically selected sample of patient stays at hospitals with hospital-based subacute units and at hospitals without such units.

Expected Issue Date: FY 1996

Three Day Hospital Stay (A-14-95-00398)

This study will determine if payment for skilled nursing facility stays meet Medicare's coverage conditions. In order to be paid by Medicare, a patient's nursing home stay must be preceded by a 3-day or more hospital stay. We have indications in one location that some nursing home stays were not preceded by the required hospital stay. This expanded review will determine if this is a national problem.

Expected Issue Date: FY 1996

Medicare/Medicaid Duplicate Payments in Nursing Facilities (OEI-02-95-00230 and A-02-95-01012)

We will assess the extent to which Medicare and Medicaid may be making duplicate payments for patients in nursing facilities. There are many nursing home residents whose care is covered by both Medicare and Medicaid. For these patients, there are numerous services (e.g., durable medical equipment) that may be covered by the Medicaid nursing facility rate and Medicare Part B. The guiding principle for payment is that Medicaid is the payer of last resort. We will assess how the system works in these circumstances. As a test case, we are performing a data match in the State of New York to identify and target specific providers who appear to be improperly claiming both Medicaid and Medicare reimbursement for clients who reside in nursing homes. Survey work will be performed at each of the targeted providers. If our survey work discloses aberrant, fraudulent, or improper claiming practices, then detailed provider reviews involving

applicable Operation Restore Trust participants will be conducted.

Expected Issue Date: FY 1996

Imaging in Nursing Homes (OEI-09-95-00090)

Our study will determine whether inappropriate payments are made for imaging services delivered to patients in skilled nursing or other nursing facilities. A significant number of diagnostic x-ray services, covered under Medicare Part B, are delivered to patients residing in these facilities. In 1992, Medicare allowed approximately \$408 million for imaging services to nursing home residents. While high utilization rates may be expected in this population, there are concerns about the general lack of controls or oversight of services delivered to nursing home residents.

Expected Issue Date: FY 1996

Nail Debridement (OEI-04-94-00440)

This study will determine why significant variances exist for nail debridement claims among carriers, and assess how carrier policies have affected payment for such claims. Expenditures for nail debridement increased 26 percent from 1991 to 1992 (1993 data not available), to reach \$167 million. Increases of 370 percent and 800 percent occurred in two carriers for one code; four carriers account for half the total expenditures for another code; and two carriers account for half of the total for a third code. We believe much of this service occurs in nursing homes.

Expected Issue Date: FY 1996

Medicare Ambulance Transportation for Nursing Home Residents (OEI-09-95-00410)

We will assess potential policy issues and appropriateness of payments for ambulance services provided to Medicare beneficiaries residing in skilled nursing and other nursing facilities. In 1992, Medicare Part B paid an estimated \$238 million for ambulance services to beneficiaries in these facilities. Approximately 18 percent of all Medicare beneficiaries in these settings received ambulance services. Substantial variation exists in the amounts spent under Medicare Part B for such services by State and by nursing home.

Expected Issue Date: FY 1996

Hospice Services Provided to Patients in Nursing Homes (OEI-05-95-00250)

We will examine how payments are being made for patients in nursing facilities who are

also receiving hospice benefits. Our goal will be to identify systemic vulnerabilities that might result from overlapping Medicare and Medicaid payment policies and to suggest possible solutions. We will also describe how nursing home patients are enrolled in a hospice and explore how responsibilities between the hospice and nursing home are being delineated for the management and delivery of care to these terminally ill patients.

Expected Issue Date: FY 1996

Overview of Hospice Services (OEI-04-93-00270)

We will examine the appropriateness of services provided to hospice patients, the payments for those services, patient selection, and patient protection. Medicare provides for two 90-day periods of hospice care, and one 30-day period, with a final unlimited period for terminally ill patients certified to have a life expectancy of 6 months or less. Covered services include nursing and physician services, counseling, durable medical equipment, home health aide services, and physical therapy. Once a patient is certified, elects a hospice, and is under a plan of care, the hospice is paid a prospective per diem rate for that patient, regardless of whether any services are rendered on a given day. The hospice's total yearly payments are subject to an aggregate cap per patient. Patients can revoke their choice of hospice once per period. Evidence from OIG reviews and other sources indicate questionable payments being made in hospice services.

Expected Issue Date: FY 1996

MEDICAL EQUIPMENT AND SUPPLIES REVIEWS

COMPLETED AUDITS AND EVALUATIONS

Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays
Questionable Medicare Payments for Incontinence Supplies
Marketing of Incontinence Supplies
Coverage of Enteral Nutrition Therapy: Medicare and Other Payers
Questionable Medicare Payments for Wound Care Supplies
Marketing of Wound Care Supplies
Wound Care Supplies: Operation Restore Trust Data
Medicaid Payments for Incontinence Supplies

ONGOING AUDITS AND EVALUATIONS

Durable Medical Equipment Payments in Nursing Homes
Enteral Nutrient Payments in Nursing Homes
Medicare Payments for Enteral Nutrition
Medicare Payments for Nebulizer Drugs
Enteral Nutrition Therapy: Utilization and Medical Necessity

PLANNED AUDITS AND EVALUATIONS

Support Surfaces
Orthotic Supplies
Portable Oxygen
Lease Purchase of Oxygen Concentrators
Certificates of Medical Necessity for Durable Medical Equipment
Discharge Planning
Physicians' Roles in Controlling Non-Physician Services and Supplies

MEDICAL EQUIPMENT AND SUPPLIES REVIEWS: PROJECT DESCRIPTIONS

COMPLETED AUDITS AND EVALUATIONS

Payment for Durable Medical Equipment Billed During Skilled Nursing Facility Stays (OEI-06-92-00860)

This report found that approximately \$8.9 million in 1991 and \$10.8 million in 1992 was incorrectly allowed for DME billed during skilled stays. Federal law states that DME may only be billed to Part B of the Medicare program if the equipment is provided in the beneficiary's residence. The law specifies that a skilled nursing facility cannot be considered a residence. For this reason, equipment billed to Part B during a SNF is incorrectly paid. We found that the inability of the suppliers and carriers to accurately determine the beneficiary's location during a skilled stay leads to the incorrect payment of Medicare funds.

Final Report October 1994

Questionable Medicare Payments for Incontinence Supplies (OEI-03-94-00772)

This report examines trends in allowances and questionable billing practices for incontinence supplies under Medicare Part B between 1990 and 1993. It describes how Medicare allowances for incontinence supplies more than doubled in 3 years despite a drop in the number of beneficiaries using these supplies. Four types of incontinence supplies account for almost all the increase in allowances. Questionable billing practices may account for almost half of incontinence allowances in 1993. A policy change which HCFA has proposed should address questionable billing practices.

Final Report December 1994

Marketing of Incontinence Supplies (OEI-03-94-00770)

This report describes supplier and nursing home practices that can lead to inappropriate payments for incontinence supplies. Nursing homes we interviewed indicated that suppliers engage in questionable marketing practices. Beneficiaries we interviewed indicated that they may be receiving unnecessary or non-covered supplies. Some nursing homes reported that suppliers present them with false or misleading information such as Medicare is introducing "new broader coverage" for incontinence supplies. Finally, we found that many nursing homes do not track Medicare-reimbursed supplies to the specific beneficiary for which they were billed.

Final Report December 1994

Coverage of Enteral Nutrition Therapy: Medicare and Other Payers (OEI-03-94-00020)

This review found that most payers surveyed routinely cover enteral nutrition therapy. Compared to other payers, Medicare's coverage requirements are similar in some areas and more restrictive than others. For example, like Medicare, the majority of other payers do not routinely cover cognitive disorders such as Alzheimer's disease. Other payers will cover patients with a functioning gastrointestinal tract with special nutrient/metabolic needs; whereas Medicare will not. Medicare policy requires specific documentation for items such as pumps, product category and caloric intake, whereas other payers do not.

Final Report May 1995

Questionable Medicare Payments for Wound Care Supplies (OEI-03-94-00790)

This report describes the questionable billing practices for wound care supplies under Medicare Part B from June 1994 through February 1995. We found that questionable payments of wound care supplies may account for as much as two-thirds of the \$98 million in Medicare allowances. Wound care activity is concentrated in States, suppliers, place of service, and one carrier. The HCFA and the four DME regional carriers have taken corrective actions to address wound care abuses and continue to explore others. We recommend a partial, long term solution that would require HCFA to bundle services, such as wound care supplies, in their Medicare or Medicaid payments to nursing homes. As an immediate solution we recommend that HCFA target limited program integrity resources to those areas identified as most vulnerable to abuse and continue to monitor wound care activity to determine if the level of questionable payments continues. If questioned payments continue unabated, HCFA may need to reconsider the current wound care benefit.

Final Report October 1995

Marketing of Wound Care Supplies (OEI-03-94-00791)

This report describes supplier and nursing home practices which can lead to inappropriate payments for wound care supplies and examines issues concerning beneficiaries' use of these supplies. We found that nursing homes and physicians determine which patients need supplies but some suppliers determine the amount provided, wound care supplies are frequently provided in standard kit form to beneficiaries, and beneficiaries may not be receiving or using all of the wound care supplies reimbursed by Medicare.

Final Report October 1995

Wound Care Supplies: Operation Restore Trust Data (OEI-03-94-00792)

This report identifies questionable billing practices and describes supplier and nursing home practices that can lead to questionable payments under the Medicare Part B wound care benefit in the five States targeted by Operation Restore Trust. We found that over \$22 million of the \$65 million in questionable payments for wound care supplies between June 1994 and February 1995 was in the five Operation Restore Trust States. Wound care activity in these five States is concentrated by product, supplier, and place of service. In addition, nursing homes in these States report similar marketing practices by wound care suppliers; however, in some States the practices are more widespread.

Final Report October 1995

Medicaid Payments for Incontinence Supplies (OEI-03-94-00771)

We found that half of the States in our sample had encountered improper billings for incontinence supplies. In one State, California, improper payments exceeded \$100 million. Other States experienced problems, but to a lesser degree. We also found that States do not generally review the appropriateness or necessity of incontinence services paid by Medicare, and that Medicare does not require carriers to notify Medicaid State agencies of improper crossover payments made on behalf of Medicaid beneficiaries. Thus, States may inadvertently make unallowable payments for Medicare copayments. We recommended that HCFA alert Medicaid State agencies about this vulnerability and take appropriate steps to ensure that States are notified of improper Medicare payments which contractors discover have been made on behalf of a Medicaid beneficiary.

Final Report November 1995

ONGOING AUDITS AND EVALUATIONS

Durable Medical Equipment Payments in Nursing Homes (OEI-06-92-00862)

This report discusses payments for durable medical equipment in nursing homes in 1992, and various options for establishing a workable system for dealing with payment for durable medical equipment while a beneficiary is in a nursing home.

Draft October 1995 Final Target November 1995

Enteral Nutrient Payments in Nursing Homes (OEI-06-92-00861)

This report discusses payments for enteral nutrients delivered to beneficiaries in nursing homes in 1992, compares Medicare payments to purchase prices commonly available to nursing homes through volume purchasing or other contractual relationships, and identifies various options for establishing a workable system for dealing with payment for enteral nutrients while a beneficiary is in a nursing home.

Draft October 1995 Final Target November 1995

Medicare Payments for Enteral Nutrition (OEI-03-94-00021)

This study will determine how Medicare compares to other payers in its pricing, payment mechanisms, and supplier networks.

Draft Target November 1995 Final Target December 1995

Medicare Payments for Nebulizer Drugs (OEI-03-94-00390)

This report examines the differences in the reimbursement methodologies used by the Medicare and Medicaid programs to pay for nebulizer drugs.

It will be followed by a separate report on retail pricing for one nebulizer drug (OEI-03-94-00391).

Draft October 1995 Final Target November 1995

Enteral Nutrition Therapy: Utilization and Medical Necessity (OEI-03-94-00022)

This inspection will assess how enteral nutrition is being used by Medicare beneficiaries.

Draft Target December 1995

PLANNED AUDITS AND EVALUATIONS

Support Surfaces (OEI-02-95-00370)

This study will determine the extent of questionable billing for support surfaces.

Expected Issue Date: FY 1996

Orthotic Supplies (OEI-02-95-00380)

We will determine the extent of questionable billing for orthotic supplies. The Medicare program reimburses the costs associated with braces, trusses, splints, and related items that immobilize and shore up diseased, injured, or weakened body parts. These devices must be "rigid or semi-rigid" and must support part of the body and/or restrict or eliminate motion. Medicare allowed more than \$63 million in 1994 for these supplies. Previous work by the OIG in the area of orthotic body jackets indicated that a substantial percentage of inappropriate payments were made.

Expected Issue Date: FY 1996

Portable Oxygen (OEI-07-95-00210)

This study will examine medical necessity issues associated with Medicare coverage of portable oxygen. Medicare beneficiaries meeting the requirements for oxygen therapy may also qualify for coverage of a portable oxygen system, either by itself or to complement a stationary system, such as an oxygen concentrator. We will also assess the prescribing practices of physicians who order the systems and how Medicare monitors utilization and medical necessity for the systems. Medicare allowed about \$83 million for portable oxygen systems in 1992.

Expected Issue Date: FY 1996

Lease Purchase of Oxygen Concentrators (OEI-07-95-00330)

This study will determine if Medicare should encourage lease-purchase arrangements for oxygen concentrators. Medicare pays rent for durable medical equipment until total reimbursement reaches 150 percent of the purchase price; from that point on, only maintenance charges are covered. In contrast, Medicare pays for oxygen concentrators (about \$320 per month) for as long as the beneficiary needs it. If the same rules that apply to durable medical equipment were applied to oxygen concentrators, Medicare would cease making payments for rent after a period of time.

Expected Issue Date: FY 1996

Certificates of Medical Necessity for Durable Medical Equipment (OEI-03-94-00420)

Our study will determine if the certificate of medical necessity forms are providing the durable medical equipment regional carriers with the information and controls that they need to assure that the equipment being provided to Medicare beneficiaries is medically necessary and appropriate. The HCFA requires that these forms be completed by physicians who authorize durable medical equipment for Medicare beneficiaries.

Expected Issue Date: FY 1996

Discharge Planning (OEI-02-94-00320)

This study will determine the extent to which financial conflicts of interest (such as hospital ownership of other providers or suppliers' businesses) or inadequate information or training may hinder effective hospital discharge planning for Medicare and Medicaid beneficiaries. Medicare requires that hospitals employ discharge planners to provide referrals to such continuing care as patients may need and to facilitate early discharge. The responsibilities range from searching for a nursing home bed to referring patients to infusion companies, medical equipment suppliers, or home health agencies.

Expected Issue Date: FY 1996

Physicians' Roles in Controlling Non-Physician Services and Supplies (OEI-03-94-00400)

This study will assess how effectively physicians are meeting Medicare's expectations that they act as controls against unnecessary use of non-physician services and supplies. This study will build on our work assessing the physician's role in home health (02-94-00170) and in completing certificates of medical necessity (03-96-00010) and identify common obstacles and successes in ensuring that physicians perform this important service.

Expected Issue Date: FY 1996

INVESTIGATIVE AND SANCTION ACTIVITIES

The OIG currently has 211 investigations underway that are related to Operation Restore Trust, including 59 joint ventures with the Department of Justice, the Federal Bureau of Investigation (FBI), the United States Postal Inspection Service, the Defense Criminal Investigative Service, the Railroad Retirement Board, and other law enforcement agencies.

The distribution of cases among the target States mirror the beneficiary population of each State. New York, California, and Florida have 75 percent of the investigations. The remaining 25 percent are equally divided between Illinois and Texas. Nursing home facilities and related medical services comprise approximately 80 percent of the cases; home health agencies the remaining 20 percent.

To date, OIG has achieved 21 criminal convictions, 9 civil judgements, 9 indictments and 33 exclusions in cases that are a direct result of the ORT initiative. Nineteen criminal convictions, 7 civil settlements and 7 indictments involved nursing facilities and related medical services cases and 2 conviction and 2 settlement concerned home health agencies. In addition, OIG has collected a total of \$34,935,422 in fines, recoveries, settlements, and civil monetary penalties during this same period. Also, a savings to the programs of \$2,176,979 has been claimed. The following is a brief summary of some of these investigations:

Home Health Agencies

- Leon McNinch, CPA for a Texas HHA, has agreed to a guilty plea in connection the HHA's 1992 and 1993 Medicare cost reports. McNinch will cooperate in identifying the fraudulent entries, and make restitution of \$200,000. The owners of the HHA are alleged to have charged false pension plan contributions and personal expenses to the Medicare program.
- With the help of HCFA, Region IX, Health Standards and Quality Division, the provider agreement for Austin Home Health was terminated. Complainants charged that the HHA was having "charting parties" to document services. There was insufficient evidence to pursue criminal charges; however, there were enough issues regarding the quality of care to terminate the provider agreement. The termination will result in savings of \$1,282,428.92.
- John Watts, President of United Care Home Health, and Gene Woods, the Administrator, pled guilty in central California for submitting false claims to Medicare totalling up to \$2.5 million during a 17-month period. These individuals billed Medicare over \$9.9 million for 88,907 home health visits to 680 Medicare beneficiaries

(some were deceased) and collected \$5.6 million. They aided kickbacks for referral of Medicare beneficiaries; created false medical records to document home visits not made; and submitted false Medicare cost reports.

Nursing Facilities

- Fort Tryon Nursing Home, a 240-bed facility in New York City, agreed to pay a civil monetary penalty of \$24,000 for filing inaccurate Medicare cost reports. Cost reports for 3 consecutive years failed to disclose that rent payments were made to a related party.
- Florida Club Care Center, a Miami nursing home, paid \$245,488 to settle its civil liability in a billing scheme. The nursing home contracted with a billing agency which billed Medicare for "lost charges," allegedly billable services that the nursing home had overlooked. The scheme resulted in a Medicare overpayment of \$62,814. As part of the settlement, the nursing home adopted a compliance plan designed to prevent future improper billing to the Medicare. A second Miami nursing home, Claridge House, contracted with the same billing agency resulting in a loss to the Medicare program of \$262,000. Claridge House paid \$414,911 to resolve its civil liability.
- Donald Reville, a Geriatric Specialist in Sacramento, California, pled guilty to all charges of a 38-count indictment, including mail fraud and false claims to Medicare totaling more than \$350,000 for a 2-year period. Reville admitted that he routinely billed Medicare for comprehensive examinations and histories of nursing home patients without ever seeing the patients. He also admitted to billing Medicare for follow-up examinations that were not performed on patients. He merely made entries in the patients' charts. This investigation was conducted jointly with the FBI.
- Donna Shelgren, former bookkeeper for SNF manager Frank Aiello, was sentenced in California for creating false documents to deceive auditors about the amount of supplies ordered by Aiello. The sentence was for 5 months in jail, a \$10,000 fine, and 200 hours of community service.
- Earlier, Mildrene Westbrook, a former claims analyst for the Medicare claims carrier, was sentenced for accepting payments from Aiello for tampering with his claims. The sentence included 5 years probation and 100 hours of community services.
- William Harrison, another former carrier employee, entered into a deferred prosecution program in return for cooperation and testimony at Aiello's trial. Harrison accepted gratuities for preferential handling of Aiello's claims and cost reports.

Medical Services

- J. Michael Pruitt, DBA Support Products, Inc., pled guilty to one felony count involving the filing of fraudulent Medicare claims for orthotic body jackets. Support Products Inc., will pay restitution of \$450,000 at sentencing September 8 in Houston, TX.

- Jose M. Ferrer, the 22 year-old owner and sole employee of Express Medical D.M.E., Inc., received approximately \$2.3 million from Medicare by submitting false claims. Ferrer obtained lists of Medicare beneficiaries by paying kickbacks to management personnel in adult living facilities, and paid a physician to sign prescriptions for DME, orthotics and medication without examining the patients. The DOJ Civil Division froze assets of approximately \$2 million.
- Chely Fernandez, Feliz A. Garcia-Loredo and Ignacio Elso through Get Well Medical Care, and C. F. Medical, purchased doctors' signatures for Medicare prescriptions and submitted bogus claims for the rental of oxygen concentrators and medications. Elso and Fernandez purchased copies of Medicare cards and received commissions for obtaining the signatures of doctors. Billings for their schemes to Medicare totaled approximately \$370,000, of which approximately \$100,000 was paid.
- Robert Allen Lopez created 11 companies for the purpose of billing Medicare for parenteral nutrition therapy. Lopez utilized his wife and nominee owners to set up fictitious companies and submitted \$4.2 million in false claims to Medicare. The OIG recovered half of the funds paid to Lopez.
- A physician formerly licensed in Florida was sentenced to 26 months in jail and ordered to make restitution of \$441,000 for submitting false Medicare claims for DME and vascular testing at nursing homes. He was forbidden to have anything to do with a medically related concern during 3 years of supervised release following his jail sentence.
- The owner of an Illinois DME company was sentenced for billing Medicare for beds and wheelchairs that were not provided to nursing home residents. This case will be referred for civil monetary action.
- A DME company operator pled guilty in Texas to a charge related to Medicare fraud in which DME companies collected more than \$1.47 million for wheelchair cushions billed to Medicare as body jackets. As part of the plea agreement, he will provide information regarding similar Texas operations. In an unrelated case, a Dallas dentist was indicted on five mail fraud counts. He operated a DME company in Texas, and was instrumental in forming four others. Each company sold wheelchair cushions to nursing home residents in five States. They were reimbursed \$1.2 million for orthotic body jackets never provided. Medicaid and private insurance carriers also paid a substantial amount.
- Universal Medical Supplies participated in a fraud scheme in which Medicare overpaid more than \$13.7 million. Seventeen persons, including doctors, salespersons, and managers, were indicted for billing Medicare for equipment never delivered, and for paying and accepting kickbacks for signing Certificates of Medical Necessity (CMNs). Harry Ullrich was convicted and sentenced earlier, and agreed to pay the Government more than \$985,700 in a civil suit settlement. Dr. Angelo Volpe pled guilty to accepting kickbacks from Universal. He also submitted bills to Medicare for office

visits never made. Two Universal salespersons are expected to plead guilty within the next few weeks. Three more physicians are scheduled for trial in January 1996, and two other civil agreements are being negotiated.

- Joseph Broccolo, a podiatrist, was sentenced in New York to 3 years probation and 4 months home confinement for providing services in patients' homes, then inflating the number of visits he billed to Medicare. Broccolo's son, Dennis Broccolo, worked for a Durable Medical Equipment company. The son recruited patients for the father. In return the father gave his son the Medicare number of his patients and signed CMNs which the son sold to his employer. Joseph Broccolo must pay more than \$13,500 in restitution. Plea negotiations are underway with the younger Broccolo who pled guilty earlier this year.
- Barry Feldman, a podiatrist and middleman for a DME company in New York, was arrested for Medicare fraud. Feldman provided kickbacks for referral of Medicare beneficiaries and physicians' UPINs and sold information to DME company. The DME company gave each beneficiary a lymphedema pump, regardless of necessity, and billed Medicare \$4,800 for each pump.
- Bernice Tambascia, owner of MedFasat, Inc., largest Medicare supplier of Lymphedema pumps in New Jersey, was convicted of Medicare fraud and obstruction of justice related to a false billing scheme involving Medicare beneficiaries in Florida and New Jersey. She billed Medicare for pumps not necessary and falsely indicated that lymphedema pumps, cheaper than the \$4,000 pumps billed, had been rented prior to prescribing the more expensive piece of equipment. Medicare overpaid Tambascia in excess of \$200,000.
- Kevin Dyeovich, President, Global, second largest DME supplier in New Jersey, pled guilty for misrepresenting lymphedema pumps billed to Medicare and/or double billing Medicare. Dyeovich billed beneficiaries in ORT States. Global will enter into a civil settlement covering the \$270,000 improperly billed, including penalties and cost of investigation.
- The owner of Absolut Medical Services, a Miami DME supplier, agreed to pay \$65,000 and accepted a 5 year exclusion from the Medicare and Medicaid programs to resolve his civil liability under the False Claims Act and the Civil Monetary Penalty Law. The company paid "recruiters" a \$25 kickback for each Medicare beneficiary they supplied. The scheme resulted in \$58,212 in Medicare payments for unnecessary DME.

OUTREACH ACTIVITIES

COMPLETED OUTREACH ACTIVITIES

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Interviews: Print, Radio and On-Camera
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ONGOING OUTREACH ACTIVITIES

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PLANNED OUTREACH ACTIVITIES

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OUTREACH ACTIVITIES: DESCRIPTIONS

COMPLETED OUTREACH ACTIVITIES

Initial Announcement

- On May 3, President Clinton announced the Operation Restore Trust initiative to delegates at the White House Conference on Aging.
- Additionally, the Secretary, the HCFA Administrator and the Inspector General briefed White House reporters on Operation Restore Trust as part of overall briefing on White House Conference on Aging.
- On May 3, the Inspector General held a press conference to announce and answer questions about Operation Restore Trust.
- On May 4, the Vice President's speech before the White House Conference on Aging addressed the Operation Restore Trust initiative.
- On May 4, a message announcing this new initiative was sent to all HHS employees via the e-mail and followed up with desk-to-desk delivery.
- On May 11, Vice President Gore visited HHS to announce REGO II with Secretary Shalala and Deputy Secretary Broadnax. Operation Restore Trust was highlighted in the Vice President's remarks. Press attended.

Press Releases/Fact Sheets

- On May 3, 1995, a press release, with three fact sheets, were issued simultaneously with the President's announcement.
 - Fact sheet describing the initiative.
 - Fact sheet detailing information on each of the five targeted States.
 - Fact sheet on the voluntary disclosure program.
- Press release issued by the Inspector General on June 12, 1995, announcing procedures for the Voluntary Disclosure Pilot program.
- On June 14, 1995, a fact sheet was released to trade publications announcing the Inspector General will undertake reviews of hospice facilities in the five Operation Restore Trust States.
- Press release issued June 27, 1995, announcing a toll-free hot line (1-800 HHS-TIPS).

- Press release issued June 29, 1995, by Secretary Shalala releasing a Special Fraud Alert on Home Health Fraud.
- Press release issued August 4, 1995, by Secretary Shalala on Medical Supplies to Nursing Facilities. Simultaneously, Secretary Shalala held a press conference in Austin, Texas and released the Special Fraud Alert and discussed this new fraud initiative. Texas Attorney General Dan Morales participated with Secretary Shalala.
- Press release issued October 10, 1995, by Secretary Shalala warning consumers and health care professionals about questionable practices affecting Medicare's hospice program.

Fraud Alerts

- On June 29, 1995, the Special Fraud Alert on Home Health Fraud was issued. Fifteen thousand copies were printed and distributed.
- On August 4, 1995, another 15,000 copies of a Special Fraud Alert on Fraud and Abuse in the Provision of Medical Supplies to Nursing Facilities was issued. This alert was released by the Secretary at a press conference in Austin, Texas.

Advisory Bulletin

- On October 10, 1995, a Medicare Advisory Bulletin was issued and copies distributed to the media. Copies are being printed and will be distributed to the HCFA, AoA and Medicare carriers and contractors.

Interviews: Print, Radio and On-Camera

- On May 16, 1995, at the first targeted State meeting in Dallas, Texas, the Inspector General and the HCFA Administrator held a joint press briefing and fielded questions related to this initiative.
- The Inspector General did an interview with Lynn Filusch for HHS Radio on the HHS-TIPS hot line on June 27, 1995.
- Lewis Morris, Office of General Counsel, did an interview with Lynn Filusch for HHS Radio on the release of the Special Fraud Alert on Home Health Fraud on June 29, 1995.
- On June 30, 1995, the Inspector General was interviewed on-camera by Medill News Service for airing on WIFR-TV in Rockport, Illinois. The interview focused on Operation Restore Trust. The hot line poster was on display and they filmed the poster for airing.

- The Chicago OI Regional Office, Robert Noble, granted an interview to Illinois Medicine. Since Illinois is one of the Restore Trust States, the interview focused on the project.
- On July 17, CNN visited the HHS-TIPS hot line and filmed the operation for a segment CNN was producing on Medicare fraud.
- On July 20, 1995, the Inspector General was interviewed on-camera for the MacNeil Lehrer NewsHour concerning health care fraud and Operation Restore Trust. The producers plan to focus attention on health care fraud in the State of Florida. They planned to interview Senator Graham and Kendall Coffee, U.S. Attorney. The segment is expected to air before the end of the year.
- On August 17, 1995, the MacNeil Lehrer NewsHour filmed the HHS-TIPS hot line operation for the segment they are producing on health care fraud.
- On October 6, 1995, the Inspector General granted an interview to NurseWeek Magazine on Operation Restore Trust. The interview should appear in the December issue.
- On October 8, the Inspector General gave the keynote address before the national meeting of the National Association for Home Care and the Hospice Association of America in San Francisco, California. A portion of the Inspector General's remarks focused on Operation Restore Trust.

Articles

- The Journal of Public Inquiry, a publication of the Inspectors General of the United States, Summer 1995, printed an article written by the Inspector General on Operation Restore Trust. The article is titled, "Partners Against Crime: Using a Culture of Collaboration to Win in the Fight Against Health Care Fraud."
- The Inspector General has submitted a guest editorial on Operation Restore Trust for Home Health Care Dealer magazine. This magazine reaches 12,000 suppliers of home medical equipment and services. The article is scheduled to appear in the September/October 1995 issue.

Speeches/Meetings

- The Operation Restore Trust team members have given presentations and speeches to the following:
 - Managed Home Care Congress
 - National Health Lawyers Association
 - Physicians Advisory Committee
 - Several Home Health Agencies

- Several Nursing Home Associations
 - Healthcare Educational Research Fund (Part of the Health Care Association of New York State)
 - Healthcare Financial Management Association
- On October 8, 1995, the Inspector General gave the keynote address before the national meeting of the National Association for Home Care and the Hospice Association of America. A portion of the Inspector General's remarks focused on Operation Restore Trust.

Hot line

- The hot line number was released to the public on June 27, 1995. The hot line received 1,990 calls, letters, and other complaints during the month of June. Of the 1,990 complaints, 719 were entered into the system for further case development or referral. Of these, 624 involved Medicare Part A and B or Medicaid, and 48 percent of them originated from target States.
- For September, the hot line received 3,023 complaints, the highest total since being announced--121 calls were ORT related.
- A hot line poster has been developed.

Congressional Activities

- The OIG Congressional staff developed an Operation Restore Trust logo.
- The OIG and HCFA Congressional Relations teams have developed a comprehensive packet of information for distribution to Congressional leaders and their staffs. All five targeted State delegations received information as it was released to the media on this initiative.
- On May 30, 1995, Restore Trust team members briefed Congressman John Dingell's staffers on the new fraud initiative. The briefing was requested by Dingell's staff.
- During the month of June, HCFA and OIG briefed the Congressional delegations of the five targeted States.

ONGOING OUTREACH ACTIVITIES

Interviews: Print, Radio and On-Camera

- The Inspector General will be interviewed on November 2 by Don McLeod, AARP, for the December issue. Part of the interview will focus on ORT.

- The OIG press office strives on a daily basis to be proactive concerning the Operation Restore Trust initiative. As inquiries come in from the media, a concerted effort is made to discuss the Restore Trust initiative in addition to what the call is in reference to. Further, calls have been and are being made to various media--broadcast and print--to discuss the initiative and hopefully generate coverage.
- The Administration on Aging has developed a media listing for editors of senior citizen publications.
- Initial contacts have been made with 48 Hours, 20/20, AARP and U.S. News and World Report concerning possible stories. Each has indicated interest.
- In early November, Dateline will air a segment on health care fraud. Linda Little, Regional IG for Investigations was interviewed on camera and she discussed the ORT project and provided the hot line number.

Fraud Alerts

- Two Special Fraud Alerts are under development and will be issued over the next 6 months. The Special Fraud Alerts will focus on the following areas with a tentative target date of issuance: (1) nursing home services by the end of December, and (2) ambulance transportation by the end of March 1996.

Hot line

- Three letters have been developed and all are in the clearance process. It is hoped the letters will be out by the end of October and no later than mid November.
 - The first letter has been prepared to editors of senior citizen publications seeking their assistance in publicizing the 800 HHS-TIPS hot line. The letter has been prepared for signature of the Inspector General, the HCFA Administrator, and the Assistant Secretary for Aging. Clearance has been obtained from HCFA and is awaiting clearance from Aging and the Inspector General.
 - The second letter is to the congressional delegations in the five target States seeking their assistance in publicizing the 800 HHS-TIPS hot line in their newsletter to constituents or other informational materials they produce.
 - The third letter is to congressional delegations outside the Restore Trust States also seeking their assistance in publicizing the hot line in their newsletter to constituents or other informational materials they produce.
- The hot line poster (large version) will be disseminated to all target States.

PLANNED OUTREACH ACTIVITIES

Press Releases/Fact Sheets

- The Inspector General has initiated a number of investigations in the target States and target areas. We expect to have early results in some of these cases in the months ahead. Many cases will come to fruition through the fall and into next year. As these cases come to completion, we will prepare fact sheets, press releases, or press events.
- A number of audit and inspections are also underway and as reports are completed and ready for issuance, we will consider preparing fact sheets, press releases, or press events based on the findings. The OIG will provide the Secretary and other Department officials advanced warning so a decision can be made about high level involvement in these areas of interest.
- Press releases will be prepared and submitted for issuance on Special Fraud Alerts as they are ready for issuance. The OIG will determine if there are targets of opportunity for media events with the Secretary or others as these alerts are nearing completion.

Interviews: Print, Radio and On-Camera

- We will be developing a listing of reporters in the five Restore Trust States and begin to cultivate relationship and interest in the Restore Trust initiative.
- We will be seeking interviews with trade press, such as Medical Economics and Modern Healthcare magazines.
- As Department officials (The Secretary, HCFA Administrator, Assistant Secretary for Aging, Inspector General) travel in the 5 target States, staff should recommend or seek additional "targets of opportunity" for doing interviews, media events, editorial boards.

Articles

- The OIG will be developing a list of topics/issues for articles that can then be written for the Inspector General's or other Department officials' by-line.

Speeches/Meetings

- In November 1995, the OIG will speak on our ongoing work at a conference sponsored by the National Hospice Organization.

Hot line

- We will be scheduling meetings to discuss publicizing the number in Spanish since many of the Restore Trust States have Hispanic populations.
- We will discuss a possible public service announcement.

Congressional Activities

- The Congressional staffs (HCFA and OIG) will continue on a daily basis to be proactive concerning the Operation Restore Trust initiative.

VOLUNTARY DISCLOSURE PILOT

The OIG's previously-announced voluntary disclosure program was officially launched on a pilot basis under the auspices of Operation Restore Trust. Through the Voluntary Disclosure Pilot (VDP) program, the OIG, in conjunction with the Department of Justice (DOJ), has established procedures by which health care corporate providers in the target health care sectors may come forward with full disclosure of potential fraud and abuse which may give rise to corporate liability. The VDP is modeled after a voluntary disclosure program initiated in 1986 by the Department of Defense for treating self-disclosed incidents of fraud by defense contractors. There have been more than 300 successful disclosures under that program.

The VDP program is available to home health agencies, nursing facilities, medical suppliers and hospice care providers whose activities affect Medicare and Medicaid beneficiaries in the five target States. The Inspector General has stated her intention that the OIG employ similar procedures in treating voluntary disclosures that do not meet the jurisdictional criteria of the pilot.

The primary purpose of the VDP program is to facilitate increased industry participation in the detection and prevention of Medicare and Medicaid fraud and abuse. Promoting self-disclosure further enables the OIG to identify developing patterns and practices of fraudulent activity in the designated industry segments. Voluntary disclosure offers self-disclosing entities the opportunity to minimize the potential cost and disruption of a full scale audit and investigation; to negotiate monetary settlements to the Medicare and Medicaid programs based upon the matter disclosed, including a possible reduction in exposure from treble to double damages; and to reduce or avoid an OIG permissive exclusion under 42 U.S.C. 1320a-7(b), as appropriate.

The joint OIG/DOJ procedures for the VDP were announced in June 1995. Since that time, the OIG has been engaged in a multi-track implementation process. The first track has addressed internal needs, with attention to staff training and development of internal program materials and protocols. A second track is aimed at educating the health care community, including the health care defense bar, about this new program and the voluntary disclosure procedures. In an effort to promote awareness of the VDP, the OIG has spoken publicly about the program, disseminated media materials about the VDP, as well as fielded telephone and written inquiries from providers and counsel.

Many internal and public activities of Operation Restore Trust have presented significant opportunities for VDP implementation. The OIG has received a growing volume of inquiries about the VDP, including significant interest from providers who are not within the jurisdiction of Operation Restore Trust. These disclosures of fraudulent practices are being handled as voluntary disclosures in the manner described by the VDP procedures. Because voluntary disclosures are accorded the same investigative sensitivity as other ongoing OIG investigations, there is little that may be disclosed about individual cases at this time.