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GAMING THE HEALTH CARE SYSTEM: TRENDS IN HEALTH CARE FRAUD

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UNITED STATES SENATE
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WASHINGTON, DC

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TUESDAY, MARCH 21, 1995

**U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
*Washington, DC.***

The Committee met, pursuant to notice, at 9:30 a.m., in room 216, Senate Hart Building, Hon. William S. Cohen (chairman of the Committee) presiding.

Present: Senators Cohen, Thompson, Pryor, Shelby, Moseley-Braun, Reid, Jeffords, Grassley, and Glenn.

Staff present: Mary Berry Gerwin, Staff Director/Counsel; Helen Albert, Chief Investigator; Priscilla Hanley, Professional Staff; Sally Ehrenfried, Chief Clerk; Theresa Forster, Minority Staff Director; and Kenneth Cohen, Investigator.

OPENING STATEMENT OF SENATOR WILLIAM S. COHEN, CHAIRMAN

The CHAIRMAN. The Committee is going to come to order. I understand that Senator Pryor and others are on their way, but we will begin. I have a somewhat lengthy statement to open, and by the time I finish, hopefully, Senator Pryor will be here to present any opening statement he would like to give.

This morning the Committee is going to examine major trends in health care fraud and abuse that have penetrated Federal, State, and private health care plans driving up the cost of health care for taxpayers and all Americans. For over 3 years my staff on this Committee has been investigating the explosion of fraud and abuse throughout the U.S. health care system, particularly Medicare and Medicaid. The purpose of our investigation is two-fold: First, to identify emerging trends, patterns of abuse, and types of tactics used by providers, patients and others to game the system in order to reap billions of dollars and reimbursements from Medicare, Medicaid and private insurers; secondly, our investigation has sought to identify the weaknesses in our Federal programs and law enforcement efforts that have made it very lucrative for unscrupulous providers to prey upon the health care system itself.

The cost of fraud and abuse to the health care system are truly staggering. Over the past 5 years the estimated losses from health care fraud have totaled about \$418 billion or as much as four times the cost of the entire savings and loans crisis to date. Last July we issued an investigative report that detailed some 50 examples of scams that have recently infiltrated our health care system. These schemes included billing for phantom services never provided, kick-

backs, double billing, billing patients and insurers exorbitant prices for dangerous, and, indeed, sometimes inferior products. And since our report was issued, taxpayers have been shocked by even more headlines about providers who have ripped off the health care system.

One of the major victims of health care fraud is the American taxpayer. Losses to Medicare and Medicaid amount to as much as \$27 billion each year. These figures are even more disturbing in light of the fact that only a tiny proportion of the providers who ravage the Federal health care system are even identified or prosecuted, and even when they're caught, they're often allowed to keep on doing business with the Federal Government and other health plans.

Our investigation has revealed that it is shockingly simple to commit health care fraud, and the size, the intricacy and the splintering of the current health care system creates an environment for abuse. Payers are running as fast as they can to keep pace with over \$4 billion in claims filed each year, and law enforcement lacks the tools and resources necessary to make a significant dent in the scams that are penetrating every facet of our health care system.

While Federal and State law enforcement agencies and private insurers have stepped up their antifraud efforts, they simply can't keep up with the charlatans who are defrauding and abusing the system.

Today is the first in a series of hearings that this Committee is going to hold on health care fraud. To open these hearings I've asked representatives of the Federal, State, and private health care fraud enforcement efforts to testify as to the extent and the patterns of health care fraud that they're witnessing and the steps that should be taken to crack down on these abuses. At later hearings, the Committee is going to hear from the providers, the program managers, and advocacy groups on how they believe we should address fraud and abuse in the health care system. Today we're going to hear disturbing testimony that organized groups are actively engaging in health care fraud on a large scale, including international organized crime groups, fake unions and networks of doctors, specialists, attorneys, and, at times, professional patients who gin up phony medical diagnoses and conditions and bill for tens of millions of dollars in unnecessary tests and services.

Of particular concern to this Committee is the growing evidence that health care fraud is systematic in the health care industries providing services to our Nation's elderly and disabled Americans. The Inspector General for the Department of Health and Human Services has cited problems in home health care, nursing home, and medical supplier industries as significant trends in Medicare and Medicaid fraud abuse. Padding claims and cost reports, charging the government and beneficiaries outrageous prices for unbundled services, and billing Medicare for costs that have nothing to do with patient care are just a few of the schemes that are occurring in these industries.

As we'll hear in testimony today, unscrupulous providers are enjoying a feeding frenzy in the Medicaid program, and this program is experiencing what has been called, quote, "unprecedented white collar wilding," in which wave after wave of multimillion dollar

frauds have swept through nursing homes and hospitals, clinics, pharmacies, durable medical equipment, radiology and labs, and, more recently, home health care. An alarming number of allegations of fraud and abuse have been leveled against home health care agencies that provide services to the homebound elderly and disabled. Last month, for example, the Inspector General at Health and Human Services proposed that ABC Home Health Services, Inc., which provides home care services in 22 States through 40 wholly-owned subsidiaries, should be excluded from the Medicare and State health care programs for a period of 7 years for allegedly padding its cost reports with entries that had very little to do with the Medicare patient service.

The list of personal items that were alleged to have been billed to the Medicare program include over \$16,000 in alcohol beverages at conferences, over \$9,800 in personal travel and entertainment for the owner's family, and over \$3,200 in golf shop expenses. The Inspector General has also found that the ABC companies allegedly charged the Medicare program for over \$100,000 in promotional items given to doctors and others to encourage them to use ABC Home Health Care, including \$85,000 in gourmet popcorn provided to doctors.

Now we learned a short time ago that some types of popcorn that is served in certain movie theaters can be harmful to your health. Let me suggest that allowing companies to get away with billing \$85,000 for gourmet is bad for the Federal budget and the integrity of the overall health care system.

I also want to share with you just two small examples of other types of scams that are preying upon Medicare and Medicaid. I have here what is an undergarment. This is an item and thousands like this item that are given to Russian immigrants in Brooklyn in exchange for their Medicaid numbers. The scam artist in this case then used these numbers to bill the Medicaid program for over \$1.2 million for medical supplies that in most cases were never ordered or needed.

The second items that we have are milk supplements that were part of a scheme in south Florida. There is a little six pack of these supplements. They come in three different flavors—strawberry, vanilla, and chocolate—but these items were brought to people who live in senior citizen apartment buildings, community centers. They were door-to-door recruiters who went to apartment buildings to solicit the sale of these, or as a gift to the residents of those homes. They would tell the seniors in these apartments that they were eligible to receive milk free of charge from the Government, and, again, they had their choices of flavors. But, in exchange, they wanted the Medicare beneficiary numbers. The recruiters had arrangements with various doctors who would then authorize the nutritional supplements for these patients, even though none of this was necessary. In addition, they added some kits that would help the so-called patients digest the milk supplements. Of course, these kits were in fact never delivered.

This free milk scam proved to be very expensive for the taxpayers, since it resulted in Medicare being defrauded for over \$14 million in phony claims.

While Medicare and Medicaid account for the largest portions of the Federal health care spending, they do not corner the market on health care fraud. Our investigation indicates that fraud is rampant in other Federal health care programs, such as the Federal Employees Worker's Compensation Program, the Black Lung Program, and the Employer Sponsored Health Benefit Programs. As we'll hear in testimony later this morning, there are networks of doctors who have been taking kickbacks for fraudulently charging prescription drugs to the Federal Employees Compensation Act Program, equipment companies and doctors have falsified certificates of medical necessity for coal miners to qualify for black lung supplies, and phony unions are signing up small businesses to provide health care benefits that beneficiaries may never actually see.

These scams are costing the Federal Government and private citizens millions of dollars in lost benefits and higher premiums.

Last Congress we worked with law enforcement agencies, particularly the FBI and others, and provider groups, I might add, in developing legislation that would toughen our defenses against fraud and abuse. These proposals would have established a coordinated anti-fraud and abuse program to health Federal, State, and private enforcement efforts to prevent, detect, and prosecute fraud, would toughen the Federal criminal laws and enforcement tools available to pursue health care fraud, and would provide a much greater range of enforcement remedies to respond to fraudulent and abusive schemes.

I must say, unfortunately, these proposals were all victim to an all-or-nothing approach that was taken on health care reform last year, and so we were unsuccessful in this effort to crack down on health care fraud and abuse. And the winners in this all-or-nothing game were the fraudulent providers who can continue to rape the system. The losers were the American taxpayers and the families who have to pay more in premiums and medical bills due to the cost of fraud and abuse.

Just as there is a call for a contract with America to make Government leaner and more efficient, we have to enforce our contract with the American taxpayers and Medicare beneficiaries to make sure that their tax dollars are being spent wisely and not lining the pockets of those who are greedily gaming the health care system. If we're asking honest health care providers to take cuts in the reimbursement levels and Medicare and Medicaid recipients to pay more of their out-of-pocket costs to bring spending under control, we have an absolute obligation to ensure the American public that their health care dollars are not being wasted on fraud and abuse.

I'm pleased to note that we're going to hear from an impressive list of witnesses today. First, we're honored to have Louis Freeh, the Director of the FBI, who will testify on the high priority the Bureau is now giving to health care fraud. We are then going to hear from a Doctor A, an anonymous Doctor A for our purposes, a health care provider who has come forth to give the Committee his first-hand knowledge of on-going schemes by doctors and other health care providers that are driving up the costs of health care insurance, and also from Agent B who will testify on prescription drug diversion schemes that are continuing to occur in cities across the country. We're then going to hear some very powerful testi-

mony about on-going scams and enforcement efforts from the Inspector Generals, of the Department of Health and Human Services, and the Department of Labor, and the Director of the California Bureau of Medi-Cal Fraud. And, finally, we're going to be pleased to have with us the Honorable Bill Gradison who is president of the Health Insurance Association of America, and William Mahon, the Executive Director of the National Health Care Anti-Fraud Association, is going to testify about health care fraud and its penetrating private insurance and health plans and the efforts of the private sector to combat fraud and abuse.

Before turning to Senator Pryor and the rest of my colleagues for any comments they wish to make, I want to point out that the Committee in no way insinuates that all health care providers are gaming the health care system. In fact, the vast majority of health care providers are honest professionals. They've had only the best interests of their patients in mind, and they are sincerely trying to comply with the often confusing health care rules and regulations, and, in fact, many health care provider groups are taking the initiative to crack down on those in their profession who are giving their industry a black eye. And I wish to congratulate those industry groups that have undertaken these efforts. They have worked closely with our staff on the Committee, and we look forward to working with them to make the antifraud laws and regulations as fair and clear as possible.

Finally, I would like to recognize Senator Pryor, who is the ranking minority member and who had chaired this Committee for many years, and commend him for his good work in working with us over years and his efforts in this particular regard, and also his support for the very tough measures that we are hoping to pass this year with the help of the Justice Department, the FBI and the Administration.

Senator Pryor.

STATEMENT OF SENATOR DAVID PRYOR

Senator PRYOR. Mr. Chairman, thank you. Our colleagues, Senators Shelby and Thompson, are here. Would you like to call on them first? They look prepared and—

Senator SHELBY. We'll defer to you, as former chairman.

Senator PRYOR. Why, thank you. I would, Mr. Chairman, ask that my statement be placed in the record. I want to first compliment you because the leadership that you have shown, Mr. Chairman, with this particular issue is truly unmatched in the Congress—House or Senate, Democrat or Republican. I am honored to be a sponsor with you of the Anti-Fraud and Abuse Bill, S. 245, that you have introduced in the Senate. I think that this legislation will go a long way in addressing some of the problems we will hear about this morning at this session of the Senate Special Committee on Aging.

Health care fraud and abuse in the health care system today is diverting billions of dollars, from American families, businesses, and government. What we must remember and must not lose sight of is that every dollar stolen from Medicare, Medicaid, and private health plans is a dollar less for patient care, for lower insurance premiums, and for the system as a whole. We also think that to

root out the fraud in this health care system will increase the respectability of that system, and certainly the credibility of that system. For any system to work it must have credibility and it must enjoy the trust of the people as a whole.

We're going to see several types of fraud this morning that will be brought before the Committee, and these are types of fraud that we must not turn our backs on. I certainly think that our Inspector General, June Gibbs-Brown, is accepting this as a reality. I think what I've understood is that for every dollar that we expend in looking at this type of fraud by the Inspector General, we get \$80 in return—I hope that's an accurate figure—and I commend her for her stepped up activity in this field as Inspector General of HHS.

Mr. Chairman, I would, once again, ask that my statement be placed in the record, and I look forward to the hearing this morning.

The CHAIRMAN. It will be included in full.

Thank you very much.

Senator PRYOR. Thank you.

[The prepared statement of Senator Pryor along with the prepared statement of Senator Larry Craig follow:]

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Mr. Chairman, I want to commend you on your decision to hold this hearing on fraud and abuse in the health care industry. The leadership you have shown in this area is unmatched. In a time of increased partisanship, this truly is something that we can all work together to correct. I am particularly pleased to be an original co-sponsor of your anti-fraud and abuse bill, S. 245, the Health Care Fraud Prevention Act of 1995. While this hearing is not specifically about this legislation, people should bear in mind that the bill would address some of the problems we are going to hear about today.

This is a subject about which I too have long been concerned. When I was Chairman of this Committee, I held several hearings on fraud and abuse in the health care system. In addition, the health care reform bill reported out of the Finance Committee last year included an anti-fraud provision which my staff worked with Finance Committee staff to develop.

Mr. Chairman, health care fraud and abuse in our health care system is draining billions of dollars a year from American families, businesses, and government. Every dollar stolen from the health care system—be it from Medicare, Medicaid, or a private health care plan—means one less dollar for patient care or for lower insurance premiums. With health care costs still escalating, the last thing we need to be doing is allowing criminals and opportunists to steal precious resources from the system. Fraud also tarnishes the good names of honest health care professionals and companies. While the vast majority of providers are honest and hard working, the crooks cast a cloud over the entire health care system.

Mr. Chairman, there are too many examples of fraud in our health care system. One type of fraud that we will hear about today is "drug diversion." As part of this Medicaid fraud, indigent individuals with no legitimate medical need for prescription drugs would enter the doctors' clinics and obtain prescriptions for expensive drugs. They, in turn, would resell the prescriptions to people on the street, who then sell to dishonest pharmacists. In exchange for the prescriptions, the "patients" subject themselves to unnecessary medical tests and procedures for which Medicaid could then be fraudulently billed. One reason why this scheme is so disturbing is that a wide range of so-called professionals are involved.

Much studying has been done on the health care fraud and abuse problem in recent years. In addition to the report issued last year by Senator Cohen, reports by the General Accounting Office, the HHS Inspector General, and congressional committees (including this panel) have also documented the extent and range of the problem. They have detailed abuses ranging from the billing of services never provided to the illegal sale of controlled substances. What these reports have in common is the conclusion that billions of dollars are lost each year to fraud and abuse.

Let me now talk about some positive things going on in this area. As we hear today about the countless scams against government and private health insurance

plans, it is important to bear in mind that there are professionals in the private and public sectors making courageous and, in many cases, substantive, efforts to combat these problems. I am particularly glad that among our witnesses today is June Gibbs Brown, the Inspector General of the Department of Health and Human Services. As Inspector General of HHS, she is responsible for overseeing some of the most expensive Federal programs, such as Medicaid and Medicare. It is my understanding that for every dollar invested in the HHS Office of Inspector General, a saving of \$80 is realized. That is quite an accomplishment. On behalf of the taxpayers, I commend June Gibbs Brown and her staff for their efforts.

Mr. Chairman, I look forward to hearing the testimony of our witnesses and again commend you on your work in this area.

PREPARED STATEMENT OF SENATOR LARRY E. CRAIG

Mr. Chairman, first let me thank you and the committee staff for the time and effort you have put into investigating fraud and abuse in the health care system. I look forward to hearing from our witnesses today and gaining a better understanding of this problem. I also hope this hearing will lead us to some answers as to how we can minimize the "rip-off" or gaming that is occurring in the health care system today.

We all pay a higher price for health care because of fraud and abuse. Gaming the Medicare and Medicaid systems results in increasing costs to the American taxpayer. In addition, escalating costs in these areas force Congress to make spending cut or changes in reimbursements. As a result, providers are forced to limit their Medicare and Medicaid patients (especially in rural areas where reimbursement rates are low), and there is cost shifting to private pay customers.

This whole scenario usually has little effect on the provider who is gaming the system because he or she will find new loopholes. However, it has a drastic effect on good providers in the system, and helps to drive up the overall cost of care. It also reduces access to services for beneficiaries.

In the past when the committee has addressed this issue, I have expressed concern that as future generations enter the Medicare rolls, we will have less vigilant participants, or partners in our effort to curb fraud and abuse. It has been my experience that our current senior population, having lived through the depression, knows the value of a dollar and does not take the Government for granted. In addition, their watchfulness has helped us to curb fraud and abuse in the past, and I applaud those efforts.

We have all heard stories about providers billing for services not rendered, or billing multiple sources in the case of a car accident or workers compensation. Sometimes the patient may be party to the scheme, and other times is oblivious to the billing activities, because bills are sent directly to the responsible insurance companies. These actions sound devious and are clearly illegal. However, fraud and abuse does not always occur in neat packages. What is another, serious form of fraud, is that which may be legal, but is intended to unnecessarily enhance reimbursements from the Government. In short, I refer to these consultants or seminars where health care providers learn how to enhance their Medicare or Medicaid reimbursements through changes in coding, tests run, etc. . . . Both activities are morally wrong, but we need to spend some time focusing on the latter, in order to close the legal loopholes that still exist.

Mr. Chairman, I like to think that fraud in the system is the exception, rather than the rule. I hope the testimony of our witnesses today will bear that out. I also hope they will help us with the difficult task of curbing or ending fraud and abuse without applying excessive regulation to the majority of providers who are operating honestly within the system. Any thoughts or recommendations from our witnesses today would be very welcome.

As we look at ways of resolving our budget deficit problems, issues like fraud and abuse will have to be addressed. The growth of Medicare and Medicaid is heavily burdening our budget and our economy. Limits in the growth of entitlement programs will add yet another pressure on the Congress to end the gaming of the system so that our taxpayer dollars go directly into programs, not into excessive bureaucracy, and not into the pockets of unscrupulous health care providers who are gaming the system.

The CHAIRMAN. Senator Shelby.

STATEMENT OF SENATOR RICHARD SHELBY

Senator SHELBY. Thank you, Mr. Chairman.

Mr. Chairman, I want to commend you as the Chairman of the Committee for calling this hearing. This is a very important hearing, and I also would be remiss if I didn't compliment Senator Pryor for his past service, as you have, to this Committee and to the older people of America, which I am one of, and that is the elderly, as we get there. I'm looking forward to the testimony of the Director of the FBI this morning. If we're spending about \$1 trillion a year, \$1 trillion a year, on health care in America—and that's what we understand we are—and if the General Accounting Office estimates is anywhere right, and they're saying that health care fraud could entail as much or be lost up to 10 percent of that—\$100 billion a year.

Mr. Director, you've got your hands full, and we want to help you in any way that you can do it because when you cheat and steal, you're stealing from the program, you're stealing from the American people, and I commend you when you say in some of your testimony that health care fraud is the number two thing on your agenda at the FBI or the Justice Department behind violent crime. I think you're on the right track, and we look forward to working with you and I hope, Mr. Chairman, that you will let my whole statement be made part of the record.

The CHAIRMAN. Senator Moseley-Braun.

STATEMENT OF SENATOR CAROL MOSELEY-BRAUN

Senator MOSELEY-BRAUN. Thank you very much, Mr. Chairman.

I would like to join my colleagues in congratulating you for this initiative. At the end of the last session you attempted to bring this issue to the floor, and, unfortunately, it got caught up in the 11th hour, 59th minute of the session, and we were not able to move forward at that time. But, frankly, I think it's probably just as well because it gives me an opportunity to serve with you and to participate in the development of your legislation and your initiative in this area. I want to congratulate and commend you because this is a very important area for the American people—not to mention for our national fiscal policy.

I would want to point out also that the estimates in terms of fraud range everywhere from about \$44 billion to \$100 billion. That is a lot of money, even if you take the low end figure. In any event, it has created a tremendous burden not only on the health care system, but on law enforcement. I'm looking forward to hearing Director Freeh because even with all of the concerns—international crime and the drug war on his plate, I think that devoting resources to this kind of preventable fraud is really something that we ought to take very seriously.

I would point out also that as a former U.S. Attorney, I hope that part of the initiative that the Director and others at HHS would take a look at is the use of civil penalties, the more expanded use of civil penalties, as a response to this kind of fraudulent activity. I think that it certainly cuts down on the transaction costs with regards to litigation and with regards to what it is that you have to do in law enforcement. It also can represent an avenue for recovery and restitution of some of the money that is lost to fraud.

And then, finally, I would like to say that in spite of the health care reform debacle that we had last year—I don't think it is ill-

spoken to call it a debacle—the fact is that we attempted to address health care reform last year and we were not successful. One of the places that I hope that we really would focus has to do with the paperwork and the administrative burden associated with health care in this country today because, quite frankly, it's a function of the fact that the process is so complicated, that there is so much paperwork, that the administrative overhead is so extreme, that I think it invites a lot of the kind of fraud that we see in the system. And so getting correction and regulatory reform with regard to the way the health care system operates I think is another kind of approach that we can take to reducing fraud in this area.

And, again, I want to commend everyone who is here today to testify. I will later file, Mr. Chairman, a written statement for the record, but I do want to, again, conclude by saying that I think that this is an idea whose time has come and past. It's something that we certainly should have moved on when you first brought it to the attention of the Senate, and I'm delighted to have a chance to move on this, and approach this issue with you now.

Thank you.

The CHAIRMAN. Thank you very much.

Senator Thompson.

STATEMENT OF SENATOR FRED THOMPSON

Senator THOMPSON. Yes, briefly, Mr. Chairman, first of all, I appreciate the opportunity to serve on this Committee, and I appreciate the leadership that you and Senator Pryor have already shown on this issue. I think, obviously, at a time when our Nation is keenly aware of skyrocketing medical costs that it's certainly appropriate that we prioritize an area of fraud that apparently is costing us upwards of \$100 billion a year. And I think that it is incumbent on us to make sure that those in charge of having to investigate health care fraud have the strongest possible tools available to them to root out fraud and abuse in the system. I would think that strengthening the tools of law enforcement in this area and prosecuting health care fraud would be one of those health care issues that we could have a very broad consensus on in the U.S. Congress, and I look forward to working with you toward that end.

Thank you.

The CHAIRMAN. Thank you, Senator Thompson.

Senator Reid.

STATEMENT OF SENATOR HARRY REID

Senator REID. Chairman Cohen, I am here today to congratulate and applaud you for holding this hearing. I think it's extremely important. I won't be able to spend a lot of time here today, even though I have my staff here, because I think this is so important.

One of my concerns is that we've held hearings similar to this previously. I can remember very clearly the hearing that we held dealing with medical implements and the fraud there is significant, to say the least, and I'm sure today will bring out other fraudulent practices that drain huge amounts of money out of the system. But I think we're kidding ourselves if we think this can be done on the cheap—that is, that we can go ahead and you tell us all these

things are going on, and we'll feel good that we had the TV cameras focusing on these fraudulent practices, and then you go back with your understaffed offices and try to do something about it. I have a friend that is an assistant U.S. attorney that works in medical fraud. I mean, there is just no way with the present resources you have that you can make a dent in what's going on, and I think we have to be realistic. If we're going to really go after these thefts and crooks—and that's what they are—we're going to have to give those people we're asking to enforce the law to bring these thefts to justice either, as Senator Moseley-Braun indicated, through significant civil penalties or through criminal prosecution. We're going to have to give the bureaucrats and law enforcement to do this and they don't have it now.

The CHAIRMAN. Thank you, Senator Reid.

I think the Director will probably indicate, for the record, that had we passed the legislation that has been pending for the past year and a half, they would have the resources necessary—or certainly greater resources necessary—to carry out the law enforcement investigations and prosecutions, but that's a debate for another time.

Senator Jeffords.

STATEMENT OF SENATOR JAMES M. JEFFORDS

Senator JEFFORDS. Thank you, Mr. Chairman. I'll be very brief. I, certainly, commend you for holding these hearings. It's extremely important. I am on the Authorizing Committee for Health, the Labor Committee, and certainly the easiest publicly accepted way of getting the health care costs down is by getting rid of fraud and induced problems like that. So I commend—I'm going to wait for the questions to interrogate on those areas that are in the jurisdiction of our Committee.

Thank you.

The CHAIRMAN. Thank you very much, Senator Jeffords.

Senator Grassley. Senator Grassley just arrived. Would you care—

STATEMENT OF SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Can you go to somebody else and come back to me or are you all done?

[The prepared statement of Senator Grassley follows:]

STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you, Mr. Chairman.

I thank you for calling today what I think will be a very informative hearing on the subject of health care fraud. I think that the testimony we will hear today will help us understand something of the magnitude and complexity of the problem of fraud in the health care system.

Testimony today will report estimates as large as \$44 to \$100 billion of health care fraud. And I believe that the very sobering testimony of our F.B.I Director and the Inspectors General who will testify show also that we are not talking about amateur night at the opera here. Their testimony will indicate that their investigations have convinced them that we are talking about well-organized efforts to plunder our public and private health care resources. If I understand the testimony correctly, some of this may be international in scope.

Mr. Chairman, some years ago, with the help of colleagues on the Judiciary Committee, I was able to amend the False Claims Act so as to greatly strengthen its

qui tam provisions. Since the False Claims Act was amended in 1986, nearly \$1 billion has been recovered under the qui tam provisions.

Early qui tam cases were dominated by defense contractor fraud, more and more health care fraud has become a focus of qui tam actions. As I understand it, there have been nearly 200 qui tam actions reporting fraud since 1986.

I bring this up, Mr. Chairman, because it is probably the case that we are never going to be able to make available to our law enforcement agencies the kind of resources that they would need to put a stop to most of this fraud. In that case, qui tam offers a proven method for citizens to help us fight health care fraud.

That is all I have for now, Mr. Chairman. I look forward to the testimony.

The CHAIRMAN. Senator Grassley has indicated that he will submit a statement for the record or perhaps raise his statement during the course of questioning of our first witness.

And we're pleased to have with us the Director of the FBI, Louie Freeh, who I want to indicate has done a major thing in elevating the entire issue of health care fraud to the level that is has been elevated to within the Bureau. You have, I think, done more to call attention to this and devote resources—dwindling as they may be—to this issue than any previous individual in the Bureau. But we want to thank you for coming and, hopefully, you will be able to—in the short time that you have before us—to enlighten us as to emerging trends and what is taking place in health care fraud.

We've had example after example in the past of durable medical equipment scams. It goes far beyond that today, although that also comprises a major part of the fraud being perpetrated today. But perhaps you can tell us who is getting into the health care fraud business, and why, and what has to be done to prevent it from taking place.

Director Freeh.

STATEMENT OF HON. LOUIS J. FREEH, DIRECTOR, FEDERAL BUREAU OF INVESTIGATION, WASHINGTON, D.C.

Mr. FREEH. Thank you. Good morning, Mr. Chairman, and members of the Committee. It's a pleasure, of course, to be here and make my presentation. I have a longer, more detailed statement for the record, which I will submit. What I would like to do in less than 7 or 8 minutes is just sketch for you overall what the problem is as we see it from a law enforcement point of view, where the important trends, and, more importantly, for your consideration, the resources and investigative tools which I think are valuable for your consideration in deciding how you want to attack the problem. I do want to applaud the Committee—Mr. Chairman, you, personally—for this initiative, which is now long-standing. The legislation, which is co-sponsored before this Committee, addresses for the first time in a comprehensive way not only the problem, but some of the important solutions which we in law enforcement look to.

Obviously, the impact of health care fraud is enormous. The numbers that we have heard kicked around this morning—whether they're \$44 billion or \$100 billion—are staggering. Our FBI budget is \$2.35 billion. The fraud affects an industry which represents approximately 14 percent of the Nation's economy, the health care system. When I left the U.S. Attorney's Office in New York in 1990, we were overwhelmed with the numbers of health care fraud cases on the shelf being unaddressed. When I got there in 1980, we had almost none under consideration. I don't think because there

wasn't a problem, but I think it was because our attention was not focused on it.

I do also want to echo your statements with respect to the fact that the overwhelming number of health care providers and people in the industry are bona fide, legitimate people who commit themselves to the care of our people, and it is the small portion of the criminal actors who take advantage of that system that we address here this morning.

In New York State, just as one small example of the scope of the problem, the Medicare officials estimate that approximately \$400 million per year in drug diversion, illegal drug diversion, is a conservative estimate with respect to that one State.

In many parts of the country we are seeing individuals turning to health care fraud, both as individual actors but also as parts of organized criminal enterprises. In southern Florida and southern California, for instance, we have now cocaine distributors and drug dealers switching from drug dealing to health care fraud schemes; the reason we believe is that the chances of detection are not only minimal in many cases, but the profits are staggering and the opposition that they have with respect to compromising a very complex system are minimal.

In the Pacific Northwest we're seeing cases of what we call broker translators, individuals who have extorted kickbacks from recent immigrants, and have paid bribes to State employees in the welfare system. Many of these immigrants become falsely certified as medically disabled to begin receiving long-term benefits from Social Security. We've also identified many cases where nursing homes and hospice operators have exploited elderly patients, including patients with Alzheimer's disease and people who are incapable of understanding the fact that they are crime victims.

Throughout the United States we are seeing organized criminal groups, compromising doctors, chiropractors, attorneys, hospitals, and these groups establish store front clinics, diagnostic testing companies, as well as bogus law offices. They stage phony car accidents. Fake patients visit the clinics where expensive medical procedures like MRIs and x-rays are billed to insurers, even though not provided to the persons posing as patients. In addition, unfilled prescriptions are billed, kickbacks are paid, and lawyers collect false personal injury claims. In some of these cases witnesses have been extorted and physically intimidated, and the schemes have resulted in literally tens of billions of dollars in losses to insurers and increased premiums to all policyholders.

The list of fraud schemes is infinite, and no segment of the health care fraud system is immune. We've long recognized that the problem is serious but it's growing much more rapidly than anyone ever anticipated. It impacts on everyone, and, more importantly, the health of our systems.

Presently, in terms of resources, we have only 249 special agents funded to work health care fraud cases. In fact, we have 294 agents working them because we've borrowed them from other programs because of the size of the problem. To give you the base line comparison, in 1992 we had 97 special agents dedicated to those programs. Last year we achieved 353 criminal convictions and obtained approximately \$480 million in fines, recoveries, and restitu-

tions. If you add to that another \$32 million in proceeds seized and forfeited to the Government, the total recoveries were over \$500 million. Given our investment of \$37 million, we're recovering approximately—

Senator REID. Mr. Freeh, can I ask, was that recovered money or just fines and assessments?

Mr. FREEH. That is fines and assessments, not all recovered.

The \$32 million in proceeds seized and forfeited is real money. By that formula, we are retrieving approximately \$13 on each investigative dollar being spent, which makes it one of the few categories in our work where we can show a definitive gain, given the investment of resources.

Many of our investigations are worked jointly. We have excellent relationships with HHS, particularly the Office of the Inspector General. We work with many private industries, insurance bureaus. We have a very, very good track record of success in working these cases jointly, one, because of their complexity; and, two, because of the very scarce resources that all the agencies have. In the near future, for instance, the FBI and the HHS Inspector General will actually exchange agents at our headquarters level to even better coordinate and work jointly the cases that face us.

In terms of our case load, it's increased now to approximately 1,500 pending cases. That is an 142 percent increase in only 2 years. As I go out to our field offices, which is about once a week, I meet not only with the agents but with the assistant U.S. attorneys, and the unanimity with respect to their perspective on health care fraud cases are that there are many, many cases on the shelf not being worked. We have complex cases that tie up an inordinate number of resources proportionate to major organized crime cases and major drug trafficking cases because of the complexity of the work.

Let me turn now very briefly to what I would ask the Committee to consider in terms of facts which, in our view, would improve our law enforcement capability—

The CHAIRMAN. Before you do, sir, I just want to take judicial notice of the fact that Senator Reid has joined a growing trend and has now joined the Republican side of the aisle. [Laughter.]

Mr. FREEH. I could have put my charts on the other side. [Laughter.]

Let me begin by saying—

Senator REID. It doesn't take much, Judge, to get me to switch. [Laughter.]

Mr. FREEH. Let me begin by saying that we are certainly not without law enforcement and investigative tools to perform our job. We have made both small and major health care fraud cases using the standard table of equipment and investigative tools that we've used for many, many years, including the Rico statute, including Title 3 Authority, the ability to get interception of court authorized communications, as well as money laundering provisions.

What I would say, Mr. Chairman, and what I would say to the Committee, however, is that those tools, obviously, were written into the statutes long before anybody contemplated the extent and the scope and the complexity of these health care fraud cases. We, therefore, have to jury-rig, to some extent, the investigative facts

before us to utilize those tools. For instance, there is no—at least at this time—Federal health fraud statute, which means to investigate one of these fact scenarios, we have to pigeon-hole, so to speak, some of the facts on occasion into mail and wire fraud schemes; that is, looking for mailings and interstate connections, which might not ordinarily be required or relevant to the main focus of the investigation. But we do that to predicate a Federal offense, specifically a mail or wire fraud statute.

To do a Title 3, again, we would have to predicate, sometimes by convoluted reasoning, a mail or wire fraud scheme in order to get the benefits of that critical investigative tool.

To do a racketeering case, which we would do in very unusual but large cases where we have organized criminal elements, we again need to predicate it on mail or wire fraud or perhaps money laundering predicates because there is no health fraud statute, per se.

In some areas there are gaps in the law with respect to our ability to conduct investigations at all. One area would be in the kickback schemes that we're seeing on a national level and of many different varieties. One example would be a recent case that we worked where a representative from a medical diagnostic company paid kickbacks to chiropractors for x-rays, MRIs, thermography tests, and other complicated procedures. The businessmen induced chiropractors to perform those tests and billed private insurers by paying kickbacks to the chiropractors, anywhere from \$100 to \$300. The amount of the kickbacks over a 3-year period exceed \$144,000. The businessman was very careful—he made sure that the patients were not Medicare or Medicaid patients. Therefore, the kickbacks being paid to the chiropractor did not violate the Federal law because the tests were actually performed and there was no fraud against the private insurers.

By organizing that scheme in that way, he evaded completely the existing Federal statutes with respect to our ability to investigate. The insurance company then insures FBI special agents, SAMBA, as well as the government insurance plan, which insures most Members of the Congress, would fall prey to the same gap in the law, so to speak. If there was a similar kickback scheme involving those companies, as I outlined, we would have no Federal violation because of the care with which the criminal actor has picked his victims.

The health care system, as I mentioned, is increasingly victimized by organized criminal elements, and this is a new trend that we're seeing across the country. We would very much like to apply in a much more logical, as well as a much more efficient way, the investigative tools which have been most helpful for us in attacking organized crime. We see large groups of Russian organized criminal actors, for instance, on the West Coast, organizing multimillion tax schemes. We see tax fraud schemes, as well as health fraud schemes. We see other groups using tactics such as extortion, violence, as well as the usual table of tricks and frauds to victimize groups of people. The phony accident schemes, which are in some cases national in scope, involve many, many actors organized on a hierarchial basis going across State borders.

These are the types of groups which are particularly amenable to racketeering prosecutions, to the use of Title 3, electronic surveillance. In many cases, outlining a complex scheme to a jury is much more probative and much more credible by having a couple of conversations between the main actors directing the scheme than having an accountant sit up on a witness stand for 4 days going through books. These are some of the tools which we think could be applied very successfully with a lot of discrimination. We don't use these tools on a routine basis, but where we have complex organized criminal groups, they are particularly successful and I think we've used them with great success in the past.

As I said, I want to applaud the Committee's work not just with respect to its investigation but the legislation which is co-sponsored. Some of the aspects of that bill—the establishment of a fraud and abuse database, the coordination that would be required in antifraud efforts between the Department of Justice and HHS, the establishment of the antifraud account—I think are tremendously innovative and helpful tools, which can only serve to make the overall problem more amenable to enforcement.

With respect to the civil aspect of it, many cases that we investigate criminally fall short of the threshold that a given U.S. attorney might require for an indictment but are very amenable to actions in civil court and the provisions outlined in the proposed co-sponsored bill address that, I think, in a very effective way.

I'll just close by saying that we are certainly prepared to work closely with the Committee. Many times in law enforcement we're a little bit behind the curve in terms of where we need to be. If you look at the history of fighting organized crime, drugs, the S&L debacle, we always seem to be a little bit behind the problem. Some of that may be institutional inertia but a lot of it is just taking very scarce resources and applying them to new problems when we have in the universe of concerns many, many other problems. But I think this is one, given the dollar amounts and given the public safety of people who are victimized by some of these schemes, is certainly worth considering additional resources, and I applaud the Committee's consideration of that.

[The prepared statement of Mr. Freeh follows:]



U.S. Department of Justice
Federal Bureau of Investigation

Office of the Director

Washington, D.C. 20535

STATEMENT
OF
LOUIS J. FREEH
DIRECTOR
FEDERAL BUREAU OF INVESTIGATION

GOOD MORNING, MR. CHAIRMAN AND MEMBERS OF THE
COMMITTEE.

TODAY THIS COMMITTEE BEGINS HEARINGS ON A CRIME PROBLEM
SO SIGNIFICANT THAT IT AFFECTS ONE-SEVENTH OF THIS NATION'S
ECONOMY -- THE HEALTH CARE SYSTEM. I APPLAUD YOUR FORESIGHT IN
HOLDING THIS HEARING. I ALSO AM COMMITTED TO WORKING WITH YOU
AND CONGRESS TO ENSURE THAT LAW ENFORCEMENT HAS THE TOOLS THAT
ARE NEEDED TO COMBAT THE BURGEONING HEALTH CARE CRIME CRISIS.
DURING THE PAST FEW YEARS, THE FBI HAS MADE AN INCREASING EFFORT
TO COMBAT HEALTH CARE FRAUD.

BY CONSERVATIVE ESTIMATES, FRAUD IN THE HEALTH CARE
SYSTEM COSTS \$44 BILLION ANNUALLY. AT PRESENT, THE FBI HAS 249
AGENTS FUNDED TO HEALTH CARE INVESTIGATIONS. LAST YEAR, THE FBI
ACHIEVED 353 CRIMINAL CONVICTIONS AND RECOVERED \$480 MILLION IN
FINES, RECOVERIES AND RESTITUTIONS, IN ADDITION TO \$32.7 MILLION
IN PROCEEDS THAT WERE SEIZED OR FORFEITED TO THE GOVERNMENT.
WHILE THESE ACCOMPLISHMENTS ARE SIGNIFICANT, THE CRIME PROBLEM IS
SO BIG AND SO DIVERSE THAT WE ARE MAKING ONLY A SMALL DENT IN
ADDRESSING THE FRAUD.

MORE RESOURCES AND LEGAL TOOLS ARE NEEDED IF LAW
ENFORCEMENT IS TO MAKE GREATER HEADWAY IN CURBING THE FRAUDULENT
ACTIVITY INVOLVED IN THE \$884 BILLION PER YEAR HEALTH CARE
INDUSTRY. IF NOT, INSURANCE COSTS TO POLICYHOLDERS WILL CONTINUE
TO SKYROCKET. TODAY, I WANT TO TALK ABOUT THE CHANGING FACES OF
THE HEALTH CARE CRIMINAL AND DESCRIBE TO THE COMMITTEE THE
CRIMINAL ENTERPRISES THAT PLAGUE OUR NATION'S HEALTH CARE SYSTEM.

AT THE OUTSET, I WOULD LIKE TO NOTE THAT A LARGE PERCENTAGE OF HEALTH CARE PROFESSIONALS AND BUSINESSES PROVIDE QUALITY MEDICAL TREATMENT AND BILL HONESTLY FOR THEIR SERVICES. SADLY, TODAY'S HONEST HEALTH CARE PROFESSIONALS MUST CO-EXIST WITH PROFESSIONAL CON-MEN AND THIEVES IN A COMPLEX BUSINESS ENVIRONMENT. THE MEDICAL COMMUNITY IS FORCED TO ENDURE THE TAINT THESE CRIMINALS BRING TO A PROFESSION DEDICATED TO HEALING THE SICK AND SAVING LIVES.

DURING THE PAST FIVE YEARS, THE LAW ENFORCEMENT COMMUNITY HAS ENCOUNTERED SOME INVESTIGATIVE AS WELL AS PROSECUTIVE HURDLES IN TRYING TO ADDRESS THESE CASES. WE HOPE THAT CONGRESS WILL EXAMINE THE NEED FOR NEW CRIMINAL ENFORCEMENT AND INVESTIGATIVE TOOLS.

SCHEMES CRAFTED BY HEALTH CARE CRIMINALS HAVE CHANGED DRAMATICALLY IN THE PAST FEW YEARS. INDEED, ORGANIZED CRIMINAL ENTERPRISES HAVE PENETRATED VIRTUALLY EVERY LEGITIMATE SEGMENT OF THE HEALTH CARE INDUSTRY. SOME EXAMPLES OF THEIR SCHEMES INCLUDE:

♦ IN SOUTH FLORIDA AND SOUTHERN CALIFORNIA, WE HAVE SEEN COCAINE DISTRIBUTORS SWITCH FROM DRUG DEALING TO HEALTH CARE FRAUD SCHEMES. THE REASON - THE RISKS OF BEING CAUGHT AND IMPRISONED ARE LESS. DRUG DEALERS WHO ARE COMMITTING HEALTH CARE FRAUD KNOW THAT THEY LIKELY WILL FACE ONLY MINOR PUNISHMENTS BECAUSE LAW ENFORCEMENT IS NOT YET EQUIPPED WITH THE LAWS NEEDED TO EFFECTIVELY ATTACK THIS PROBLEM.

♦ THROUGHOUT THE UNITED STATES, ORGANIZED CRIMINAL GROUPS HAVE COMPROMISED DOCTORS, CHIROPRACTORS AND ATTORNEYS. THESE GROUPS ESTABLISH STOREFRONT CLINICS, DIAGNOSTIC TESTING COMPANIES AND BOGUS LAW OFFICES. THEY STAGE PHONY CAR ACCIDENTS. AS PART OF THE SCHEME, PHONY PATIENTS VISIT THE CLINICS, GENERATING BILLS FOR EXAGGERATED MEDICAL PROCEDURES THAT ARE PROVIDED. THESE INCLUDE UNNECESSARY TESTS FOR MRI'S, X-RAYS AND OTHER SOPHISTICATED TESTS WHICH ARE PERFORMED AND BILLED TO INSURERS. IN SOME CASES, BILLS ARE SUBMITTED WHEN NO MEDICAL TREATMENTS WERE EVEN ADMINISTERED. THE BOGUS LAW OFFICES THEN COLLECT PERSONAL INJURY CLAIMS. FURTHER, THESE GROUPS HAVE EXTORTED AND PHYSICALLY INTIMIDATED WITNESSES. THEIR SCHEMES HAVE RESULTED IN BILLIONS OF DOLLARS IN LOSSES TO INSURERS AND INCREASED PREMIUMS TO POLICYHOLDERS. IN FACT, THE NATIONAL INSURANCE CRIME BUREAU REPORTS THAT THE AVERAGE HOUSEHOLD PAYS \$200 A YEAR IN ADDED AUTO INSURANCE PREMIUMS DUE TO FRAUD.

♦ IN THE PACIFIC NORTHWEST, "BROKER-TRANSLATORS" HAVE EXTORTED KICKBACKS FROM IMMIGRANTS AND PAID BRIBES TO STATE EMPLOYEES IN THE WELFARE DEPARTMENT. THE IMMIGRANTS, WHO ARE CERTIFIED MEDICALLY DISABLED, BEGIN RECEIVING LONG-TERM SOCIAL SECURITY BENEFITS. THE SAME IMMIGRANTS HAVE BECOME ELIGIBLE FOR MEDICAID AND FOOD STAMP BENEFITS. IN ONE CASE, LOSSES TO SOCIAL SECURITY, MEDICAID AND THE FOOD STAMP PROGRAM ARE IN THE HUNDREDS OF MILLIONS OF DOLLARS.

♦ WE HAVE SEEN NATIONAL HEALTH CARE CORPORATIONS ENGAGING IN CRIMINAL BILLING SCHEMES TO INCREASE PROFITS. LOSSES FROM FRAUD IN THESE CASES ARE IN THE BILLIONS OF DOLLARS.

♦ THROUGHOUT THE UNITED STATES, MEDICAL INSTITUTIONS WORKING ILLICITLY THROUGH "BROKERS" ARE PAYING KICKBACKS TO MEDICAL PROFESSIONALS AND OTHERS RESPONSIBLE FOR REFERRING CHEMICALLY DEPENDENT AND DEPRESSED PATIENTS TO THEIR FACILITIES.

♦ NURSING HOME AND HOSPICE OPERATORS EXPLOIT THE ELDERLY AND ALZHEIMER'S PATIENTS BY FRAUDULENTLY BILLING FOR SERVICES, INCONTINENCE SUPPLIES AND MEDICATIONS. TRAGICALLY, CRIMINALS PREY ON PATIENTS WHO HAVE DIFFICULTY UNDERSTANDING OR REMEMBERING THESE ILLEGAL ACTIVITIES, MUCH LESS ALERTING LAW ENFORCEMENT ABOUT THE PROBLEM.

THE LIST OF SCHEMES IS AS BROAD AS THE CRIMINALS' IMAGINATIONS. THE SINGLE THREAD THAT WEAVES THROUGH EACH INVESTIGATION IS CORRUPTING THE BUSINESS-SIDE OF MEDICAL CARE. WHETHER IT IS A GOVERNMENT AGENCY, PRIVATE INSURER, OR PRIVATE CITIZEN -- THE SYSTEM IS BUILT ON PAYORS WHO MUST TRUST THOSE WHO SUBMIT CLAIMS FOR MEDICAL SERVICES, MEDICATIONS, TREATMENTS AND SUPPLIES.

HEALTH CARE FRAUD IS A TOP NATIONAL PRIORITY OF THE FBI. DEDICATED HEALTH CARE FRAUD SQUADS HAVE BEEN ESTABLISHED IN SEVEN OF OUR LARGEST FIELD OFFICES: BALTIMORE, CHICAGO, DETROIT, LOS ANGELES, MIAMI, NEW YORK AND PHILADELPHIA. WE HAVE FORMED ADDITIONAL HEALTH CARE FRAUD SQUADS IN DALLAS, HOUSTON AND NEW HAVEN. MOST RECENTLY, TWO HEALTH CARE FRAUD SQUADS HAVE BEEN DEVELOPED IN WASHINGTON, D.C.

THE FBI HAS DEDICATED MORE MONEY, RESOURCES, TIME AND ENERGY TO ITS HEALTH CARE FRAUD INITIATIVE. MORE MUST BE DONE. HEALTH CARE FRAUD HAS NOT BEEN INVESTIGATED AND PROSECUTED AS EFFICIENTLY AND EFFECTIVELY AS WE WOULD LIKE DUE TO RESOURCE ISSUES AND LITIGATION OVER SCOPE OF FEDERAL LAWS. UNFORTUNATELY, MOST FBI FIELD OFFICES REPORT A LARGE NUMBER OF UNADDRESSED CASES. SEVERAL OFFICES HAVE CHARACTERIZED THE HEALTH CARE FRAUD PROBLEM WHICH THEY CAN ADDRESS AS ONLY THE "TIP OF THE ICEBERG" IN THE OVERALL HEALTH CARE CRIME PROBLEM FOR THEIR TERRITORIES.

AS I STATE, THE FBI PRESENTLY HAS 249 AGENTS ASSIGNED TO HEALTH CARE CASES, UP FROM 97 IN 1992. (SEE ATTACHED CHART). THE FBI'S HEALTH CARE CASELOAD HAS INCREASED TO OVER 1,500 PENDING MATTERS - A 142 PERCENT INCREASE IN ONLY TWO AND A HALF YEARS.

AS I INDICATED PREVIOUSLY, NO SEGMENT OF THE HEALTH DELIVERY SYSTEM IS IMMUNE FROM FRAUD. IRONICALLY, ALL TYPES OF RECIPIENTS, PROVIDERS AND BUSINESS PEOPLE ARE COMMITTING FRAUD. MANY OF THE SCHEMES PRESENTLY UNDER INVESTIGATION ARE HIGHLY COMPLEX AND DIFFICULT TO PROVE. THESE INVESTIGATIONS REQUIRE LARGE INVESTMENTS OF RESOURCES, TIME AND EFFORT.

BECAUSE OF THE DEMANDS OF THESE INVESTIGATIONS, THE FBI HAD ADOPTED A TEAM CONCEPT IN ADDRESSING THIS PROBLEM. A LARGE PERCENTAGE OF OUR INVESTIGATIONS ARE BEING CONDUCTED JOINTLY WITH OTHER AGENCIES, PARTICULARLY THE HHS OFFICE OF INSPECTOR GENERAL AND THE STATE MEDICAID FRAUD CONTROL UNITS. MOST OF OUR FIELD OFFICES ARE ENGAGED IN ONE OR MORE HEALTH CARE FRAUD TASK FORCES OR WORKING GROUPS. THE FBI ALSO HAS REGULAR AND PRODUCTIVE CONTACTS WITH STATE AND LOCAL AGENCIES AND THE INSURANCE INDUSTRY, INCLUDING GROUPS SUCH AS THE NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION OF THE NATIONAL INSURANCE CRIME BUREAU. WE HAVE REACHED OUT TO PROFESSIONAL ORGANIZATIONS SUCH AS THE AMERICAN MEDICAL ASSOCIATION AND THE FEDERATION OF CHIROPRACTIC LICENSING BOARDS. EACH OF THESE ORGANIZATIONS BRINGS ESSENTIAL SKILLS AND KNOWLEDGE TO OUR ENFORCEMENT EFFORTS. WE ARE EXPANDING OUR RELATIONSHIPS WITH SIMILAR TYPES OF ORGANIZATIONS.

THE FBI HAS EXPANDED ITS HEALTH CARE FRAUD TRAINING PROGRAM TO INCLUDE AGENTS, STATE AND FEDERAL PROSECUTORS, INVESTIGATORS FROM PRIVATE INSURERS AND REPRESENTATIVES FROM STATE AND FEDERAL REGULATORY AGENCIES. SINCE 1992, THE FBI HAS SPONSORED FIVE TRAINING SEMINARS FOR PRIVATE HEALTH INSURANCE EXECUTIVES. ALL OF OUR TRAINING SEMINARS HAVE FOCUSED ON IDENTIFYING FRAUD TRENDS IN THE MEDICAL SYSTEM, COORDINATION OF INVESTIGATIONS, DEVELOPING INNOVATIVE INVESTIGATIVE TECHNIQUES, SHARING INFORMATION, AND DAY-TO-DAY STRENGTHENING OF WORKING RELATIONSHIPS.

THIS COORDINATED EFFORT WITH PRIVATE INSURERS AND OTHER AGENCIES HAS RESULTED IN MANY CHANGES. THESE CHANGES HAVE MADE IT HARDER FOR CRIMINALS TO PURSUE THEIR ILLEGAL ACTIVITIES.

IN ONE OF THE FBI'S BIGGEST HEALTH CARE FRAUD CASES, CODE-NAMED "GOLDPILL", THE FBI ATTACKED DRUG DIVERSION ON THE STREETS OF NEW YORK AND IN SEVENTEEN OTHER CITIES THROUGHOUT THE UNITED STATES. PRIOR TO EXPOSURE OF THE CRIME PROBLEM, MEDICAID PATIENTS WERE ALLOWED TO BILL MEDICAID FOR UNLIMITED SUPPLIES OF

PRESCRIPTION DRUGS. MEDICAID PATIENTS WOULD VISIT CLINICS AND PHARMACIES ON A DAILY BASIS AND SELL THEIR PRESCRIPTIONS ON THE STREET FOR CASH. NEW YORK'S MEDICAID SYSTEM ESTIMATED OVER \$400 MILLION WAS BEING SQUANDERED ANNUALLY THROUGH THESE SCHEMES.

THE CLINIC VISITS OF MEDICATIONS WERE ALL BILLED TO MEDICAID. SINCE EXPOSURE OF THE PROBLEM, NEW YORK AND OTHER STATE MEDICAID SYSTEMS HAVE ADJUSTED THEIR REIMBURSEMENT PROCEDURES. THEY NOW LIMIT THE NUMBER OF PRESCRIPTIONS MEDICAID PATIENTS CAN RECEIVE ON AN ANNUAL BASIS.

IN ANOTHER EXAMPLE, THE INVESTIGATION OF A NATIONAL PSYCHIATRIC HOSPITAL CHAIN PROMPTED MANY PRIVATE INSURERS, AS WELL AS THE GOVERNMENT, TO REVIEW REIMBURSEMENT POLICIES FOR PSYCHIATRIC AND CHEMICALLY DEPENDENT PATIENT HOSPITAL STAYS.

STATISTICALLY, FBI HEALTH CARE FRAUD CONVICTIONS HAVE RISEN DRAMATICALLY EACH YEAR SINCE 1992. (SEE ATTACHED CHARTS). FINANCIAL RECOVERIES HAVE RETURNED MONEY TO THE FEDERAL GOVERNMENT, STATES AND PRIVATE INSURERS. INDEED, THESE ACCOMPLISHMENTS HAVE MORE THAN PAID FOR THE COSTS ASSOCIATED WITH INVESTIGATING MANY OF THESE COMPLEX CASES AND ENTERPRISES. IN HEALTH CARE INVESTIGATIONS, THE RETURN HAS BEEN \$13.65 IN FINES, RECOVERIES, RESTITUTIONS AND FORFEITURES FOR EVERY DOLLAR SPENT.

ACCORDING TO THE NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION AND OTHER INDUSTRY WATCHDOGS, THIS NATION'S HEALTH CARE SYSTEM LOSES UP TO FIVE PERCENT OF WHAT AMERICANS SPEND ON HEALTH CARE, OR \$44 BILLION EACH YEAR, TO FRAUD. MANY OF THESE SCHEMES HAVE BECOME VERY IMAGINATIVE. THEY OFTEN ARE SO CREATIVE THEY AFFORD CLEVER DEFENSE ATTORNEYS THE OPPORTUNITY TO ARGUE THAT THEY DO NOT FALL STRICTLY WITHIN THE ELEMENTS FOR PROSECUTION UNDER CURRENT FEDERAL LAWS.

THERE ARE MANY COMMON HEALTH CARE FRAUDS THE FBI HAS UNCOVERED: FRAUDULENT BILLING SCHEMES BY DURABLE MEDICAL EQUIPMENT SUPPLIERS; NURSING HOMES SCAMS; HOSPITAL BILLING FRAUDS; PSYCHIATRIC HOSPITAL AND DIET CLINIC SCAMS; LABORATORY FRAUDS; PHARMACEUTICAL FRAUDS; CORRUPT BILLING SCHEMES BY PHYSICIANS; "ROLLING LAB" SCAMS WHICH PREY ON THE ELDERLY AND DEFRAUD MEDICARE AND PRIVATE INSURERS; WORKMEN'S COMPENSATION FRAUDS; HOME HEALTH CARE SCHEMES; AND, MANY OTHER FRAUDS BY CORRUPT BUSINESSES WHICH PROVIDE ANCILLARY SERVICES TO THE HEALTH CARE INDUSTRY. LET ME ELABORATE ON SOME OF THE SCHEMES WE HAVE DETECTED.

KICKBACKS

KICKBACKS OCCUR IN VIRTUALLY EVERY SEGMENT OF THE HEALTH CARE SYSTEM. THE INDUCEMENTS OFFERED TO PROVIDERS TAKE BOTH UNSOPHISTICATED AND COMPLEX FORMS. IN ONE RECENT CASE, A MAJOR HOSPITAL CORPORATION SOUGHT THE REFERRAL OF PATIENTS FROM DOCTORS IN THEIR COMMUNITIES. TO INDUCE THOSE DOCTORS TO REFER PATIENTS TO THEIR FACILITIES, THE MEDICAL CENTER PURCHASED THE OFFICE BUILDINGS OWNED BY THE DOCTORS AT TWICE THE BUILDING'S VALUE. ANOTHER MEDICAL COMPANY SELLING PACEMAKERS PROVIDED FREE TRIPS AND PROSTITUTES TO DOCTORS TO INDUCE THEM TO USE THEIR PRODUCT.

SOME COMPANIES PAY MEDICAL DOCTORS AND ADMINISTRATORS IN TEACHING HOSPITALS HUGE SUMS OF MONEY FOR ACCESS TO THEIR PATIENT BASES. THE FUNDS PROVIDED TO THE DOCTORS ARE DISGUISED AS INDIVIDUAL RESEARCH GRANTS. IN SOME CASES, THE RESEARCH REPORTS ARE PREPARED BY COMPANY EMPLOYEES OR STUDENTS AND SUBMITTED UNDER THE DOCTOR'S NAME. IN SOME CASES, CASH IS PAID FOR THE DOCTOR'S REFERRALS.

THE LIST OF TYPES OF KICKBACKS IS ENDLESS. REGRETTABLY, THE FEDERAL ANTI-KICKBACK LAW ONLY APPLIES WHEN MEDICARE OR MEDICAID PATIENTS ARE BEING TREATED, AND DOES NOT EXPLICITLY COVER OTHER GOVERNMENT PROGRAMS AND PRIVATE INSURANCE PLANS. CURRENT FEDERAL LAW DOES NOT EXPLICITLY COVER OTHER GOVERNMENT HEALTH CARE PROGRAMS. BROADER KICKBACK LAWS ARE NEEDED WITH BOTH CIVIL AND CRIMINAL REMEDIES TO COVER ALL FEDERAL HEALTH CARE PROGRAMS AND PRIVATE INSURERS.

DURABLE MEDICAL EQUIPMENT (DME) FRAUDS

FBI INVESTIGATIONS AND THE RESULTING INTELLIGENCE DEVELOPED HAVE SHOWN THAT DME FRAUD IS A SIGNIFICANT CRIMINAL PROBLEM. DME FRAUDS ARE PERPETRATED THROUGH SEVERAL SCHEMES. DME COMPANIES OFTEN PAY KICKBACKS TO DOCTORS, NURSING HOMES, AND HOSPITALS FOR OBTAINING SUPPLY CONTRACTS. MEDICARE AND PRIVATE INSURANCE COMPANIES ARE PROGRAMS EASILY TARGETED BY THESE UNSCRUPULOUS BUSINESSMEN. IN NEW YORK, RUSSIAN ORGANIZED CRIME HAS ENGAGED IN A COMPLEX CONSPIRACY THROUGH THE SUBMISSION OF TENS OF MILLIONS OF DOLLARS IN FRAUDULENT DME CLAIMS. SUBJECTS HAVE BEEN KNOWN TO USE AGGRESSIVE TELEMARETING SCAMS TO FRAUDULENTLY BILL FOR UNNECESSARY DME SUPPLIES AND SERVICES. OTHER SUBJECTS OBTAIN PATIENT LISTS FROM NURSING HOMES AND ROUTINELY BILL FOR PRODUCTS OR SERVICES WHICH ARE NEITHER NEEDED NOR RENDERED.

PSYCHIATRIC HOSPITALS

IN RECENT YEARS, HEALTH CARE BENEFITS HAVE EXPANDED TO COVER TREATMENTS FOR SUBSTANCE ABUSE, ALCOHOLISM, AND MENTAL DEPRESSION. PUBLICLY TRADED COMPANIES ENGAGE IN CORPORATE-DRIVEN SCHEMES TO MAXIMIZE BILLINGS FOR PATIENT BENEFICIARIES. GENERALLY, HEALTH INSURANCE ALLOWS FOR COVERAGE OF IN-PATIENT TREATMENT UP TO 28 DAYS, THUS ENABLING HOSPITALS TO COLLECT UP TO \$40,000 PER PATIENT. UNFORTUNATELY, GREEDY BUSINESSMEN ARE PREYING ON INDIVIDUALS WITH HEALTH PROBLEMS, PROFITING AT THEIR EXPENSE. IN ADDITION, THESE BUSINESSMEN AND PROFESSIONALS ARE DEFRAUDING GOVERNMENT PROGRAMS AND PRIVATE INSURERS OF BILLIONS OF DOLLARS ANNUALLY FROM IN-PATIENT HOSPITALIZATION. WE HAVE EVEN IDENTIFIED CASES WHERE PATIENTS HAVE BEEN FRAUDULENTLY DIAGNOSED AND FORCIBLY ADMITTED INTO PSYCHIATRIC TREATMENT PROGRAMS WHEN LEGITIMATE DOCTORS DETERMINED THEY POSED NO THREAT TO THE COMMUNITY OR THEMSELVES.

OFTEN, PATIENTS ARE SUBJECTED TO BATTERIES OF BLOOD TESTS, X-RAYS, SHOCK TREATMENT, AND OTHER SERVICES. ONE SUCH TREATMENT INVOLVES THE DOCTOR PROVIDING THE PATIENT WITH "WAVE" THERAPY, WHICH INVOLVES A SIMPLE "WAVE" OF THE DOCTOR'S HAND DURING ROUTINE ROUNDS. THEREAFTER, THE DOCTOR'S SUBMITS BILLS TO THE GOVERNMENT PROGRAM OR INSURANCE COMPANIES FOR \$125 FOR INDIVIDUAL THERAPY. THERE HAVE BEEN NUMEROUS ALLEGATIONS ABOUT THIS FROM PRIVATE INSURERS INVOLVING MILLIONS OF DOLLARS OF FRAUDULENT BILLINGS.

DIET CLINICS

DIET CLINICS INVOLVED IN CRIMINAL ACTIVITY PERPETUATE FRAUD BY SOLICITING PATIENTS -- USUALLY THROUGH MASS MEDIA -- AND PROMISE WEIGHT LOSS AT NOMINAL EXPENSE TO THE PATIENT. CUSTOMERS WHO FREQUENT DIET CLINICS ARE OFTEN REQUIRED TO UNDERGO A CURSORY PSYCHOLOGICAL EXAMINATION, A SERIES OF BLOOD TESTS, X-RAYS AND OTHER ANCILLARY TESTS. THESE SERVICES ARE THEN BILLED TO INSURERS UNDER THE FALSE PRETENSE OF A MANUFACTURED PSYCHOLOGICAL MALADY.

THESE CLINICS SOLICIT PATIENTS PROMISING AN IN-HOUSE RESPITE AT A COUNTRY CLUB-TYPE FACILITY. PATIENTS ARE PROVIDED AIRFARE AT NO EXPENSE -- AND ARE OFTEN PROVIDED A CHAUFFEURED LIMOUSINE TO THE HOSPITAL. GROUP THERAPY SESSIONS, SUCH AS TRIPS TO SHOPPING MALLS, AMUSEMENT PARKS AND DEEP SEA FISHING EXCURSIONS, ARE BILLED AS TREATMENT FOR MENTAL ILLNESS. THE HOSPITAL STAY, AS WELL AS ALL SERVICES PROVIDED, ARE BILLED TO PRIVATELY INSURED CARRIERS BASED UPON A PURPORTED PSYCHIATRIC DIAGNOSIS WHEN, IN FACT, THE PATIENTS WERE AT THE CLINIC TO LOSE WEIGHT.

THE CLINICS ACCOMPLISH THE FRAUD BY MISREPRESENTING THE MEDICAL CONDITIONS OF THEIR CUSTOMERS IN ORDER TO JUSTIFY PAYMENTS FOR THE TESTS AND OTHER SERVICES.

WHEN CONDUCTING THESE INVESTIGATIONS, IT IS DIFFICULT TO DIFFERENTIATE CONCERN FOR THE PATIENT'S RECOVERY AND BUSINESS PROFITS. MANY CASES ARE SOLVED BY THE COOPERATION OF HONEST EMPLOYEES AND THE USE OF SOPHISTICATED INVESTIGATIVE TECHNIQUES. SOME INVESTIGATIONS HAVE REVEALED THAT TAXI, LIMOUSINE, AND SHUTTLE BUS SERVICES ARE OFTEN DISGUISED IN BILLINGS TO INSURANCE COMPANIES AS AMBULANCE SERVICES. TO DATE, FRAUDS OF THIS NATURE HAVE RESULTED IN BILLIONS OF DOLLARS PAID BY PRIVATE INSURANCE COMPANIES.

SOME DIET CLINICS AND PSYCHIATRIC HOSPITALS NOW CONTRACT WITH AND PAY FOR "OUTREACH COUNSELOR" OR "BROKERS". THEY ACT AS MIDDLEMEN WHO, IN TURN, PAY PSYCHIATRISTS, PSYCHOLOGISTS, SOCIAL WORKERS, ALCOHOL COUNSELORS, SCHOOL COUNSELORS AND PROBATION OFFICERS FOR SENDING PATIENTS TO THESE FACILITIES.

PHARMACEUTICAL DIVERSIONS AND PHARMACY BILLING FRAUD

THE FBI'S EFFORTS IN OPERATION GOLDPILL, IN COORDINATION WITH THE FOOD AND DRUG ADMINISTRATION AND THE DRUG ENFORCEMENT ADMINISTRATION, MAY BEST ILLUSTRATE THE BREADTH OF CRIMINAL ACTIVITY CONTAMINATING THE HEALTH CARE INDUSTRY.

OPERATION GOLDPILL INVOLVED THE INVESTIGATION OF TWO TYPES OF MEDICAL FRAUD SCHEMES. THE FIRST SCHEME INVOLVED THE DIVERSION OF NON-CONTROLLED PHARMACEUTICAL MEDICATIONS -- THE KIND OF DRUGS ALL OF US OBTAIN LEGALLY WITH A DOCTOR'S PRESCRIPTION. DIVERTED, CONTAMINATED PRESCRIPTION DRUGS WERE SENT THROUGHOUT THE UNITED STATES AND WERE BEING SOLD TO THE UNSUSPECTING PUBLIC.

IN OPERATION GOLDPILL, THE FBI USED COURT-ORDERED TELEPHONE WIRETAPS TO BROADEN ITS INVESTIGATION. IN WRITTEN AFFIDAVITS SUPPORTING THE ARRESTS, SUBJECTS WERE QUOTED SPEAKING TO PHARMACISTS AND OTHER DIVERTERS ABOUT THEIR ACTIVITY.

TWO DIVERTERS WERE OVERHEARD MOCKING CRIMINAL PENALTIES SAYING "...MOST OF THE TIME YOU GET TWENTY YEARS TO LIFE YOU WALK OUT ON YOUR OWN RECOGNIZANCE." LATER IN THE SAME CONVERSATION, THE DIVERTERS DISCUSSED THE VAST AMOUNTS OF CASH BEING GENERATED BY THE FRAUD SCHEME AND SAID THEY COULD NOT KEEP PUTTING TWENTIES IN THEIR "VAULT BOX" BECAUSE IT WAS TAKING UP SO MUCH SPACE. ONE DIVERTER REMARKED, "YOU'RE GOING TO HAVE TO HAVE A MAUSOLEUM."

OTHER FBI INVESTIGATIONS CONTINUE TO DEMONSTRATE THAT PHARMACEUTICAL DIVERSIONS REMAIN A SIGNIFICANT CRIMINAL PROBLEM THROUGHOUT THE UNITED STATES.

THE SECOND PERVERSIVE CRIMINAL ACTIVITY THAT THE "GOLDPILL" CASES FOCUSED ON IS THE FRAUDULENT SUBMISSION OF BILLS BY PHARMACIES. THIS SCHEME DELIBERATELY DEFRAUDS FEDERALLY FUNDED MEDICAID PROGRAMS AND PRIVATE INSURANCE CARRIERS, DRIVING UP THE COSTS OF HEALTH CARE TO ALL CONSUMERS AND TAXPAYERS.

DOCTORS

PHYSICIAN FRAUDS REVOLVE AROUND THE SUBMISSION OF FALSE CLAIMS TO THE GOVERNMENT AND PRIVATE INSURERS, AS WELL AS THE RECEIPT OF KICKBACKS. INVESTIGATIONS HAVE REVEALED FALSE BILLINGS BY DOCTORS OCCURRING WHEN:

- ♦ THE SERVICE WAS NEVER RENDERED;
- ♦ A SERVICE WAS IN FACT RENDERED, BUT A MORE EXPENSIVE PROCEDURE WHICH WAS NOT PERFORMED WAS BILLED;
- ♦ THE SERVICE WAS PERFORMED FEWER TIMES THAN IT WAS BILLED;
- ♦ THE DIAGNOSIS CODE ON THE BILLING WAS ALTERED TO REFLECT MORE EXPENSIVE TREATMENT AND PROCEDURES;
- ♦ THE SERVICES WAS NOT RENDERED BY THE QUALIFIED PROFESSIONAL BUT WAS RENDERED BY A LESSER QUALIFIED OR UNQUALIFIED INDIVIDUAL;
- ♦ CHIROPRACTORS PERFORMING SIMPLE THERAPY ON A PATIENT AND THEN BILLING FOR MULTIPLE PROCEDURES; OR,
- ♦ PODIATRISTS BILLING FOR EXTENSIVE MEDICAL PROCEDURES WHEN THEY ACTUALLY ONLY CLIPPED A PATIENT'S TOENAILS.

LABORATORY SCAMS

ONE EXAMPLE OF A TYPICAL LAB SCAM INVESTIGATED BY THE FBI INVOLVED MEDICAL LABORATORIES WHICH "SINK TEST" BLOOD AND URINE. IN THIS "PROCEDURE," BLOOD AND URINE SPECIMENS ARE DUMPED DOWN THE SINK BY LAB PERSONNEL WITHOUT PERFORMING ANY TESTS. THE LAB THEN REPORTS THE TEST RESULTS AS BEING WITHIN NORMAL RANGE.

TODAY, INVESTIGATION HAS SHOWN SOME CLINICAL LABORATORIES ENGAGE IN MASSIVE BILLING FRAUD SCHEMES. FOR EXAMPLE, CORPORATE OFFICERS HAVE CONSPIRED TO INCREASE BILLINGS TO THE GOVERNMENT AND PRIVATE INSURERS BY ADDING TESTS TO THEIR AUTOMATED BLOOD CHEMISTRY PANEL KNOWN AS SMAC (SEQUENTIAL MULTI-ANALYSIS COMPUTER). BECAUSE IT IS HIGHLY INFORMATIVE AND RELATIVELY CHEAP, THE SMAC SERIES IS THE SINGLE MOST POPULAR BLOOD LAB TEST ORDERED BY DOCTORS.

AS A PART OF THESE SCHEMES, COMPANIES MARKET THE CHEMISTRY PANEL AS PART OF A HEALTH SURVEY PROFILE THAT ALSO INCLUDES TESTS NOT INCLUDED IN THE STANDARD SMAC. AS A RESULT, DOCTORS WANTING THE STANDARD SMAC ARE MISLED INTO ORDERING THE ENTIRE PROFILE. HOWEVER, WHEN THE COMPANIES BILL THE TESTS TO THE GOVERNMENT, INSURERS OR PATIENTS, THE EXTRA TESTS ARE BILLED SEPARATELY AT A MUCH MORE EXPENSIVE RATE.

WHILE THIS MAY NOT SOUND SIGNIFICANT, THIS TYPE OF SCAM HAS A DRAMATIC PAYOFF. IN ONE RECENT CASE, TWO YEARS BEFORE A COMPANY ADDED FERRITIN (A TEST THAT MEASURES IRON IN THE BLOOD) TO THE PROFILE, MEDICARE PAID LESS THAN \$500,000 TO THE COMPANY FOR THE FERRITIN BLOOD TEST. TWO YEARS AFTER THE FERRITIN TEST WAS ADDED, THE COMPANY RECEIVED MORE THAN \$31 MILLION FROM MEDICARE IN INCREASED REVENUES.

ALSO, WE HAVE SEEN EVIDENCE OF LABS PAYING KICKBACKS TO CLINIC OWNERS OR DOCTORS FOR PERFORMING EXTENSIVE BLOOD WORK, URINE TESTS, MRI'S OR X-RAYS. PATIENTS THEMSELVES HAVE ACCEPTED CASH FOR PROVIDING THEIR MEDICARE/MEDICAID CARDS TO THE CLINIC OR LAB OWNERS.

WORKERS COMPENSATION AND ACCIDENT CLAIMS

PRIVATE INSURERS AND THE GOVERNMENT LOSE BILLIONS OF DOLLARS ANNUALLY TO PHONY AUTOMOBILE ACCIDENT AND "SLIP-AND-FALL" CLAIMS. ONGOING INVESTIGATIVE MATTERS AND THEIR RESULTING INTELLIGENCE INDICATE THAT FEDERAL AND STATE GOVERNMENTS, AS WELL AS PRIVATE INSURERS, LOSE BILLIONS OF DOLLARS IN MEDICAL AND LIABILITY CLAIMS ANNUALLY TO MEDICAL DOCTORS, LAWYERS, AND PARTIES FAKING INJURY. NORMALLY, BASED STRICTLY ON THE FINANCIAL DECISION TO AVOID LITIGATION COSTS, INSURANCE COMPANIES AGREE TO SETTLE CLAIMS, AT TIMES THROUGH ARBITRATION. THE CORRUPT CHIROPRACTOR, DOCTOR AND ATTORNEY SOMETIMES CONSPIRE IN STRUCTURING THE FRAUD SO THAT THE ARBITRATOR IS NOT ABLE TO DETERMINE THAT THE CLAIM IS INVALID.

HOSPITAL AND NURSING HOME FRAUDS

SOME NURSING HOMES AND HOSPITALS OFTEN BILL INSURERS OR FEDERAL GOVERNMENT PROGRAMS. FRAUDS REVOLVE AROUND THE SUBMISSION OF FALSE CLAIMS. FALSE BILLINGS BY HEALTH CARE PROVIDERS GENERALLY OCCUR WHEN:

- ♦ SERVICES ARE NEVER RENDERED;
- ♦ A SERVICE IS RENDERED, BUT A MORE EXPENSIVE PROCEDURE IS BILLED;
- ♦ THE SERVICE IS PERFORMED FEWER TIMES THAN IT IS BILLED;
- ♦ THE DIAGNOSIS CODE IS ALTERED TO JUSTIFY MORE EXPENSIVE TREATMENT AND PROCEDURES; OR,
- ♦ THE SERVICE IS NOT RENDERED BY THE QUALIFIED PROFESSIONAL BUT IS RENDERED BY A LESSER QUALIFIED OR UNQUALIFIED INDIVIDUAL.

IN TWO RECENT CASES IN SEPARATE PARTS OF THE COUNTRY, HOSPITAL ADMINISTRATORS HAVE BEEN CONVICTED FOR EMBEZZLING FUNDS FROM THEIR FACILITIES USING ELABORATE MONEY LAUNDERING SCHEMES. EACH OF THOSE CASES HAS LED TO OTHER SIGNIFICANT FRAUD

INVESTIGATIONS INVOLVING DOCTORS AND BUSINESSES THAT DO BUSINESS OR PRACTICE MEDICINE AT THE HOSPITALS.

FALSE REPRESENTATIONS ARE ALSO MADE IN THE PREPARATION OF MEDICARE COST REPORTS. COST REPORTS ARE PREPARED BY ALL HOSPITALS, NURSING HOMES AND HOME HEALTH CARE AGENCIES WHICH PROVIDE SERVICES, TREAT OR BILL MEDICARE PATIENTS. THESE COST REPORTS ARE PREPARED BY EACH SEPARATE MEDICAL FACILITY AND SUBMITTED ON AN ANNUAL BASIS TO A MEDICARE FISCAL INTERMEDIARY OR MEDICARE CARRIER. OFTEN, THE COST REPORTS CONTAIN IMPROPER AND EXTRAVAGANT EXPENSES ATTRIBUTED TO THESE FACILITIES WHICH ARE PASSED ON TO MEDICARE.

HOME HEALTH CARE

HOME HEALTH CARE IS FAST BECOMING AN ALTERNATE PRESCRIPTION FOR IN-PATIENT HOSPITAL TREATMENT. UNFORTUNATELY, NO RECIPE FOR IMPROVING PATIENT CARE CAN EXIST WITHOUT POTENTIALLY ADDING THE FRAUD INGREDIENT. SOME HOME HEALTH CARE PROVIDERS FRAUDULENTLY BILL FOR SERVICES NOT RENDERED, PAY KICKBACKS TO HOSPITAL STAFF AND DOCTORS FOR PATIENT REFERRALS, AND BILL FOR A SERVICE WHICH WAS PERFORMED MORE TIMES THAN IT WAS PROVIDED.

IN A RECENT CASE, AGENTS DISCOVERED THE PRESENCE OF AN ORGANIZED CRIMINAL ENTERPRISE PROVIDING FRAUDULENT HOME HEALTH CARE SERVICES. THIS CONSPIRACY OPERATED THROUGHOUT MANY STATES. FURTHER INVESTIGATION DETERMINED THAT SEVERAL BUSINESSES OPERATED AS BROKERS WHO SOUGHT OUT CORRUPT PHYSICIANS AND MATCHED THEM WITH HOME INFUSION AGENCIES WHICH ENCOURAGED THE USE OF THEIR SERVICES. THE HOME INFUSION PROVIDERS WERE FOUND TO BE PAYING KICKBACKS TO THE PHYSICIANS FOR EACH PATIENT PRESCRIBED IN HOME TREATMENT. THE FEDERALLY FUNDED MEDICARE PROGRAM AS WELL AS PRIVATE INSURERS FELL VICTIM TO THESE BILLING FRAUD SCHEMES.

AMBULANCE SERVICES

ANOTHER AREA SUSCEPTIBLE TO FRAUD INVOLVES AMBULANCE COMPANIES BILLING FOR EMERGENCY CONVEYANCE WHEN NO "EMERGENCY" EXISTED, SUBMITTING INVOICES FOR TRIPS INVOLVING NON-EXISTENT OXYGEN USE, AND CHARGING FOR HIGHER THAN AVERAGE MILEAGE PER TRIP.

AS AN EXAMPLE, IN A RECENT CASE IN THE SOUTHEAST, AN INDIVIDUAL OPERATED AN AMBULANCE SERVICE THAT ALSO PROVIDED NON-EMERGENCY TRANSPORTATION FOR MEDICAL TREATMENT FOR MEDICAID RECIPIENTS. TRANSPORTATION SHOULD HAVE BEEN BILLED AT THE RATE OF \$2.95/ROUND TRIP. INSTEAD, TRIPS WERE BEING FRAUDULENTLY BILLED AS AMBULANCE TRANSPORT BY STRETCHER AT THE RATE OF \$55.00/ROUND TRIP. AS MANY AS 175 TRIPS A DAY WERE BEING BILLED AT THE HIGHER RATE, CREATING A FRAUDULENT DIFFERENCE OF \$9,108.75 PER DAY.

CONCERNS WITH EXISTING FEDERAL LAWS

WITH ALL OF OUR SUCCESSES, THERE ARE MANY CASES WHICH MAY GO UNADDRESSED OR ARE DIFFICULT TO PROSECUTE DUE TO DEFENSE ATTEMPTS TO EXPLOIT ARGUABLE GAPS IN THE LAW.

IN A RECENT CASE, A MEDICAL DIAGNOSTIC COMPANY PAID KICKBACKS TO CHIROPRACTORS FOR X-RAYS AND FULL BODY STUDIES WHICH INCLUDED THERMOGRAPHY TESTS, NERVE CONDUCTION TESTS AND MRI'S. THE BUSINESSMAN BILLED PRIVATE INSURERS BETWEEN \$1,500 AND \$4,000 FOR EACH PATIENT TESTED. HE PAID KICKBACKS RANGING FROM \$100 AND \$350 PER TEST TO APPROXIMATELY 20 CHIROPRACTORS. THE INVESTIGATION DETERMINED THAT THE KICKBACK INCENTIVES AFFECTED THE MEDICAL JUDGMENTS OF THE CHIROPRACTORS. REGRETTABLY, THIS KICKBACK ACTIVITY IS NOT DIRECTLY COVERED BY FEDERAL LAW, CRIMINAL OR CIVIL. THIS BUSINESSMAN TOOK GREAT CARE NOT TO TEST MEDICARE PATIENTS, KNOWING THAT TESTING THEM IN RETURN FOR PAYING A KICKBACK WOULD VIOLATE THE FEDERAL ANTI-KICKBACK LAW. SIMILAR KICKBACK SCENARIOS ARE COMMON THROUGHOUT THE COUNTRY.

THE HEALTH CARE SYSTEM IS BEING INFILTRATED BY CORRUPT CRIMINAL ENTERPRISES. THERE ARE A NUMBER OF HEALTH CARE FRAUD CASES UNDER INVESTIGATION WHICH REPRESENT CRIMINAL ORGANIZATIONS. LAWS MUST BE TOUGHENED TO AFFORD LAW ENFORCEMENT THE ABILITY TO DISMANTLE THESE ORGANIZATIONS.

FOR INSTANCE, MANY OF THE STAGED AUTOMOBILE ACCIDENT CASES INVOLVE HIGHLY STRUCTURED GROUPS WHICH OPERATE ORGANIZATIONS THROUGHOUT THE UNITED STATES. WE HAVE IDENTIFIED DOZENS OF THESE GROUPS AND THEY GENERATE BILLIONS OF DOLLARS IN FRAUDULENT CLAIMS TO INSURERS. FBI INVESTIGATIONS ARE REVEALING SIMILAR TRENDS IN HOME HEALTH CARE, CLINIC OPERATIONS AND NURSING HOME ENTERPRISES.

TOOLS FOR INVESTIGATORS/PROSECUTORS

AS I HAVE STRESSED, HEALTH CARE FRAUD CASES ARE OFTEN COMPLEX SCHEMES WHICH ARE DIFFICULT TO INVESTIGATE AND PROSECUTE. THESE SCHEMES ARE A RELATIVELY NEW PHENOMENON THAT, AT TIMES, HAVE PUT CRIMINALS AHEAD OF THE LAW. INVESTIGATORS AND PROSECUTORS LACK TOOLS THAT WOULD GREATLY ENHANCE THE EFFECTIVENESS OF THE FEDERAL GOVERNMENT'S ENFORCEMENT EFFORTS. FOR EXAMPLE:

♦ THE CURRENT KICKBACK STATUTE COVERS ONLY MEDICARE AND MEDICAID. IT DOES NOT COVER OTHER GOVERNMENT PROGRAMS, PRIVATE INSURERS OR OTHER HEALTH CARE PROVIDERS. THE COVERAGE OF THE FEDERAL ANTI-KICKBACK STATUTE NEEDS TO BE EXPANDED. WE WILL WORK WITH THE COMMITTEE TO EXPLORE THE MOST EFFECTIVE WAYS TO ACCOMPLISH THIS. THERE SHOULD BE AN EXPLICIT CRIMINAL AND CIVIL BAR ON SUCH KICKBACKS.

♦ COMPLEX CRIMINAL ORGANIZATIONS ARE INVOLVED IN MULTI-MILLION DOLLAR HEALTH CARE SCHEMES. THERE MUST BE EFFECTIVE PROSECUTIVE TOOLS TO COMBAT THIS TYPE OF CRIME.

♦ LIKEWISE, CRIMINAL ORGANIZATIONS INVOLVED IN HEALTH CARE FRAUD ARE OFTEN IMPENETRABLE BY INFORMANTS OR OTHER MEANS. CRIMINAL CONVERSATIONS, AS YOU KNOW, ARE VITAL EVIDENCE OF INTENT. THUS, COURT AUTHORIZED WIRETAPS ARE A NECESSARY MEANS TO COLLECT THE EVIDENCE NEEDED TO PROSECUTE HEALTH CARE FRAUD VIOLATIONS. HEALTH CARE FRAUD, HOWEVER, IS NOT A PREDICATE OFFENSE FOR COURT AUTHORIZED WIRETAPS.

♦ THERE IS NO SPECIFIC HEALTH CARE FRAUD STATUTE. AS A RESULT, PROSECUTORS MUST RELY UPON COMPLEX LEGAL THEORIES IN PROSECUTING HEALTH CARE FRAUD CASES. A STRAIGHTFORWARD HEALTH CARE FRAUD STATUTE WOULD SIMPLIFY THE PROSECUTION OF THESE CASES AND GREATLY ENHANCE THE ABILITY OF LAW ENFORCEMENT TO ATTACK THIS PROBLEM.

♦ OTHER TOOLS, SUCH AS A SPECIFIC FALSE STATEMENT PROVISION, THE ABILITY TO SHARE GRAND JURY INFORMATION WITH CIVIL ATTORNEYS AND FORFEITURE PROVISIONS, LIKEWISE WOULD BE OF GREAT HELP.

CONCLUSION

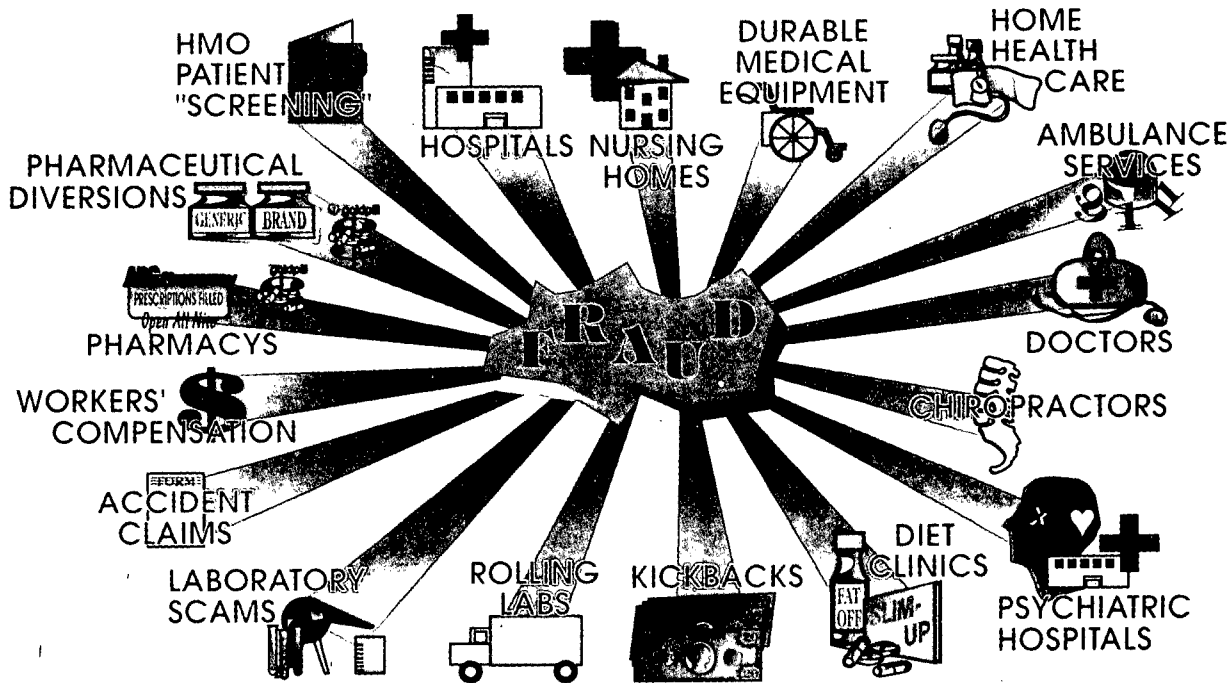
MR. CHAIRMAN, DURING THE 1980'S, THE COUNTRY ENDURED A HOST OF MAJOR CRIME PROBLEMS INCLUDING THE WAR AGAINST ILLICIT DRUG TRAFFICKING, THE SAVINGS AND LOAN CRISIS, DEFENSE PROCUREMENT CORRUPTION, ORGANIZED CRIME SYNDICATES, AND SECURITIES SCANDALS. WHEN CONFRONTED WITH THOSE CRISES, CONGRESS PASSED TOUGHER FINANCIAL INSTITUTION LAWS, FORFEITURE LAWS, DRUG LAWS, AND MONEY LAUNDERING LAWS.

HEALTH CARE FRAUD IS A VERY SERIOUS CRIME PROBLEM IN THE 1990'S. FRAUDULENT ACTIVITY IN THE NATION'S HEALTH CARE SYSTEM -- ONE-SEVENTH OF OUR ECONOMY -- IS ON THE RISE. TODAY, WE SEE COCAINE DEALERS TURNING INTO HEALTH CARE FRAUD ENTREPRENEURS. THE RUSSIAN MAFIA, AS WELL AS OTHER ORGANIZED CRIME GROUPS, ARE ENGAGED IN CREATIVE SCHEMES TO SIPHON MONEY FROM GOVERNMENT AND PRIVATE HEALTH CARE TRUST FUNDS.

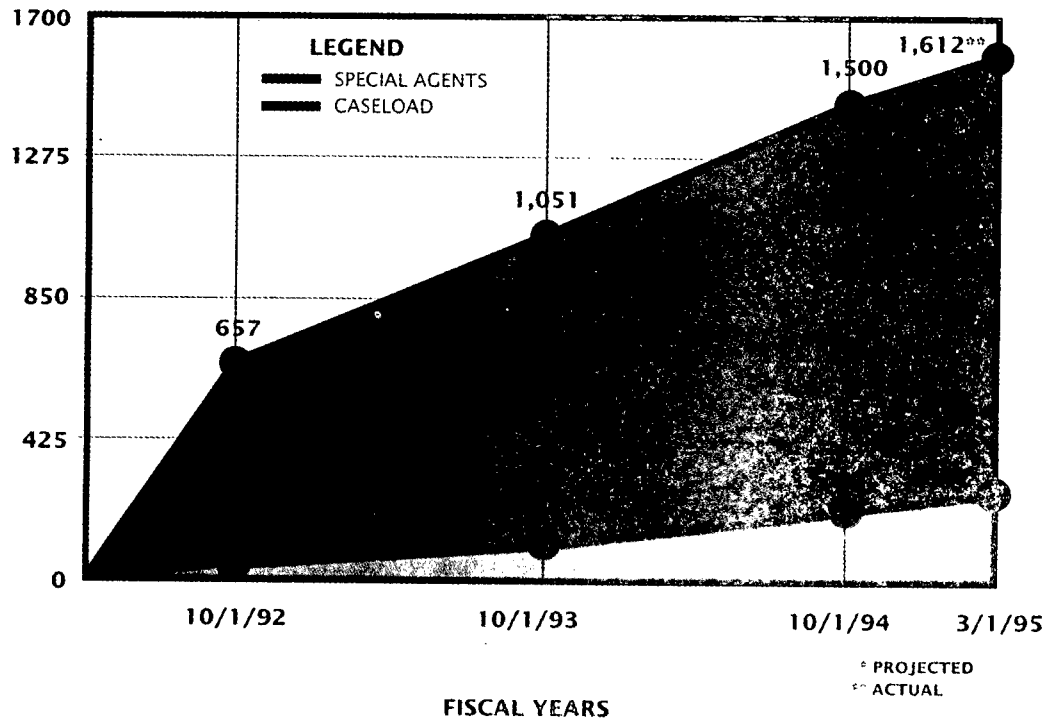
THE FBI WILL CONTINUE TO PLACE A HIGH PRIORITY ON THIS IMPORTANT WORK. WE LOOK FORWARD TO WORKING WITH LOCAL, STATE AND FEDERAL LAW ENFORCEMENT, REGULATORY AGENCIES AND THE PRIVATE SECTOR IN COMBATTING HEALTH CARE SCHEMES.

I WOULD BE HAPPY TO RESPOND TO ANY QUESTIONS FROM YOU OR MEMBERS OF THE COMMITTEE.

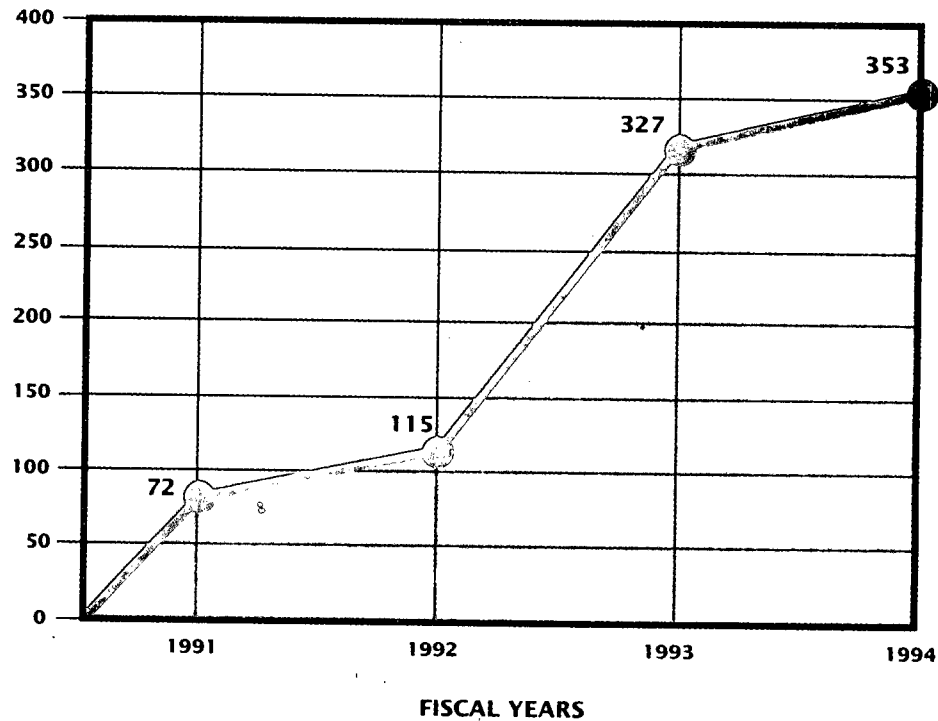
HEALTH CARE



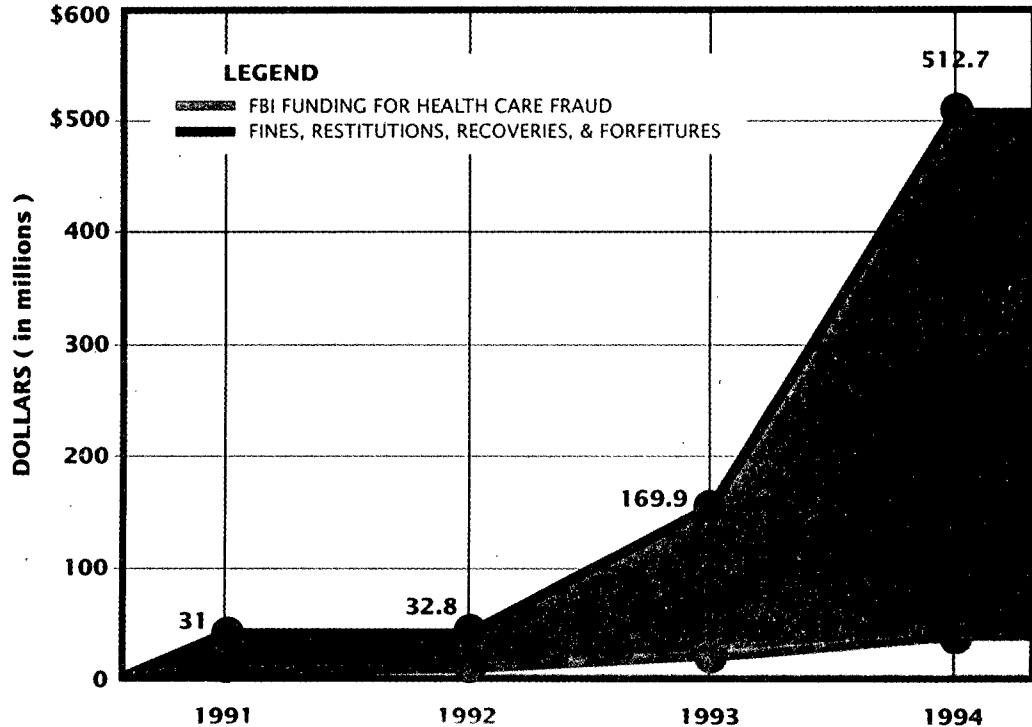
NUMBER OF FBI SPECIAL AGENTS ASSIGNED TO HEALTH CARE FRAUD COMPARED TO CASELOADS



FBI HEALTH CARE FRAUD CONVICTIONS



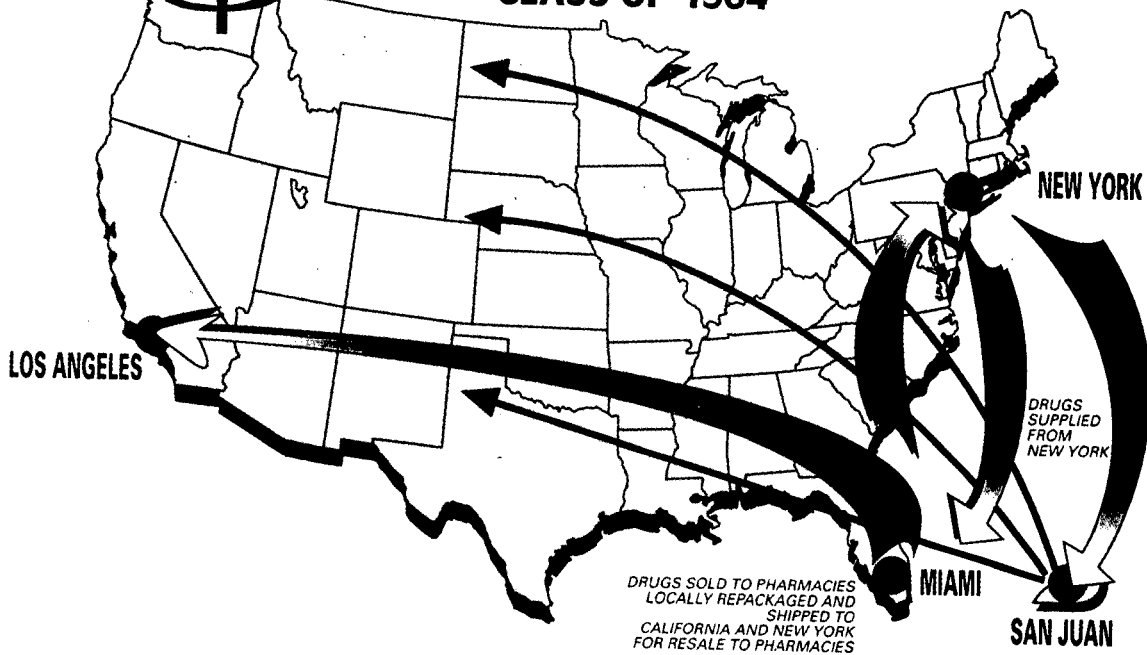
FBI FUNDING FOR HEALTH CARE FRAUD COMPARED TO FINANCIAL RECOVERIES OBTAINED





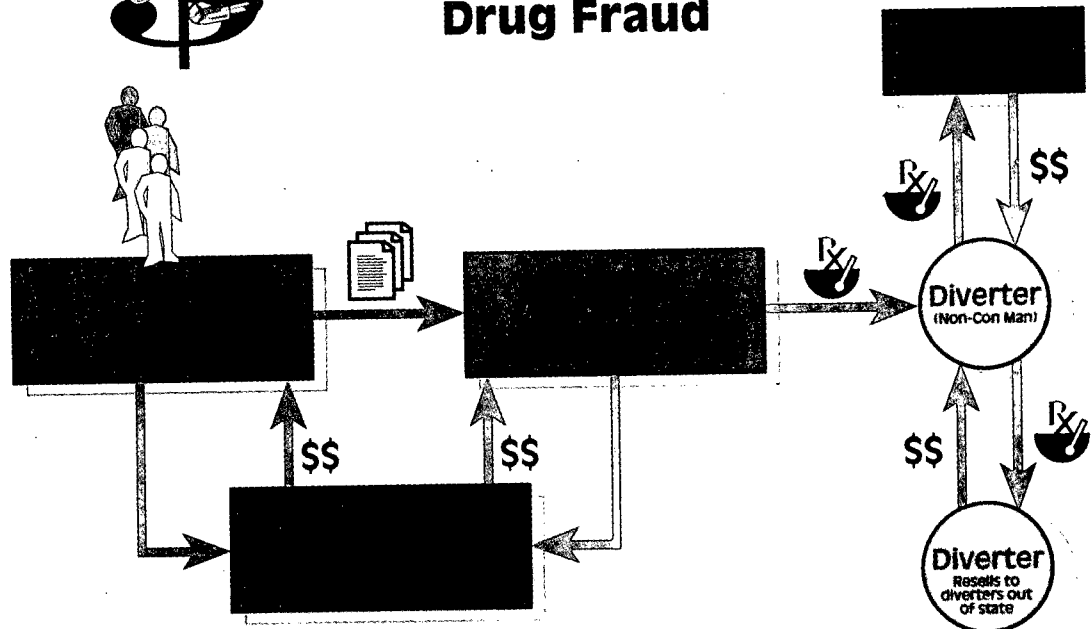
DIVERSION SCHEME

"CLASS OF 1964"



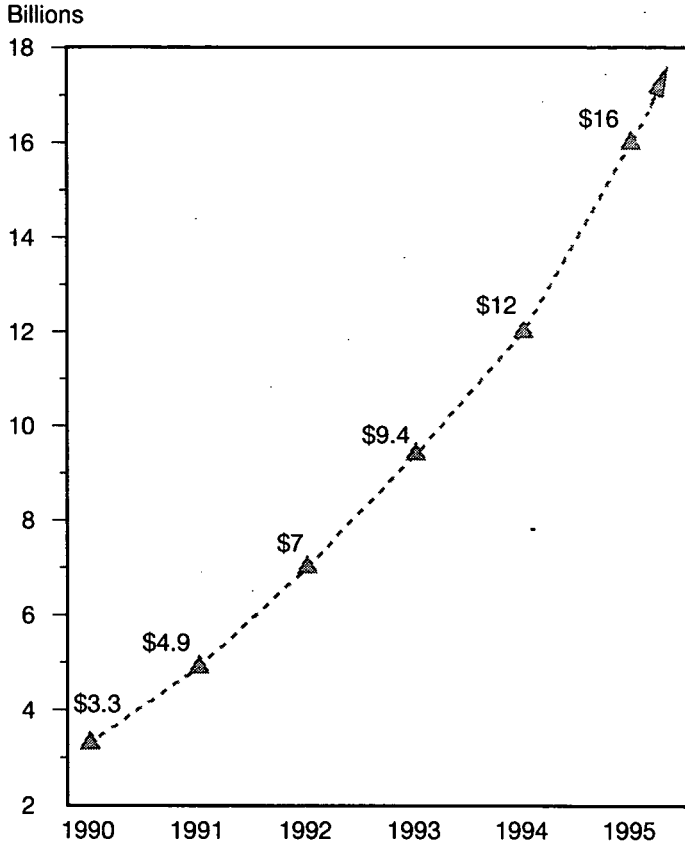


Medicaid Prescription Drug Fraud



Home Health

Rapid Growth of Medicare Expenditures



The CHAIRMAN. Thank you very much, Director Freeh.

I'll have a couple of questions and then yield to my colleagues and try to complete this round as quickly as possible.

You mentioned drug diversion perhaps—we're going to have testimony in this later—but perhaps you might just spend a moment outlining the chart that apparently has been put on the board over there in terms of how that actually operations. If you don't have it up now, we have a copy of it—Operation Goldpill.

Mr. FREEH. This was a very well-known and well-investigated case. It dealt with an international and mostly national scheme to do two things—one, to illegally divert prescription medicines. Part of that scheme had to do with buying and creating false prescriptions and then trading them for patients who would use them to defraud the insurance companies. Another part of it involved the phony claims and submissions to various insurance companies for drugs which were billed as name drugs but were actually dispensed as generic drugs. Part of it was, as you can see, a very active and multimillion fraud scheme, which moved not just the prescriptions around the country but rolled and alternated the number of insurance companies which received the diversions to create overall the idea that this was just a regular insurance fraud.

The overall results of the investigation included 276 indictments around the country, \$12 million in fines and forfeitures. It was a case that was also worked by the FBI, the DEA and the FDA, which again showed a very important and very effective alliance of the different agencies that have responsibility. Again, it's a case that was worked intensively with a great number of resources from all three agencies but represents just a small part of the overall problem.

The CHAIRMAN. How much in the way of dollars are you spending now on investigating health care fraud?

Mr. FREEH. Approximately \$37 million.

The CHAIRMAN. \$37 million?

Mr. FREEH. \$37 million.

The CHAIRMAN. Involving approximately 200—

Mr. FREEH. Approximately 249 agents and support personnel behind that.

The CHAIRMAN. And one of the questions that is frequently asked is how in the world are people able to get around the system and to bilk it so easily. If you consider the fact that we probably have less than 200 agents—and you take into account the 200 or so people at the Department of Health and Human Services Inspector General—people that are supposed to be investigating. If you take roughly 200 people engaged in overseeing a trillion dollar industry you can see—a system that large with that much money involved—you can see how easy it really is for them to get away with it.

What we found over the years from these subcommittee investigations in particular is that historically whenever you have a large amount of money involved and if you have lots of quick profits available with little risk of detection, little risk of prosecution, little risk of conviction and little risk of punishment, then you have a major attraction to that particular pile of money, and that's what is taking place here in health care fraud.

So I think Senator Reid was correct before in saying that you've got to have more manpower, and, of course, the legislation that we have proposed for the past 2 years would in fact provide more resources to the FBI and Justice Department to go after those very schemes that are starting to proliferate.

Could I ask you how long did it take—Operation Goldpill was, what, 3 years or more?

Mr. FREEH. Yes.

The CHAIRMAN. Is it because you have to go through mail fraud statutes and wire fraud statutes that you don't have a clear Title 18 statute in which you can just simply go after those engaged in these types of schemes?

Mr. FREEH. Part of it is certainly the lack of a statute, but part of it is the lack of resources, also the complexity of the cases. If you go around our offices and you go to the squad area where they're working one of these cases, one of them, you will literally see boxes piled to the ceiling, which require all of the lengthy grand jury processes to acquire, as well as to analyze. If you couple that with the overburdened assistant U.S. attorneys—in most of the 94 U.S. attorneys' offices, they do not even dedicate one or two assistants to work on these particular cases. They're part of a major fraud squad or a major case unit in the office, and it's not to be critical of them. They don't have the resources either. This kind of a case would take two assistants full-time using a grand jury meeting a couple of times a week, at least 12 months, just to ascertain the facts.

So it's a combination of all these problems.

The CHAIRMAN. Earlier before I held up this angora undergarment, which apparently is being used as a great inducement to Russian immigrants living in the New York area, and perhaps elsewhere. These are being used as an inducement to get the Medicaid numbers, and then the Medicaid numbers, of course, are turned over to those who are simply submitting bills fraudulently for services or equipment never ordered or delivered.

I wouldn't want to give the impression that it is only Russian elements involved in this. We are talking, I believe, about virtually every ethnic group in this country, are we not, from Asian gangs to Caribbean gangs to Hispanic gangs to Chinese gangs to—virtually every gang known to the FBI is now turning to health care fraud, are they not?

Mr. FREEH. That's absolutely true. We also have to contend with the combination of lawyers and doctors and insurance estimates who sometimes are more formidable as organizations than even some of these organized criminal groups.

The CHAIRMAN. We're going to hear about that with our next panel of witnesses, but one final question. You gave an example in your prepared statement of a hospital that had purchased the office of a building that was owned by doctors and paid twice the value of the building as an inducement for the doctors to then start referring patients to the hospital.

Is there something inherently wrong with this kind of a referral system as such or arrangement?

Mr. FREEH. Their real estate transaction is probably not the best example of an inducement to a doctor or a chiropractor to either

commit a crime or to use their medical judgment in such a careless fashion as to really cause tests and expensive procedures that are not necessary.

Part of the problem is that there is no check with respect to the different varieties of kickback schemes and inducements that people in the system can utilize to induce others to either commit crimes or abuse medical judgments, both of which result in the unnecessary and accelerating costs. I think that in terms of a kickback, most American juries listening to those facts if they thought that the doctors were abusing their medical judgment to perform tests would find that to be a kickback worthy of some type of criminal or civil sanction.

The CHAIRMAN. In that particular case that you cited, were there any amounts passed on to Medicare or to private insurers in the way of higher costs, billing costs?

Mr. FREEH. I don't know the answer to that. I'll find that out for you, though.

The CHAIRMAN. Okay, thank you very much.

Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

Mr. Director, in my opening comments I failed to applaud you. I applauded our Inspector General of the Department of HHS. I apologize to you because these charts that you've brought forth this morning show an incredible amount of progress that is being made. To a large extent, this success is due to your personal leadership and your personal interest and commitment in this field.

I specifically call our attention, once again, to the particular chart that shows just what a very few million dollars will do and the number of dollars that we get in return from fines and from recoveries. I think that's an amazing chart, incredible.

The fact that the number of convictions have gone up since 1992, as indicated here on the purple chart and the graphs that you have given us this morning, represents remarkable progress and I attribute a great deal of this to your leadership and also to what you have been able to do in bringing about a new sense of cooperation between all of the Federal agencies involved, and I truly want to commend you on that.

We are hearing a great deal today about electronic processing of income tax returns, and the problems associated with that medium. Many Medicare claims are electronically submitted and in the next few years, if they haven't started out already in the States, Medicaid claims are going to be filed and paid for electronically, and private insurance claims are going to be filed and paid for electronically. Now what is increased electronic filing going to do to the overall checks and balances, the policing mechanisms that we have in place?

Mr. FREEH. I think it would challenge probably one of the most fundamental mechanisms currently in place, and that is a trained auditor, even on a selective basis, going through returns and filings, and kicking out—because of that auditor's excellent experience—apparent filings which merit closer scrutiny. I think even contemplating the incorporation of computer checking systems, the ones that might be programmed to kick out a statistically rare combination of arithmetic are not as efficient, and certainly not as reli-

able, from a law enforcement point of view as a trained auditor who sits there and can selectively review with experience the filings.

Senator PRYOR. What about the legal aspect of enforcement with electronic filings and payment? Does this give us a new ball game in terms of enforcement?

Mr. FREEH. It might very well. I mean, one particular area I can think of—if we were conducting a Title 3 on a clinic or a filer who we believed was engaged in a criminal conspiracy or something relevant to a fraud scheme, we might have more difficulty than normal in trying to intercept those data communications dealing from everything to encryption problems because a lot of this data, as with financial data, will be encrypted in the years to come for privacy reasons, which are good reasons to encrypt it. But it may make the investigator's job harder in terms of accessing and comprehending what will be transmission and filings in a very secure network.

Senator PRYOR. I just had one final question and then I'm going to have to leave, Mr. Chairman. We're looking at the nomination for a new Secretary of Agriculture. Congressman Glickman is before the Committee and I must run for a few minutes there.

My question is, what right now can you do, can HHS do, or can we do to assist in increasing the cooperation between the Federal and perhaps even the State agencies involved in policing this and in bringing about the convictions that we're going to have to have to clean up this fraud? What can we do together?

Mr. FREEH. I think one very good aspect which we, again, can show a positive return is the training function. We have now in our Quantico, Virginia facility on five separate occasions held training seminars for private health care officials, people who are in the industry who without being educated are not going to be aware of some of the complexities and vulnerabilities with respect to fraud schemes.

So a training component, particularly for State health care officer and professionals, would be very, very important and OIG and the FBI are particularly able to put that presentation on because of their experience. I think exchanging officers and continuing with these joint investigations is probably the best single method of ensuring that we're working on the same sheet of music.

Senator PRYOR. Good, thank you sir. Thank you very much, Mr. Director.

Mr. FREEH. Thank you, Senator.

The CHAIRMAN. Senator Thompson.

Senator THOMPSON. Yes, Director Freeh, I was wondering whether or not you have done any analysis of the underlying health care statutes with a view toward maybe amending them in some way to make your job a little easier? It seems to me like oftentimes we create these elaborate statutory schemes without really much thought of how easy it is. It's an open invitation to those who would engage in illegal activities, and perhaps we might can go back and revisit the underlying statutes from a criminal justice standpoint and maybe revise them in some way to make it more difficult for them to carry out these fraudulent schemes. I know that this is not your primary job but I was wondering if anything

has been done along those lines or whether or not might be worth considering as you consider your normal law enforcement activities also?

Mr. FREEH. Senator, it's certainly an area that we've been very interested in. We've worked with the Committee staff on that specifically. The basic statutes that we have right now for enforcing our health care program are the mail and wire fraud statutes and the money laundering statute. Those statutes, obviously, were written when nobody contemplated a \$44 billion a year fraud scheme. One of the things to bring statutes into focus is to make it easier to take advantage of their jurisdictional basis and put into the mix the particular investigative tools that are very, very helpful, which is why I mentioned wire tapping, which we use very selectively but in a case that involves subjects in six different States with huge amounts of money being transacted. In a hierarchy that we can identify it is really the ideal investigative network, particularly if we can't use an undercover agent to penetrate the group. If it's a group of Russian organized crime subjects, it's very hard for an FBI undercover agent to approach them as he or she might a different kind of group.

Right now if we want to use our Title 3 authority, which is the court authorized electronic surveillance, we really have to in a convoluted manner predicate the various fact patterns to meet the requirements of the statute. The same is true with respect to putting together a Rico or racketeering case.

One of the issues would be to streamline that investigative job by putting the Title 3 and Rico predicates into the health care fraud statute per se and just save those extra steps, which in many cases would make for a more efficient investigation.

Senator THOMPSON. All right, in the area of investigative tools, you know, Congress has provided law enforcement with a lot of different tools in the white collar area. For example, many of the Federal inspector generals have the authority in white collar cases to use administrative subpoenas. Does the FBI have the authority to subpoena business and financial records in the course of their white collar investigations, and, if not, would this help in combating health care fraud more efficiently?

Mr. FREEH. In my view, it would greatly facilitate our ability to do these cases if we had administrative subpoena power. We do not have that now. You are correct—the Office of Inspector General does have it. Having been a prosecutor for 10 years where we supervised the use of administrative subpoenas, particularly by the inspector general, my view is that the FBI could certainly use well and efficiently and properly that technique. It would save incredible amounts of time and resources by giving the agents the ability under the close supervision—and prosecutors—to use that very, very selectively but very efficiently in cases where records come in 40-foot trailers as opposed to file cabinets.

Senator THOMPSON. In the course of—you mentioned the anti-kickback statutes a minute ago. I'm not sure that I picked up on all of that. Has the FBI encountered any legal impediments in the enforcement—in the use of the anti-kickback statutes which affect your investigations in this area?

Mr. FREEH. Not with respect to Medicare and Medicaid patients and payments. In that area the law is very well defined and we use it very regularly. The gray area is when you get beyond that and the patient is not a Medicare or Medicaid patient or you have a private insurance company or you have a government insurance agency, such as the ones that insure Members of Congress and FBI agents. In those particular areas it is a very gray area and we don't feel confident that we have the statutory basis to work an anti-kickback case.

Senator THOMPSON. Would you like to see a little improvement in that area statutorily?

Mr. FREEH. Yes, sir. I think that would be of great help.

Senator THOMPSON. Nothing further, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Thompson.

I will call on Senator Moseley-Braun in a moment, but I think the first question you asked is whether there should be some changes in the underlying statutes, namely, dealing in Medicare, Medicaid, and perhaps some of the other Federal health programs. As a result of the hearings that have been held by this Committee over the past 2 years, there have been a number of changes made in the way in which those systems operate. We've had, for example, provider numbers where you simply as an individual could send in a letter requesting a provider number and put down Fred Thompson doing business as XYZ corporation with a post office box and you get a provider number. Once you got that number, you could just start submitting bills to the Medicare system.

So there have been a number of changes made in the operation of the law as a result of exposing the kind of scams that are still to this day taking place but a number of improvements have been made in the operation of the underlying statutes.

Senator Moseley-Braun.

Senator MOSELEY-BRAUN. Mr. Chairman, I want to thank you very much. I do have another committee commitment, and I appreciate this opportunity to ask a couple of questions of Director Freeh.

With regard to the application of the law on kickbacks across the board, you noted that current law does not apply to all payers. It only applies to Medicare and Medicaid. It does not apply to FEHBP, for example, the program under which most Federal employees are covered or other payers. Senator Cohen's legislation under Section 102 would expand that across the board and make it an all payer section of the law. So I think that that issue is addressed in the bill that's pending about which this hearing is being held.

I would like to ask the question specifically, Director, in terms of prevention. I am convinced that an ounce of prevention is worth a pound of cure. Particularly in law enforcement, a lot of attention goes on the back end, what to do once the fraud has been committed, once the problem has happened. But the question arises—what are we going to do to prevent it in the first place? In that regard, I would ask you one question with four parts. With regard to prevention efforts, what recommendations do you have, if any, with regard to simplification of the process as a way of preventing fraud? Are we ensuring that providers are held accountable? Are we keep-

ing track of people who actually provide these services to weed out the fraudulent actors? For those people that are found guilty of fraud, are we actively seeing that they don't continue to participate covertly in the system? And finally coordination with other agencies—because I know we have a lot of effort at HHS, and other agencies in the Federal system, and, of course, State agencies as well—What is being done to coordinate?

And so, again, in terms of prevention—efforts to prevent this fraud from happening in the first place with all the cost to the taxpayer—how would you describe and rate the successes in those four areas?

Mr. FREEH. I think that to date we have not really done a good job in terms of the preventive strategies. The issue with respect to health care fraud is similar to any other crime.

First of all, in terms of prevention there has got to be some minimal amount of education done with respect to the remedies that are available, the criminal sanctions, as well as civil penalties which adhere to this conduct. There needs to be training, as I mentioned before, I think very significant training of State and local and even Federal officials in the health care industry in all of its different aspects. Unless someone is aware of the nature of these fraud schemes, there is almost a natural inability in many cases to detect them.

I think maybe more importantly is the credibility that the investigators have when they begin a case. As you know as a former prosecutor, if the assistant U.S. attorneys and the agents have strong credibility on the street in terms of working their cases, you will get witnesses very early in the investigation, you will get companies who will do their own internal investigations to beat the grand jury clock and then present that to the Government. With 249 special agents in this program and obviously years of backlog in terms of getting and analyzing records and producing indictments, I don't know that we have enough credibility to get the maximum efficiency that we would get if these companies knew that when the OIG inspector together with the agent knocks on the door, this is a serious matter and not something which is going to take 3 or 4 years to resolve.

So I think training and certainly more credibility in terms of resources and turnaround time would be important. The database which is contemplated in the legislation before this Committee, the coordination of our activities with OIG also in the legislation, are very, very positive in terms of the other issues that you mentioned. In terms of debarment, I think as in any criminal program there needs to be certainty with respect to preventing people who are obviously inclined to engage in this activity from having any other opportunity from coming back in as a player, and that certainly is a critical area. The accountability, again, I think goes to the certainty of the investigation and the swiftness of resolution, which we certainly don't have right now.

Senator MOSELEY-BRAUN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. Director, that was excellent testimony and I deeply appreciate all you're doing. I am on the Labor Committee

and preparing a bill in a sophisticated area of ERISA reform, which sends shudders through most people when you talk about it, but it's also an area that is touched by the problems which we are discussing here. And, first of all, I'm glad to hear that you're talking about the team concept and the cooperative approach being conducted interagency and between the Federal and State law enforcement. In the ERISA area we get into that area.

Although you didn't address the multi-employer Welfare arrangements, commonly called MEWAs. Under ERISA there is about 3,000 of them. The Inspector General Masten states in his testimony, and I quote, "While it is the money and cash flow that attracts criminals to benefit plans, it is the complexity of ERISA that all too often allows them to elude regulators and investigators," end of quote.

I have been informed that the States and Federal agencies have been working cooperatively in solving the MEWA fraud area and abuse problems. Would you tell us how extensive an effort that your department has expended in this area and whether the problem is under control or is it continuing to expand, and what suggestions do you have to limit criminal behavior in this area? Would it be helpful to remove some of the ambiguities in ERISA which allows all sorts of weird arrangements to be made to escape being under either State or Federal law, and what kind of help do you need in the ERISA statute itself, if you can get into that—I know it's a complicated area—please.

Mr. FREEH. Sure, it is a complicated area and one that I spent a little time working on. In fact, the only case that I had as a district judge that got up to the Supreme Court—it's up there now—is an ERISA case. So I have a particular interest in that statute as well as its implications for multiemployer plans, which was the subject matter of the case in part.

I think it's a case of resources. These plans are not—from my perspective—comfortably within our jurisdiction purview and investigations because of the nature of them, the complexities, and also the number of different players that get involved in the distribution systems, distribution of services. I don't know whether from a law enforcement point of view it's a question of the complexity of the plans and the preemptive impact between the State and the Federal schemes. I think it's more of a resource problem. That's an area that we have not spent a lot of investigative time in, and I think that is because in health care fraud we're drawn to much more obviously notorious cases and cases that involve a little less expenditure of very scarce resources.

To answer your question, I don't think it's an area where I feel comfortable saying we have a lot of information or investigative control. I think we're probably very lean there.

Senator JEFFORDS. Well, thank you, I appreciate that. It isn't an area that many people are very versed in you'll find, so we'll have to deal with that. I'll take it up with the Inspector General. I think that's an area that he has developed more expertise.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Jeffords.

Senator Grassley.

Senator GRASSLEY. Thank you.

Do we know how much of this fraud is Medicare and Medicaid, a percentage, or don't we know at all?

Mr. FREEH. We do have estimates of that—

Senator GRASSLEY. Just roughly; you don't have to be exact.

Mr. FREEH. I believe it's around \$47 billion for Medicare and Medicaid.

Senator GRASSLEY. Okay, the Chairman has it for at least one. So a significant amount, well over half then, it seems like. There are, of course, in every department people assigned the task of digging out fraudulent examples of possible fraud, and then, of course, involving the FBI.

Is there—I know that there is a great deal of cooperation between the FBI and these departments—is there any problem with that cooperation?

Mr. FREEH. There is none that come to mind, Senator, and that makes it unusual in terms of a lot of the relationships that we have in these multijurisdictional cases.

Senator GRASSLEY. Particularly, do you feel that the cooperation is good enough, then, so you can respond adequately to it?

Mr. FREEH. Yes.

Senator GRASSLEY. I think, for instance, there was the body jacket scheme or expenditures that went from \$200,000 in 1990 to \$18 million in 1992. The Inspector General of HHS brought that to our attention, but you feel that there is adequate cooperation to get the job done.

You spoke about the \$37 million that you spend with 249 agents, and I see from your chart that you have a pretty record of recovery with the resources that you have.

Are your resources adequate?

Mr. FREEH. Not if you take the problem as seriously as I think everybody in this room takes it, no.

Senator GRASSLEY. Okay, so in a sense, you're here to ask for some additional resources if we can find it and some additional legal?

Mr. FREEH. It's certainly necessary to deal with the problem.

Senator GRASSLEY. Okay, while I'm on the subject of resources, I would like to bring up something that you and I have discussed periodically and I think you've always been friendly to our approaches, and that is qui tam, the law suits that individuals can bring. Since the False Claim Act was amended in 1986 nearly \$1 billion has been recovered under qui tam provisions, and, as I understand it, there are nearly 200 qui tam actions reporting health care fraud. Many of these have exposed significant fraud. We recovered one time in a penalty \$110 million from one case a couple of years ago in California, but let me ask you how important you believe qui tam actions are in the overall effort against health care fraud, more specifically given that the Federal resources are always going to be limited. Can't qui tam help make up for insufficient Federal resources in an effort against health care fraud?

Mr. FREEH. Yes, absolutely. I think it's an essential part of the strategy. It puts the burden of the resources on a different group of enforcers and plaintiffs and gives the program and the country the same benefit of results.

Senator GRASSLEY. Could you give me any ideas if you have any thoughts on it about how your agency might make the most of private resources that are available through qui tam actions? Could you point to any steps that your agency has taken or might contemplate taking to encourage meritorious qui tam actions?

Mr. FREEH. I think part of it, again, is the educational phenomena. We need to spread throughout the country, and particular the industry, the benefits of that kind of an action, as well as the assistance that we could properly give them as a law enforcement agency to pursue that endeavor.

In terms of the parts of our investigation that are not grand jury related and also after cases are fully presented, there are many facts and witnesses in the control and possession of the Government which could be made available to this type of litigation which we would certainly encourage.

Senator GRASSLEY. Now are those things that you are doing or are those things that would be good for us to do? You appear friendly toward the concept of educating people about this tool. Do you do that?

Mr. FREEH. We do it in the sense that we respond to requests from litigants or parties for information that we have to use in qui tam suits. We do not do it in terms of promoting on a very broad base basis the assistance that we can give private litigants through the Freedom of Information requests and documents which are in the public domain to assist them in their actions.

Senator GRASSLEY. Have you thought about doing what you just stated in the latter part of your comment to me, that you should take aggressive action to encourage use and that sort of information that comes through the qui tam process?

Mr. FREEH. Certainly, I have thought of it. Again, it's a resource problem but certainly worth pursuing.

Senator GRASSLEY. Okay, thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Grassley.

Senator Glenn.

STATEMENT OF SENATOR JOHN GLENN

Senator GLENN. Thank you, Mr. Chairman, and I want to congratulate you for having this hearing. It's a very important subject, and I know personally of your interest in this, not only from this Committee but on the Governmental Affairs Committee, where we both serve, and where we've been looking into some of these same problems. So I think that it's great that you're looking into this and taking an active role in it.

We've got about a trillion dollars a year going into health care across this country right now. Some of the estimates are that about 10 percent of that goes into fraud and abuse. That would be \$100 billion in the overall health bill. Just in Medicare, we're paying out about \$440 million a day, as I understand it, or \$162 billion a year.

Just since people walked in here about an hour and a half ago—I was just doodling—that means we've paid out in Medicare some \$27 million just since people walked in here this morning. These are enormous figures and we're talking about that \$162 billion. In 8 years, in the year 2003, it's estimated it will have gone up to

about \$389 billion. The point I'm making is the bait is there, and things are going to get a lot more attractive to, as the title of our hearing says, gaming the system. It's going to be very much more attractive to do that, and I think you need all the help you can get.

I wanted to follow up a little bit on Senator Grassley. What resources would it take to eliminate your 1,500 backlog as well as build for the future so we have a good handle on this? Can you be specific on it? Do you need more agents? Do you have a dollar figure that you would give us? I don't like to see this. I don't care whether we've got a contract with America over in the House or not. Some of these areas need to be expanded, not contracted, and I think yours is one of them.

Can you give us specifics on what you would like to have?

Mr. FREEH. I think if we doubled the number of agents and support staff who will work on this problem, we would be making a billion dollars in terms of recoveries instead of a half a billion dollars, maybe more, because of the—

Senator GLENN. How many additional positions would that be?

Mr. FREEH. It would be approximately 249 new special agents assigned to that program and probably another 100 support staffers beyond that.

Senator GLENN. And what would that cost? Do you have an estimate on that?

Mr. FREEH. Approximately \$37.6 million.

Senator GLENN. Okay, I think that's something we ought to try and take on if that's what you need to do the job.

I would be interested in any further information too on other resources—everything doesn't center just in the FBI and law enforcement, good though you are. We've got people across the country like State Medicaid fraud units, the State attorneys general, State inspectors general and so on that I think you can—do you have a program for working with and utilizing them in this effort, and what is it?

Mr. FREEH. We certainly do. We have in 12 of our offices full-time task forces, which not are made up of special agents and inspector generals from HHS but include representatives of the State insurance agencies, as well as their OIGs and equivalents. We have found that the combination of those investigators in one place—and that's usually the FBI space—has been an extremely effective mechanism for not just coordinating their activities but for throwing all the different tools against the subjects that one agency by itself does not have.

So I think the great strides that we've made with HHS and duplicating those on a State level—particularly on a task force level. That's how we attacked organized crime in the 1960's and that's how it worked—is probably the quickest method for doing that.

Senator GLENN. Now in your work at HHS do you work mainly through the IG?

Mr. FREEH. Yes, sir, directly with the IG.

Senator GLENN. Okay, do they need expanded facilities there?

Mr. FREEH. I don't want to speak for them. I'm sure—

Senator GLENN. Feel free, go ahead. That's all right. [Laughter.]

Mr. FREEH. I'm sure that they could use as many new resources as we could and still be working very, very hard against a difficult problem.

Senator GLENN. I know that in a hearing like this sometimes we get the opinion that everything in a certain industry is all fouled up and everybody is a crook, and that certainly is not the case in the medical industry or any place else. But do you have out of our experience a figure as to what percent of doctors and lawyers are involved in abusing the health system?

Mr. FREEH. I don't. I could try to see what data I can pull together to estimate that for you. I really wouldn't be comfortable making an estimate at this point.

Senator GLENN. I don't know whether this was covered earlier, but did anyone ask you if we need additional legislation to let you do your job better? Has that been covered, Mr. Chairman?

The CHAIRMAN. It has.

Senator GLENN. Okay, well, I won't get into that then, but I'll read the record on that, and I'll try and be back a little bit later for other witnesses.

Let me just say on the Governmental Affairs Committee we both serve on also we have the IG Act—we've expanded that. We have the CFO Act on how the department is operating and making more efficient use of the people they have. We also have GAO who does their high risk list every year, and one of the areas they cover is in this area of medical fraud and abuse. So we have several different sources of information, and I think we need the best of all of our efforts on this.

Thank you very much, Mr. Chairman.

[The prepared statement of Senator Glenn follows:]

STATEMENT OF SENATOR JOHN GLENN

Mr. Chairman, as the senior member of the Senate Special Committee on Aging, I would like to take this opportunity to publicly congratulate you on becoming Chairman. Throughout the years, we have worked together on issues of importance to older Americans both on the Aging Committee and on the Governmental Affairs Committee.

I know that under your leadership, and with the assistance of Senator David Pryor, who is now Ranking Minority Member, the Aging Committee will continue to be productive as we seek to maintain and improve programs for today's older Americans, and, at the same time, plan ahead for our growing elderly population.

I commend you for holding this hearing on health care fraud. Last year's health care reform debate made us all aware that as a nation we are spending nearly one trillion dollars annually on health care, and that even so over 40 million Americans lack health insurance and access to high-quality care. To add insult to injury, it is estimated that nearly 10 percent of this health spending, or \$100 billion, is due to health care fraud and abuse.

I look forward to hearing from today's witnesses about the latest trends in health care fraud, and their recommendations for cracking down on those who are making money for themselves by defrauding and abusing our health care system. Whatever one's views are on the best way to improve our health care system, I believe we all would agree that stronger action is needed to combat fraud and abuse in our public and private health insurance programs.

Over the years, as Chairman and now Ranking Minority Member of the Committee on Governmental Affairs, I have worked to strengthen and expand the Inspectors General Act to detect and prevent fraud, waste, and abuse; and I have worked with the General Accounting Office (GAO) on its high-risk program to identify the federal program areas they consider most vulnerable to waste, fraud, abuse, and mismanagement. The GAO recently released its second series of reports on high-risk programs, including one on Medicare.

The General Accounting Office concluded that Medicare claims fraud and abuse is widespread. Last year the government spent over \$440 million a day, or \$162 billion, on Medicare. Only the costs for DoD, Social Security, and interest on the debt are higher. And it is estimated that Medicare spending will more than double by the year 2003 to over \$389 billion.

No one has quantified exactly how much of Medicare spending is attributable to fraud and abuse; but even if it is less than the estimated 10 percent of national health spending that is lost to such practices, it is a large and ever-increasing amount. And, at a time when Congress is looking at reductions in Medicare to balance the budget, it is money that should be available to benefit older Americans and the health providers who are caring for them.

Our country has the best medical care in the world, and most health professionals are providing care in an honest and straightforward manner. However, changes are needed in our health care system to ensure that all Americans have access to high-quality care. Drastically reducing the amount of money that is lost due to waste, fraud and abuse in health care should be a top priority.

I am hopeful that today's Aging Committee hearing will help step up our efforts to eliminate the "bad apples"—providers, patients and others—who are making money by abusing and defrauding our public and private health care plans. I thank our witnesses for the valuable information they will be providing today about trends in health fraud and their recommendations to combat this problem.

The CHAIRMAN. Thank you, Senator Glenn. We're looking at as much as \$275 million a day lost through fraud and abuse. That works out to \$11.5 million an hour so since this hearing started. We're approaching about or close to \$21 million lost so far this morning. And the clock keeps ticking and we have postponed taking action, that Director Freeh has endorsed, in the past year and a half. We have postponed taking action during that time so the American people are out as much as \$100 billion this year.

Suppliers start billing Medicaid for orthotic body jackets and these supposedly fitted jackets, are for people who have suffered spinal injuries or compression fractures. Usually it's used following surgery for back surgery, and they're supposed to be custom fitted. What in fact takes place is an item like this which was recovered in one of the kickback schemes. As you can see, it's a piece of plastic. It cost approximately \$15 to \$19 to manufacture. If you bought it at a medical store, it would cost between \$30 and \$50. This particular item was billed to Medicare for \$520. This particular item was billed to Medicare on a national level for about \$18 million back in 1992. You can see the tremendous explosion in the charges that are now being billed to Medicare or Medicaid and how easy it has become, and has been, to defraud the system with something described as an orthotic body jacket, which is neither, with tremendous mark-up in this particular case.

Director Freeh, thank you very much.

We've got an important panel coming up with a doctor who has personal knowledge of those who have engaged in the defrauding of the system, and because of his need to protect his own anonymity at this point—he's been most cooperative in coming forward to describe the kinds of schemes that are devised to defraud the American taxpayer—we're going to ask, as he comes forward, for the cameras to turn away and perhaps focus upon the audience. He will be coming through the rear door here, and we would like the cameras to be focused upon the audience and any camera that might be in the back of the room to be turned off to protect his identity.

So I will call our next two witnesses to give their first-hand views on health care fraud.

Thank you, Director Freeh.

The CHAIRMAN. Dr. A, as I am calling him, is a health care provider who is coming forward to give the Committee his first-hand knowledge of current and on-going schemes by doctors and other health care providers that are driving up the costs of health insurance.

We also have Agent B who will testify on drug diversion schemes that are continuing to occur in cities across this country, and so if we can arrange for the screen to be placed up here.

First, let me thank those operating those television cameras for accommodating this request. We're now going to hear from—not Dr. No but Dr. A. Why don't you proceed with your statement?

STATEMENT OF DR. A, HEALTH CARE PROVIDER, TESTIFYING ANONYMOUSLY

Dr. A. Good morning, Mr. Chairman, and Senators. I appreciate this opportunity to speak before this Committee today. I will begin my statement by giving you an overview of my experience with no-fault and personal injury cases. I will focus on the treatment of patients by doctors, both medical and chiropractic.

In my capacity as a paid consultant for various insurance companies as well as a practitioner in a profession that see a high volume of no-fault claimants, I can state quite emphatically that it's not unusual for an individual with no injury or relatively minor injury resulting from a motor vehicle accident to have thousands, perhaps tens of thousands, of dollars in medical unnecessary treatment and diagnostic testing. I am going to outline several schemes which involve multiple levels of what is known as the "ping-ponging" of the patients.

Typically, in a motor vehicle accident, if an individual is legitimately injured, they will seek treatment from qualified physicians such as chiropractors or medical doctors. These providers will render appropriate treatment with a minimum amount of outside testing. However, in my review of patient files, it is very common for me to find that the alleged injured patient has first sought the advice of an attorney who specializes in personal injury cases and it is here that the ping-ponging of the patient begins.

The attorney accepts the case provided that the patient agrees to follow through on a treatment program. The attorney will then refer the patient to a doctor who is very often a chiropractor or an M.D., with whom he has an established relationship. The doctor will initiate a very intense treatment program, which usually involves several weeks or months of treatment. The chiropractor also refers the patient for expensive diagnostic testing, such as Magnetic Resonance Imaging or MRI studies. It is not unusual for patients to have six or more MRI studies, in addition to the x-rays performed by the chiropractor. In addition to the testing being ordered by the DC, treatment is being rendered three or more times per week.

Now the chiropractor frequently refers the patient to other specialists, such as a neurologist, medical neurologist. Many times this neurologist is a participant in this network loop of doctors and lawyers. The neurologist will most likely have at his disposal sophisticated diagnostic equipment with which to perform neurophysi-

ological testing and evaluation. A number of these tests costs insurance companies up to \$1,000 each.

At this stage the patient is then referred by either the attorney, the chiropractor, or neurologist to an orthopedist who is a participant in this loop. The orthopedist typically will order unnecessary diagnostic tests, such as a C-T Scan or additional MRI studies and recommends that the patient see a physiatrist or a physical therapist for rehabilitative therapy. This scheme and similar schemes effectively run up costs to the insurance companies by several hundreds of thousands of dollars, and the scheme does not stop here.

I have repeatedly examined patients with alleged injuries. These patients are, for the most part, young and healthy, but as a participant in these schemes are receiving household assistance from health care services which are being paid for by the patient's insurance company. Fraud in the no-fault system is uncomplicated and easily committed. The patients in this instance are participants in this fraud, as are the doctors and the lawyers. The patient is motivated by greed thinking that he or she will receive financial benefits and will often do whatever is asked of them. In any case, whether the patient participates or not, the doctors will receive substantial remuneration, inasmuch as no explanation of medical benefits or EOBs are sent to the patient by the insurance company regarding the treatment rendered.

Therefore, the provider—that is the chiropractor, the physical therapist or M.D.—can submit bills for treatment that was never rendered without anyone's knowledge, most especially the patient's.

To take this to another level, it is not unusual for the provider to bill the patient's private insurance company in addition to the no-fault carrier. Likewise, if the patient was previously being treated in connection with a worker's compensation claim, the worker's compensation carrier is billed as well. These double billings—and I must say sometimes triple billings—are possible because many States do not routinely send EOBs in connection with worker's compensation matters. Here again, the patient will never know what is being billed. By the mere flick of a pen the doctor is able to submit bills for payment without anyone's approval or knowledge. This is done at a cost of hundreds of thousands of dollars to private insurance companies.

Now moving on to yet another common fraudulent scheme, I would like to address the problem of kickbacks. Kickback schemes, like other health care frauds, can take many forms. One which I have observed is precipitated by the fact that the DCs or the chiropractors are not eligible for reimbursement for many of the same procedures as medical doctors.

For example, with regards to no-fault and worker's compensation in some States, DCs cannot bill for ultrasound, or for that matter, for muscle stimulation. Yet, medical doctors can and do bill for these services. In order to make the ordering of these tests profitable for both parties, the DC refers the patient to the M.D. and in return receives a referral fee, or in real terminology, a kickback. This practice becomes particularly lucrative when the DC begins referring patients who have no legitimate medical need for the tests, as previously described.

Another kickback scenario comes about when the service is in fact performed illegally by the DC but submitted for payment as if it had been performed by the M.D. In these instances, the M.D. is reimbursed for legitimizing the claims.

It is important to note that in many States reimbursements are based on the level of experience and training of the provider, which in most instances translates to a higher reimbursement rate for medical doctors, as opposed to DCs or chiropractors. Due to this perceived disparity, it is common for medical doctors to bill for services that were actually provided by the DC in order to receive the higher rate, and this overpayment is then split between the two providers.

As you can begin to see, the area of rehabilitative services is inundated with fraud and unscrupulous providers.

Now I would like to share with you a scenario about which I have personal knowledge which involves false billing and fee splitting. Now this example should help to clarify the points I've mentioned over the past few minutes.

I know of a chiropractor who owns and operates a large chiropractic care and rehabilitation facility. In this instance, the commingling of these two services is unusual inasmuch as in the State where this facility is located a DC, a chiropractor, is prohibited from performing rehabilitation or physical therapy services. A medical physician can perform and bill for these rehabilitative and physical therapy services, particularly if that medical physician is a physiatrist. Now a physiatrist specializes in muscular skeletal rehabilitation. The chiropractor in this case hired a medical doctor as a consultant. The M.D. was responsible for obtaining person history information from the patient and conducting an initial physical exam.

However, this initial examination was often less than 5 minutes in duration. After examining the patient, the physician routinely prescribed physical therapy for the patient, and in many instances, the M.D. does not conduct any examination of the patient. Instead, he simply allows the chiropractor to use his or her name for billing physical therapy. In return for the use of the M.D.'s name, the chiropractor splits the collected fees with the medical doctor.

Typically, the patient would begin a physical therapy program immediately. This physical therapy at the facility was administered by an unlicensed and untrained employee of the facility. The claims for physical therapy was submitted to the patient's insurance company and falsely indicated that a physician was the provider of physical therapy services.

Subsequently, the insurance carrier reimbursed the facility for physical therapy services, reimbursement checks were made payable to the facility and the medical physician. Upon receipt of the insurance reimbursement check, the DC and the M.D. split the fees.

As a chiropractor, I have known practitioners in my field to earn in excess of \$2 to \$3 million per year by committing the fraudulent acts that I have described to you today.

Now I would be remiss if I did not add that insurance companies at times do contribute to the health care crisis. The insurance companies, particularly the worker's compensation carriers in some

States, appear to create an almost adversarial climate between themselves and honest doctors. Legitimate services rendered by honest providers are often going unpaid. Some honest doctors feel as though they are being encouraged by the insurance companies to break or bend the rules in order to get paid, and the chiropractic and medical fields are honorable professions. However, there are a small percentage of individuals in the medical and the legal fields that are tainting both professions by participation in these unscrupulous schemes, and these schemes net the participants incredible amounts of money and are largely responsible for the escalating costs of health care.

In summary, I would like to leave you with a few facts regarding the exorbitant amount of our tax dollars which are being funneled into the no fault and worker's compensation areas. Between 1982 and 1992 the Nation's workman's compensation costs soared to a staggering \$66 billion. In 1993 alone, over \$5.7 billion in losses were suffered by workman's compensation insurers as the average premium outlay for these benefits skyrocketed 153 percent. Citing figures supplied by private insurance carriers, approximately 25 percent of the total compensation claims filed are fraudulent.

Based on a survey conducted by the National Insurance Crime Bureau (NICB), the insurance industry has placed a \$2 billion price tag on a scheme known as staged automobile accidents. These accidents relate directly to the scheme I described earlier pertaining to no fault claimants. Nowhere is the ping-ponging of patients more apparent than in the area of staged automobile accidents.

These costs cannot continue to rise, nor can unscrupulous providers continue to practice. They must be dealt with severely and insurance fraud must be turned into a not-for-profit business. The public and honest health care providers can be best protected by the adoption of a health care fraud statute. Such a statute will not only allow for the successful prosecution of unscrupulous providers, but will significantly deter providers who view the submission of fraudulent or inflated claims as a lucrative, acceptable way of doing business.

Sir, thank you for allowing me to speak to you today and for the opportunity to share my experiences and my resolve to help solve the health care fraud crisis, which exists in the United States today.

The CHAIRMAN. Dr. A, let me thank you for stepping forward and let me make it perfectly clear for the record that you yourself have not participated in these types of kickback schemes, or inflated billings, or fee-splitting scheme, but rather are personally familiar with colleagues who have. And, as you've indicated, chiropractors and others are legitimate medical specialists, and most are honest and forthcoming, but there is a small percentage who are in fact gaming the system and gaming it to the score of millions of dollars every year.

Dr. A. Right.

The CHAIRMAN. I want to take just a few minutes to go through your testimony a little bit because it may be confusing in terms of exactly how it all works as far as this ping pong scheme is concerned.

On the one hand, you've indicated that the patient never really understands what's being billed by the doctors, and the lawyers, the chiropractors, the neurologists, and orthopedist specialists. But we have to draw a distinction, I would assume, between legitimate patients and illegitimate patients. On the one hand, you've indicated that a number of the people who come for the treatment are in fact young and physically in good shape—

Dr. A. Fit, robust individuals, right.

The CHAIRMAN [continuing]. And they may in fact be involved in fraudulent auto accidents that are really scams. They allege an injury and they come in to see a doctor or they see a lawyer first, and that lawyer is part of this loop of fraudulent activity that you've described. The lawyer then refers that individual, first, to either a medical doctor or a chiropractor who is part of the scheme.

Dr. A. Right.

The CHAIRMAN. They then conduct as many as six MRIs, and I would point out for the record that most MRIs go for about \$1,000 per MRI.

Dr. A. It's up there; it's \$800 to \$1,000, yes.

The CHAIRMAN. On the medical therapy or therapeutic sessions at least three times a week. They then are referred to a neurologist, in turn referred to orthopedist specialists who in turn call for more—

Dr. A. Right. This patient, by the way, can enter this loop anywhere. It doesn't have to begin with the attorney.

The CHAIRMAN. Exactly, but we're talking about a fraudulent scheme right now in terms of someone who has not in fact been injured, who is really part of this loop of illegitimate patients, so to speak. Correct?

Dr. A. Right, yes.

The CHAIRMAN. That's one situation that we're talking about, and so whether or not that patient ever receives an explanation of medical benefits really is irrelevant because he or she is part of the fraud to begin with.

Dr. A. They don't care about that.

The CHAIRMAN. They don't care about it. The second situation is where someone who is in fact injured in an automobile accident or similar type of accidental injury that he suffers and then goes to an attorney who then recommends that that individual go to see a whole series of specialists. That person may, who is legitimately injured, be treated legitimately by physicians, but is never apprised of what the charges are.

Dr. A. Correct.

The CHAIRMAN. So that even though that person in fact has suffered an injury that is required to be treated, that individual never gets a statement of what services have been rendered. Frankly, I should state for the audience that even in the Medicare and Medicaid system when patients do receive an explanation of medical benefits, you might be an expert in Egyptian hieroglyphics in order to determine exactly what that statement reads because it's fairly complicated and confusing, and most people don't understand it in any event.

But there is at least an opportunity if you see, for example, that you received six MRIs on a statement and you never had any, then

the bell should go off that something fraudulent is taking place. But in the schemes that you've just alerted us to, no such explanation of medical benefits is ever received by a legitimate patient, so that legitimate patient is never in a position to call anyone's attention to the fact that he is being—not he but his private insurance company, or Blue Cross/Blue Shield, or Medicare, or Medicaid—is being charged for services never rendered.

Dr. A. That's right.

The CHAIRMAN. So we have two different types of schemes involved here—one where you have an illegitimate patient who is part of the scheme and one where you have a legitimate patient who is completely unaware that the system is being gamed by his treating specialist, correct?

Dr. A. That's correct. Now would this legitimate patient—only to the fact that they are legitimate and if that patient goes through a treatment program rendered by the chiropractor or the physical therapist, for instance, that patient doesn't really want to be there. They want to get well, they want to get out of pain and get on with their lives. So, typically, that patient would achieve that goal of feeling well and getting on with their lives and not come back for services.

However, if the case is still open at that point in time, that provider of service can continue to bill unnoticed and unbeknownst to anyone.

The CHAIRMAN. So, in other words, assuming the patient—a legitimate patient—receives treatment, sound medical treatment, and the charges are never explained to him or to her—then he or she is cured for all practical purposes?

Dr. A. Right.

The CHAIRMAN. But the billing continues?

Dr. A. That's correct, until at which time the insurance company typically in the State where I practice will send out for independent medical examination, and that examiner would end the case if indeed he thought that the patient had achieved maximum medical benefits.

The CHAIRMAN. Now, is it your statement that this is something that is selective in your area of practice, or is it something that is widespread based upon your talk with other colleagues?

Dr. A. This is a widespread practice, depending on the type of service being administered. Seeing that chiropractic care or physical therapy care is usually on-going during an active phase of treatment, it's not unusual to see a patient three times a week for 4 or 6 weeks in the curative phase.

However, there are other doctors who are in this loop as well, and they might be having an appointment with an orthopedist or an internist for injections, trigger point injections. And if the patient is not there for the appointment, that doctor is free to just charge for the services that were not rendered. It's very easy and it's—

The CHAIRMAN. Now is the problem because we have a no-fault insurance statute in any given number of States? In other words, the whole concept of no-fault was adopted because the public outcry was that it takes too long. We have a backlog of cases, people who have been injured, who may have to wait 3, 4, 5 years before they

ever get to trial. They have medical expenses that are piling up. They need to get rehabilitative services, but since the providers can never be sure that they will ever get paid, the people are left out in the cold, so to speak. So many States have adopted the no-fault insurance policy or statute where you don't have to establish fault in order to receive these kinds of services.

The difficulty is if you had to establish fault in an accident and you had to go to trial to prove the fault, then you would have to prove the medical expenses.

That attorney would have to come forward with a sheaf of documents saying, "Dr. A, B, C, D rendered the following services on each and every date," and so you at least would have a check by forcing the attorneys, and the doctors to come forward to justify their expenses at that time. Is that what you're saying?

Dr. A. That's right, sir.

The CHAIRMAN. And by virtue of the fact that that never has to take place since it's no-fault, you don't have to establish liability. Liability is, in effect, been socialized. We all paid for it and no one person then has to pay for it out of his pocket or out of his insurance company's pocket.

Dr. A. Exactly.

The CHAIRMAN. Therefore, we have spread the risk but we don't establish fault and we never then have to come forward and establish legitimacy of the charges involved.

Dr. A. Exactly.

The CHAIRMAN. Is that how it works?

Dr. A. My view on that might be a little bit simplistic. In my State it's my understanding that given the—you know, there are advantages to the no-fault system.

Dr. A. Exactly.

The CHAIRMAN. Exactly.

Dr. A. To minimize a patient's payday, so to speak, when a settlement is made, I would tend to think that if a patient had no real injury that was seen on a MRI study or an x-ray, that there should be no claim. But the fact is in my States there are huge claims being settled with people with no injuries, and I don't understand the concept of that. In other words, if there is a patient with multiple herniations and fractures and they were wrongfully hit in an automobile accident, then a patient is due an award, a settlement. However, if a patient has a simple whiplash injury with no documented tissue damage other than subjective complaints of pain, the patient should not be awarded anything. So this would eliminate the lawyers taking on these people to begin with.

The CHAIRMAN. Okay, well, I'm going to come back to that in a moment because we may have some lawyers who would like to come forward and challenge that particular assumption, that just because an MRI doesn't show soft tissue damage, doesn't mean the pain doesn't exist.

Dr. A. And I agree with that to a certain extent. However, there should be some type of a constraint. As it is now, there is not even a skeleton of constraint on this.

The CHAIRMAN. All right, we've got to move on. I'm going to yield in a short time to Senator Jeffords, but I, first, want to hear from Agent B. I would like to talk about this a bit more because you're

really going to the heart of the entire tort system, or worker's compensation system or no-fault insurance system. And, as you've indicated, there is a legitimate argument to be made in favor of no-fault in order to expedite the processing of the claims. It's just that there doesn't seem to be much in the way of a paper trail in order to make sure that those claims in fact are justified, the charges are reasonable and not exploitive or fraudulent, as you've outlined. But we can talk a bit about that more.

Agent B, why don't you now testify?

STATEMENT OF AGENT B, TESTIFYING ANONYMOUSLY

Agent B. Good morning, Mr. Chairman, and Senator Jeffords. Thank you for the opportunity to talk to you today regarding my perspective as an FBI agent investigating health care fraud. I've been investigating health care fraud in New York City since 1986. During that time I've encountered hundreds of cases involving a spectrum of fraud scams. The most significant of my FBI investigations was an undercover operation which span from 1989 through 1993, which was code named Operation Goldpill.

This case involved the hard work of many FBI agents, as well as the expertise of the Food and Drug Administration, and the New York Department of Professional Discipline. The investigation focused on Medicaid recipients who obtained expensive noncontrolled drugs from Medicaid mills that were staffed by shady doctors and physicians' assistants in a blood for pill scheme. The Medicaid cardholder would allow a physician's assistant to draw blood and perform unnecessary medical tests in return for a prescription for expensive drugs that the patient did not intend to take. The Medicaid patients did not need the drugs and filled these prescriptions at pharmacies at taxpayer expense. The Medicaid recipients then illicitly sold the drugs to street level diverters, which were also called non-con men, for approximately 10 cents on the dollar. The street level diverters then sold the drugs to high level diverters, who in turn sold them to other high level diverters or directly to pharmacies. Pharmacists bought the drugs at significant discount from the price they would have had to pay legitimate suppliers. Then these same pharmacists dispensed the diverted drugs to the unsuspecting public. The Medicaid recipients and drug diverters frequently removed the drugs from the original bottles and repackaged them in plastic baggies or other containers. In other instances, diverters, using counterfeit labels and counterfeit safety seals, repackaged the drugs.

As a result, the consumer was put in jeopardy of receiving tainted or unsafe medications. In particular, these drugs often lacked expiration dates, which are necessary to monitor a drug's potency, and lot numbers which are necessary in case of a manufacturer's recall.

We found that the diverter drugs were often stored in conditions which were unsanitary and that were not temperature controlled. This posed further risk to the consumers who were ultimately dispensed these drugs.

For example, in a spin-off case in Miami, agents seized approximately \$750,000 worth of loose pills from a storage shed. The heat and high humidity had caused some of the drugs to break down,

become powdery and contaminate other medications with which they were stored. In New York a similar search warrant uncovered antibiotics which had been stored in a roach infested closet.

Our first break in the New York case came in the summer of 1991 with the arrest of a high level diverter who operated a health and beauty aid store in the Bronx. When we arrested him, he had over \$1 million in diverted drugs, which were packed in baggies and stored in plastic bins.

I've brought a few examples which reflect the manner in which these pills had been sold to the public. During this same search, we found approximately \$500,000 in cash, and we seized over \$100,000 in stolen over-the-counter medications. This particular diverter agreed to cooperate with the FBI and opened our eyes to the world of health care fraud pharmacy diversion. The diversion market is not isolated to New York City. Our cooperating subject and others that later cooperated described for us the national magnitude of drug diversion. The criminal network we investigated operated throughout New York, New Jersey, Florida, Puerto Rico, and California. In working with our cooperators, we found that penetrating this veil of criminal activity was very difficult. The existence of long-term personal and business relationships between the participants of the crime made it almost impossible to penetrate many of their activities using traditional investigative techniques.

As an example, the subjects developed their own warning system. Sources later confided that the diverters had agreed to order drug XYZ over the telephone to signal to their colleagues that someone had been arrested. Another interesting facet of this investigation involved the repackaging and resale of these loose pills. In a second floor room on the top of a health and beauty aid store in Harlem, illegal immigrants were paid pennies to clean up and bottle street drugs which were bought from non-con men by the owner of the health and beauty aid store. On a daily basis, these so-called employees would ship dozens of cartons of tainted drugs via overnight courier to another diverter operating as a drug wholesaler in San Juan, Puerto Rico. The drugs would once again be examined in San Juan so that their illegal nature could be concealed before being shipped back to the mainland United States where they were sold for a full retail price to unsuspecting businesses.

Another link discovered in the diversion scheme involved the backgrounds of many of the key diverters. As the chart entitled, "Diversion Scheme Class of 1964" reflects, drugs were shipped through a complicated maze from New York, to Miami, to San Juan and to Los Angeles. We discovered that many of the members of this particular conspiracy had all graduated from the same pharmacy college in 1964, but by the early 1990's most of the conspirators had relocated to cities throughout the United States but continued to remain in contact through their criminal activities.

Following the conclusion of the Goldpill case, cooperating subjects confided in our investigators that although they were aware of the criminality of their actions, they did not feel that it was a crime of interest to the FBI. In the last 6 months of the case we developed two more cooperating subjects who expanded this investigation and gathered evidence against 25 additional diverters. FBI

New York had now dedicated one full-time investigative squad to this singular case. We also dedicated full-time surveillance teams to monitor the daily contacts between the high level diverters and the pharmacies. The surveillance teams were able to successfully identify location where these contaminated drugs were stored. Agents similarly identified and tracked financial assets generated from the sale of these tainted medications.

In May 1992 we identified the three highest level diverters operating in New York. At that point, and after obtaining the approval of a Federal judge, we were able to establish a court-ordered electronic surveillance of their telephones. During a 45-day period of monitoring these telephones, the number of subjects of our investigation quickly tripled. The wire taps revealed these subjects did not limit their criminal activities to drug diversion alone. Their tentacles spread to include a plan to pay kickbacks to hospitals for patient referrals involved with home infusion therapy and laundering their money through an ambulance service and a real estate venture.

Finally, on June 30, 1992, 500 Federal agents took this case down as a part of the FBI's national health care initiative. In New York City alone 69 Federal arrest warrants, 58 Federal search warrants, and 12 Federal seizure warrants for the actual pharmacies were executed simultaneously. In addition to this, over 300 financial accounts which were used to shelter these illegal gains were restrained.

To date 65 defendants have pleaded guilty to felonies, 53 of the defendants pleaded guilty under a collective plea agreement. Under the plea agreements, those pharmacists who had licenses agreed to surrender them to the New York State Office of Professional Discipline. Those pharmacies where drug inventories were seized agreed to forfeit the inventories. Those who had bank accounts or other property seized agreed to forfeitures of all or part of their property. In all, the New York defendants have agreed to forfeitures totally in excess of \$3.5 million.

Most of the pharmacists and street level diverters have received jail sentences between 8 months and 12 months, with fines ranging to \$40,000. The high level diverters have received jail sentences ranging from 1 year to 3 years with similar fines.

The sale of these contaminated and adulterated medications directly affects the unsuspecting consumer and drains the Medicaid coffers. Up until we began this investigation, very little intelligence existed about this type of health care fraud, which reaped massive losses for the Medicaid program in New York City. Today drug diversion continues to be a serious problem. Sources tell us that the criminal activity is too profitable and the risks remain minimal, and thus it continues. We have seen diverters now tie themselves to elements of traditional organized crime, which are aiding them in the facilitation of this enterprise.

We learned a number of lessons during the course of this investigation:

Number one, these criminal organizations cannot be dealt with effectively using traditional investigative tools; two, these investigations require tremendous amounts of manpower in order for

them to be effective; and, three, there needs to be straightforward, legislative material for the prosecution of health care fraud.

I will be happy to answer any questions that you might have.

The CHAIRMAN. Thank you, Agent B.

Senator Jeffords, would you like to begin?

Senator JEFFORDS. Well, first of all, I want to commend you, Mr. Chairman. I think your questions were very precise and very helpful with respect to Dr. A—and I have no questions—and also with respect to Agent B. I deeply appreciate the information you have furnished us. This is an incredibly important area, and thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

I don't think as a result of the screen that many in the audience can see the evidence that has been furnished to the Committee. I will stand up and hold these items so that you can see them. I might say that they're not as exciting as a bloody glove in a bag, but, nonetheless, I think perhaps even more dangerous under the circumstances. [Laughter.]

But these are the bags that were furnished by FBI's Evidence of the kinds of volumes of pills that are now being diverted and taken out of their original containers and placed in large bags and re-packaged and then sent to other areas.

Agent B, take us through again how this happens with the Medicaid beneficiary as such. What kind of inducements are made to individuals who come forward to seek some kind of a prescription? For example, I've heard that certain types of inducements—we've heard about television sets and others, microwaves, health equipment—a number of inducements made to individuals saying here is something for free, please give us your card or go to a pharmacist who will fill a prescription. How does this all happen? What is the genesis of it?

Agent B. That is absolutely correct. I operated for a number of years a particular source that used to support herself financially through this drug diversion enterprise. So the actual inducement is a cash incentive, similar to that of which would be an inducement to be involved in low level narcotics. Your Medicaid card is equivalent to your Visa card with no payments. You would get up early in the morning, see your Medicaid physician, hand your card which would be billed for tests which were not performed on you. In return for letting this particular physician bill for these unnecessary tests, you would receive your laundry list of prescriptions, a prescription form from the physician's assistant. Rarely would you even see the doctor. This particular Medicaid patient would then have these laundry lists collected from various doctors throughout the day filled at cooperating pharmacies.

The CHAIRMAN. In other words, I get up one morning and say I don't feel well—

Agent B. Well, you may feel fine but you would still do this.

The CHAIRMAN. Well, I feel fine but I'm going to go see my doctor anyway. I go through the doctor and I don't even see the doctor. I see a doctor's assistant, and I tell that individual that I'm not feeling well?

Agent B. Exactly, you would know the symptoms required to get these very specific medications—ulcer symptoms, rashes, whatever it would take to get a prescription.

The CHAIRMAN. Are there also cases in which people walk in seeking medications for treatment of AIDS?

Agent B. Yes, exactly. Retrovir is highly sought after by people involved in this particular scheme simply because the cash value of a bottle of Retrovir—

The CHAIRMAN. Is very expensive.

Agent B. Extremely.

The CHAIRMAN. So I walk in and I give a list of symptoms as to how I feel that day. That individual gives me a list of medications. I then go to the pharmacist. Now is this any pharmacist or are they referred to a specific pharmacist who will fill it out? Is that pharmacist legitimate at that point?

Agent B. Some of the pharmacists we found were involved in the scheme. In other words, you would walk into your Medicaid clinic and there would be a sign on the wall that says, "The doctor is only prescribing Mevicore today." So you would only ask for Mevicore. Then you would go to the neighboring pharmacist, and low and behold, that particular pharmacist would only have Mevicore on his shelves. So in some cases we did find that they did operate in tandem.

The CHAIRMAN. Okay, so then the pharmacist fills out the prescription?

Agent B. Yes.

The CHAIRMAN. And that pharmacist then bills—

Agent B. Medicaid once again.

The CHAIRMAN. Medicaid pays the pharmacist. I then, the patient or recipient of this bag of drugs now, I go to a nonlegitimate individual and I say, here, I've got \$100 worth or \$1,000 worth of medication and I'm selling it to you for either \$10, if it's \$100 charge. Here it is for \$10?

Agent B. Precisely.

The CHAIRMAN. And that person does what? That person then goes—

Agent B. That person, which is your street level dealer, your non-con man, takes the pills out of their original container which the pharmacist dispensed them in the amber vile or the original bottle, and he dumps them into larger plastic bottles or plastic bags and then sells them again to someone that is higher up and has more cash to deal in greater volumes.

The CHAIRMAN. He may sell it for 50 cents on the dollar.

Agent B. Exactly, everyone profits.

The CHAIRMAN. And then we finally get to that higher level who then goes to another pharmacy?

Agent B. Who actually sells them back to a pharmacist.

The CHAIRMAN. Who sells it to a legitimate—in many cases, pharmacist?

Agent B. No, the pharmacist is well aware that the drugs are coming from a less than reputable sources, a criminal source, and he pays the money and his motivation is that he can obtain the drugs that are 25- to 40-percent discount, from what he would pay a legitimate wholesaler.

The CHAIRMAN. And then he in turns sells it to unsuspecting patients?

Agent B. Exactly.

The CHAIRMAN. One of the problems as you've indicated, are that many times these pills carried around in trunks of cars, where temperatures may exceed 110 degrees on a hot summer day, whereby they lose their potency and become either noneffective or perhaps even dangerous in terms of their combination. We've had examples, not here this morning, but similar situations occurring with pacemakers. With pacemakers that have been labeled for animal use only being implanted in humans. For a pacemaker whose expiration dates have come and gone and nonetheless are being implanted in unsuspecting humans.

So this is not simply confused to a drug diversion. It's just one aspect of the kind of fraud that is being perpetrated as very, very dangerous to the health of our unsuspecting patients.

I want to switch and get back to you, Dr. A. You've indicated that if billings by doctors went on for a long period of time, the insurance company may ultimately come in and send an independent medical examiner. Has this happened frequently or is this something that is rare?

Dr. A. In my State it's reasonably frequent.

The CHAIRMAN. I am told that you have plane to catch so I'm going to wrap this up.

Dr. A. I'm sorry about that.

The CHAIRMAN. That's quite all right. I will say for later witnesses to point out that we have to proceed with some caution in the field of tissue damage because in fact people can in fact suffer serious injuries and it may not show up. Certainly, it won't show up on an x-ray and it may not show up on an MRI. That doesn't necessarily mean that those individuals are engaged in fraudulent behavior.

Dr. A. That's absolutely correct. I didn't mean for it to be perceived that way. I was thinking of some type of a similar—

The CHAIRMAN. And I want to make it clear that there are legitimate patients and there are phony patients.

Dr. A. Absolutely, the majority of patients are legitimate.

The CHAIRMAN. The majority of patients are legitimate, and even where they are in fact legitimate, the system is structured as such that they may never know what charges are being made and billed to an insurance company, or to Medicare or Medicaid, for which the service was never rendered, and that Medicaid may be paying double the price. There may be kickbacks going on and a whole variety of things going on and these legitimate patients never know about it.

Dr. A. Correct.

The CHAIRMAN. Okay, let me thank both of you for coming forward and testifying on ways in which these scams are being operated. It will add, hopefully, to the momentum for passage of this legislation will give the kind of tools that are necessary to the FBI, the State law enforcement official, to really crack down on the small percentage—again, we want to emphasize—of people who are gaming huge amounts of dollars by feeding off the system in illegal and fraudulent fashion.

I am going to ask the cameras once again to turn toward the audience and the cameras in the rear of the room to be turned away to allow Dr. A and Agent B to exit the room, and let me thank you both once again for your very important testimony.

Dr. A. It's been my pleasure, sir.

The CHAIRMAN. Our next panel of witnesses will be the Inspectors General of the Department of Health and Human Services and Department of Labor, June Gibbs Brown and Charles Masten, and the Director of the California Bureau of Medi-Cal Fraud, Tom Temmerman, who will give testimony about on going scams and enforcement efforts. It's my understanding that Inspector General Brown is due at another speaking engagement shortly so we'll let her go first, and as soon as you conclude, Inspector Brown, we're going to let Senator Jeffords ask questions of you because he has another meeting to go to as well.

Ms. BROWN. Okay, thank you.

STATEMENT OF HON. JUNE GIBBS BROWN, INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, D.C.

Ms. BROWN. Good morning, I am pleased to be here today to discuss health care fraud and abuse. Mr. Chairman, we very much appreciate your effective leadership over the years on the issues of health care fraud and abuse. It's a problem that squanders our limited governmental resources and which can adversely affect our program beneficiaries. At a time when very health care cost savings proposals are being considered by Congress, it's appropriate that I focus my remarks this morning on concerns we have regarding home health care, nursing home services, and durable medical equipment.

The Office of Inspector General is charged with protecting the integrity of the HHS programs and promoting their economy, efficiency, and effectiveness. In fiscal year 1994 we achieved 1,169 successful criminal prosecutions, 1,334 administrative sanctions, and we generated savings, fines, restitutions, penalties, and receivables of over \$8 billion. This represents \$80 in savings for each Federal dollar invested in our office or an average of \$6.4 million in savings per OIG employee.

Let me first discuss the issues associated with home health care. As you can see from our chart, Medicare costs have risen from \$3.3 billion in 1990 to \$12 billion in 1994. Costs are expected to reach \$16 billion and more than \$22 billion by the year 2000, if left uncontrolled. The number of Medicare beneficiaries receiving home health care has increased 72 percent from \$1.9 million in 1990 to \$3.3 million in 1994. The average number of benefits for beneficiary is increased from 36 in 1990 to 65 in 1994, more than an 80-percent increase.

We're finding various types of fraud and abuse, including unallowable expenses in cost reports, billing for excessive services or services not rendered, use of unlicensed or untrained staff, falsified plans of patient care, forged physician signatures, and illegal kickbacks.

Last month the OIG proposed a program exclusion which is comparable to debarment mentioned earlier of a home health care

agency doing business in 22 States. We determined that ABC Home Health Care, Inc., had filed false or fraudulent cost reports seeking Medicare payments for expenses unrelated to patient care. Those, as you referenced in your opening remarks, included utility costs for a luxury beach condo, golf course memberships and green fees, personal airplane and auto expenses, lobbying expenses, alcoholic beverages and promotional items such as earrings, cuff links, combs, sewing kits, and \$84,341 of gourmet popcorn.

I have an audit report on that ABC Home Health Care which is being released today, and, by the way, once this was done they changed their name. They're now known as First American Health Care, Inc.

With respect to another home health care agency in Florida, we found that 75 percent of the claims submitted did not meet Medicare guidelines. Visits were claimed but not made, visits were made to persons who were not home-bound, visits were made which physicians denied authorizing, and visits were made to beneficiaries who did not want the services.

We've just issued a draft report on our audit of other home health care providers in Florida. We randomly reviewed HHA claims and found that 26 percent of the claims did not meet Medicare guidelines. Eight percent of them were for visits to beneficiaries who were not home bound, 13 percent were for unnecessary services, and 5 percent were for visits that were not provided, provided less frequently than claimed or not documented.

The second area that I would like to discuss is nursing home services. Problems exist with respect to overlapping claims to both Part A and Part B of Medicare. We've become increasingly aware of cost shifting engaged in by nursing homes and third-party providers under Parts A and B of Medicare in the provisions of services to nursing home patients.

For example, they are billing separately under Part B for items which should be included under the overall daily rate under Part A. One reason for these problems is that no single institution or individual is held responsible by Medicare for managing a beneficiary's care while in a nursing home and ensuring that only medically necessary services are provided and properly billed.

Almost \$57 million in enteral nutrition charges were allowed and paid under Medicare Part B, even though much of these costs should have been included in the nursing home's Medicare Part A costs. Also \$55 million was charged to Medicare Part B for rehabilitation therapy provided to nursing home patients, and these services should have been provided by the nursing home and included as part of the Medicare Part A costs. Also \$44 million was improperly paid under Medicare Part B for surgical dressings, incontinent supplies, braces, catheters, and similar items provided to nursing home patients.

Our recent work suggests that systematic problems also exist in the billings to Medicare for the provisions to beneficiaries of various types of medical equipment and supplies. For example, the example you mentioned earlier, Medicare payment for orthotic body jackets went from \$217,000 in 1990 to \$18 million in 1992. The OIG found that 95 percent of the payments were for devices more properly considered seat cushions.

Medicare allowances for incontinent supplies more than doubled in 3 years to \$230 million in 1993. This was despite a drop in the number of beneficiaries using these supplies. This is illustrated in our second chart. For example, female urinary collection pouches went from virtually no billings in 1990 to \$15.3 million in 1993.

I have one of these devices with me, and it's designed to be used in conjunction with a catheter. We found that in many instances that not this item but cheap ordinary diapers were provided instead of these a little bit more expensive pouches which were billed to Medicare.

Mr. CHAIRMAN. Is that called upcoding?

Ms. BROWN. Well, I think this is a rather exaggerated type of upcoding because what we were talking about is type of diaper that you could buy in the local drug store.

Mr. CHAIRMAN. Give us some example of the cost between the item that was billed to Medicare and the item that you can buy in the store.

Ms. BROWN. Okay, this collection device is billed for \$7.38, and the diaper would be about .33 cents, depending upon where you bought it. But the main thing is that this is to be used with a catheter, which is a function that isn't working in the individual and the diaper is not to be billed at all. So when they put that in, it's not only falsifying the dollar amount, but also billing for something which shouldn't be covered.

Let's see, the number of beneficiaries using these devices increased from 600 to 9,400. We've initiated a major national investigation in the marketing and billing of incontinence care kits and supplies to nursing home patients, and that's called Project Overflow.

I would like to now address the broad issue of how we can best protect the Medicare and Medicaid programs from fraud and abuse in the future.

The CHAIRMAN. Did you come up with that name? [Laughter.]

Ms. BROWN. Not personally.

If you ask me what is different today from several years ago in the health care fraud enforcement arena, I would make three points—rising Medicare and Medicaid expenditures create a more attractive target for the unscrupulous, fraud schemes are demonstrating increased sophistication and complexity, and inadequate resources are available to address the problem. The extensive amount of fraud identified in governmental health care financing programs illustrates the desperate need for more resources, investigators, auditors, and program evaluators to address the problem. Because of the general trend over the past few years toward Government downsizing, the OIG has significantly reduced funding and staff available today to fight fraud and abuse.

We support the establishment of a mechanism to increase funding available to combat health care fraud and abuse without drawing down from the U.S. Treasury or further burdening taxpayers. Under such an approach, financial recovery resulting from anti-fraud activities would be deposited into a reinvestment fund to support additional enforcement activities in the future. Thus, the individuals who actually perpetrate fraud against or otherwise abuse our Nation's health care programs or beneficiaries would foot the

bill for increased enforcement. Of course, restitution to the affected Government programs would be made before any moneys could be deposited into the account. In the last Congress this approach had wide bipartisan support.

Mr. Chairman, we strongly support the bill that you have introduced, S. 245, which proposes a number of innovative ways to address health care fraud and abuse—first, the All-Payer Fraud and Abuse Control Program. Such a program would enhance the efforts of Federal and State government, as well as private, third-party payers to coordinate enforcement efforts, similar to the health care fraud and abuse control account, which I've already mentioned. We support such an approach whereby increased resources would be available for the enforcement activities and legal remedies. Strengthening existing legal remedies for addressing fraud and abuse, amending current criminal laws, as well as enhancing administration sanction authorities available to the Department, such as civil monetary penalties and program exclusions would aid in the fight against health care fraud and abuse.

In addition to the control program, we also support the proviso establishing a health care fraud and abuse data collection program for the reporting of final adverse actions taken against health care providers and practitioners. Ideally, this data bank could also be made available to the public so that beneficiaries can remain informed and vigilant about health care providers and the practitioners.

This concludes my oral testimony, and I'll be happy to answer any questions you may have.

[The prepared statement of Ms. Brown follows:]

Testimony of
June Gibbs Brown
Inspector General, Department of Health and Human Services

INTRODUCTION

Good Morning Mr. Chairman and members of the Committee. I am June Gibbs Brown, Inspector General of the U.S. Department of Health and Human Services. Thank you for giving us the opportunity to testify on the subject of health care fraud and abuse, and what can be done to address it.

Mr Chairman, we very much appreciate your effective leadership over the years on the issue of health care fraud and abuse - a problem which squanders our limited Governmental resources and which can adversely affect our program beneficiaries. At a time when various health care cost savings are being considered by Congress, it is appropriate that we discuss fraud and abuse in order to assure that our Federally funded health care programs operate efficiently, economically, and effectively. Also, it is important that any changes in our financing and delivery systems be made in a manner consistent with minimizing the potential for fraud, waste, and abuse.

At the outset, let me indicate our support for your legislative proposal to establish a new, comprehensive "All-Payer Fraud and Abuse Control Program." Such a program would enhance the current efforts of federal and state governments, as well as private third party payers, to coordinate their enforcement efforts. Ten years ago, the OIG helped establish the National Health Care Anti-Fraud Association (representing both Governmental and private third party payers and law enforcement agencies) to coordinate Governmental and private health care fraud enforcement activities. Over the years, this governmental/private partnership group has been extremely successful in fostering collaboration.

Moreover, the OIG has recently established with the Department of Justice and other enforcement agencies an Executive Level Working Group to focus on health care fraud, and we have started to see positive results. However, better communication and coordination of law enforcement activities are clearly needed in the fight against health care fraud and abuse. Your legislative proposal would foster such activities.

Based on our ongoing investigations, audits, and reviews of Medicare and Medicaid program costs, the OIG has recently begun major initiatives in several program areas where we believe there is systemic fraud, waste, and abuse: Home Health Care, Nursing Home Services, and Durable Medical Equipment (DME). I will focus my testimony this morning on these three areas of the Medicare program where we have serious concerns regarding the exposure to fraud, waste, and abuse. I will also address proposals being considered by Congress to improve the effectiveness of fraud and abuse enforcement efforts in the future.

OVERVIEW - THE OFFICE OF INSPECTOR GENERAL

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

Within the Department, the OIG is an independent organization, reporting to the Secretary and communicating directly with the Congress on significant matters. We perform our mission through a field structure of 8 regional and more than 60 field offices, staffed by auditors, evaluators, and investigators.

In Fiscal Year (FY) 1994, we were responsible for 1,169 successful criminal prosecutions and 1,334 administrative sanctions imposed against individuals and entities that defrauded or abused the Department's programs and/or beneficiaries. Last year, the OIG also generated savings, fines, restitutions, penalties, and receivables of over \$8 billion. This represents \$80 in savings for every Federal dollar invested in our office, or \$6.4 million in savings per OIG employee.

CURRENT HEALTH CARE DELIVERY SYSTEM - THE PROBLEMS

Let me briefly summarize for you certain statistics regarding health care spending in our country today. At the beginning of this year, the Department of Health and Human Services announced that national health care expenditures had increased to \$884.2 billion in 1993, or 7.8 percent higher than in 1992. The Federal Government was found to be the fastest growing payer of health care costs in 1993, paying over 31 percent of the nation's health care bill. Medicare and Medicaid expenditures totaled \$272 billion in 1993, or 30.8 percent of health care spending. In issuing these figures, Secretary Donna Shalala stated: "We need to address the underlying causes that are driving up health care spending faster than other costs and distorting our health care delivery system." The Secretary has directed the OIG to redouble its efforts in targeting and remedying fraud, waste, and abuse in the Department's health care delivery systems.

The Department's recently published statistics should be considered in conjunction with a General Accounting Office (GAO) report issued several years ago, which found that fraud and abuse in the health care industry accounts for an estimated 10 percent of our yearly expenditures. In 1993, this would have totaled almost \$90 billion.

Last month, GAO issued another report discussing "Medicare's exposure to losses through waste, fraud, and abuse." GAO noted that Medicare is the "fastest growing program in the [Federal] budget." It reported that "Medicare's expenditures have more than doubled, from \$70 billion in 1985 to \$162 billion in 1994." In identifying Medicare as a "high risk" program, GAO concluded that the program remains "highly vulnerable to exploitation." Among the continuing problems cited by GAO were:

- Inadequate funding for fraud and abuse detection, investigation, and enforcement activities;
- Inconsistent implementation of payment controls;
- Flawed payment policies; and
- Abusive billing practices.

Because there is no indication that fraud and abuse in the health care industry is abating, the OIG is seeking to broaden its investigative, audit, and evaluation activities aimed at curbing over-utilization and unnecessary spending in the Medicare and Medicaid programs.

HOME HEALTH CARE

Under its Part A coverage, Medicare pays for home health services for eligible beneficiaries. Among the services that beneficiaries may receive under this Medicare benefit are:

- (1) part-time or intermittent skilled nursing care and home health aide services; (2) physical, speech, and occupational therapy; (3) medical equipment and supplies; and (4) social services. These services must be provided by a Medicare certified home health agency (HHA), and certified as medically necessary by a physician.

To be eligible for home health care, Medicare beneficiaries must be (1) homebound; (2) in need of care on an intermittent basis; and (3) under the care of a physician, who both establishes a plan of care and periodically reviews it. Once these eligibility criteria are met, the benefit is unlimited as long as the services are considered medically necessary for the treatment of the beneficiary's illness. In addition, beneficiaries are not required to pay any coinsurance or deductibles (except for related DME, which requires a 20 percent copayment).

Medicare expenditures for home health services have grown dramatically in recent years. In FY 1990, the Medicare program spent \$3.3 billion on home health care. By 1994, 4 years later, Medicare was spending over \$12 billion - a 263 percent increase. These costs are expected to reach \$16 billion this year, and more than \$22 billion by the year 2000, if not controlled.

During this same period, we have also seen increases in both the number of beneficiaries receiving home health care services, and the average number of visits per beneficiary. The number of beneficiaries receiving home health care has increased 72 percent, from 1.9 million in 1990 to 3.3 million in 1994. Similarly, the average number of visits per person has increased from 36 in 1990 to 65 in 1994, more than an 80 percent increase.

Numerous factors have contributed to the dramatic increase in home health care services. The aging of the Medicare population and the development of complex medical technologies that can be provided in the home are two such factors.

Unfortunately, another significant reason for the dramatic increase in home health care costs has been fraud and abuse in the delivery of services and submission of claims for reimbursement. The OIG has observed several types of fraud in HHA operations, including:

- Cost report fraud;
- Billing for excessive services or services that were not rendered as claimed;
- Use of unlicensed or untrained staff;
- Falsified plans of patient care;
- Forged physician signatures on patient plans of care; and
- Illegal kickbacks.

Between 1990 and 1994, OIG investigations led to 25 successful criminal prosecutions of HHAs or their employees, and three civil money penalty actions. In 1993 and 1994 alone, 39 HHAs or their employees were excluded by the OIG from participating in the Medicare and Medicaid programs. Within the past several months, we have also undertaken several other initiatives in the home health care area.

Cost Report Fraud

On February 24, 1995, the OIG issued a notice of proposed exclusion from participation in Medicare and State health care programs to ABC Home Health Services, Inc. (ABC), now doing business as First American Health Care Inc. ABC is a Georgia-based corporation that provides home office services to approximately 40 wholly-owned subsidiaries providing home health services in 22 states. The OIG's proposed program exclusion is based on claims filed by ABC during FY 1988 and FY 1992. For these time periods, ABC filed cost statements with the Medicare Intermediary, listing certain expenses as related to the care of Medicare patients. These expenses were then reflected in the cost reports filed with Medicare by all of ABC's individual HHAs, as a portion of the sums sought for reimbursement.

The OIG determined that the cost reports filed by ABC contained a number of false or fraudulent cost entries, unrelated to Medicare patient care, including items solely for the personal use and enjoyment of its owners. These personal expenses included utility costs for luxury beach condominiums; golf course memberships, greens fees and pro shop purchases; airplane and automobile expenses for personal trips; lobbying expenses, such as 98 bags of onions sent to state legislators; alcoholic beverages; advertising expenses to increase patient utilization; and promotional items, including \$84,341 in gourmet popcorn, ABC golf tees, ABC earrings and cufflinks, and ABC combs and sewing kits. Furthermore, we also considered other improper charges to the Medicare program dating back to 1987 as aggravating circumstances. These additional charges included items such as maid services for the owners' luxury beach condominium, and a BMW automobile used by the owners' son while in college.

We have just issued a separate report and recommendations to the Health Care Financing Administration (HCFA) reflecting our conclusions with respect to the allowability of general and administrative costs claimed by ABC in its fiscal year 1992 Medicare cost reports. Our auditors concluded that ABC had claimed unallowable expenses totaling over \$14 million, including computer software, salaries and fringe benefits, marketing and promotional activities, entertainment and gifts, and lobbying.

In another case, our auditors' review of home health agency cost reports provided the underlying basis for a grand jury indictment earlier this month against Healthmaster, Inc., another home health care agency, as well as various officers and employees. Healthmaster, with its home office in Augusta, Georgia, provides home health care throughout Georgia and other Southeastern states. The Federal indictment, issued on March 8, 1993, alleges a conspiracy to defraud the Medicare program of millions of dollars through the submission of fraudulent cost reports. Among the improper expenses for which Medicare reimbursement was sought were political contributions, non-Medicare related work, personal expenses including pleasure trips, and payments to "related" companies owned and controlled by officers, owners and employees of Healthmasters.

False or Improper Billing Practices

Last month, we issued another report pertaining to an audit OIG conducted of home health care visits for which Medicare reimbursement was sought by St. Johns Home Health Agency (St. Johns), in Miami Lakes, Florida. Our review of Medicare claims submitted by St. Johns during the fiscal year that ended June 30, 1993, showed that 75.5 percent of the claims did not meet Medicare guidelines:

- 21.5 percent were for visits not made;
- 29 percent were for visits made to individuals who, in their own opinion, or in the opinion of medical experts, were not homebound;
- 23.5 percent were for visits that physicians denied authorizing; and
- 1.5 percent were for visits that the beneficiary did not want or were not adequately documented.

Thus, of the \$45.4 million claimed by St. Johns for the fiscal year ending June 1993, the OIG estimated that \$25.9 million did not meet Medicare reimbursement guidelines. While St. Johns' officials blamed subcontractors for causing the submission of claims for visits that did not meet Medicare reimbursement rules, we believe that St. Johns cannot escape responsibility for the actions of its subcontractors.

We have also issued another draft report pertaining to our recent audit of services rendered by other home health agencies in Florida. We randomly reviewed HHA claims and found that 26 percent of the claims did not meet Medicare guidelines. Specifically, we found that: 8 percent of the claims were for visits to beneficiaries who were not homebound; 13 percent were for unnecessary services; and 5 percent were for visits that were either not documented, not provided, or provided less frequently than actually claimed. Based on these preliminary findings, we are planning to expand our review to other areas of the country where we have reason to believe that problems exist with respect to the delivery of home health care services to Medicare beneficiaries.

Physician Certification of a Plan of Care

We recently issued another draft report reviewing the physician's role in home health care. This is an important area because we know that many inappropriately paid claims could have been prevented with more physician involvement. We interviewed physicians and HHAs around the country and found that physicians generally have a relationship with patients for whom they sign plans of care. Physicians reported initiating referrals for home care and reviewing the plans of care they sign. However, it was also clear that physicians remain primarily involved with patients with complex medical problems, and are less involved with patients with chronic, but less complex, conditions. Thus, they frequently are not aware of the ongoing HHA services being provided to patients and billed to the Medicare program. Moreover, it is also important to recognize that physicians do not make home visits themselves to monitor the HHA services provided, nor do they directly manage the care a patient receives from a HHA.

Other Third Party Payers

I also want to bring to your attention another report we plan on issuing shortly that provides information about how third party payers other than Medicare structure and manage home health care benefits. We have found that the primary difference between Medicare and other payers is not the benefit packages offered, but rather the way home health costs are monitored and controlled. Other payers are more involved in assessing how beneficiaries may benefit from home health care, and utilize case managers to ensure that beneficiaries are properly selected, care is properly provided, and utilization and progress monitored. Moreover, unlike Medicare, beneficiaries are charged copayments and told what the insurer has paid the HHA on their behalf. Certain health plans also set limits on the home health care benefit, capping the number of visits that can be made over a specified period.

Clearly, the provision of home health care to Medicare beneficiaries is an area that is vulnerable to fraud and abuse. The current unlimited benefit structure and lack of copayments provides an incentive for the provision of unnecessary services. Also, the current "cost-based" payment structure provides an incentive for fraudulent providers to seek reimbursement for expenses totally unrelated to the care rendered to Medicare beneficiaries. Increased vigilance is needed if we are to ensure that medically necessary, quality home health care services are rendered to Medicare beneficiaries.

NURSING HOME SERVICES

Let me now turn to the issue of nursing home services. Our concerns regarding nursing homes primarily are focused on the fragmentation of responsibility and accountability for the delivery of and billing for services.

Medicare and Medicaid Coverage

Medicare pays for services delivered to beneficiaries in nursing homes under both Part A and Part B of the program. Medicare Part A covers 100 days of extended care services for qualified beneficiaries in a Medicare participating skilled nursing facility (SNF). To qualify for the benefit, a patient must have spent at least 3 consecutive days in a hospital, and require daily skilled nursing care or skilled rehabilitation services. In 1993, Medicare spent over \$5 billion for SNF stays by more than 728,000 beneficiaries under Part A of the program. Medicare Part B also comes into play, regardless of which payer covers the stay in the nursing home itself. In 1992, we estimate that Medicare Part B allowed approximately \$4 billion for services delivered to 2.1 million beneficiaries in nursing homes. Services to nursing home patients that can be billed to Medicare Part B include physician, laboratory, radiology, ambulance, and medical equipment and supplies.

State Medicaid programs are required to cover nursing home care for eligible individuals over the age of 21. Approximately 2 million Medicaid recipients receive nursing home coverage at a combined Federal/State cost of \$25 billion. This represents approximately 24 percent of all Medicaid expenditures.

Fragmentation of Responsibility and Accountability

The OIG has become concerned about the provision of excess and medically unnecessary services and equipment to program beneficiaries in nursing homes. This situation results from the fact that no single individual or institution is held responsible by Medicare for managing the beneficiary's care while in a nursing home. Indeed, the incentives exist to provide excessive and unnecessary items and services.

For example, a Medicare Part B provider who offers therapy services to residents of nursing homes easily can gain a market for his or her services; the patient is happy to receive services of any kind, with the expectation that they may help medically or socially; and the nursing home's staff is relieved of caring for the patient during the time the provider is delivering therapy services to the patient. Unfortunately, no one is assessing whether the therapy services are medically necessary and properly billed to Medicare Part B. Problems also exist with suppliers delivering unneeded and unordered supplies to nursing homes for patients and billing this DME to the Medicare program. The nursing home has little incentive (except for limited storage space) to return the supplies.

We have become increasingly concerned about the cost shifting between Part A and Part B of the Medicare program in the provision of SNF services. HCFA determines the daily rate it will pay for care in a SNF. This rate is calculated to include the totality of SNF services, including room and board, nursing care, rehabilitation services, and other routine SNF services. However, for some additional services, SNFs are permitted to bill Part B of Medicare separately. Through various audits and reviews which we have conducted, the OIG has found the following:

- Enteral nutrition is a liquid dietary form of feeding certain patients. It is clear that, with respect to SNF patients, patients' dietary needs, including enteral nutrition, should be covered by the Medicare Part A nursing home payment. However, we have identified roughly \$57 million in enteral nutrition charges that were allowed and paid in both 1991 and 1992 under Medicare Part B, even though much of these costs should have been included in the Medicare Part A SNF payment.
- We have also determined that as much as \$55 million in 1992 was charged to Medicare Part B for rehabilitation therapy provided to SNF patients. Rather than the SNF providing these ancillary services to patients and including them as part of their Medicare Part A costs, these therapy charges were improperly billed to Medicare Part B by third party providers.
- And finally, we determined that as much as \$44 million was improperly paid under Medicare Part B in 1992 for surgical dressing, incontinence supplies, braces, catheters, and similar items provided to SNF patients.

Significant Medicare savings could be realized if such DME was purchased by nursing homes, acting as a prudent purchaser and taking advantage of volume discounts, rather than being provided and billed to Medicare Part B on an individual beneficiary basis. We will be issuing a report shortly on issues related to the pricing and billing of DME provided to nursing home patients under Parts A and B of Medicare, and the Medicare cost savings which could result from eliminating the separate billing and payment for DME under Part B. We intend to work with the HCFA in reviewing the fragmentation of billing for services provided to Medicare beneficiaries in nursing homes, with the goal of identifying ways of achieving cost savings, while ensuring that needed items and services are provided to program beneficiaries.

MEDICAL EQUIPMENT AND SUPPLIES

We are continuing to focus our activities on the provision and billing for medical equipment and supplies provided to Medicare beneficiaries overall. Between 1990 and 1994, our investigations led to 131 successful criminal prosecutions of DME suppliers or their employees. During the same period, we imposed civil monetary penalties in 38 cases. During the past two years alone, we have excluded 114 DME companies or their employees from the Medicare and Medicaid programs.

We try to target our reviews at specific items or supplies that have experienced a significant increase in claims and payments over a short period of time. In the absence of coverage or coding changes, or new medical information about the proper use and application of technology, such increases have often been an indication of fraud or inappropriate billings.

For example, payments for orthotic body jackets --customized, rigid devices intended to hold patients with muscular and spinal conditions immobile-- went from \$217,000 in 1990 to \$18 million in 1992. We reviewed the devices being provided to program beneficiaries and determined that approximately 95 percent of those payments were for devices more properly considered to be "seat cushions" rather than body devices. We have alerted HCFA to this problem, and its carriers have taken steps to deny such improper claims, resulting in a significant decrease in payments.

Incontinence Supplies

Another area that we believe is susceptible to abuse is the provision and billing for incontinence supplies. Incontinence supplies are used by individuals who have bladder or bowel control problems, and include catheters and external collection devices such as pouches or cups. The Medicare program covers these supplies when incontinence is of long and indefinite duration. HCFA will also reimburse for accessories that aid in the effective use of such devices, such as drainage bags, irrigation syringes, and sterile saline solutions and lubricants. However, certain items, such as absorbent undergarments or diapers, are specifically excluded from Medicare coverage.

We have determined that Medicare allowances for incontinence supplies more than doubled in 3 years despite a drop in the number of beneficiaries using these supplies. The amount allowed for incontinence supplies rose from \$88 million in 1990 to \$230 million in 1993, an increase of \$142 million. During the same period, the number of beneficiaries receiving incontinence supplies fell from 312,000 to 293,000, causing the Medicare allowance per beneficiary to increase from \$282 to \$786, a 179 percent increase.

We believe that questionable billing practices may account for almost half of Medicare allowances for incontinence supplies in 1993. Approximately \$88 million was allowed for accessories that were not billed along with a catheter, indicating that coverage guidelines were not being met. Another \$19 million in allowances were made for beneficiaries who appeared to receive more supplies than necessary.

We have also secured information from nursing homes indicating that unscrupulous suppliers engage in questionable marketing practices to increase their business in incontinence supplies. 24% of nursing homes surveyed reported that supplier representatives decided independently on the amount of supplies to be delivered in a given month for Medicare beneficiaries. In addition, nursing homes reported other improper practices by suppliers, including the routine waiving of beneficiary coinsurance amounts, as well as offers of kickbacks in exchange for allowing suppliers to provide incontinence supplies to patients.

Nursing homes also reported to the OIG that some suppliers present them with false or misleading information. For example, 22 percent of nursing homes surveyed received false information from suppliers stating that Medicare was introducing "new and broader coverage" of incontinence supplies. One out of ten nursing homes had also been misinformed by a supplier that Medicare would separately cover other routine incontinence supplies such as absorbent undergarments if syringes, sterile solutions, and lubricants were purchased.

As a result of these alarming findings regarding the provision and billing of Medicare for incontinence supplies, we have initiated a major national investigation into the marketing and billing of these supplies to Medicare beneficiaries in nursing homes. Clearly, greater vigilance and detection is necessary as we strive to protect the Medicare program and vulnerable beneficiaries from unscrupulous DME suppliers.

RECOMMENDATIONS

I would also like to address the broader issue of how we can best protect the Medicare and Medicaid programs from fraud and abuse in the future. If you were to ask what is different today from several years ago in the health care fraud enforcement arena, I would make three observations -

- Rising Medicare and Medicaid expenditures create a more attractive target for the unscrupulous;
- Fraud schemes are demonstrating increased sophistication and complexity; and
- Inadequate resources are available to address the problem of health care fraud and abuse.

When Willie Sutton was asked why he robbed banks, he responded: "Because that's where the money is." Today's criminals continue to be attracted to where the money is. In 1980, Medicare program costs were \$34 billion. In 1990, that number had increased to \$107 billion; and estimated Medicare costs in 1995 will be \$177 billion. With that much money at stake, the lure of a fast buck is irresistible to wrongdoers.

Second, we see a trend toward increased complexity and sophistication in the various schemes used to defraud the Medicare and Medicaid programs. When we first started investigating health care fraud almost 20 years ago, we were primarily seeing instances of individual providers filing false claims for relatively low dollar amounts. Today, we see increasingly complex fraud schemes involving groups of perpetrators and large dollar amounts. The health care fraud environment today involves complicated reimbursement issues, medical questions, and financial arrangements. Recently, a major health care corporation that owned and operated over 60 psychiatric hospitals agreed to settle the Federal Government's fraud claims against them by entering into a criminal plea agreement and agreeing to pay \$379 million in penalties and restitution. In another major case, a laboratory corporation agreed to pay the Government more than \$110 million to resolve outstanding fraud charges. The size and complexity of these cases demand increased resources dedicated to fighting health care fraud and abuse.

Third, despite increased demands, the OIG's investigative and audit resources have declined in the past several years, from 1,411 employees in 1991 to 1,207 employees in 1995. By the end of FY 1994, 10 OIG investigative offices in 9 states (including Maine) and Puerto Rico were closed. During the same period, the OIG was required to implement the financial statement audit provisions of the Chief Financial Officer's Act of 1990, other new audit responsibilities, as well as 32 new civil monetary and exclusion authorities, without any additional funding for these new responsibilities. Our next challenge will be to absorb the loss of 259 staff members who will be transferred to the Office of Inspector General in the new Social Security Administration at the end of this month.

Funding for OIG activities has also been hampered by the discretionary freeze provisions of the Budget Enforcement Act. Budget constraints have produced the illogical result that spending on fraud prevention and detection - activities that pay for themselves many times over - has actually been curtailed. New resources are needed to fight burgeoning health care fraud and abuse.

Accordingly, we strongly support a bill you have introduced, S. 245 (The Health Care Fraud Prevention Act of 1995), which proposes a number of innovative steps for addressing the problems I just highlighted.

Coordination and Resources

We support your proposal to establish an "All-Payer Fraud and Abuse Control Program." Such a program would clearly enhance the efforts of federal and state government, as well as private third party payers to coordinate their enforcement activities. Better communication and coordination of law enforcement activities is needed in the fight against health care fraud and abuse. Your proposal would foster such activities.

Additionally, the establishment of a Health Care Fraud and Abuse Control Account would also increase enforcement activities. We support a mechanism whereby funding to combat fraud and abuse is increased without drawing down from the U.S. Treasury, or burdening taxpayers further. Under the approach you have suggested, financial recoveries derived from health care fraud case, e.g., criminal fines, civil penalties and damages under the False Claims Act, and administrative penalties and assessments, would be deposited into an account, to be made available for the future funding of fraud and abuse enforcement activities. Under such an approach, the individuals who actually perpetrate fraud against, or otherwise abuse, our federal health care programs, and are adjudicated as guilty, will be paying the costs of increased enforcement in those programs. Of course, full restitution of monies lost due to fraud would be made before any funds are to be deposited in the Account.

Legal Remedies

As the extent and amount of health care fraud and abuse has grown in recent years, it has become clear that we also need to strengthen the available legal remedies. Your proposals for amending current criminal provisions of law will aid in targeting wrongdoers, as well as serve as increased deterrence. We are especially interested in your proposals for enhancing the administrative remedies available to the Department for sanctioning aberrant health care providers. As previously mentioned, we utilize civil monetary penalties and program exclusions to protect the Medicare and State health care programs, and program beneficiaries, from unscrupulous and incompetent providers. For example, in FY 1994, we excluded 1265 health care providers and practitioners from program participation. Of these exclusions, 288 were imposed as a result of Medicare/Medicaid program-related convictions; 183 were imposed as a result of patient abuse or neglect convictions. Your proposals for improving upon our administrative authorities for sanctioning health care providers will make these provisions much more effective in maintaining the integrity of our health care financing programs.

Communication

Clearly, if we are to maximize our resources in fighting health care fraud and abuse, we need to enhance communication between federal and state law enforcement agencies, as well as federal and private third party payers. Certainly, your proposal to establish an All Payer Fraud and Abuse Control Program will facilitate such communication between enforcers and payers. However, we also welcome your proposal to establish a Health Care Fraud and Abuse Data Collection Program. It is important that federal, state, and local governments, as well as third party payers, communicate with one another with respect to sanctioned providers. The establishment of a central repository for the reporting of final adverse actions taken against health care providers will permit federal, state, and private payers to become aware of and take reciprocal actions to sanction health care providers who abuse or defraud health care financing programs. We would suggest that this data bank also be made available to the public so that beneficiaries can be informed and vigilant about health care providers and practitioners whom they utilize.

We look forward to working with the Committee in addressing the issues of enhancing resources, coordination, remedies, and communication directed against health care fraud in our country. As you have requested, we will be providing specific comments to the Committee staff with respect to your legislative proposals aimed at combating health care fraud and abuse.

CONCLUSION

As the Congress contemplates changes in our health care system, the problems of fraud, waste, and abuse must be addressed. We stand ready to work with you on these issues.

This concludes my prepared testimony. I would be happy to answer any questions that the Committee may have.

The CHAIRMAN. Thank you, Ms. Brown.

I misspoke earlier. I indicated that Senator Jeffords wanted to question you. He actually would like to question Charles Masten.

Senator JEFFORDS. I don't want to hold up Inspector Brown's plane problems, but I just have one question which I would like to ask Inspector Masten.

I have read your testimony—and I know that you were here earlier—and talked about the problems with ERISA and how they assist in some fraudulent schemes. So I—being on the Labor Committee and preparing a bill to make some reforms to ERISA, I want to make sure that when we do that, we can take care of the problems which might be as a result of the ERISA complexities. So I would like to ask you a question involving that.

You stated in your testimony that the complexity of the ERISA is allowed unscrupulous MEWA—that is, multiple employee welfare arrangements—operators to conduct Ponzi schemes and claim to be ERISA covered plans to try and elude any State scrutiny under ERISA's preemption clause.

Doesn't most of the MEWA problem revolve around MEWA structures that are self-insured?

Mr. MASTEN. Well, that is some of the problem, Senator, but some of the other problems revolve around the fact that these MEWAs are not regulated by the States. They are not clearly defined in ERISA. ERISA takes great effort in defining the pension plans but it does not go into detail on health benefit plans. This fact gives MEWAs an opportunity to operate in the States and give the State regulators the impression that they are under ERISA, the Federal jurisdiction. Therefore, they are preempted from being regulated by the States and they continue to operate for an indefinite period of time, until the States gets involved with our office or with the Department of Labor and find that it is in fact not a legitimate MEWA. An additional problem occurs when these schemes cross State lines. Now when they cross State lines, that particular State, as I indicated with an example in my written testimony, doesn't have any more jurisdiction. These operators simply move on to the next State, and they continue the same thing, avoiding any regulation.

Senator JEFFORDS. Is there any indication that this is increasing or decreasing as far as operators, Ponzi-type of operations, or operations to defraud otherwise?

Mr. MASTEN. In view of the number of investigations we are getting over the years, I would say it's increasing.

Senator JEFFORDS. Do you have adequate resources in the Department of Labor to try and sort out these operations?

Mr. MASTEN. Senator, we use the resources we have and the priorities that we have listed, but, as Director Freeh stated earlier, we could always use additional resources to address these issues.

Senator JEFFORDS. Well, I just ask our cooperation as we try to figure out just where the basic problems and confusion on who's covered where, and, if so, would it be better for us to strength at the Federal or to strength the preemption to allow the States more ability to be able. I understand it's a very complicated area and I'm hopeful that we can work with you to try and just decide how to help alleviate these problems.

Mr. MASTEN. I really appreciate that, Senator. I would say all the above, and my staff is willing to work with the Committee in coming up with some language that would help us out in this regard.

Senator JEFFORDS. Thank you very much, Mr. Chairman. I deeply appreciate these hearings. They've been extremely instructive and hopefully will help us to keep cost under control.

That you very much, Mr. Chairman.

The CHAIRMAN. Mr. Masten, would you and Mr. Temmerman both like to perhaps summarize your statements. They will be included in the record in full but if you could take 5 minutes or whatever to summarize, that would be helpful. We have one last panel to go.

Thank you. And, Ms. Brown, let me know when you have to depart. If it's now—

Ms. BROWN. I have until 12:30. I can stay.

The CHAIRMAN. Okay.

Mr. Masten.

STATEMENT OF HON. CHARLES C. MASTEN, INSPECTOR GENERAL, U.S. DEPARTMENT OF LABOR, WASHINGTON, D.C.

Mr. MASTEN. Mr. Chairman and members of the Committee, thank you for inviting me here in my capacity as the Inspector General of the Department of Labor to testify on such an important issue, health care fraud. From the outset, though, I would like to state for the record that the comments made here today would be in my capacity as the Inspector General of the U.S. Department of Labor and may not be the official position of the Department of Labor.

I have submitted for the record a prepared statement, and I will now summarize that statement in discussing three areas of responsibility in the Department of Labor that are subject to a lot of health care fraud today.

The first area is the Federal Employee Compensation Act Program, known as FECA; the second area is the Black Lung Program; and the third area is the Employee Retirement Income Security Act, known as ERISA.

The FECA Program is a basic worker's compensation program that pays benefits to Federal employees and certain other covered workers who incur disability or disease through on-the-job injury or exposure. During fiscal year 1994, Federal agencies spent over \$1.2 billion for compensation and \$485 million on medical benefits. Over the years our investigations have uncovered many schemes where doctors, clinics, pharmacists, physical therapists, medical technicians, and providers of medical equipment have defrauded the Government.

To illustrate, a recent investigation in Texas resulted in a physician pleading guilty to submitting false billing for services never rendered. An undercover agent posing as a patient told the doctor she needed 2 months to prepare for her wedding. The doctor had our agent return to his office weekly, and at each visit he billed the FECA program for physical therapy, biofeedback and family counseling, even though none of these services were provided. The OIG has also uncovered a virtual network of doctors who were taking

kickbacks for frequently charging prescription drugs on the FECA program; collectively, this fraud costs the Federal Government millions of dollars each year.

A persistent problem in the Black Lung Program has been fraud by companies providing claimants with durable medical goods, such as oxygen tanks. The companies often falsify the need for this equipment and then, consequently, charge the Black Lung Program for equipment that is not needed. They falsify the certificates, they give these false papers to the claimants, and they bill the program. In this case, the program paid out about \$3.7 million to the conspiring doctors and the medical equipment providers.

Another area where we have identified fraud is in health insurance plans under the employee benefit plan statute known as ERISA. The search for more affordable health care insurance has caused many small employers to buy insurance through self-funded group health plans known as MEWAs. MEWAs can allow several small employers to pool their premiums and secure coverage at rates similar to those that a large employer might pay. Most MEWAs are well run where premiums are collected and benefits are paid as promised.

Occasionally, a plan may fail because it has not been well managed. Unfortunately, however, some MEWAs have failed for other reasons, including fraud and embezzlement by plan operators. One illustration of the devastating effect these fraudulent MEWA schemes have on everyday citizens is an investigation, we conducted of a fraudulent MEWA in Florida. This fraudulent MEWA billed more than 40,000 policyholders out of \$34 million and left the victims stuck with over \$50 million in unpaid medical claims and pre-existing conditions, making it difficult for them to receive coverage by a new insurer.

As Federal and State investigative pressure has been applied to "traditional" fraudulent MEWA schemes, they have attempted to cloak their operations by portraying their fraudulent MEWAs as labor union-sponsored health plans. Our investigations have revealed that some individuals form what they hold out to be unions, but which are in fact just a ruse to avoid State insurance regulation.

Our investigations have shown that fraudulent plans have been misusing the ERISA exemption for union plans as a "safe harbor," as I explained to Senator Jeffords earlier, from State regulations in order to sign up small businesses for benefits that they may never see. These phony unions are fast becoming a potential prescription for disaster in the health insurance field.

Before concluding, Mr. Chairman, I would like to join my colleagues in commending you and the Committee on your efforts to address the issue of health care fraud. In my full statement I have taken the liberty to include some specific recommendations for additional legislative changes that you may wish to consider including in your health care reform bill, S. 294. These include, number one, including the new crimes in S. 294 as predicate activities for RICO prosecution, as was suggested by Director Freeh; number two, strengthening the ERISA administration bar provision; and, number three, exempting law enforcement investigations from the private health information restriction provision in S. 294.

Mr. Chairman, that concludes the summary of my statement, and I would be happy to answer any questions.

[The prepared statement of Mr. Masten follows:]

STATEMENT OF
CHARLES C. MASTEN
INSPECTOR GENERAL
U.S. DEPARTMENT OF LABOR
BEFORE THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

March 21, 1995

Mr. Chairman and Members of the Committee:

Thank you for inviting me to testify before you in my capacity as the Inspector General of the U.S. Department of Labor. You asked me to present my views on the very important issue of current trends in health care fraud. From the outset, I would like to make it clear that these are my views as the Inspector General and they may not reflect the official position of the United States Department of Labor.

Since its inception in 1978, the Office of Inspector General (OIG) at the Department of Labor (DOL) has been heavily involved in combatting health care fraud. As you are aware, the Department of Labor administers, operates, or oversees many worker-related health care programs. These include the administration of the Federal Employees' Compensation Act (FECA) program, which provides medical benefits and disability compensation to Federal employees who are injured; the Black Lung Benefits program, which provides medical costs and monthly compensation to former coal miners disabled from pneumoconiosis (black lung); and the Longshore and Harbor Workers' Act program, which provides benefits to certain injured and disabled maritime employees. The Department also has oversight responsibility for all employee health benefit plans that are covered under the Employee Retirement Income Security Act (ERISA).

Today I will discuss the problem of fraud in the three largest DOL health care-related programs: the FECA program, the Black Lung program, and employer-sponsored health insurance under ERISA, and describe some of our efforts to combat this fraud.

Federal Employees' Compensation Act Program Fraud

FECA is the basic workers' compensation program that pays benefits to Federal employees and certain other covered workers who incur disability or disease through on-the-job injury or exposure. During FY 1994, Federal agencies spent over \$1.2 billion on compensation and \$485 million on medical benefits.

Our investigative focus in the FECA program can be divided into two areas of concentration: medical provider fraud and claimant fraud. As my colleague for the Department of Health and Human Services has pointed out today, medical provider fraud cuts across virtually all health benefit programs. Consequently, the OIG has placed increasing investigative emphasis in this area. Over the years, our investigations have uncovered many schemes where doctors, clinics, pharmacists, physical therapists, medical technicians, and providers of medical equipment have billed the government for services that were not rendered, filed multiple bills for the same procedure, billed for non-existent illnesses or injuries or overcharged for services.

As you can imagine, medical provider fraud in the FECA program can be a difficult area in which to obtain prosecutions and convictions. It is often extremely difficult to disprove a physician's medical opinion, and gathering sufficient evidence to sustain a prosecution often requires undercover operations.

To illustrate, a recent investigation in Texas resulted in a physician pleading guilty to submitting false billings for services never rendered. Our undercover agent, posing as a patient, told the doctor she needed a couple of months off work to plan her wedding. The doctor had our agent return to his office weekly. At each visit, he billed the FECA program for physical therapy, biofeedback and family counselling even though none of these services was provided. Another undercover investigation exposed a doctor who regularly pressured patients into consenting to unneeded visits, therapy and even surgery. The OIG has also uncovered a virtual "network" of doctors who were taking kickbacks for fraudulently charging prescription drugs to the FECA program. As the OIG has focused on FECA medical provider fraud, we are finding more and more of these types of schemes throughout the nation. Collectively, this fraud is costing Federal agencies millions of dollars.

We generally find two distinct types of FECA claimant fraud -- one where the actual injury being claimed has been falsified, and the other where the claimant had an injury, recovers and then conceals or falsifies non-injury information, particularly unreported income, that could reduce or terminate benefit payments. In many instances, it is very difficult to disprove certain types of injuries actually occurred or, if they occurred, that they were work-related. Consequently, many of our successful prosecutions are based on "paper cases" where we can demonstrate, through wage earning and medical records, that the individual was performing work which is incompatible with the type of injury claimed. We are usually successful in these cases because, by law, FECA claimants receiving disability benefits must report any outside income they have earned while they are drawing benefits. The fraud against the government occurs when the claimants, who must annually self-certify any outside employment, attempt to conceal it.

Black Lung Program Fraud

The Black Lung Benefits program, another workers' compensation program that is administered by the DOL, pays monthly compensation payments and medical diagnostic and treatment costs to coal miners who have been totally disabled from pneumoconiosis (black lung) arising from breathing coal dust during their employment. In Fiscal Year 1994, the Black Lung program paid out \$444 million in compensation benefits and \$110 million for medical benefits.

A persistent problem in this program has been fraud by companies providing durable medical goods -- such as oxygen concentrators or oxygen tanks -- to claimants. The companies often falsify the need for this equipment, and then bill the Black Lung program for the costs. One investigation we conducted in Virginia exposed a conspiracy between physicians and medical equipment providers to defraud the government by falsifying medical test results on coal miners. Without the knowledge of the miners, the false score would be entered on a "Certificate of Medical Necessity" used as supporting documentation for the purchase of the unnecessary oxygen concentrators. This case resulted in a \$3.7 million judgment against the conspiring doctors and medical equipment companies.

Other Black Lung investigations have uncovered physicians who were routinely filing false medical reports which would certify black lung eligibility for perfectly healthy miners. Since the medical reports are the most important supportive documentation for program eligibility, there is little room for non-physicians to question the test results. However, we have been making some progress. Not only have we prosecuted physicians for fraud under Federal criminal statutes, but we have also been successful in bringing civil actions under the False Claims Act.

Health Insurance Fraud

A third area of fraud that I will discuss here today is fraudulent health insurance involving employee benefit plans. From the criminal enforcement perspective, any time there is money involved, especially where the amounts are significant, there is a potential for abuse. Employee benefit plans offer an especially inviting target for the unscrupulous because the cash flow that is typically involved with health care plans makes them particularly susceptible to manipulation. Since the money often passes through numerous hands and several administrative layers, there are multiple opportunities to divert funds at each level. In addition, the very nature of the insurance industry -- the receipt of money today to pay expenses for a future event (that may or may not happen) -- makes it inviting to criminals.

Employee benefit plan fraud investigations are conducted by the OIG's Division of Labor Racketeering. The Division of Labor Racketeering was created in an effort to combat the influence of organized crime in labor unions. Our initial entry into health care fraud was through our investigations of multiple-employer, union benefit plans. Those early investigations disclosed that organized crime elements had infiltrated benefit plans through the control of certain unions by organized crime families. These organized crime individuals siphoned millions of dollars out of legitimate union plans through excessive administrative costs, unauthorized participants, or outright embezzlement of plan assets.

While it is the money and cash flow that attract criminals to benefit plans, it is the complexity of the Employee Retirement Income Security Act (ERISA) that all too often allows them to elude regulators and investigators. For years, operators have exploited the lack of clarity in the provisions of ERISA regarding its preemption of state laws. Since its inception, ERISA has offered a single set of Federal standards to regulate pension plans. However, ERISA also includes health plans under its definition of employee benefit plans, but fails to include corresponding regulatory standards. As a result, fraudulent health insurance plan operators can claim to be ERISA-covered plans and try to elude any state scrutiny under the statute's preemption clause. The crooks realize that, with fewer than 500 Federal regulators and over 3 million health plans, the odds are stacked in their favor. As a result of our investigative successes with union plans, several years ago, a number of state insurance commissioners came to us asking for our assistance because of difficulties they were having in investigating other multi-state schemes and obtaining jurisdiction over persons and assets. The Division of Labor Racketeering, at the urging of the Congress, expanded its scope of investigations into general employee benefit plans.

Multiple Employer Welfare Arrangements

Soaring health insurance costs and the difficulty in obtaining major insurance company coverage in the small-employer market have forced many small companies to search for more affordable health care coverage. This search has caused many small employers to buy insurance through self-funded group health plans, known as multiple employer welfare arrangements (MEWAs). MEWAs can allow several small employers to pool their premiums and secure coverage at rates similar to those that a large employer might pay -- rates that are often significantly below those traditionally charged for small group coverage. I must take a moment to point out that most MEWAs are well-run, collecting premiums and paying benefits as they had promised. Occasionally, a plan may fail because it has not been well-managed, has had inadequate reserves, or has set premium rates that are too low to cover the costs of the claims.

Unfortunately, some MEWAs have failed for other reasons -- including embezzlement, and diversion of premium monies to fund the operators' lifestyles or to shore up their other businesses. One illustration of the devastating effect these fraudulent MEWA schemes have on everyday citizens, is an investigation of a fraudulent MEWA we conducted in Florida. This operation bilked more than 40,000 policy holders out of over \$34 million in premium payments, leaving the victims stuck with over \$50 million in unpaid medical claims. In addition, Mr. Chairman, it is important to note that an important impact of these schemes is that some of the victims will be left not only with unpaid bills but also "pre-existing conditions," making it difficult for them to receive coverage for these "conditions" under a new insurer.

Non-Existent Labor Unions

As Federal and state investigative pressure has been applied to traditional MEWA schemes, they have attempted to cloak themselves in other disguises. One of these disguises involves portraying themselves as labor union-sponsored health plans. Our investigations reveal that some individuals form what they hold out to be "unions," but which are in fact no more than a ruse that they create to sell health plans and to avoid state insurance regulation. These bogus unions generally fail to do the kinds of things that typically define a union, such as truly providing representation to members with respect to labor-management issues. Under ERISA, health plans that are part of a union's collective bargaining agreements are exempt from state regulation. For years, many unions have run completely legitimate health plans under this exemption. However, our investigations have shown that fraudulent plans have been misusing this exemption as a "safe harbor" from state regulation in order to sign up small businesses for benefits that they may never see. These phony unions are fast becoming a potential prescription for disaster in the health insurance field.

One recent example of a non-existent union scheme that the Division of Labor Racketeering worked on involved a MEWA in California. After a two-year investigation, the State of California issued a cease and desist order on that plan. Within a week after issuance of this order, the operator of the MEWA had moved all of his bank accounts, plan records, and staff to Arizona, where he reopened his business under a new name -- this time operating as a union -- even though no union actually existed. In fact, it is doubtful that the plan participants ever even knew that they were actually in a union. This case is a particularly striking example of how difficult it is for law enforcement agencies to enforce the current statutes concerning ERISA-covered health insurance plans. The State of California could do nothing more in this case because the cease and desist order pertained to a MEWA which no longer existed. The State of Arizona simply was not yet prepared to address this brand new "union."

As an additional example of the adaptability of these non-existent union operators, I would like to discuss a New York case that we conducted. This investigation involved an individual who set up a local union solely for the purpose of collecting premium payments, with no intention of ever providing benefits. After we shut down his operation, this "entrepreneur" simply went a step further and created an international union. Apparently, he had analyzed his previous mistakes and decided that he needed to remove himself from the level of actually selling insurance, to the level of selling union local charters to other individuals who would peddle the insurance. In other words, he was selling the "franchise" to market fraudulent union-sponsored health plans.

Recommendations on S. 294

Mr. Chairman, at your invitation, I also would like to comment on a few of the provisions of your own health care reform bill, the Access to Affordable Health Care Act (S. 294). I applaud your efforts in the bill's anti-fraud provisions. The establishment of an inter-agency coordinated approach to health care fraud promises to have a significant impact. In fact, in this era of diminishing fiscal budgets, it is imperative that the law enforcement community coordinate even more than it ever has before. Specifically, I would also like to thank you for recognizing the investigative role that the OIG and its Division of Labor Racketeering at the Department of Labor has in this area. I look forward to working with Inspector General Brown, other Inspectors General, and the Department of Justice in the fight against health care fraud.

I support S. 294's amendments to the U.S. Criminal Code. In particular, I am pleased to see that health care fraud will be made a 10-year felony. I also support the extension of the asset forfeiture and money laundering statutes to health care fraud. I believe it is important that those who engage in health care fraud should have all their ill-gotten gains disgorged. In line with these improvements, I might suggest some additional areas which could strengthen the battle against health care fraud. One extremely effective statute currently being used to combat welfare plan fraud is the Racketeering Influenced and Corrupt Organizations (RICO) Act. The RICO statute bases prosecutions on certain enumerated crimes; that is, certain crimes are set forth in the RICO statute itself which can be used as predicates to a RICO prosecution. If violations of the new criminal provisions were added to RICO predicate crimes, the law enforcement community would have an even more effective investigative weapon in its arsenal.

In addition, we have found that a very effective deterrent in ERISA is its bar against individuals who have been convicted of certain enumerated crimes. Following their convictions, they are disqualified from holding any employee welfare plan position (including being employed as a paid "consultant" to provide assistance in planning or operating a benefit plan). Section 411 of ERISA could be amended to include all of those new criminal offenses that you have included in S. 294. In addition, section 411 could be expanded to cover additional offenses which provide compelling evidence that persons who are convicted of those crimes are unfit to serve in employee benefit plan positions of significant trust and responsibility. We also support a clarification of section 411 to make it clear that Federal district courts and courts of appeals are not free to stay the bar pending appeal.

Mr. Chairman, S. 294 contains provisions regarding disclosure of certain health information. I certainly support the bill's goal to protect an individual's privacy by placing limits on the collection and disclosure of health information. But in order to conduct a thorough investigation of health care fraud, it is essential that we examine certain medical records. S. 294, however, requires a finding of probable cause before grand jury or administrative subpoenas may be issued. This is a departure from current standards since neither Inspector General (IG) subpoenas nor grand jury subpoenas presently require a finding of probable cause. It also contains a notice provision and a formal challenge procedure, which I believe will encourage litigation over what are now routine subpoenas. This probable cause standard, coupled with the notice and challenge procedure, will in all likelihood limit the use of IG subpoenas and our ability to conduct criminal law enforcement investigations into health care fraud. I believe that criminal law enforcement should be exempted from all of these provisions.

Mr. Chairman, my staff and I are ready and willing to work with the Committee to combat health plan fraud. This concludes my prepared statement, and I would be pleased to answer any questions that you may have.

The CHAIRMAN. Thank you very much, Mr. Masten, for summarizing.

Mr. Temmerman.

STATEMENT OF THOMAS A. TEMMERMAN, DIRECTOR, BUREAU OF MEDI-CAL FRAUD, WASHINGTON, D.C.

Mr. TEMMERMAN. Thank you, Mr. Chairman, I appreciate the opportunity to come here today on behalf of the Medicaid Fraud Control Units from the various States. I am, of course, from California. I'm a Senior Assistant Attorney General with the Attorney General's Office, obviously, and I'm the Director of the Bureau of Medi-Cal Fraud. Medi-Cal is our term, for Medicaid. For the most part, I'll try to keep saying Medicaid but once in a while I slip up.

The MFCUs, as we call ourselves, the Medicaid Fraud Control Units, consist of units in 44 States currently. There are approximately 1,100 people that are State employees. For the most part, we are in the attorney general's offices, although some are in law enforcement offices and other locations. We have been in operation now for 17 years, and during those 17 years we have done only two tasks—not to minimize it, but we do patient abuse cases and we also do Medi-Cal or Medicaid fraud cases. And in those 17 years of the fraud cases we have amassed approximately 7,000 cases that we have to draw on; and from which to make projections and make estimates of what might be going on.

Our funding source, I'm sure, as you well know, is 75 percent Federal, 25 percent State, with Federal match depending upon how much the State actually puts forward. We are part of the legislation that encompasses the administration or the nonmandatory portions of the Medicaid program.

Now in looking at the cases and trying to come up with some kind of projections or some type of trends, it helps us to go back and look at trends that we have seen come and go in the past. The DME, certainly, as Inspector Brown has pointed out, they had their hay day in California a few years ago. I think the folks have moved on now to Medicare now that we've chased them out of California, but approximately \$80 to \$100 million was lost in about 5 years based on the various schemes involved in that.

We have clinics or nonclinics, I guess you call them—not really legal clinics. They start as doctor's offices and we've seen them progress from just being the doctors, doing all the fraudulent billing things that people have been talking about to include having drivers or middlemen bringing people, getting paid to bring in people, and in turn paying the folks to come in to what we now see. It is those folks, those middlemen, or those drivers, who are now the clinic owners. And for the most part what they have evolved into is a private business run by nonmedical owners who hire, generally speaking, Anglo doctors who do not speak the ethnic language of the patients coming in. Therefore, the owner has to translate and you eliminate the problem of trying to coach patients on what to tell a doctor. The owner of the clinic simply tells the doctor what symptoms the doctor needs to hear.

We've also seen fewer and fewer doctors involved in these clinics. They are there and they will always be there because they are the only ones that have access to the money. They have a provider

number and that provider number gets the money, and what we have seen is that the doctors themselves first started hiring lesser licensed people, appropriate people, to see patients. They would supervise too many of them, but, nonetheless, they were appropriate people.

As the doctors moved out, the entrepreneurs moved in. The obvious is that a physician's assistant is going to command a lot more money than a clerk, and so the clerk dons the white coat and starts seeing the patients and you save the money by not paying a physician's assistant.

The clinics have continued and they probably will continue. There is a lot of money in it. They're very difficult to detect because they're practically invisible from the system's standpoint. What the system sees is billings on behalf of the individual physician; it's an individual number. There is no way to know who is in there without literally going inside and looking to see who is standing there delivering the service, which we do, but it's very time consuming to do that.

The other areas that we have seen coming up—we have discerned by virtue of a kind of little test that we came up with that there is a common thread that runs through these trends or these schemes that kind of come and go. Generally speaking, it's easy money and it's very little control. Hence, you have, like the clinics—there is really no one to control the entrepreneur. His sole license is to go down to the City Hall and take out a business license—that's it. He is not certified by the State as a clinic. If he were, he could actually get paid more money; but he can't be because he doesn't meet the requirements.

So we have somebody who has very little control. DME was the same thing. Here were people that had virtually no professional licensure whatsoever. They did not have anybody else looking over their shoulders and they relied on the system to believe them when they said they were selling diapers to, you know, entire families. There for a while we were all speculating that incontinence must be genetic because entire families would be receiving incontinence supplies every month.

So applying those to what is up and coming—well, what's up and coming is big business. Business is taking over the medical profession. We all see them. There's acquisitions, there's mergers, there's joint ventures, there's all kinds of business arrangements going on and it's good business. It makes sense from an economic standpoint for all these medical people to get together and let the business people worry about the business part of health care delivery.

The problem then comes in when you have the business people who are somewhat unregulated—not as bad as the DME folks—but they are somewhat unregulated. They do not have professional licenses, they are business people by orientation, they are not health care givers, and the rub comes in when they see how to make more money by making business decisions and they have control over the providers.

Hence, you have instead of good medical decisions directing the health care delivery, you have what are tantamount to good business decisions, but, nonetheless, bad decisions when it comes to the delivery itself, when it comes to the health care. And then, of

course, the problem is does that translate to fraud; and, when it does, how do we term that fraud?

There was some discussion about statutory changes and things like that. This is one of the real problems that we have found when you have business entities making business decisions who has a specific intent to defraud whom, and that's what we have to prove when we are dealing criminal cases.

The other thing in the business field that we have seen is the advent of the standard practices in businesses. We have the NME case, the NHL case, these big cases of big business where there were some things that were very standard in the business, very standard in the industry. Take the NHL case, for instance. With the labs, the kinds of billings, the bundling and unbundling, the tying of services or tests together are very common in the industry. It's still being done throughout the industry, despite the fact that there is this big case.

So we have those kinds of business practices that we now are looking at and contending with; and, we are the people that are used to looking at—you know, the guy that signs his false claims. It's moving way beyond that.

"Standard practices" involves pharmacies. Pharmacies are at the forefront of the electronic billing process, at least in California, because they are the only ones at this point that rather than using—if you can see that from up there—the standard I've had blown up, of the Medi-Cal card where they would take it in and peel off a little sticker and hand it to the pharmacist to pay, they now are using swipe cards. This is a photocopy, again, of your standard credit card, your swipe card, where it has the strip on the back that runs through a little device.

Currently, they are not billing with those but that is in the works. That's the way it's going to be in the future. Right now, it's an identification measure and it's confined to the dentist at this point, but the pharmacies will soon be able to use it.

The problem with the pharmacies—again, it's good business practice—you have a procedure whereby when a prescription comes in, it's entered into the computer, the computer notes the prescription, creates the bill, and in this day and age they no longer even need to run tapes and send them in—it's modem to modem—the bill can go directly into Medi-Cal. But the drugs haven't been picked up yet and if the drugs are never picked up, Medi-Cal has paid for them.

The other thing that happens so frequently is prescriptions are multiple; there are refills. The computer is set to bill the refills. Whether or not anybody comes in for them doesn't really matter because the computer knows it's supposed to bill for refills and that's what the computer does. We're looking at it again saying who is intending to defraud whom here? This is computer programming, at least that is the excuse that we hear.

The kickbacks have been something that have been seen throughout, and as these business entities are growing, it becomes more and more apparent that the kickbacks are intertwining with business dealings. It's very difficult to buy up—and hospitals buy up doctors' practices with some frequency—it's very difficult to buy up a practice without tying it to the volume of that doctor's work,

and when that volume is Medicare or Medicaid, it's a kickback. And I know the health lawyers are tearing their hair out but they get paid more money than I do to figure those things out, but that's something that is real apparent to everybody, that it's a difficult area, and it's one that we are working hard to bring ourselves up to speed so that we can properly address it.

Home health is another one that cries out for fraud. Again, you have here the worst of all worlds, not just an unregulated industry and in some States the regulations vary. But its not just the industry, you have all kinds of peripheral people that are involved, some of whom are regulated by licensures and some of whom are not, and there's only two people involved. You go into somebody's house, you take care of somebody, and there's only two of you who know what you did. So it is ripe for fraud. I mean, we're even seeing some of it in California where we only pay for two services. It's very, very little pay, but where we are seeing it and where the trend seems to be going is that at least in California it's administered by the counties. The counties receive multiple grants or block grants funding sources. The county sorts it out and decides who gets paid out of which source.

So, as we found, Medi-Cal is really paying for a lot more home health care than we realized it was paying when we first started looking at it because there is no direct billings. So now we have this added component that we have seen, and the crooks seem to pick up on it real quick. When you have multiple agencies and multiple billing sources, it is literally true that the right hand does not know what the left one was doing, and there are people out there that are getting very wealthy off of taking money out of both hands at the same time. We see that in the drug rehabilitation type of programs, the same sort of thing.

Managed care, finally, is the biggest of the new that is on the horizon and it really isn't all that new but it is pretty new to us. Managed care is probably the single most difficult type of health care delivery system that the Medi-Cal Fraud Units have to deal with, and it's because you're dealing here with entities, with businesses, that are not providers. They are deliveries of the providers. They are getting huge chunks of money and they have total control over that money.

In California we have a case that is just being settled out currently where what happened between a contractor and a sub-contractor they wound up keeping 63 percent of the money as administrative fees. Now they can argue about whether they were administrative fees, but, nonetheless, 63 percent of the money that used to go for the care of Medi-Cal recipients was now going for the care of administering the managed care programs.

I think the balance of it is included in the written statement. I tried to rush through some of this, and I hope I didn't take too much time.

[The prepared statement of Mr. Temmerman follows:]

TESTIMONY OF
THOMAS A. TEMMERMAN
DIRECTOR, BUREAU OF MEDI-CAL FRAUD

Mr. Chairman, Members of the Committee:

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

The Medicaid program, which was established to provide health care to indigent patients, has seen its enrollment explode. Nationwide, the Health Care Financing Administration expected to spend more than \$170 billion in FY 1996 to sustain the Medicaid Program. Thirty years ago, when the Program started, Medicaid expenditures were \$1.5 billion. State expenditures for Medicaid have doubled in the past five years and in some urban areas, such as Los Angeles, Baltimore and New York, it is not uncommon for one-fourth of the population to rely on the Medicaid program for their basic health needs. Even though Medicaid is generally funded 50% by federal money, several states now spend between 15 to 20% of their general budget to sustain the program. Medicaid also continues to finance almost half of the total costs for nursing homes, spending 45 percent of the \$53 billion that was spent on institutionalized care in 1990.

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

The General Accounting Office (GAO) recently estimated that fraud and abuse accounts for 10% of health care costs, currently exceeding \$800 billion, and while there may not be a way to establish a precise figure, we are certainly talking about many hundreds of millions of dollars of fraud and abuse in the Medicaid program alone. GAO stated further in testimony before the House Subcommittee on Crime and Criminal Justice on February 4, 1993 that only a fraction of health care fraud and abuse is identified and prosecuted. GAO acknowledged that without adequate resources effective investigation and prosecution of health care fraud is not possible.

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

STATE MEDICAID FRAUD CONTROL UNITS

While the investigation and prosecution of health care fraud has only recently become a top national law enforcement priority, the states have been combatting health care fraud for the past 17 years and are viewed as leaders in the detection and prosecution of fraud in the health care industry. Medicaid, established by Congress in 1965 is of course, the primary government health care program for approximately 34 million of America's poorest and oldest citizens. For the first decade after Medicaid was created, the system operated with few controls against fraud. Inadequate safeguards combined with multi-billion dollar expenditure levels made a substantial amount of fraud inevitable. The result was an unprecedented theft of government dollars as local prosecutors struggled with the difficult task of prosecuting these highly sophisticated crimes. Congress came to recognize an urgent need to address this loss after much media attention and Congressional hearings highlighted the theft of taxpayer dollars and the harm suffered by Medicaid patients who were deprived of basic medical care. The result was legislation to establish specialized state-based strike forces to police the Medicaid program.

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

States which establish Units receive 90% of their operating costs from the federal government for the first three years -- the so-called "start up" period. After that, the Units are reimbursed at 75%. This federal grant money is transferred from the Medicaid trust fund to the HHS Office of Inspector General, which administers the grants to the states.

Since the inception of this pioneering program, 44 federally certified state units have successfully prosecuted over 7,000 corrupt medical providers and vendors and elder abusers -- convictions that would not have occurred without this vital piece of legislation. These 44 Units police 92% of the nation's Medicaid expenditures with combined staff of approximately 1,150 and a total federal budget of \$69 million. This amount represents a small fraction of the total Medicaid budget that the Units are responsible for policing. Georgia and Wyoming were certified in January of this year and became the 43rd and 44th MFCUs. Unit size varies state-by-state and is dictated to some extent by the state's Medicaid program. In California, for example, our Medi-Cal budget is \$16 billion and the Bureau of Medi-Cal Fraud (BMCF) employs 110. (Medi-Cal is the Medicaid program in California.) New York is the largest Unit with approximately 304 staff and Oregon is the smallest with four.

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

While this remarkable success in detecting and prosecuting Medicaid provider fraud is widely recognized, it is perhaps less well known that the Units are the only law enforcement agencies in the country specifically charged with investigating patient abuse and neglect. Congress enacted P.L. 95-142, not only because of the widespread evidence of fraud in the Medicaid Program, but also because of the horrendous tales of nursing home patient abuse and resident victimization -- and the Units are justly proud of their record in protecting the frail and vulnerable institutionalized elderly.

PROVIDER FRAUD SCHEMES

In the past decade, we have seen a rapid increase both in the number of fraudulent schemes and the degree of sophistication with which they are committed. Although the typical fraud schemes such as billing for services never rendered, double billing, misrepresenting the

nature of services provided, providing unnecessary services, false cost reports and kickbacks still regularly occur, new and often innovative methods of thievery have consistently occurred and are even just beginning to appear.

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

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

1. *Billing for services not rendered* - A provider bills for services not rendered, x-rays not taken, a nursing home or hospital continues to bill for services for a patient who is no longer at the facility either due to death or transfer, and psychiatrists bill for SSI qualifying exams which do not occur.
2. *Double-billing* - A provider bills both the Medicaid program and a private insurance company (or the recipient) for treatment, or two providers request payment on the same recipient for the same procedure on the same date.
3. *Substitution of generic drugs* - A pharmacy bills the Medicaid program for a brand name prescription drug, when a low cost generic substitute was supplied to the recipient at a substantially lower cost to the pharmacy.
4. *Unnecessary services* - A physician performs numerous tests which are medically unnecessary and result in great expense to the insurer.
5. *Upcoding* - A physician bills for more expensive procedures than were performed, such as a comprehensive procedure when only a limited one was administered, a psychiatrist bills for individual therapy when group therapy was given.
6. *Kickbacks* - A nursing home owner requires another provider, such as a laboratory, ambulance company or pharmacy, to pay the owner a certain portion of the money the second provider receives from rendering services to patients in a nursing home.
7. *False Cost Reports* - A nursing home owner or operator includes inappropriate expenses for Medicaid reimbursement.

NEW SCHEMES AND TRENDS

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

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

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

BUSINESS MANAGEMENT COMPANIES

A significant trend is the merger, acquisition, consolidation, affiliation, and joint venture of health care corporations as a cost-saving business practice. The result is that the business judgments are overriding medical practices -- witness the laboratory cases, such as NHL and the National Medical Enterprises, Inc. (NME) cases. In addition, we are beginning to see this in the form of self-referrals. Couple this with greed, unregulated businesses, and big government dollars, and it equals disaster.

LABORATORIES

Aggressive marketing techniques, not traditionally associated with the health care industry, have increased costs by adding marginally necessary or totally unnecessary tests to health care bills. One such example is the recent National Health Laboratories, Inc. (NHL) case where physicians were misled into ordering a rare, but expensive, diagnostic test when they needed only an inexpensive and basic blood chemistry. Investigators found that NHL induced doctors to order laboratory tests which were medically unnecessary by assuring that the additional tests would be free or of minimal cost. In fact, NHL was billing government insurers for these tests without the referring physician's knowledge. As a result of this scheme, the president and chief operating officer of NHL was sentenced to jail; and the corporation, after pleading guilty, settled with the federal government for \$100 million and 33 state MFCUs for \$10.4 million.

Billing for useless laboratory tests and cheating both government and private insurers is still occurring. In Maryland, a laboratory and its owner were found guilty of numerous counts fraud and theft. The defendants were charged with billing government and private insurers for performing more than 8,000 unauthorized and useless diagnostic tests totaling nearly \$150,000. The owner was also convicted of representing a laboratory which was in violation of the state's quality assurance laws. He was sentenced to serve five years in and ordered to pay \$161,000 to Medicaid, Medicare and several commercial health insurance companies.

The Illinois MFCU has charged several defendants with allegedly establishing a phony lab and billing Medicaid and private insurance companies for lab tests that allegedly were never performed by the lab. During a search of one of the defendants' home, tubes of what appeared to be human blood were found in the garbage can. Before the scheme was exposed, over \$300,000 in payments from Medicaid and insurance companies passed through the corporate bank account.

Laboratories that provide drug testing for substance abuse programs have also been the subject of MFCU investigations. The Massachusetts MFCU indicted a drug testing laboratory and its president for allegedly overcharging Medicaid for tests it performed and then used in a series of fraudulent billing schemes to increase their billings even more. In Pennsylvania, a laboratory agreed to pay \$750,000 to settle allegations that it overcharged the state for testing done for drug and alcohol facilities and hospitals in the Pittsburgh area.

HOME HEALTH CARE

Already the fastest growing part of the Medicaid-funded health care system, state and federal outlays in the home health industry have ballooned in the last five years. In 1994, more than 7.1 million people were expected to receive some form of home care. The current Medicaid federal share for home health care is \$4.1 billion and is expected to reach \$18.4 billion by the year 2000. This increase is due to an aging population, shorter hospital stays and an increase in technology. Since the 1970s, technology has advanced to the point of allowing more and more patients to remain in their homes and receive treatment. The profile of a typical home health care recipient is one who is elderly, disabled, has AIDS, heart disease, diabetes or has been discharged from the hospital and needs more care.

Not only are home health care agencies charged with grossly inflating the number of hours their employees worked, but, more importantly, in some cases with recklessly sending untrained, unqualified, and unlicensed aides into private homes of thousands of critically ill and care-dependent patients. It is an industry that contains all of the components for disaster. It is unregulated in the traditional medical sense, multiple agencies are involved with large amounts of government money and it is attractive to the consumer.

Let me highlight a few examples of the Units' work in this area:

- In California, an elderly man who died by starving and in his own filth, was locked in a room by his sons and daughter while they enjoyed Thanksgiving dinner in another room. They were his government paid home health caregivers.
- Five individuals in Massachusetts were charged on a variety of Medicaid fraud charges as a result of the MFCU's investigation into Medicaid's personal care attendant program which allows disabled individuals to remain in a community setting with the aid of personal care attendants. Each of the defendants charged the stated for services which were not provided and/or inflated billings made to the agencies.

- Five people in California were paid for up to a year for caring for relatives who had died. These caretakers were also recipients of other government programs. Both they and the program paying them failed to report the offsetting income.
- Similarly, in Washington State, two home health care providers continued to bill the Medicaid program after the patients had died. In one of these cases, the defendant continued to bill the state while living with the victim's ex-wife.
- A certified nurse's aide in Maine was sentenced to three years in jail, with all but 30 days suspended, and to four years probation for adding her name to a number of credit cards that belonged to the patient and making purchases on those cards totalling \$7,196.13.
- The owner and billing clerk of a New York home health care agency were convicted of stealing more than \$1.1 million dollars, during a three year period for fraudulently billing the state for professional nursing services rendered to thousands of homebound Medicaid patients by these unqualified workers.
- A recent statewide audit of New York's Care At Home Program (also known as the Katie Beckett Waiver Program) identified more than \$2.4 million in Medicaid overpayments. The audit revealed that during a four year period, Medicaid was not only charged for services more properly payable to patients' private insurance policies, but also billed via special codes that bypassed the routine prior approval process and resulted in substantial overpayments.
- In one county in California, there are no less than 74 home health service agencies, many of which line up, literally, at board and care homes offering competitive incentives for home health care business within the facility. These agencies are potentially turning board and care homes into health facilities that are virtually unlicensed, non-certified, non-regulated and practically invisible.

Among the most rapidly growing segments within the home health care industry is home infusion treatments, currently estimated to cost \$4 billion.

Home infusion treatments include more than the actual medication. In addition to drugs and nutritional formulas, supplies such as tubing, syringes, alcohol swabs, bottles, gloves and needles, and expensive equipment such as pumps, nebulizers, glucose monitors and blood pressure kits that are regularly utilized by the victims of these serious illnesses, all of which are billed on a regular basis. A large amount of the funds, too, are spent in the area of home care services. Regular visits, frequently more than once a day, by an R.N., nurse practitioner, home health aide, a physician's assistant or even a physician, are required and reimbursed. Further, regular visits to a physician for certification of continued need and dosage adjustment are necessary. Again, a classic recipe for fraud with fragmented billings; drugs are billed by the pharmacies; the supplies used to assist in administering the drugs are billed by the DME

provider; professional services are billed by the home health service company or individual providers; and personal services may be billed to various agencies. In California, Medicaid block grants are given to counties who pay in-home services out of various funding sources.

The potential for fraud in this rapidly-expanding and highly expensive industry is clear. Kickbacks to doctors to authorize medically-unnecessary treatment, services or supplies, whether provided or not, is cause for MFCU concern.

Several multi-billion dollar home health care corporations are currently the subject of both federal and state investigations.

MEDICAL TRANSPORTATION

Virtually every state MFCU has found egregious examples of fraud by non-emergency medical transportation companies. Medicaid will generally pay for a patient's transportation to a medical provider either when mass transit is unavailable in the recipient's area or when the patient, because of a debilitating physical or mental condition, cannot use this method of transportation. Examples of medical transportation fraud include; billing for an excessive number of miles per trip for services actually provided, billing for recipients who drove themselves, paying kickbacks to recipients who used the medical transportation services, allowing non-eligible persons to use another recipient's card, submitting falsified appointment dates for round-trip transportation services to a provider's offices, charging billing for emergency transportation for non-emergency situations, billing for fictitious services not covered by the Medicaid program or for transportation that was not provided, and creation of phoney certificates of need ostensibly by doctors, and kickbacks to doctors for improperly certifying the need.

Transportation fraud is also committed by ambulance providers as well. For example, in Pennsylvania claims were filed to the state requesting reimbursement for ambulance trips that were not medically necessary. Many of these trips were to doctors' offices, which are not reimbursable under Medicaid regulations, but were misrepresented as being trips to hospitals. A Minnesota company that provided ambulance and medical transportation reached a \$3 million dollar settlement with state and federal authorities for falsely billing the Medicaid and Medicare programs. The company billed these programs for basic life support ambulance transportation, claiming that the rides were medically necessary; when a lesser form of transportation would have been adequate.

The general transportation program in Maryland virtually collapsed under the weight of fraud and abuse. In 1988, the program cost taxpayers \$4.5 million per year. Fraud, abuse and aggressive marketing caused the demand for program services to increase four fold in four years, for a cost of \$16.2 million in 1992, at which time it was abolished.

In California, a state that pays for almost no transport services, we recovered nearly \$1 million from bank accounts hours before the money was to be transferred out of the country. The defendants had already fled. They had used a combination of phoney certificates of need, lying about the mileage and kickbacks to board and care operators for access to Medi-Cal patients.

DRUG DIVERSION

In the early 1980s, drug diversion or more properly the diversion of legal drugs for illegal purposes in the Medicaid program, frequently involved pharmacists filling prescriptions with generic or other cheaper substitutes for the more expensive, brand name drugs that were being prescribed by physicians or submitting false Medicaid reimbursement claims for higher-priced, brand name medicines. Drug abusers have turned to prescription drugs as their drug of choice and this demand has generated a supply of dishonest health care providers who both abuse their prescribing privileges and incur great costs to prescription plans, such as Medicaid. In large urban centers, it is not uncommon to find a so-called "pill mill" which has as its primary purpose the issuance of prescriptions for controlled drugs in exchange for cash or, in some cases, sexual favors. These drugs may then be resold "on the street" or sent abroad for black and gray markets for several times their cost, sustaining the continued addiction of countless individuals. In some instances, we have found that the street addicts resold the prescription drugs to other pharmacies at a fraction of their original cost and at some risk to the unsuspecting customers of the second pharmacy.

However, while drug diversion is often used in the context of pill mills and script selling doctors, the definition should include such cases as nurses who work in nursing homes who order prescriptions from pharmacies without a physician's order and then obtain the prescription from the pharmacy delivery person and either sell the drugs or use the drugs for themselves.

Although it is impossible to quantify the losses to the Medicaid program as a result of this illegal drug diversion, the potential impact is considerable. Medicaid prescriptions alone cost the government \$5.5 billion in 1991, a cost that is expected to nearly double by 1996 to \$10 billion. These costs are not confined to the actual reimbursement for the drugs dispensed, but rather include much greater costs which society must absorb from the continuation of the addiction cycle and its ensuing impact on the health of the individual. According to a study released on July 15, 1993 by the Columbia University Center on Addiction and Drug Abuse, \$4.2 billion of the \$21.6 billion paid by Medicaid for hospital care in 1991 was for care attributable to substance abuse. If one applies that same ratio--just under 20%--to all U.S. health care expenditures, this nation is spending nearly \$200 billion a year on care attributable to substance abuse.

The larger point-of-entry cities of the United States have noted so-called "hit and run" schemes in which foreign nationals fraudulently obtain a Medicaid provider number and then submit invoices for services not rendered. In larger cities, these fake providers often are able to obtain hundreds of thousands of Medicaid dollars before their detection, at which time they flee to their homeland. In one such case in New York, the perpetrators went so far as to establish a medical laboratory and then offer to buy the blood of Medicaid patients for \$10 a pint. Once the owners of the laboratory obtained the blood and the Medicaid eligibility numbers of the patients, they would submit astronomical bills to Medicaid, representing that they had performed an extensive and costly blood work-up, the results of which the patients would not receive. The laboratory owners were discovered only when numerous "patients" began appearing at hospital emergency rooms after selling excess amounts of blood and rendering themselves gravely ill.

In many of the nation's larger urban centers, it is not uncommon to find so-called "pill mills" -- medical centers whose primary purpose is the issuance of prescriptions for controlled drugs in exchange for cash. In a typical scenario, a "patient" will visit an unscrupulous doctor and buy, for instance, a prescription for 90 Valium (10 mg) tablets at a price of about \$1 a pill. After "busting" the scrip (having it filled) at an accommodating pharmacy, the patient will resell the pills to individuals at \$5 a pop and thereby net a profit of \$360. Not factored into this economic equation, however, is that each participant in the scheme is sustaining the continued addiction of countless individuals.

In Texas, for example, as in a number of other states, the drug diversion problem is most commonly seen in the following schemes:

1. A Medicaid recipient goes to a doctor's office and pays cash for a controlled drug prescription, which is then filled by a pharmacy. The doctor does not bill the Medicaid Program, the pharmacy does;
2. A "middle man" (i.e., non-recipient) goes to a doctor and gives him cash for a number of prescriptions for controlled substances with no names or addresses on any of the prescription forms. The middle man then "rents" Medicaid cards from recipients, inks in the blanks on the forms, and goes to a pharmacy to have the prescriptions filled. The pharmacy bills Medicaid;
3. A Medicaid recipient goes to a doctor for a legitimate medical reason and the doctor gives the recipient a legitimate prescription. The recipient is approached outside the doctor's office with an offer to buy the prescription. The recipient often sells the prescription. A business arrangement is then established.

FRAUD IN MANAGED CARE

Both the Medicaid and Medicare programs are utilizing managed care delivery systems. In some states, managed care has been in existence since the early 1980s. Currently, more and more states are requiring greater numbers of their Medicaid population to participate in their managed care programs.

Proponents of the managed care system believe that it is the best method for providing low cost, high quality health care to more people. Managed care is supposed to save money not only in the delivery of services but by cutting down on the amount of paperwork. While many observers point out that the very nature of managed care prevents fraud, the experience of the fraud units, the Arizona Unit in particular, the Medicare Program and the private insurance industry, reveal that no health care plan is immune from fraud and indeed fraud does occur in managed care plans. Rather, fraud simply takes different forms, in response to the way the program is structured.

While the traditional Medicaid provider fraud investigation focuses on overutilization of services and fraudulent billing, in managed care investigations, the evil more likely lies in the underutilization of services. Unlike the typical Medicaid provider fraud case, the human cost in terms of reduced access to quality care may be tremendous.

The MFCUs have documented certain types of criminal activity in managed care plans. Fraudulent subcontracts, fraudulent related party transactions, excessive salaries and fees to the entrepreneurs involved, bribery, tax evasion, kickbacks, rebates and other illegal economic arrangements, and fraud in the administration of the program. Quality of care problems such as the underutilization of necessary services, falsification or misrepresentation of professional credentials, and the use of unlicensed providers may occur more frequently in managed care programs than in the traditional fee-for-service payment program. Further, instead of billing numerous unnecessary procedures for a few existing clients, physicians may legally increase their income by agreeing to provide care for hundreds or even thousands of clients for monthly capitation fees. The patients become a captive audience, and the physician has less incentive to find sufficient time to provide good care for his patients.

One Maryland case illustrates one kind of fraud and patient neglect that will be a problem faced by managed health care programs in future years. The Maryland Medicaid program has initiated a limited managed care approach which pays physicians a minimal monthly fee for each patient for whom they assume primary responsibility. The Maryland MFCU recently prosecuted a physician who "treated" between 90-100 patients a day, recording for each patient the identical blood pressure and pulse rate, and using a rubber stamp to diagnose the same ailment for most. The amount of his Medicaid payment was based upon his rendering a "comprehensive" medical examination for each patient. The sad truth was that his patients received no medical care and, in several cases, suffered from conditions that worsened due to his neglect. When questioned by MFCU staff, he was unable to provide the name of a single patient for whom he allegedly provided care. The physician was convicted of felony Medicaid fraud.

In California, the state enrolled 1.1 million Medi-Cal beneficiaries in 1993 and expects to have 2.5 million beneficiaries (or 50% of the Medi-Cal population) enrolled by early 1996. Bids for contracts with health care service plans, commonly called HMOs, are being reviewed at this time.

In California's managed care system, the single state agency (Medicaid agency) contracts for some or all of its Medicaid covered services and supplies. The contractor is most often a coordinating business entity, *not* an actual provider. The services are rendered by employees of the contractors or by subcontractors. The victim of fraud may be the program, the contractor, the subcontractor or the individual provider. The perpetrator of fraud may be an individual within the single state agency, the contractor, an employee or agent of the contractor or subcontractor, or individual provider, or even a related entity that controls the service provider. An example of this is found in the Arizona experience.

The Arizona Health Care Cost Containment System (AHCCCS), a state-wide prepaid capitated program, that is designed to provide the same quality health care to the poor that is provided to private pay patients, began on October 1, 1982 and was the first in the country to offer its citizens a managed care program. The AHCCCS Fraud Unit was established two years later. That Unit has extensive experience in investigating fraud in managed care.

In one Arizona case, three former officials of one of the largest health care providers under the AHCCCS program were indicted on charges of fraudulent schemes, conspiracy, theft and illegally conducting an enterprise, Health Care Providers of Arizona (HCPA). The three were charged with conspiring to defraud HCPA and AHCCCS by diverting funds lawfully belonging to HCPA to themselves and their businesses. The investigation revealed that the monies were taken out of HCPA in various fraud schemes and thefts in the guise of capitalization, management fees, medical directors fees, bonuses, medical equipment and excessive rental charges. The licensed doctor of osteopathy and the medical doctor both pleaded guilty to one count of fraudulent schemes, and two counts of facilitation of theft. Both were sentenced to three years probation and ordered to pay a \$14,000 fine, \$50,000 in restitution and \$50,000 in costs of prosecution. The registered nurse pleaded guilty to two counts of facilitation of theft, and was sentenced to three years probation, and ordered to pay a \$5,400 fine, \$5,000 in court costs, and \$4,556 in restitution.

Huge dollar amounts are at stake in California's managed care program unlike the average individual provider. While Medicaid and/or Medicare providers who have been convicted of health care fraud are subject to civil fines, sanctions and exclusion from the programs, managed care plans would suffer a far greater financial loss if sanctioned or excluded from participation in the health care delivery system. The system would suffer the loss of a major provider and therefore the ability to deliver health care to large numbers of beneficiaries. The Bureau of Medi-Cal Fraud (BMCF) has partially settled a case with one of the managed care contractors and, as we speak, is finalizing the settlement with its subcontractor. In the settlement, program losses of over \$1 million were recouped. This California case involved a contract that was for a full range of medical services, including dental. A subcontractor was

to provide for the dental services. The subcontractor's prior administrators made business decisions that potentially jeopardized participation by beneficiaries and dentists. These alleged practices included:

- delays in notification of beneficiaries regarding selection of dental providers;
- delays in approving and providing services;
- the improper influence over medical decisions by those charged with fiscal responsibilities; and
- difficulty accessing services during a transition from a fee-for-service to a capitated delivery system.

As the experience of the state MFCUs demonstrates, fraud does occur in managed care plans. As health care delivery systems become bigger and bigger business, not only will unscrupulous providers find new and innovative ways to criminally profit at the expense of patients and health care payers but so will enterprising businessmen and women.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS (NAMFCU)

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

The Association employs a Medicaid Fraud Counsel, located at the National Association of Attorneys General in Washington, D.C. The Association coordinates and disseminates information to the various Units, maintains a library of resource materials, and provides informal advice and assistance to its member Units and to those states considering establishing a Unit. NAMFCU conducts several training conferences each year and is called upon regularly to supply speakers for numerous health care fraud seminars. It has also co-sponsored training programs with the F.B.I. and the American Bar Association and conducts a specialized academy at the Federal Law Enforcement Training Center. The Medicaid Fraud Report, published ten times a year, is the Association's newsletter. The newsletter contains information concerning prosecutions by various states, reports of legal decisions affecting fraud control prosecution, and analyses of legislation affecting the Medicaid program and units. NAMFCU also serves as a clearinghouse for state/federal cooperative efforts and provides a responsive voice to Congressional inquiries.

MULTI-STATE/FEDERAL COOPERATIVE EFFORTS

Cooperative efforts between state and federal authorities have proven very effective in protecting Medicaid and Medicare from health care providers or vendors whose activities involve both programs and cross state lines. Joint federal and state task forces have been established in states throughout the nation, and agents increasingly are working together to detect fraud against government insurers. One side effect of these efforts has been the recognition by seasoned practitioners that *all* parties must be at the table when any case resolution is discussed. A settlement reached with a state Medicaid Fraud Control Unit in which all Medicaid claims are resolved, for example, does not necessarily resolve those in other states or any outstanding Medicare claims or their attendant sanctions. The result has been an unprecedented willingness on the part of state and federal authorities to reach "global" settlements in which all outstanding claims by government insurers can be resolved, and in which all administrative sanctions can be addressed. Mechanisms are now in place in most states which facilitate the prompt resolution of federal and state claims, and the MFCUs themselves have developed uniform procedures to coordinate joint efforts in resolving Medicaid-related claims arising from interstate providers through the National Association of Medicaid Fraud Control Units.

For example, last year, the Department of Justice announced that a settlement was reached with NME Psychiatric Hospitals, Inc., which manages more than 60 psychiatric hospitals and substance abuse centers nationwide. NME Psychiatric Hospitals is a wholly owned subsidiary of National Medical Enterprises, (NME) Inc., which is headquartered in Santa Monica, California.

In the largest multistate agreement of its kind, 27 state Medicaid Fraud Control Units and the District of Columbia negotiated a final settlement with NME for \$16.3 million. The charges were based on NME Psychiatric Hospitals' payment of kickbacks to doctors, referral services, and other persons so that they could refer patients to NME hospitals. The patients were insured under such government health programs as Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Federal Employees Health Benefit Program.

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

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

The CHAIRMAN. Not at all. Your full statement will be included in the record. That will allow me to just ask one sort of general question to Ms. Brown so she can catch her next assignment. I would point out on that chart with reference to incontinent supplies, it's really quite striking that between the years 1990 and 1993 the number of patients who received these incontinent supplies declined from 312,000 down to 293,000. At the same time you have a decline in the number of patients receiving these supplies, the charge went from \$88 million to \$230 million. I could say is there any rational explanation of that, but I think it's one of these—what lawyers call *res ipsa loquitur*—the thing sort of speaks for itself. And I won't take the time right now to explore that with you, Ms. Brown, but let me just ask or put to you at least a line of argument that has some validity and perhaps some weaknesses as well.

Many of the people who are in the provider business are going to come before this Committee if not today, then at our next series of hearings. They will say, many of the rules and regulations that we have to comply with—first, let me take one step back. Most of us are honest. The overwhelming majority of us are honest, and they're in the business to provide good, and decent and proper service to the people that they're supposed to serve. Let's start with that premise. They will then testify that many of the rules and regulations are vague, that in fact to hold the civil penalty rule or the possibility of prosecution over their head, like a Damocles sword, is really fundamentally unfair, that it's forcing them into settling cases because they can't afford the attorney fees and the other expenses associated with litigation or fighting the system. And so paying these fines, according to them, is the equivalent of extortion, that there is no room or flexibility left for innocent mistakes, particularly in light of the enhanced penalties in the legislation that I have drafted there. The fear is that the sword will come down, that there may be many, many instances of innocent mistakes and that there should be at least a one-bite rule.

So I would like you to respond to this line of argument, some of which may have some validity, but I would like to get your response before you have to depart. What about the argument that regulations are vague, that they can in fact be fined in a civil way, prosecuted possibly for so-called upcoding, which they may or may not have a legitimate basis for such a thing, and that this is being used to punish innocent people when in fact the responsibility or the problem is not generated by them but by the rules and the enforcers? What do you say to that?

Ms. BROWN. Well, of course, the very thought of using capabilities for extortion is abhorrent to me, and I would never allow our power to be used that way. We're very short of staff and so we go after the most flagrant offenders, for one thing. I think most of these things that you're speaking of here would fall under the administration remedy category, and we have an excellent record with that. We've had more than 8,900 administrative sanctions that have been imposed by my office over an 11-year period, and of all of those going through the appeal processes and so on, there have only been about 25 overturned.

The CHAIRMAN. Out of 1,100?

Ms. BROWN. No, out of 8,900.

The CHAIRMAN. 8,900?

Ms. BROWN. Yes, So I think that speaks for the conservative approach that we're using when we go to impose these remedies. However, I also hear many of the people who have aired their concerns, and in response to them we issue fraud alerts and we're issuing about eight more in the next few months. Fraud alerts are documents that are distributed throughout the industry to explain the kind of fraud we're finding in a particular area, such as laboratories. Occasionally we have people we aren't aware that they are doing something illegal or they had been approached and not recognized it as an illegal scheme. The fraud alerts help them to understand the kinds of temptations that might be coming up, so they don't inadvertently get involved in some scheme.

We're trying to approach the industry in as many ways as we possibly can.

The CHAIRMAN. What about the one-bite rule? In other words, I made a mistake, I'll correct it in the future, no need to impose a civil fine or possibly call in the FBI.

Ms. BROWN. I think if we found anyone who had done something, one instance which didn't show a pattern or anything of that nature, we do not impose any significant remedies against them. We might ask for the money back. but that's the kind of remedy that we would be looking for for somebody who just made a single error.

The CHAIRMAN. Well, I see the hour of 12:30 has arrived and I will excuse you.

Ms. BROWN. Thank you.

The CHAIRMAN. And thank you very much for staying, and I hope I didn't tread too much upon your next appointment.

Mr. Masten, just a couple of quick questions. You describe how bogus unions are now being formed to allegedly sponsor some health care plans and some of these operators are moving from State to State, once they get detected.

What do we do to try to counteract this? What do you recommend.

Mr. MASTEN. Well, one of the things I think that can be done is the creation of a very clear definition of exactly what a health benefit plan is under ERISA. This would clearly define whether a plan falls under the jurisdiction of ERISA or whether it falls under the jurisdiction of the State insurance commissioner.

That ambiguity has permitted these unscrupulous people to operate, and when they get a cease and desist order, for example, as they did in California, the operator simply moved over to Arizona and opened up a "bogus" union. A lot of the participants had no idea they were even in a union. Therefore, the State of California could no longer do anything to him because the MEWA no longer existed. It created a union, a bogus union, in order to continue his fraudulent activities.

The CHAIRMAN. Well, you indicated in your prepared remarks that there are about 3 million ERISA sponsored-health plans, right?

Mr. MASTEN. Yes.

The CHAIRMAN. And you've got less than 500 Federal investigators and auditors monitoring the program. I mean, how do you ever level the playing field under those circumstances?

Mr. MASTEN. It's very, very, difficult, and the bad guys can figure out the odds of getting caught using those statistics, and they play the game very, very well. Unless you get a cooperative effort, as we have seen recently with a number of the insurance commissioners contacting our Division of Labor Racketeering and there has been a cooperative effort to address some of these issues. In addition we use some of the same statutes that the Director Louis Freeh, was talking about earlier, mail fraud, embezzlement, kickbacks, et cetera, in order to get them.

But unless we have a very definitive statute to address ERISA's ambiguities, our hands are tied.

The CHAIRMAN. Well, we hope to present you with a very definitive statute in the very near future.

Mr. MASTEN. I would appreciate that, sir.

The CHAIRMAN. Mr. Temmerman, in your prepared statement you indicate the number of foreign nationals. They fraudulently obtain a Medicaid provider number and they submit it for services that are never rendered, and then when they're detected, they take off and flee the country, right. Do they come back in?

Mr. TEMMERMAN. We would like to think no. We've had some reports that some of them have come back in, and in fact we do continue to monitor. For the most part, as far as I know, they have not come back in.

The CHAIRMAN. How easy is it to get a provider number?

Mr. TEMMERMAN. Well, times have changed. Back in the heyday of our DME cases, it was I think, as you yourself had characterized, you write in, you say, I live at a P.O. Box. We had a person living at a P.O. Box in Mexico that had a provider number. Virtually, no one would challenge them or check them. The presumption always was these are regulated, professional people. We don't need to go out and look at them in the face and see that they exist. The DME cases really demonstrated that that was not so. Our Department of Health Services, the single State agency, has changed the regulations and they have really tightened it down quite a bit.

As far as a legitimate provider, it really is still a matter of just filling out the paperwork and submitting it and have the bureaucracy move it along.

The CHAIRMAN. When you say DME, for the benefit of those who are watching, durable medical equipment suppliers, and I might point out also for the benefit of those who might be watching that most of the professionals in the field have been very helpful to this Committee in working with the Committee to try and fashion appropriate legislation because they're the ones who are getting the black eye when in fact you have fly-by-night operations coming in, setting up phony operations, setting up a whole line of bank of telephone operators, kids coming out of high school after school closes, calling up senior citizens and saying, "hey, we've got a deal for you;" and supplying pieces of pink foam as flotation pads for wheelchairs, et cetera. But most of the professionals are very supportive of our efforts to pass legislation because the integrity of the system is at stake and their livelihood is at stake, and they want to see

the ones who are really committing the fraud and abuse taken out of the system.

Let me just ask you, finally, Mr. Temmerman, which foreign groups do you find engaged in the Medicaid fraud in your State? Is it limited to one or several or is it endemic?

Mr. TEMMERMAN. It probably runs almost the whole gamut. Generally speaking, what we have found is immigrant populations that come in mass—now, of course, being the West Coast we've seen a lot of Asian immigrants coming in.

The CHAIRMAN. Right, do they tend to target their own ethnic groups? In other words, the Asians would target the Asians, the Russians target the Russians?

Mr. TEMMERMAN. Absolutely, absolutely. South Americans target their own populations, and that ties right in with what we've seen in the clinics because that's the preferred method of operation to open the clinic, and then they go out and hire the English-speaking doctors who don't have a clue what's really going on.

The CHAIRMAN. Well, thank you very much for coming forward to testify. We have one more panel to go and I want to accommodate them as well but I appreciate both of you for coming in and Ms. Brown as well.

Thank you very much.

Mr. TEMMERMAN. Thank you.

Mr. MASTEN. Thank you.

The CHAIRMAN. Our final panel consists of the Honorable Bill Gradison, who is President of the Health Insurance Association of America, and William Mahon who is the Executive Director of the National Health Care Anti-Fraud Association. They are both going to testify on health care fraud and abuse as it relates to private insurance and health plans and the efforts that the private sector is making to combat the problem.

I also understand that Mr. Gradison has another event that he has to go to and so he will testify first.

Bill, welcome.

STATEMENT OF HON. WILLIAM GRADISON, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, D.C., ACCOMPANIED BY KATHLEEN FYFFE

Mr. GRADISON. Thank you, Mr. Chairman.

I am Bill Gradison, President of the Health Insurance Association of America which represents 230 of the Nation's health insurers, who in turn cover tens of millions of Americans. I am accompanied by Kathleen Fyffe, who is putting up the charts over there, from our staff who is a true expert in this field, Mr. Chairman, and will lend me a hand if you have any technical questions.

We deeply appreciate the opportunity that we've had to meet with your staff about this important subject and stand ready to help in any way that we can in the future.

As you've heard from others this morning, health care fraud is an important problem, the existence of which adds billions of dollars to the Nation's annual health care bill. HIAA is the only organization that maintains statistics about fraud in the private health insurance system. We develop those statistics by periodically surveying insurers to determine the types of health care fraud occur-

ring in the field and to find out what anti-fraud activities insurers are utilizing.

Our last survey covered the years 1990 through 1992. Seventy-eight percent of insurers responding to the survey have developed anti-fraud programs. The cost benefit ration for these anti-fraud programs was one to nine; in other words, for every dollar spent on anti-fraud programs there was a savings on average of \$9.

I would like to share with the Committee some charts that illustrate other key findings from our survey. In 1992 provider fraud constituted 65 percent and consumer fraud constituted 35 percent of fraud cases. Of those cases reported as provider fraud, 43 percent were fraudulent diagnoses or dates, 34 percent were provider billing for services not rendered, 21 percent were providers inappropriately waiving co-payments and deductibles, and 2 percent were other types of fraud. Of those cases reported as consumer fraud, 40 percent were falsified claims, 25 percent were falsified records of employment and eligibility, 5 percent were fraudulent misrepresentation and applications, and 30 percent were other types of consumer fraud.

One of the disappointing findings was that the vast majority of fraud cases under investigation by insurers are not referred to law enforcement agencies, and even fewer cases are successfully prosecuted. There are two probable reasons for this—Many cases referred to law enforcement agencies are not prosecuted largely because, as you've already heard, Federal and local law enforcement agencies are often overburdened with other types of criminal cases and have neither the expertise nor the resources to devote to health insurance fraud. This problem has been partially alleviated by a recent increased awareness among law enforcement personnel of health care fraud and by an increase in the number of Federal personnel dedicated to fighting this problem.

But why don't insurers report and help prosecute more instances of fraud? The answer is troublesome. Mr. Chairman, despite the attention that you and others in the Congress and the Federal Government have focused on the problem of fraud in our health care system, there is an unfriendly legal environment for anti-fraud activities by private health insurers and other third-party payers.

I would like to share three recommendations for ways to improve the legal environment:

First, immunity protections. Private third-party payers need protection from tort suits such as defamation suits when they, in good faith, participate in fraud investigations. Federal immunity is essential because State immunity statutes vary in their protection of insurers and because many fraud investigations cross State lines.

Second, mandatory restitution to the victims of fraud. Restitution would provide further resources for insurers and other payers to fight fraud and to assist them in keeping down health insurance premiums.

Third, a Federal civil cause of action for recovery of fraudulent payments. Insurers and other health plans incur significant expense when bringing legal action against the perpetrators of fraud. The creation of a private cause of action modeled after the Federal False Claims Act would allow private payers to recover damages and attorneys' fees.

Mr. Chairman, an area of the evolving health care system that deserves special attention is managed care, as was mentioned by the final witness in the previous panel. HIAA is convinced that managed care has the potential to solve some of the most persistent problems in today's health care system. But when considering anti-fraud activities, it is important to recognize that many of the methods that are effective in fee-for-service arrangements are simply not applicable to network-based health care delivery arrangements. Detecting fraud in fee-for-service arrangements requires a review of individual claims. In contrast, the shift toward managed care requires the ability to detect fraud through the evaluation of patterns of care.

As network-based plans continue to expand, and as more Medicare and Medicaid beneficiaries utilize managed care options, it will be increasingly critical that Federal anti-fraud efforts are based on a clear understanding of the structure of managed care. Management of provider payment rates and practices is inherent in network-based plans. Many of these plans impose an obligation to accept health plan enrollees and to refer enrolled members to participating providers. The financing and organizational characteristics of these managed care arrangements face a complex framework for compliance with Medicare and Medicaid anti-kickback laws. These laws complicate the offering to Medicare beneficiaries of many innovative managed care arrangements that are common in the private sector.

Finally, I want to mention one of the newest areas of private sector anti-fraud activities—disability income insurance. We believe that DI, or disability income, represents a very promising area for savings. In 1993 DI carriers collectively achieved a return on their anti-fraud activities of 44 to 1. HIAA is working with our members in the disability income lines in these efforts, and we now collect systemwide data regarding fraud and DI.

In conclusion, Mr. Chairman, let me reiterate that combating fraud and putting the savings back into the health care delivery and financing system has the potential to help control health care premiums, making coverage more affordable for consumers. Federal legislation should encourage insurers aggressively to pursue anti-fraud activities and must recognize the vast array of evolving health care delivery arrangements.

Again, thank you for the opportunity to testify and to work with you and your staff on this important issue.

[The statement of Mr. Gradison follows.]

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

on

HIAA'S VIEW OF

HEALTH CARE FRAUD

Presented by

THE HONORABLE BILL GRADISON

PRESIDENT

OF THE

HEALTH INSURANCE ASSOCIATION OF AMERICA

Good morning Mr. Chairman and members of the Committee. I am Bill Gradison, President of the Health Insurance Association of America (HIAA). The HIAA represents 230 of the nation's health insurers, who in turn cover tens of millions of Americans. I am delighted to have the opportunity to participate in this important hearing on health care fraud.

INTRODUCTION

HIAA member companies are involved in all aspects of health insurance: as providers of traditional indemnity health and accident insurance; as providers of health care through managed care arrangements; as providers of disability income insurance; and as providers of a wide variety of supplemental insurance products. Our member companies are also involved in many aspects of the Medicare program.

Health care fraud is a serious white-collar crime that has a significant effect on the private and public health care payment systems. According to a May 1992 report to Congress by the General Accounting Office (GAO), health care fraud and abuse cost the nation as much as 10 percent of the money it spends on health care annually. If, as estimated, national health care expenditures reached a trillion dollars in 1994, last year's loss could be as high as \$100 billion. The GAO report stated that "only a fraction of the fraud and abuse committed against the health care system is identified." Of those abuses that are discovered, fewer still are prosecuted. Health care fraud is a contributing factor to the immense problem of rising health care costs in the United States. However, it is a factor that can be significantly reduced through anti-fraud programs and activities.

Health care fraud affects every citizen. We all pay higher taxes because of fraud in public programs such as Medicare and Medicaid, and employers and individuals pay higher private health insurance premiums because of fraud in the private sector health care system. As our nation searches for ways to make health care coverage more affordable, we should focus particular attention on efforts like anti-fraud activities, that can eliminate wasteful spending.

THE PROBLEM

Health care fraud is difficult to detect. The current environment in which the health care industry operates contributes to difficulty in detection.

- State and federal statutes require prompt payment of health insurance claims. Fraud investigations however, can be time consuming. With the pressure to pay claims quickly, payers have trouble detecting possible problems.
- Individual claims may not appear fraudulent; rather, patterns of fraudulent claims give clues to investigators.
- Most providers engaged in fraud do not limit their activities to transactions involving only one payer. Because information-sharing among payers is problematic, (for reasons outlined below) it is difficult to detect patterns of fraudulent behavior.

Despite these difficulties, health plans (including insurance arrangements, network-based plans, and self-insured plans) engage in a wide variety of anti-fraud efforts. HIAA member companies' anti-fraud activities include:

- Working closely with the FBI to investigate and prosecute fraud cases;

- Conducting joint anti-fraud training seminars (with the FBI);
- Working closely with law enforcement agencies to provide evidence for prosecuting cases;
- Working with the National Association of Insurance Commissioners (NAIC) to develop anti-fraud model acts;
- Using computer programs to detect potential fraud cases;
- Conducting claims audits and reviews;
- Establishing consumer hotlines;
- Promoting consumer and employee awareness of fraud.

Additionally, HIAA is the only organization that maintains statistics about fraud in the private health insurance system. We develop those statistics by periodically surveying health insurance companies to determine the types of health care fraud occurring in the field and to ascertain what specific anti-fraud activities insurers are utilizing. Our last survey was performed for the years 1990, 1991 and 1992. (The survey is appended to my testimony) Our next survey will be performed at the end of 1995. Key results of our 1990-1992 survey are as follows:

- Seventy-eight percent of insurers responding to the survey have developed health care anti-fraud programs.
- The cost/benefit ratio for the anti-fraud programs was 1 to 9. In other words, for every dollar a carrier spent on anti-fraud programs, there was a savings on average, of 9 dollars. This is an example of a "good" administrative cost.

[Charts on Display:]

- In 1992, provider fraud constituted 65%, and consumer fraud constituted 35% of fraud cases.
- Of those cases reported as provider fraud in 1992, 43% were fraudulent diagnoses or dates, 34% were provider billing for services not rendered, 21% were providers inappropriately waiving co-payments and deductibles, and 2% were other types of fraud.
- Of those cases reported as consumer fraud in 1992, 40% were falsified claims, 25% were falsified records of employment and eligibility, 5% were fraudulent misrepresentation in applications, and 30% were other types of consumer fraud.

One of the disappointing facts revealed through our 1992 health care fraud survey was that the vast majority of fraud cases under investigation by our member companies are not referred to law enforcement agencies. Even fewer cases are successfully prosecuted. There are two probable explanations for this. First, federal and local law enforcement agencies were often overburdened with other types of crime cases and had neither the expertise nor the resources to devote to health insurance fraud. This problem has been partially alleviated by a recent increased awareness of health care fraud among law enforcement personnel and by an increase in the number of federal personnel dedicated to fighting this problem.

The second explanation is more troublesome to us. There is an "unfriendly" legal environment for anti-fraud activities by private health insurers and other third-party payers. For example, when carriers participate in the investigation of fraud, they risk lawsuits from the fraud perpetrators. Requirements to pay claims promptly are inconsistent with the time required to conduct fraud investigations, and cause insurers to be vulnerable to bad faith liability for claims denials or claims delays. If insurers share information, they are vulnerable to the risks posed by antitrust liability.

RECOMMENDATIONS

HIAA suggests that three provisions be adopted in federal law to allow the industry to more effectively combat health care fraud:

- ***Immunity Protections.*** Private third-party payers need protection from tort suits, [for example, defamation of character] when they in good faith, participate in fraud investigations. At present, this protection is limited because state immunity statutes vary in their protection of insurers. Many fraud investigations cross state lines making effective federal immunity essential.
- ***Mandatory restitution to the victims of fraud.*** This will provide further resources for insurers and other payers to fight fraud and enable them to keep premium costs down.
- ***Federal civil cause of action for recovery of fraudulent payments.*** Insurers and other health plans incur significant expense when bringing legal action against the perpetrators of fraud. The creation of a private cause of action, modeled after the federal False Claims Act, would allow private payers to recover damages and attorneys' fees.

FRAUD AND MANAGED CARE

HIAA member companies provide a variety of managed care plans to employers and consumers. Managed care has the potential for solving some of the most persistent problems in today's health care system. The shift of the U.S. health care system toward managed care affects insurance companies, providers and consumers. To manage these new systems effectively will require new skills. This is because managed care encourages the participants in the health care system to work together more closely than ever before. This represents a significant change in the role of insurers. Insurance companies are increasingly playing an active role in selecting health care providers, and managing the delivery of health care services. This role promises efficient delivery of health quality health care services.

Detecting fraud in fee-for-service arrangements requires a review of individual claims. In contrast, the shift toward managed care transforms the ability to detect fraud through the evaluation of patterns of care. The health care fraud statistics presented to you earlier involved fee-for-service transactions. These fee-for-service transactions will continue to exist in many managed care arrangements because not all managed care plans rely completely on pre-paid financing. However, health care fraud legislation needs to recognize the evolving health care marketplace.

FRAUD AND MEDICARE MANAGED CARE

The Medicare fraud and abuse laws were developed under a structure of traditional fee-for-service health care reimbursement arrangements. In contrast, the management of provider payment rates and practices are inherent to managed care arrangements. Many network-based health plans prescribe an obligation to accept health plan enrollees and to refer enrolled members to participating providers. The enrolled members have joined a network-based health care plan which offers services through a specified group of providers.

The financing and organizational characteristics of these managed care arrangements face a complex framework for compliance with the Medicare/Medicaid anti-kickback laws. These laws complicate the offering to Medicare beneficiaries of many innovative managed care arrangements that are common in the private sector.

There are a number of types of managed care arrangements for which Medicare beneficiaries are eligible. HCFA is expected to announce shortly its intention to increase these options to include a Preferred Provider Organization and a Point Of Service option. The current statutory and regulatory safe harbors are not broad

enough to cover a wide variety of managed care plans, such as Medicare Select programs, Medicare risk contracts, Medicare cost reimbursed contracts and Medicare eligible retirees who are in their employer's HMO plan.

There are numerous types of managed care arrangements with complex contractual and financial relationships. Some examples of managed care arrangements include staff models, group models, and independent practice associations. Also, contracting arrangements within managed care plans may vary. For example, an HMO can contract with large multispecialty groups of physicians who then contract with hospitals. The current statutory and regulatory framework does not allow for a variety of contractual relationships.

DISABILITY INCOME INSURANCE FRAUD

Potential savings from curbing insurance fraud are substantial. A particularly promising area for such savings is disability income ("DI") insurance. As with general medical fraud, the HIAA is the only organization that maintains statistics about the composition of DI fraud. Tracking quantifiable fraud-related data in DI is relatively new. The majority of insurers surveyed by HIAA implemented DI anti-fraud programs only within the last three years. Traditionally, many insurance companies have combined medical care and DI fraud statistics.

The composition of DI insurance fraud is as follows:

- one third of the fraud cases involved falsifying the severity of a disability;
- 40% involved claimants reporting false income earnings to the insurance company or IRS, or receiving income from an unreported source; and
- 12% involved the claimant failing to disclose a pre-existing condition.

Anti-fraud activities conducted by disability income insurers generate immense benefits. In 1993, DI companies collectively achieved a return on their anti-fraud investment of 44 to 1. In other words, for every dollar spent on DI anti-fraud activities, there was a savings of 44 dollars.

The anti-fraud activities undertaken by DI insurance companies include:

- Audits of medical reports, tax returns, Independent Medical Examinations and other indicators;
- Investigations and surveillance, and using detective agencies; and
- Training programs for employees and claims processors.

CONCLUSION

Health care fraud is a critical problem facing this nation. Combating fraud and putting the savings back into the health care delivery system has the potential to help control health care premiums, making coverage more affordable for consumers.

Federal legislation should encourage insurers to aggressively pursue anti-fraud activities. Federal legislation must recognize the vast array of evolving health care delivery arrangements in our health care market.

Again, Mr. Chairman, I thank you for the opportunity to present our views. HIAA stands ready to work with the Congress to improve public and private anti-fraud activities.

**MANAGED CARE & INSURANCE
PRODUCTS REPORT**

**DISABILITY INCOME
INSURERS'
ANTI-FRAUD PROGRAMS**

**RESULTS OF A SURVEY
OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA**

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September 1994



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Potential savings from curbing insurance fraud are substantial. A particularly promising area for such savings is disability income ("DI") insurance.

A recent Health Insurance Association of America ("HIAA") survey shows total realized savings in 1993 for the DI insurance business at \$61.2 million. Net savings (total less the annual anti-fraud program costs) stood at 97 percent or \$59.8 million. Moreover, these numbers derive from only a portion of disability writers and thus represent a conservative approximation of DI fraud cases and savings. Actual savings may be higher; and potential savings are certainly higher.

Tracking quantifiable fraud-related data in DI is relatively new. The majority of insurers surveyed by HIAA implemented DI anti-fraud programs only within the last three years. Moreover, many insurance companies combine medical care and DI fraud statistics. Anti-fraud programs may be more effective if information is separated by business line. While overall fraud detection is beneficial, HIAA data show insurers reporting \$115 million in total realized savings from overall health care anti-fraud programs in 1992. Companies could increase efficiency, thereby savings, by separating fraud detection activities by business line and focusing on high-yield areas.

For writers of DI insurance, anti-fraud activities generated immense benefits. In 1993, DI companies collectively achieved a return on their anti-fraud investments of 44 to 1; because of its high per-claim dollar volume, DI offers substantial potential for savings. Indeed, the cost/benefit analysis shows that the efforts and funds allocated to DI anti-fraud activities already have gone well beyond merely paying for themselves.

Anti-fraud programs need not be elaborate to be effective. Activities can include networking with other companies and/or anti-fraud associations, promoting consumer and employee fraud awareness through seminars and training, and setting up specialized internal investigative units. Further savings can be achieved by deterring potential perpetrators through incentive plans or by concentrating efforts in areas of need in already-implemented programs. In sum, anti-fraud programs can yield considerable savings, which may translate into lower insurance costs for the public.

Fraudulent claims increasingly contribute to the rise in health care costs in the United States. However, the effect of such claims can and should be reduced significantly through anti-fraud programs.

With overall health care fraud comprising as much as 10 percent of all health care expenditures (an estimated \$100 billion in 1994), the health insurance industry has the potential to realize additional savings from anti-fraud programs. However, little information is available on the types of anti-fraud activities undertaken, the number of companies engaging in such activities, and the actual savings such activities yield.

In 1993, HIAA surveyed its member companies specifically to determine the extent to which they were engaged in general health care anti-fraud activities and to document the accrued savings from these programs. Because the 1993 survey produced meaningful, quantifiable data on health care anti-fraud activities, HIAA conducted another survey in summer 1994, requesting member companies to separate and identify DI anti-fraud measures. Fraud was defined in the DI survey as an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, the entity, or some other party. (See Appendix A.)

Prior to this, no such statistics had been collected on DI anti-fraud activities. HIAA distributed the DI fraud questionnaire to select member companies and National Health Care Anti-Fraud Association (NHCAA) affiliates, all believed to write DI. Each company could send more than one response as the questionnaire was forwarded to both group and individual DI departments. The following analysis is based upon the sample of 89 companies.

The HIAA survey asked each company if it identifies fraudulent DI claims and if it has established DI anti-fraud programs and/or specialized anti-fraud divisions. In addition, the survey requested information on the number and types of cases investigated in 1991, 1992, and 1993, and the estimated savings resulting from DI anti-fraud activities.

Fifty-seven companies (64 percent of the sample) responded, representing large, medium, and small companies. Of these 57 companies, all are commercial companies, representing 44.6 percent of the commercial market.¹ Since some companies do not track DI fraud separately from medical care fraud, or do not have data available,

OVERVIEW

RESULTS

or have only recently begun their anti-fraud programs, the results represent a conservative approximation of DI fraud cases and savings, and actual numbers may be much higher.

Forty-seven of the responding companies (82 percent) reported identifying fraudulent DI claims; 38 companies (67 percent) either developed a stand-alone DI anti-fraud program or combined DI with a medical care anti-fraud program. For those companies that have such programs, half of the programs are led by a specialized anti-fraud department. Where no such unit exists, companies most often conduct activities within their claims and benefits departments.

Companies that write individual but NOT group disability insurance are twice as likely to have an anti-fraud program. Of the 19 companies that have neither a stand-alone DI anti-fraud program nor a combined DI/medical care anti-fraud program, 11 companies plan to institute such a program in the near term.

Some responding companies implemented their DI anti-fraud programs as early as 1960. However, almost 70 percent of the responding companies established their programs since 1985; half of these began within the last three years.

Within DI anti-fraud programs, companies include the following activities:

- investigations and surveillance, using detective agencies;
- fraud awareness programs;
- presentations, newsletters, and brochures;
- special investigative units or internal investigation advisory panel;
- internal anti-fraud manuals;
- education of employees and claims processors by anti-fraud seminars and other means; and,
- audits of medical reports, tax returns, police reports, Independent Medical Examinations (IMEs), and other indicators.

In addition, companies also report suspicious or questionable claims to state fraud bureaus; network with other organizations; and work with anti-fraud organizations and postal inspectors to provide evidence for prosecution.

In general, companies determine their personnel needs for anti-fraud activities based on case volume, volume of fraud referrals, and cost/

benefit analyses. Overall, companies require either investigators to be Certified Fraud Examiners and/or to have significant—i.e., five to fifteen years—claims and/or investigation experience. Approximately 50 percent and 15 percent of the responding companies respectively are members of the NHCAA and National Insurance Crime Bureau (NICB), while half belong to other state and federal anti-fraud associations.

Additionally, some companies track "ring activity" patterns, developing profiles of various physicians and attorneys. Of the sample, 21 percent and 16 percent of companies respectively track certain physicians or attorneys during their investigations.

HIAA asked companies to categorize DI fraud cases by type of fraud as well as by type of perpetrator, finding that tracking DI fraud by type is a relatively new practice. Companies reported that in 1991, the total number of DI fraud cases reported was 118; investigated cases rose to 214 (in 1992) and 681 (in 1993), an increase of 81 percent and 218 percent respectively. The most common type of DI fraud is a false statement, misrepresentation, or deliberate omission of information critical to the determination of benefits. Since claimants were most often reported as the general perpetrator compared to health care providers, attorneys, or employers, common types of disability fraud include:

- reporting false income earnings to the company and/or to the IRS;
- falsifying the severity of the disability;
- misstating one's occupation or duties;
- failing to disclose a pre-existing condition; and,
- receiving additional income from an unreported source.

(See Figure 1.)

Survey findings show that in 1993 only 10 percent of the 681 suspected fraudulent cases were referred to law enforcement agencies; 22 percent of these referred cases resulted in criminal convictions. Nevertheless, the numbers point to a steady increase of reported fraudulent cases from year to year. (See Table 1.) Moreover, according to HIAA findings, insurers are taking appropriate measures without costly formal legal action. Over the three years examined, the numbers of DI applications denied, policies rescinded/canceled, policies modified, and claims rejected dramatically increased. (See Figure 2.)

FRAUD CASES BY TYPE OF FRAUD

Figure 1

1993 DISABILITY FRAUD by Type

Total Cases: 681

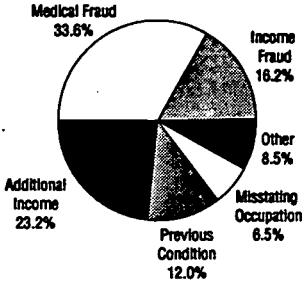
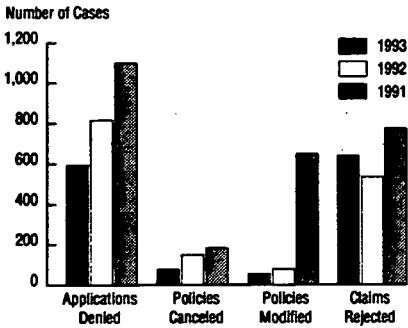


Table 1

REFERRALS AND CONVICTIONS by Case	1991	1992	1993
Referrals to Law Enforcement Agencies	7	9	60
Criminal Convictions	2	3	13

Figure 2

RESPONSES TO FRAUDULENT CLAIMS



The reported increases in DI fraud cases are attributable to several factors. Not only have companies reported more fraud, but more companies are initiating anti-fraud programs. In addition, insurers are becoming more adept at identifying fraud. The recession of the 1990s may be another explanation as to the overall growth of DI claims, in conjunction with the growth of fraudulently filed DI claims. (See Appendix B.) Cases that previously would have gone unnoticed are now detected through more sophisticated claims systems and networks. Companies employ on average 2, with as many as 6, employees for the specific purpose of investigating suspected fraudulent DI claims.

Companies with DI anti-fraud programs reported total savings for 1993 of \$61.2 million, more than twice the savings of 1992 (\$27.7 million) and almost six times as much as those for 1991 (\$10.2 million). After deducting costs for DI anti-fraud activities, companies reported net savings of \$59.8 million (see Table 2), a dramatic increase from 1991, when net savings were a mere \$9.5 million. Compared to the \$26.8 million in net savings for 1992, the 1993 net savings of \$59.8 million represents a 123 percent increase in just one year. (See Figure 3.) Net savings as a percent of an insurer's total DI business from established DI anti-fraud programs range from 0.5 percent to 10.5 percent, with many companies experiencing an average 1 percent in savings.

The 1993 \$61.2 million in total savings represents a cost/benefit ratio of an overwhelming 1 to 44, up from 1 to 32 in 1992 and 1 to 14 in 1991. These savings compare to the 1 to 9 cost/benefit ratio for general health care claims reported by health care companies in the 1993 HIAA Health Care Fraud Survey. The increasing cost/benefit ratio for DI business indicates that companies not only are becoming more efficient in their anti-fraud programs and training of employees, but can make a large impact in savings on their DI business for minimal costs.

The \$61.2 million in total savings is the result of the efforts of 18 responding companies. This low number of responding companies reflects, first, that many DI anti-fraud programs are of recent vintage, and second, that many companies have not separated DI fraud claims from general health care fraud claims. Using this report of net savings to extrapolate to the industry as a whole, it is estimated that DI anti-fraud activities insurers could potentially save at least \$134 million each year.²

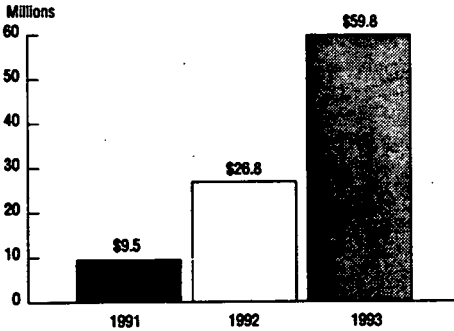
REALIZED SAVINGS

Table 2

SAVINGS	1991	1992	1993
Actual savings (no monies paid)	\$199,960	\$612,240	\$1,222,800
Reserve savings due to closure	\$9,985,000	\$27,034,000	\$59,086,653
Overpayments recovered	\$45,879	\$21,372	\$178,147
Savings identified, but not yet recovered	\$28,106	\$50,000	\$692,774
Total	\$10,258,945	\$27,717,612	\$61,180,374
Program costs for disability and anti-fraud activities	\$721,723	\$874,342	\$1,383,949
Net savings	\$9,537,222	\$26,843,270	\$59,796,425
Net savings as a percentage of total savings	92.96%	96.84%	97.73%

Figure 3

COMPANIES' NET SAVINGS FROM ANTI-FRAUD ACTIVITIES



As companies increase their DI anti-fraud activities, claimants and others who commit fraud are more likely to be caught and convicted. This, in turn, will deter others who might be tempted to engage in fraud.

Companies should consider tracking DI fraud cases by dollar volume and case volume as well as by type of perpetrator and type of fraud. If DI information is separate from medical care information, companies could determine areas where the highest number of fraud cases—and potential savings—occur and could then focus and improve their anti-fraud efforts in those areas.

To determine which anti-fraud activities to use for DI, companies should consider those previously listed. Of particular value are: networking with other organizations; promoting consumer and employee awareness of fraud; and employing individuals to concentrate investigation in this arena. Companies should also consider offering incentives for consumers to assist in detecting DI fraud cases, possibly implementing a fraud "hotline" for consumers. Instituting fraud awareness within the company's organization could aid in detecting and reducing fraud, and publicizing the company's anti-fraud program to employees, patients, and providers will act as a disincentive to commit fraud. Although fraud is difficult for companies to detect, the substantial savings make the effort worthwhile.

Cost-effective anti-fraud programs must yield savings that exceed their own budgets. Because of DI's high per claim dollar volume, DI potential savings are considerable, and the cost of implementing an anti-fraud program may be minimal. However, implementation costs for a DI anti-fraud program may not be recaptured immediately; but the longer a program has been in place, the more cost-efficient it will become.

Anti-fraud programs have a large potential for savings. This should enable companies to save future dollars, and may well lead to lower health care costs for the public.

IMPLICATIONS

DEFINITIONS OF DISABILITY INSURANCE FRAUD AND ABUSE**Disability Insurance Fraud**

DI fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, the entity, or some other party.

The most common kind of fraud is a false statement, misrepresentation, or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are almost invariably criminal, although state law may define the specific nature or degree of the criminal acts differently.

Fraudulent practices in DI include misrepresentations of the level of work activity, and the need for services, procedures, and/or supplies. The most common fraudulent acts include, but are limited to:

1. **INCOME** - Claimants report false income earnings to carrier and/or IRS.
2. **MEDICAL** - Claimant and/or health care provider falsify disability or the intensity of disability.
3. **MISSTATEMENT ON APPLICATION FOR DISABILITY POLICY:**
 - a) Misstatement of occupation or duties
 - b) Failure to disclose pre-existing condition
 - c) Misstatement of income
 - d) Nondisclosure of other disability coverage in force
4. **CLAIMANT RECEIVING INCOME FROM UNREPORTED SOURCES WHILE DISABLED.**
5. **FRAUDULENT EMPLOYER ACTIVITY** - The improper reporting of work by employer, i.e. working and not reporting activity to carrier.

Disability Insurance Abuse

DI abuse describes the misrepresentation or omission of information by DI claimants or providers which, although not considered fraudulent, is inconsistent with ethical, medical, business, or fiscal practices and which could directly or indirectly result in unnecessary costs or reimbursement.

APPENDIX A

Such abusive incidents or practices, misrepresentations or omissions can consist of, but are not limited to:

- ordering unnecessary tests or treatments;
- making unnecessary referrals;
- overutilization in duration or frequency of treatment;
- ordering and/or recommending inappropriate length of stay in a facility;
- rendering unwarranted, inappropriate, unnecessary, or questionable/unproven treatment and/or care;
- billing for, referring or recommending services, treatment or care which would not have been rendered in the absence of insurance;
- refusal to provide psychiatric records;
- failure to respond to requests for medical records;
- refusal to provide information on physical or mental capacity;
- certification of disability in area in which physician is not qualified; and
- physical certification of disability based on non-medical factors, including, but not limited to, education, training, or lack of work experience.

CYCLICAL ECONOMIC IMPACT ON DISABILITY INSURANCE

APPENDIX B

The state of the national economy is one factor that causes DI claimants to have an increased or decreased "will to work." Studies have examined persons' "frame of mind" within various economic cycles. While some reports do not show any patterns, others demonstrate that the economy has had a consistent effect on the history of disability business. In the early 1930s, with the deepening Depression and high unemployment, DI writers suffered both increases in the number of claims and increases in the average length of claims. As a result, many insurance companies left the disability marketplace; others failed financially. All companies took measures—through underwriting and rating approaches—to readjust their positions in the marketplace.

Clearly, in good economic times, all insurance lines tend to prosper — life, medical care, disability, and casualty. Conversely, in poor economic times, each line of business feels the effects of the economic downturn. In a stable economy, individuals with serious and significant physical impairments continue to work. If the same individuals, however, become unemployed during recessionary times, their tendency to present a claim is greater. Additionally, the average length of claims tends to increase during downturns in the economy since individuals collecting under a policy may attempt to extend a claim if no employment is anticipated.

The impact of economic cycles on the DI business has been further aggravated by several industry practices. In a prosperous economy, when claims are lower and profits somewhat higher, "there is a natural tendency for disability insurers to begin to liberalize their product assumptions. The longer the good economic period lasts, the greater the temptation to relax underwriting, treat the claims somewhat more liberally, develop more liberal product language, and lower premiums."¹ Thus, when a recession occurs, serious financial consequences flow from the liberalizations in product assumptions.

With increases in the number and duration of claims also come increases in fraudulently filed claims. How can the disability industry prepare for both the public's "will to work" and the inevitable economic swings? Can the disability industry adequately protect itself against adverse swings? The answers to these questions are not clear. However, one approach the industry can afford is to protect itself by instituting anti-fraud programs.

¹ Calculation based on 1992 Accident & Health Premiums for Commercial Insurers.

² Calculation based on 1992 Accident & Health Premiums of Commercial Insurers.

³ Soule, Charles E., *Disability Income Insurance: The Unique Risk, Business One*: Irwin, Illinois, 1989: 43.

ENDNOTES

HIAA

Health Insurance Association of America

**MANAGED CARE & INSURANCE
PRODUCTS REPORT
HEALTH INSURERS'
ANTI-FRAUD PROGRAMS**

**RESULTS OF A SURVEY
OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA**

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Health care fraud is a contributing factor to the immense problem of rising health care costs in the United States. However, it is a factor that can and should be significantly reduced through anti-fraud programs and activities.

With health care fraud comprising as much as 10 percent of all health care costs (an estimated \$70 billion in 1992), the health insurance industry was aware of the savings that could accrue from anti-fraud programs. However, little information was available on the types of anti-fraud activities undertaken, the number of companies engaging in such activities, and the actual savings that could be derived from these programs.

To bring these activities to the attention of its members, the Health Insurance Association of America (HIAA) held a seminar on anti-fraud in the winter of 1990. To prepare for that seminar, and to gather data on anti-fraud programs, HIAA surveyed its members: the survey, which collected information as of fall 1989, yielded the first quantifiable data on anti-fraud programs and their savings.

As the health care reform debate has intensified over the past three years, various ways to curb costs have been proposed. Many of these proposals have noted the potential savings achievable through anti-fraud programs.

In response to reform proposals, and because current data were needed, HIAA conducted a survey in 1993 (1) to determine the extent to which member companies engage in health care anti-fraud activities and (2) to document the accrued savings from these programs.

Overview

The survey asked each company if it identifies fraudulent health care claims and if anti-fraud programs and/or specialized anti-fraud divisions exist. In addition, the survey asked for the number and types of cases investigated over the past three years and the estimated savings.

Responses to the survey came from 86 companies, representing large, medium, and small insurers. Of these 86 companies, 79 are commercial insurers representing 65 percent of the commercial market and 7 Blue Cross/Blue Shield (BC/BS) plans, representing 14 percent of the BC/BS market. However, since some companies do not track all of the requested information, or do not have data available, or had just recently implemented anti-fraud programs, the results that follow represent a conservative approximation of fraud cases and savings.

1993 HIAA SURVEY OF HEALTH INSURERS' ANTI-FRAUD PROGRAMS

Since more companies were able to provide data for 1992, the 1992 figures contain the most complete and accurate reflection of the industry.

Over 90 percent of the responding companies reported having identified fraudulent health care claims; 78 percent have developed health care anti-fraud programs. For those companies that have such programs, over half of the programs are carried out by a special anti-fraud unit within the company. Where no special unit exists, companies most often conduct these activities within their claims departments.

Health care anti-fraud programs began as early as 1968, but almost 70 percent of the responding companies have established their programs since 1985. Indeed, almost a third of the responding companies started their programs within the last three years.

Within their health care anti-fraud programs, companies include the following activities:

- networking with other organizations;
- referring cases to the proper regulatory agencies;
- working with law enforcement agencies to provide evidence for prosecuting cases;
- using computer programs to detect potential fraud cases;
- conducting claims audits and reviews;
- establishing consumer hotlines;
- promoting consumer and employee awareness of fraud;
- reviewing questionable claims;
- establishing training programs and attending anti-fraud seminars;
- identifying providers and insureds who are suspected of having committed fraud; and,
- identifying new trends and staying informed of the latest techniques in fraud detection.

Health insurers generally determine their personnel needs for anti-fraud activities based on case volume, volume of fraud referrals, and cost/benefit analyses.

Fraud Cases by Type of Fraud

Companies were asked to categorize health care fraud cases that had been investigated by type of fraud as well as by type of perpetrator.

According to HIAA findings, the number of fraud cases investigated in 1989 was 19,600 (data from 1990 survey), yet the number of cases investigated decreased to 15,246 in 1990 (data from 1993 survey). This decrease may reflect responses from different insurance companies rather than an actual decrease. However, the number of fraud cases investigated by responding companies increased over 75 percent in two years from 15,246 in 1990 to 26,755 in 1992. (See Figure 1 and Table 1.)

The number of cases referred to law enforcement agencies increased by more than 63 percent from 1,624 in 1990 to 2,645 in 1992. And the number of criminal convictions increased more than 150 percent from 323 in 1989 to 822 in 1992. Thus, in 1992, about one third of the referred cases resulted in criminal convictions.

**Number of Fraud Cases Investigated
1990-1992**

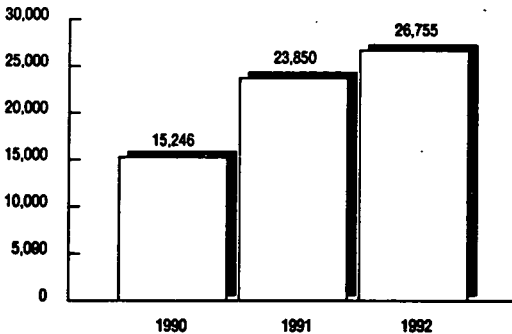


FIGURE 1

**Health Insurance Fraud:
Number of New Cases Investigated 1990-1992**

TABLE 1

NUMBER OF NEW CASES BY TYPE OF FRAUD	1990	1991	1992
Total new cases, by type of fraud	15,248	23,850	26,758
• Unallocated	4,250	3,489	4,348
• Provider, consumer, agent, and "other" fraud	10,996	20,361	22,407
Total provider fraud	3,972	11,311	14,824
• Unallocated provider fraud	0	1,275	2,550
• Allocated provider fraud	3,972	10,036	11,974
Billing for services not rendered	1,907	3,019	4,065
Fraudulent diagnoses or dates	698	3,971	5,080
Brand name billing for generic	62	59	65
Waiving copays and deductibles	1,305	2,838	2,543
Labs, weight loss, physical therapy	0	147	82
Unbundling	0	0	100
Questionable provider functions	0	2	39
Total consumer fraud	6,871	8,878	7,699
• Unallocated consumer fraud	4,045	5,270	3,735
• Allocated consumer fraud	2,826	3,606	3,964
False records of employment/eligibility	224	983	1,006
Falsifying claims	1,194	1,299	1,586
Fraudulent misrepresentation in applications	261	106	184
Other	1,147	1,218	1,188
Total agent fraud			5
Total other fraud	153	174	179
NUMBER OF NEW CASES BY TYPE OF PERPETRATOR			
Total new cases by perpetrator	14,001	21,248	23,775
• Unallocated	4,323	7,481	6,899
• Allocated	9,678	13,765	16,876
Psychiatric hospital	11	54	291
Other hospital	191	370	673
Laboratory	152	225	568
Durable medical equipment supplier manufacturer	65	90	160
Physician	1,395	3,593	5,201
Other provider	1,058	1,097	2,310
Consumer	6,806	8,325	7,600
Agent			5
Other	0	11	68
Number of cases referred to law enforcement agencies	1,824	2,236	2,645
Number of criminal convictions	616	725	822
Number of full-time employees assigned to antifraud activities	170	221	265

The reported increases in fraud cases investigated, fraud cases referred, and criminal convictions are attributable to several factors. Not only have companies reported more fraud, but more companies are initiating anti-fraud programs; in addition, programs are becoming more adept at identifying fraud. Cases that would have previously gone unnoticed are now detected through more sophisticated claim systems and networks.

In recent years, the percentage of provider fraud appears to have decreased while the percentage of consumer fraud has increased. In 1989, 93 percent of health care fraud resulted from provider actions, and only 4 percent from consumer actions. (The remaining 3 percent had "other" bases for fraud.) But in 1992, approximately 55 percent of all health care fraud cases were the result of provider actions, while 30 percent of fraud cases were the results of deliberate consumer actions. (Note that 15 percent of the fraud cases were not tracked by type.) Therefore, of the cases that were tracked by type of fraud, provider fraud constituted 65 percent and consumer fraud 35 percent. (See Figure 2.)

Fraud Cases Allocated by Type of Perpetrator 1992

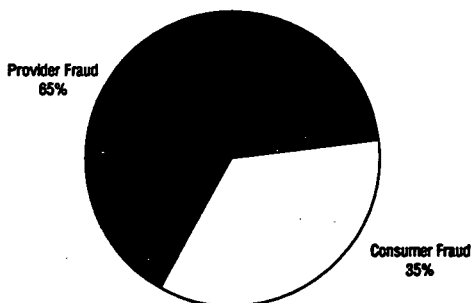


FIGURE 2

Provider Fraud

In 1992, of the 11,974 instances of provider fraud, the most frequently reported was fraudulent diagnoses or dates, which accounted for about 43 percent of the cases. (See Figure 3.) Providers may alter the diagnoses to accommodate coverage policy of insurance programs or change dates for services to fall within coverage requirements.

Next in order of frequency was billing for services not rendered, which accounted for approximately 34 percent of the provider cases. These charges may be "padded" or billed under false procedure codes to raise the level of payment or billings from two or more providers for the same service to the same patient on the same day.

Providers waiving co-payments and deductibles accounted for 21 percent of fraudulent activities. However, some health insurers believe this practice is much more widespread and may accompany almost all other types of health care fraud. In such cases, the cost to the patient may be zero, but the charge to the insurer is inflated to cover the provider's costs. The remaining 2 percent consisted of various other types of provider fraud.

An additional 2,550 provider fraud cases were reported but were not tracked by specific type; however, it is expected that they would follow the same pattern of distribution.

Provider Fraud Cases by Type
1992

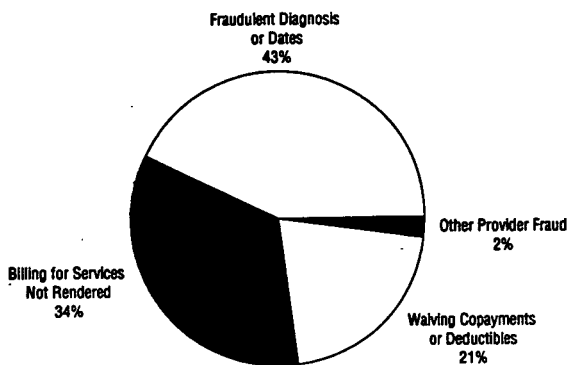


FIGURE 3

Consumer Fraud

In 1992, of the 3,964 allocated consumer cases, categorized by type of fraud, the most frequently reported was falsifying claims; this accounted for 40 percent of the cases. (See Figure 4.) False records of employment and eligibility accounted for 25 percent, fraudulent misrepresentation in applications accounted for 5 percent, and the remaining 30 percent consisted of various other types of consumer fraud.

An additional 3,735 consumer fraud cases were reported but were not tracked by specific type of fraud. However, it is also expected that they would follow the same pattern of distribution.

Fraud Cases by Type of Perpetrator

In 1992, 23,775 cases were reported by type of perpetrator. The cases reported by type of fraud exceed this number because one perpetrator may have committed more than one type of fraud against a company and because many companies could be investigating many cases committed by one perpetrator. (See Table 1.)

Consumer Fraud Cases by Type 1992

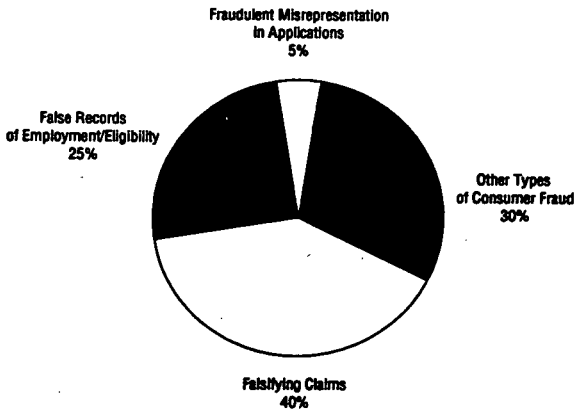


FIGURE 4

Of the 16,876 cases allocated by type of perpetrator, the most frequently reported was consumer: this accounted for 45 percent. Next in frequency were physicians (31 percent), other providers (14 percent), non-psychiatric hospitals (4 percent), and laboratories (3 percent). (The remaining 3 percent were other types of perpetrators.)

An additional 6,899 cases were reported but were not tracked by specific type of perpetrator. However, it is also expected that they would follow the same pattern.

In 1992, companies reported total savings of \$115 million, a 130 percent increase from total savings of \$50 million in 1990. (See Table 2.) Companies that reported both their total savings and their anti-fraud budgets showed total savings of \$112 million compared to total budgets of \$12 million. Thus, their net savings were \$100 million.

**SAVINGS FROM
ANTI-FRAUD
ACTIVITIES**

Realized Savings from Anti-Fraud Programs

TABLE 2

SAVINGS IN DOLLARS	1990	1991	1992
Actual savings (no monies paid)	\$38,199,393	\$40,210,197	\$73,217,311
Overpayments recovered	4,944,052	9,402,417	10,539,798
Savings identified, but not yet recovered	<u>4,882,541</u>	<u>9,753,121</u>	<u>26,593,920</u>
Allocated savings	48,005,986	59,365,735	110,351,029
Unallocated savings	<u>2,227,487</u>	<u>3,852,852</u>	<u>4,818,267</u>
Overall total savings	\$80,233,473	\$63,318,567	\$115,169,296
Budget for anti-fraud activities	\$7,273,474	\$9,086,396	\$12,169,122
Companies that provided both savings and budget figures:			
Total savings	\$47,944,798	\$62,648,384	\$112,173,105
Budget	<u>(\$7,273,474)</u>	<u>(\$9,086,396)</u>	<u>(\$12,169,122)</u>
Net savings	\$40,671,324	\$53,561,988	\$100,003,983
SAVINGS BY PERCENTAGES	1990	1991	1992
Actual savings (no monies paid)	79.57%	67.73%	66.35%
Overpayments recovered	10.30	15.84	9.55
Savings identified, but not yet recovered	<u>10.13</u>	<u>16.43</u>	<u>24.10</u>
Allocated savings	100.00%	100.00%	100.00%
Unallocated savings	95.57%	93.76%	95.82%
Total savings	<u>4.43</u>	<u>6.24</u>	<u>4.18</u>
Total savings	100.00%	100.00%	100.00%
Companies that provided both savings and budget figures:			
Total savings	100.00%	100.00%	100.00%
Budget	<u>-15.17</u>	<u>-14.50</u>	<u>-10.85</u>
Net savings	84.83%	85.50%	89.15%

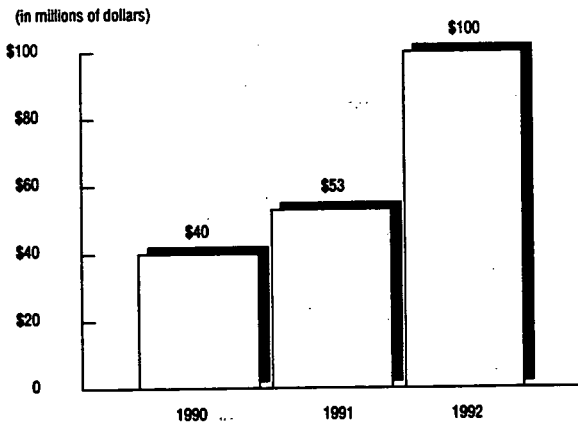
Net savings from anti-fraud activities have been increasing since 1987 when net savings were \$13 million. Compared to the \$53 million in net savings for 1991, the 1992 net savings of \$100 million represents an 88 percent increase in net savings in just one year. (See Figure 5.)

The 1992 \$112 million in total savings represents a cost/benefit ratio of 1 to 9, up from 1 to 7 in 1991 and 1 to 6 in 1989. This increasing cost/benefit ratio indicates that companies are becoming more efficient in their anti-fraud programs.

The \$112 million in total savings is the result of the efforts of 42 responding companies. Of these 42 companies, 35 are commercial insurers representing 39 percent of the commercial market; 7 are BC/BS plans representing 14 percent of the BC/BS market. Using their reports of savings and their share of business to extrapolate to the industry as a whole, it is estimated that the commercial market could save at least \$261 million and the BC/BS market could save at least \$99 million each year as a result of anti-fraud activities.

As companies increase their activities, providers and consumers who commit fraud are more likely to be caught and convicted. That will deter others who might be tempted to engage in fraudulent activities. Thus, the figures represent conservative estimates that do not include the significant, but difficult to estimate, savings from deterred fraudulent activities.

Net Savings from Anti-Fraud Activities 1990-1992



Health Insurance Association of America

FIGURE 5

Since in 1992 about 66 percent of savings were actual savings where no monies are paid, the most effective way to save money is to prevent fraud from occurring in the first place. (See Table 2.) In addition, the figure used for actual savings is conservative: in some cases it is difficult to quantify how much was saved because fraud was deterred or prevented before it spread. Thus, actual savings are probably even more substantial. Only 24 percent of savings are gained from savings identified, but not yet recovered, and only 10 percent of savings are actually overpayments recovered. (This is a downturn from 1990 when 80 percent of savings were actual savings.)

This change could indicate that perpetrators are becoming more effective at acquiring money from fraudulent claims, and insurance companies are discovering the fraud after they have already paid the perpetrators. On the other hand, this trend could indicate that insurers are becoming more effective in discovering fraud cases that previously would have gone undetected.

Insurance companies should consider tracking fraud cases by dollar volume and case volume as well as perpetrator type and type of fraud. Thus, they could determine areas where the most fraud and savings occurred and could then focus their anti-fraud efforts in those areas.

To decide upon anti-fraud activities, health insurance companies should consider those listed above, especially networking with other organizations, using computer programs to detect potential fraud cases, and promoting consumer and employee awareness of fraud. Since fraud cases are often difficult for insurance companies to detect, but the savings can be very high, insurance companies could consider offering incentives for consumers to assist in detecting fraud cases. In addition, instituting fraud awareness within the insurance company's organization could aid in detecting and reducing fraud. Publicizing to employees, patients, and providers that an insurance company has an anti-fraud program will further reduce incentives to commit fraud.

In instituting anti-fraud programs, savings obviously need to exceed the budget in order to be cost effective. However, insurance companies should recognize that they may initially incur high start-up costs, but over time, the longer a program has been in place, the more efficient it will become at decreasing fraud and increasing savings.

Fraud is an area where the potential for savings is phenomenal. The efforts and funds put into anti-fraud activities have been shown to pay for themselves several times over, and further savings can be achieved by deterring potential perpetrators. Anti-fraud programs will enable insurers to save significant amounts of money, ultimately leading to decreased premiums and lower health care costs for the public.

**Health Care Fraud Detection
in an Electronic Data Interchange Environment:
A White Paper for the Workgroup
for Electronic Data Interchange (WEDI)**

The Workgroup for Electronic Data Interchange (WEDI) was formed to assess and mobilize the health care industry's use of technology to streamline health care financing. The 1993 WEDI Report includes the complete White Paper on Health Care Fraud Detection in an Electronic Data Interchange Environment.

Executive Summary

Fraud clearly contributes to the enormous problem of rising health care costs in the United States. According to a May 1992 report to Congress by the General Accounting Office, medical fraud and abuse consume as much as 10% of the money that the nation spends on health care annually—or \$70 billion in fiscal year 1992 alone. The GAO estimates by 1995, unless checked, annual losses could approach \$100 billion.

Generally criminal in nature, health care fraud has been defined as "an intentional deception or misrepresentation that could result in some unauthorized benefit to the individual, or the entity or to some other party." Health care fraud schemes range from those committed by individual providers and/or consumers acting alone, to broad-based operations conceived for the purpose of committing fraud. Health care fraud includes activities such as:

- Billing for services not rendered,
- Falsifying diagnoses or treatment records,
- Undisclosed waiver of co-payments or deductibles in schemes designed to remove the patient from the billing process,
- Falsifying employment records, and
- Brand-name billing for generic drugs.

Electronic Data Interchange has the potential to assist and hinder the perpetration of health care fraud. Electronic environments can provide opportunities for us to improve our ability to detect health care fraud by virtue of generating more comprehensive and standardized data in which fraudulent billing patterns might be detected. Faster electronic claims payment systems reduce the opportunity for individuals to detect and prevent the payment of inappropriate claims. Widespread use of EDI can improve and lower the cost of the overall administration of health care information. In addition, EDI reduces the cost of claims

processing by reducing the flow of paper, and it increases service by allowing for faster claims payment. However, without proper front-end safeguards, EDI can also increase the private and public systems' exposure to health care fraud, creating the potential for losses far greater than any administrative savings.

Automated tools that can assist in fraud detection range from simple to complex. There are tools that involve simple automatic "red flags" that highlight a suspicious activity in a health care claim. Sophisticated tracking mechanisms can categorize activities so that suspicious trends or patterns can be identified. Computers can assist in performing statistical analyses of health care services. Medical services behavior patterns can be defined so that behavior can be viewed and measured in order to define "normal" or "exceptional" events.

General recommendations for provider and clearinghouse participation and audit, investigative and prosecutorial capabilities in an electronic environment are:

- The establishment of quality criteria for provider and clearinghouse eligibility to participate in EDI systems or networks.
- The application of certain contractual agreements governing medical and claims records, and the provision of payor access thereto, to which participating providers and clearinghouses must adhere (refer to Appendix 3).
- The development and use of a unique provider identification mechanism through which claims submitted electronically may be traced with certainty to their source.
- Edits or "red flags" that highlight unusual or suspicious activity for further review. For example, an edit that highlights illogical combinations of medical services (i.e., medical procedures performed on persons of the inappropriate gender). At a minimum, these edits would include, but are not limited to, those system edits presently required of intermediary carriers by Medicare.
- Definitions of potential fraudulent activities or behaviors by health care specialty to identify high risk suspects.
- Historical tracking of overall behavior and individual components of behavior for providers over several years.
- Statistical analysis tools to define behavior patterns that are at a high risk of being fraudulent.
- Flexibility to add new red flags in the electronic system as they are developed from statistical analyses.
- System designs that allow for admissibility in legal proceedings of data generated by EDI systems and that allow for single-source expert testimony as to the workings and integrity of the EDI process.
- Discussion, with developing technology in mind, of the most effective point of application of system edits and controls (i.e., in individual payors' systems, and/or at the clearinghouse stage).

In short, if properly implemented, electronic environments can help us detect health care fraud and reduce health care costs.

NHCAA



NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

GUIDELINES TO HEALTH CARE FRAUD

ADOPTED BY THE
NHCAA BOARD OF GOVERNORS

NOVEMBER 19, 1991

Health care fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party.

The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are almost invariably criminal, although the specific nature or degree of the criminal acts may vary from state to state.

The variety of fraudulent reimbursement and billing practices in the health care area is potentially infinite. The most common fraudulent acts include, but are not limited to:

1. Billing for services, procedures and/or supplies that were not provided.
2. The intentional misrepresentation of any of the following for purposes of manipulating the benefits payable:
 - a. The nature of services, procedures and/or supplies provided;
 - b. The dates on which the services and/or treatments were rendered;
 - c. The medical record of service and/or treatment provided;
 - d. The condition treated or diagnosis made;
 - e. The charges or reimbursement for services, procedures, and/or supplies provided;
 - f. The identity of the provider or the recipient of services, procedures and/or supplies.
3. The deliberate performance of unwarranted/non-medically necessary services for the purpose of financial gain.

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Example Electronic Claims Contractual Agreement**APPENDIX 3**

Return to:

Name Of Physician, Supplier, or Group_____
Address_____
Contact Person() _____
Telephone Number_____
Insurance Identification Number_____
Tax ID No.

If using outside Billing Services, specify name:

Software Vendor Name

Electronic Billing Media:

() 800 () 1600 () 6250

Magnetic Tape: Specify BPI

() Yes () No

Plan to use Reconciliation Tape

Dial Up (Telephone Transmission):

() Synchronous () Asynchronous

Specify Protocol

() 1200 () 2400

Indicate Preferred BAUD Rate

In Accordance With Specifications Set Forth By "Insurance Company" And The Health Care Financing Administration For Submission Of Automated Claims, We Agree To:

- Allow "Insurance Company" reasonable access to all source documents and medical records related to any claim.
- Research and correct any and all billing discrepancies caused by submission of automated claims.
- Ensure that every automated claim can be associated and identified with a source document and medical record.
- Maintain all source documents and medical records for a period of six years after the month the bill was submitted. Records may be maintained on microfilm.
- Accept the liability for all claims submitted to "Insurance Company" by myself and my agent. Refund any overpayments made to "Insurance Company" Subscribers, to Medicare beneficiaries or to me personally as a result of information submitted by me or my agent on automated claims, as determined by "Insurance Company" within 30 days of the date of notifications.
- Submit automated claims in accordance with the rules and regulations set forth by "Insurance Company" and the Health Care Financing Administration.
- In submitting automated claims, I understand that I am certifying that required patient signatures or appropriate signatures in behalf of patients are on file in accordance with prescribed procedures, and that anyone who misrepresents or falsifies essential Medicare claims information may, upon conviction, be subject to fines and/or imprisonment under Federal law. If assignment is accepted, I agree that the reasonable charge, as determined by the Carrier, shall be the full charge for the services on the claims.
- For anesthesia billers, completion of this form indicates compliance that you have on file each procedure performed and the name of each anesthetist directed for services on their claims.
- Maintain the confidentiality of passwords, preventing unauthorized users from committing data security violations with my logon ID.

Signature of Physician, Supplier or Authorized Representative

Title

Type or Print Name

Date

The CHAIRMAN. Thank you, Mr. Gradison.

What is your time schedule? Are you okay?

Mr. GRADISON. As much time as you require, Mr. Chairman. I also have a rather lengthy statement with the details on this that I would appreciate your putting in the record.

The CHAIRMAN. That will be included in full.

Mr. GRADISON. Thank you, Mr. Chairman.

The CHAIRMAN. We'll go on quickly to Mr. Mahon.

STATEMENT OF WILLIAM MAHON, EXECUTIVE DIRECTOR, NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION, WASHINGTON, D.C.

Mr. MAHON. Thank you, Mr. Chairman. We appreciate the opportunity to comment today. I will try to keep my comments concise and make them represent the summary of our more extensive written statement.

There is a great deal of detail on the membership and make-up of our organization in our written statement, and I will summarize it just by saying that we are a combination private and public sector organization that brings together the anti-fraud operations of the private health insurers—the commercials and the Blue Cross and Blue Shield plans—with the public sector law enforcement agencies who have jurisdiction to investigate and prosecute health care fraud. We engage in two principal areas of internal activity—one is cooperative education and training in the nuts and bolts of detecting, investigating, and prosecuting health care fraud cases; second, and perhaps most important, we are a medium for the organized sharing of investigative information both between our insurer, or private sector members, and between the private sector and law enforcement.

Those principal activities are a reflection of why we were founded and of several fundamental aspects of health care fraud. I would agree with everyone today who has said that the overwhelming majority of parties to the system are acting honestly and ethically. Unfortunately, there is simply so much money in the system that even a very small proportion of dishonest individuals can do massive damage. The cases are legion of individual providers racking up fraud totals in the vicinity of \$500,000 to \$2.5 million. At the other end of the spectrum, as has been noted, there are now much broader-based entrepreneurial criminal schemes turning their attention to the system—the best known of all, the California rolling lab scheme, is said to have accounted for just under \$1 billion in false claims over roughly a 10-year period.

By the same token, you almost never find someone defrauding only one payer at time. Typically, the preferred method is to defraud a variety of payers simultaneously and in smaller, less conspicuous increments. What that does, obviously, is prolong the lifespan of a scheme before any one of those parties detects the activity. And, similarly, you almost never find someone defrauding the private or the public sector exclusively. Generally, if they defraud Medicare, Medicaid, CHAMPUS, and so on, they are also defrauding private payers and vice versa.

In virtually every major case that has come to light in the last several years—National Health Laboratories in 1993, the National

Medical Enterprises case last year and a variety of others—the private sector has been equally victimized as the government, and in many of those cases the private payers have pursued their own civil remedies and their private investigations, concurrent with the government criminal actions and settlements.

The only way to attack the problem, Mr. Chairman, if you want to get at the active frauds, is to take this coordinated approach and to provide for the right hand being able to know what the left hand is investigating in the private sector. If it's left to any one organization's designs to detect a very broad-based fraud scheme, it is going to take much longer to do that than if Company A has a means of notifying Company B that it suspects a given fraud that is also victimizing B.

The types of fraud themselves, Mr. Chairman, run the gamut, and many of the trends that have been cited today are things that I would also note. Like Mr. Temmerman, we also see a great influx of what I would call more "institutional" or corporate type of fraud by organizations as opposed to individual providers. As Senator Glenn said this morning, this system has so much money that it represents tremendous bait for those who are attracted for criminal enterprises.

The point you made this morning—that whenever you create a new benefit or you begin to pay a higher price for a given benefit, you often act as a magnet for fraud schemes—was very much to the point. We've seen that every time a new benefit has come along, most recently in home infusion therapy, for example. Often times a little cottage industry for fraud is created until and unless the system catches up with it, by which time the perpetrators often have leap-frogged on to the next new gold mine for fraud. Medical transportation is a very good case in point in Medicaid programs. Again, there are many cases there of individual taxi companies and other transportation companies taking the Medicaid programs to the cleaners for trips that never took place and inducing the patients to collude in those schemes by signing phony vouchers.

As Mr. Gradison said, Mr. Chairman, the private payers are often hamstrung. It was pointed out throughout the hearing today that what is illegal against Medicare and Medicaid is not always illegal against private payers unless State law somehow addresses it; specifically—kickbacks, the waiver of co-payment when it is used as a marketing hook or what turns out to be a fraudulent billing scheme such as the rolling lab schemes.

The CHAIRMAN. I take it then that you would favor any statute including not only Medicare and Medicaid but also private insurance as well?

Mr. MAHON. Absolutely, I think the approach that you and other members have suggested in the last couple of years of addressing "all-payers" fraud and abuse is precisely the way to go, because without that the private payers have big areas in which they can be victimized but can do nothing from a legal standpoint.

One of the other two principal trends, Mr. Chairman, without getting into specific cases, with which we are concerned is the implication of moving from the fee-for-service to the managed-care environment. It is a very challenging environment, as Mr. Temmerman said. It represents a great proportion of the health

care industry today, both in the commercial side and the government side. And nothing I say should be construed as anti-managed care but in the initial stages of examining the fraud implications, we encountered many people who were under the impression that, well, somehow fraud goes away by the nature of managed care—that is, when you get away from fee-for-service and into pre-paid capitated payments, you've taken away the incentive for fraud.

We had a task force examine in depth the implication and the new vulnerabilities to frauds that are characteristic of managed care plans. We published their report last fall, and, in general, I would summarize by saying managed care does not eliminate incentives or opportunities for fraud. In some cases, it alters the fundamental nature of the fraud. If in fee-for-service your incentive is to do more, or to say that you did more, for the patient in order to bill for more money, then in managed care if you're accepting a fixed upfront payment in exchange for potentially unlimited treatment of the patient—

The CHAIRMAN. You would do less.

Mr. MAHON [continuing]. If you're dishonest, you're going to do less in exchange for that payment than the patient requires.

Also when you examine the working of various managed care models, you find that there is still a great deal of fee-for-service medicine taking place within managed care plans. Patients have "point-of-service" options in which they can elect to see a fee-for-service provider for a given visit or to see the HMO provider. Many services such as laboratory services are not covered under capitation payments; they are still billed on a claims basis. So the bottom line is that we're still going to have to be concerned with all of the familiar frauds, even as we begin to look into the more difficult frauds in the areas of underprovision of care and inflation of patient treatment costs and so forth.

We've also seen, Mr. Chairman, in the public sector side, instances of States that are converting their Medicaid system to managed care from fee for service running into a host of problems such as false enrollments. In the State of Florida and in the State of Tennessee there have been cases widely reported in recent months of the private HMO companies who are becoming State contractors who in the State's zeal to sign up Medicaid recipients for managed care plans—are engaging in marketing efforts that in some cases border on the unethical and at least unwise. In other cases private HMO companies are literally scouring the streets in an effort solely to enroll the names of indigent persons they encounter. Having that patient name on the book is what triggers the fixed capitation payment from the State. In the worst cases, they are providing little or no information to the homeless people they sign up about what it means to be in this new Medicaid HMO. So, naturally, when the individuals need treatment, they are turning to their only familiar source, which is the hospital emergency room.

When that activity becomes very conscious and deliberate, we consider it to be fraudulent—an outright enrollment fraud in these plans. So I think that States simply have to be careful that in looking at the perceived benefits of switching Medicaid to managed care, they are aware of the vulnerabilities and the types of prob-

lems that some States are encountering in this area already and are prepared to deal with them.

The second principal trend that has been cited today too is the move from a paper-based claim system into the all-electronic system. As Director Freeh said, you give up the familiar audit trail that's been one of the basic investigative tools for health care fraud. You also lose physical scrutiny by experienced claims processors. In the process you also, I think, are creating a more conducive environment in which some providers may find it easier to commit fraud at the touch of a button because of the perception of anonymity. They're not signing any document. They're simply hitting a computer key that sends off the claim to trigger a return payment.

We are this year devoting a great deal of attention to the precise implications of moving into electronic data interchange, or EDI, systems and we are studying exactly what you lose in the translation from paper to electronic and how insurers must compensate in the electronic environment for the loss of the familiar traditional detection means.

We'll be glad to share all of the information that that task force develops on EDI this year with the Committee, Mr. Chairman. I would wrap up just by commending you and the Committee. You have been consistently very diligent in addressing this problem, and we are very happy to work with you when it comes to the specifics of how Congress may address it.

Thank you.

[The statement of Mr. Mahon follows:]

NHCAA**NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION**

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■ FORTIFYING MEMBER COMPANIES

AETNA Life Insurance Company
CIGNA
Employers Health Insurance
The Guardian
METLIFE
Mutual of Omaha Companies
Pennsylvania Blue Shield
The Travelers Companies

■ CORPORATE MEMBERS

Allmerica Financial
American Republic Insurance
Arkansas Blue Cross Blue Shield
Blue Cross Blue Shield Association
Blue Cross Blue Shield of Connecticut
Blue Cross Blue Shield of Florida
Blue Cross Blue Shield of Georgia
Blue Cross Blue Shield of Illinois
Blue Cross Blue Shield of Louisiana
Blue Cross Blue Shield of Maryland
Blue Cross Blue Shield of the National Capital Area
Blue Cross Blue Shield of New Hampshire
Blue Cross Blue Shield of New Jersey
Blue Cross Blue Shield of the Rochester Area
Blue Cross Blue Shield of Texas
Blue Cross of California
Blue Cross of Washington & Alaska
Blue Cross of Western Pennsylvania
Blue Shield of California
CalPERS Life Insurance
Central States Health & Welfare Fund
Chubb LifeAmerica
Community Mutual Blue Cross Blue Shield
Delta Dental Plan of California
Delta Dental Plan of Michigan
Empire Blue Cross Blue Shield
Federated Mutual Insurance
Foundation Health Federal Services
General American Life
Golden Rule Insurance Company
Hawaii Medical Service Association
Honolulu Life Financial Assurance Corporation
Humana, Inc.
Independence Blue Cross
Jefferson-Pilot Life Insurance Company
John Deere Health Care
King County Medical Blue Shield
MassMutual Life
The Mutual Group
National Travelers Life Company
New York Life
North American Benefits Network
Northwestern National Life
Pharmacia Home Life
Physicians Health Services
Pioneer Life Insurance
Prudential Financial Group
The Prudential Insurance Company
Time Insurance Company
Triplex Blue Cross Blue Shield
Trustmark Insurance Company
United States Life Insurance Company
Washington National Insurance
WCA Insurance Corporation
Wisconsin Physicians Service

■ PUBLIC SECTOR

National Association of Medicaid
Fraud Control Units
US Dept. of Defense
 • *Office of Inspector General*
US Dept. of Health & Human Services
 • *Health Care Financing Administration*
 • *Office of Inspector General*
US Office of Personnel Management
 • *Office of Inspector General*
US Postal Inspection Service

■ LAW ENFORCEMENT LIAISONS

Federal Bureau of Investigation
US Department of Justice
US Department of Treasury
 • *Internal Revenue Service*
 • *Criminal Investigation*

Testimony of

William J. Mahon
Executive Director

National Health Care
Anti-Fraud Association

before the

Special Committee on Aging

of the

United States Senate

Tuesday, March 21, 1995

Mr. Chairman, Members of the Committee.

The National Health Care Anti-Fraud Association appreciates your invitation to testify today, and we commend the leadership that you personally and this Committee have long demonstrated in addressing health care fraud and your commitment to taking strong action against the problem.

We also agree wholeheartedly, Mr. Chairman, with the conclusion you reached in 1994 that we can no longer wait to act against health care fraud as part of any broader Congressional initiative on various other health care issues. The problem both demands, and lends itself to, direct action independent of any broader debate.

As the accompanying Fact Sheet [APPENDIX I] indicates, NHCAA is a 10-year-old private-public non-profit organization that combines the anti-fraud operations of private-sector health care payers with those of the public-sector agencies responsible for investigating and prosecuting health care fraud.

Our mission is to improve the private and public sectors' detection, investigation, civil and criminal prosecution, and ultimately, prevention of health care fraud.

From the private sector, NHCAA numbers 63 commercial and not-for-profit insurers as Corporate Members. The public-sector members of the Association's governing board are:

- the Deputy Inspector General for Investigations and the Assistant Inspector General for Civil Fraud and Administrative Adjudication of the Office of Inspector General of the Department of Health and Human Services;
- the Assistant Inspector General for Investigations of the Department of Defense;
- the Deputy Chief Inspector for Criminal Investigations of the US Postal Inspection Service;
- the Senior Auditor in Charge of the US Office of Personnel Management;
- the Deputy Director of the Office of Medicare Benefits Administration in the Bureau of Program Operations of the Health Care Financing Administration; and
- the Medicaid Fraud Counsel of the National Association of Medicaid Fraud Control Units.

In addition, NHCAA maintains working "law enforcement liaison" relationships with officials of the Department of Justice, the FBI and the Criminal Investigation Division of the Internal Revenue Service.

We also number nearly 700 individual members, from the ranks of health care insurers, third-party administrators, self-insured corporations and from a wide variety of other state and federal law enforcement organizations.

Internally, NHCAA pursues its mission through two principal areas of activity:

- cooperative education and training in the specifics of health care fraud detection, investigation, prosecution and prevention; and
- the sharing of information on convicted, indicted and, most important, suspected frauds—both among private insurers and between insurers and law enforcement agencies.

Externally, we serve as a resource for a wide variety of parties concerned with the nature, scope and impact of health care fraud and the development of more effective measures to combat the problem.

**PRIMARY FOCUS MUST BE
ON FRAUD BY
HEALTH CARE PROVIDERS**

Although individual patients can and do commit or conspire in health care fraud, our principal focus as an organization is on health-insurance claims fraud committed by dishonest health care *providers*—for several reasons:

- (1) it is the health care provider who, if so-inclined, is equipped with all the tools needed to commit fraud on a broad scale and an ongoing basis;
- (2) it is fraud by providers that accounts for the overwhelming majority of the financial loss and that directly preys on the patient population, sometimes putting those patients at physical risk;
- (3) almost never do dishonest providers defraud only one payer at a time—indeed the safest approach (and the most lucrative) is to defraud multiple payers simultaneously and in less conspicuous increments;
- (4) similarly, almost never do dishonest providers defraud either the private or public sector exclusively: Experience shows that the provider who defrauds Medicare, Medicaid, CHAMPUS or other government programs in all likelihood also defrauds private insurers, and vice-versa; and
- (5) it is that multiple-target fraud by providers that can be addressed most effectively by concerted private-public efforts—both in general and at the individual case level.

Those fundamental aspects of health care fraud led to the formation of NHCAA in 1985, and they remain a reality today.

PRIVATE PAYERS ARE EQUALLY VICTIMIZED

Equally real is the need to address fraud against private insurers as part of any new coordinated enforcement effort.

According to 1992 figures from the Health Care Financing Administration, for example, most of the nation's total health care bill—56%—is paid with private-sector dollars (37% by insurers and 19% by consumer out-of-pocket payments).

Especially given that it is more risky to defraud the government than private payers, there is no reason to think that the private sector is any less victimized than are Medicare, Medicaid and other government programs. In this context, the public is often being twice victimized—once through fraud against those government programs, and again when their private health insurance plans are the target.

By the same token, many private insurers have long maintained aggressive and effective anti-fraud operations—in the face of significant legal constraints and, until recent years, in a law-enforcement environment where health care fraud was not the priority that it is today. In our view, the private sector represents both an area where better legal tools are needed and an invaluable partner to law enforcement.

TYPES OF FRAUDS ARE ALMOST LIMITLESS

Health care frauds run the gamut, occurring virtually everywhere the opportunity exists, or can be created, to bill for a health care service:

- from individual providers who routinely and deliberately fabricate claims or bill for higher-priced services than the ones they actually provided;
- to medical equipment and home health businesses that target the Medicare program and private payers, often paying kickbacks to dishonest physicians who facilitate the fraud;
- to free-physical schemes such as "rolling lab" operations established solely as vehicles for committing diagnostic-testing fraud;
- to physicians and chiropractors who support false-injury claims as part of staged auto accident rings operating throughout the country;
- to psychiatric-hospitalization schemes that masquerade as spa-like weight loss programs, falsifying victims' admission diagnoses and treatment information for false-billing purposes;

- to institutional frauds by hospitals, laboratories and clinics, all or part of whose basic business operation revolves around the systematic commission of fraud.

What these various schemes have in common is the quite deliberate, and criminal, intention to defraud [see APPENDIX II, *NHCAA Guidelines to Health Care Fraud*]. As such, they represent the actions of the small proportion of health care providers who are dishonest and also of professional criminals to whom the health care system is a highly vulnerable and thus appealing target. However, because health care is "where the money is" today, even a small minority can steal in enormous amounts.

ESTIMATED LOSSES TOTAL TENS OF BILLIONS ANNUALLY

How much do we lose in all?

By its nature, the amount lost to any ongoing fraud can never be quantified to the exact dollar and thus must be estimated in an educated context. In that context, NHCAA estimates the loss to outright fraud at between 3% and perhaps as much as 10% of what we spend as a nation on health care each year.

In 1994, then, when the Department of Commerce estimates that our health care expenditure totalled \$1.006 *trillion*, that translates to a minimum loss to outright fraud of at least \$30 billion—and in all likelihood substantially more, perhaps as much as \$100 billion. [See APPENDIX III, *U.S. Health Care Spending & the Impact of Fraud*.]

DETECTION IS DIFFICULT, INVESTIGATION AND PROSECUTION OFTEN COMPLEX

How are such losses possible?

First, and as a general observation, they stem from the efforts of a small proportion of providers to defraud a huge and diversified system that rests on an assumption of honesty and thus is designed to pay health care claims efficiently and—often by statute—faster than ever before. In that context, claims payers are being called on both to pay claims faster and faster, AND to put a stop to fraud in the system—two demands that are not easily reconciled.

Putting a stop to a given fraud means (1) detecting it through one or more of the various means employed for that purpose; (2) investigating it properly with regard for appropriate procedures; (3) in the private sector, involving law enforcement and prosecutorial authorities at the appropriate stage; and (4) in the case of prosecutions, proving the case.

Detecting most fraud is itself no easy matter, because taken at face value, any one fraudulent claim may appear perfectly legitimate. Generally, it is only when fraudulent claims are placed into a given pattern, or when the payer's attention is otherwise called to them, that they become suspect.

The investigation and prosecution processes also present private payers with a number of obstacles, both real and perceived.

First, actions that are illegal against Medicare and Medicaid are not always illegal when private payers are the target: for example, the payment of "kickbacks" for referral business which has a snowball effect on the volume of claims; or the waiver of the patient's insurance co-payment when used systematically as a "free-service" marketing hook with which to lure patients into fraudulent-billing schemes.

Second, the government enjoys two very effective enforcement tools for which the private sector has no legal counterparts: the ability to sanction fraudulent providers from participation in a given health plan, and the legal weight of the federal civil False Claims Act, which imposes heavy civil penalties on any individual or entity filing a false claim against a government payment program.

Third, insurers referring cases for criminal investigation and prosecution often confront the very real hierarchy of law enforcement resources and priorities, where health care fraud cases must be weighed according to their nature and financial dimensions.

Fourth—although the sharing of case information and aggressive investigation are essential to the early detection and effective prosecution of health care fraud—insurers conducting investigations, exchanging case information and pursuing cases in good faith, expose themselves to widely varying degrees of potential civil tort liability to the subjects of those investigations or prosecutions (e.g., for defamation, invasion of privacy, malicious prosecution).

Some state laws grant insurers relatively strong immunity from such civil liability in that good-faith investigative information-sharing and reporting activity; other states, however, provide no such protection. Furthermore, the value of state immunity laws is at best limited with respect to the increasingly common circumstance of multi-state or nationwide fraud schemes.

Finally, private payers also face the uncertainty that a successful prosecution will result in a recovery or restitution of funds lost to the fraud. The absence of such reasonable assurance represents yet another factor that insurers must weigh in pursuing a given case.

**MANAGED CARE DOES NOT
INHERENTLY PRECLUDE
FRAUD**

Any discussion of health care fraud and of proposed new countermeasures must also consider that both government and private health care plans are evolving toward more and more types of "managed care" delivery and financing methods.

We can be sure, however, that wherever more than \$1 trillion changes hands annually, some will always try to steal from the system. Contrary to many initial impressions, that is as true in managed care as it has been in the indemnity, or fee-for-service, environment.

In 1994, a special NHCAA Task Force performed the first broad-based analysis of the anti-fraud implications of managed vs. fee-for-service health care provision. [See APPENDIX IV, *Executive Summary of NHCAA Task Force Report on Fraud in Managed Health Care Delivery and Payment.*]

Among the conclusions that the Task Force reported:

- The nature of fraud is *altered* by some managed care models, but managed care does not inherently eliminate incentives and opportunities to commit fraud.
- Whereas in fee-for-service medicine, the fraudulent provider's incentive is to do more (or claim to have done more) in order to bill and be paid more, under so-called "capitated" provider-payment plans, the dishonest provider's incentive is to provide *less* treatment than the patient requires in exchange for the fixed capitation payment.
- Whereas dishonest fee-for-service providers falsify claims, dishonest managed-care providers will falsify reports of patient encounters, treatment outcomes and treatment costs in efforts (1) to disguise undertreatment and (2) to artificially inflate the amounts of future capitation payments.
- Few plans represent "pure" managed care: In almost all managed-care models, many services and patient options are not covered by fixed prepayments but rather are billed and paid on a fee-for-service basis—meaning that payers will still encounter all of today's familiar frauds while having to deal with new frauds spawned by managed-care structures.
- Detecting and investigating managed-care fraud are far more challenging, and they require (1) a sophisticated understanding of the contractual agreements with providers, the financial workings and the nature of providers' financial risk in any given managed care plan; and (2) far greater reliance on analysis of data pertaining to treatment outcomes and costs in given plans.

In 1995, this Task Force will begin to assemble and report information on specific managed care-fraud cases. There is already cause for concern, however, related to various states' conversion of their Medicaid programs from fee-for-service to private health maintenance organizations (HMOs).

Specifically, in their zeal to place as many Medicaid recipients as possible into private HMOs—where competing HMOs will receive capitation payments from the state for each person they enroll—the states must carefully guard against false enrollments designed only to trigger those capitation payments, partly by paying close attention to the marketing efforts that those HMOs undertake in pursuit of the states' maximum-enrollment objectives.

Florida, for example, is dealing with widespread cases of HMOs literally scouring the streets to enroll patients but giving those patients so little HMO information as to ensure that they will never have to incur the costs of treating them. As a result, when those patients need treatment, they invariably turn to the only source familiar to them, and the most costly source of all: the nearest hospital emergency room.

In Tennessee, investigators have uncovered cases of numerous false enrollments in the state's Medicaid managed care program, TennCare. One individual there was recently indicted for falsely enrolling some 260 state prison inmates, whose health care is already covered through the state prison system. In another case, state investigators discovered forged enrollments of 75 Saturn automobile employees. In both cases, the objective of the fraud was to start the flow of per-head payments from the TennCare program.

In citing these examples, by no means is NHCAA is arguing against managed care, which plays an increasingly prominent and important role in government and in the health insurance industry. Rather we are cautioning that managed care is not a panacea for health care fraud, and that the private and public sectors can ill afford to let down their guard in the managed-care environment.

ELECTRONIC CLAIMS SYSTEMS MUST BE DESIGNED WITH FRAUD IN MIND

Similarly, the private and public health care payment systems are evolving more and more toward a "paperless" electronic-claims environment, which when universally achieved will yield significant efficiencies and savings in administrative costs—estimated at several billions of dollars each year.

Like managed care, the evolution toward so-called *electronic data interchange*, or EDI, is a fact of life in health insurance operations; and just as in managed care, its implications for the detection, investigation and prosecution of fraud demand careful examination.

Certain of those implications are immediately apparent. For example, the loss of physical scrutiny by experienced human claims processors, and the loss of the "paper trail" and familiar physical evidence used to investigate and prove most fraud cases.

We must also realize that the speed and efficiencies of electronic claims processing will be enjoyed by honest and dishonest providers alike—increasing payers' vulnerability to "big scores" by criminal entrepreneurs who drop from sight with the fraud proceeds long before payers know they have been victimized by computer.

By their nature, EDI systems also necessitate the linking of payers' internal computer systems with many other systems in the "outside world"—increasing their vulnerability to such schemes as claims diversion and the creation of phony provider accounts by criminal computer hackers.

Fraudulent providers also may view the electronic claims environment as being more conducive to the commission of fraud by virtue of the ease and perceived anonymity of carrying out the crime at the touch of a button.

In the long run, an all-electronic claims environment should be conducive to more effective detection of claims fraud by virtue of its broader and deeper bodies of standardized data, within which patterns suggestive of fraud might be more readily seen—but only if:

- fraud detection is taken into account and appropriate technical safeguards are incorporated in the design and implementation stages of electronic claims systems;
- in their electronic filing agreements with providers, payers ensure (1) that providers assume responsibility for all claims filed on their behalf, and (2) that providers maintain all original paper documentation related to those claims and make it available for examination by payers upon request;
- federal and state anti-fraud laws keep pace with the health care system's technological evolution, so as not to leave legal loopholes for electronic claims fraud; and
- health care fraud investigators and prosecutors develop the thorough working knowledge needed to detect and prove electronic-claims cases.

Another NHCAA Task Force is conducting an in-depth examination of EDI's impact on health care fraud and will publish a formal report this May, at which time we will be happy to share its findings with members of this Committee and with other concerned parties.

In the last three years, a number of members of Congress have filed a variety of proposed health care fraud bills—some incorporated in broader health care reform bills, others presented as independent legislation.

Again, Mr. Chairman, we agree entirely with your assessment of the urgent need to act against fraud independently and with the clear need for the "all-payer" approach that you and other members have advocated.

At the appropriate time, we would appreciate the opportunity to comment on the specifics of proposed legislation. In the meantime, we thank you and the Committee for your consistent diligence in exposing the nature and impact of health care fraud and for the opportunity to comment today.

We look forward to assisting you and the Committee in any way possible in your continuing efforts to address the problem.



FACT SHEET

Founded in 1985 by several private health insurers and federal/state law enforcement officials, the National Health Care Anti-Fraud Association (NHCAA) is a unique, issue-based organization comprising private- and public-sector individuals and organizations responsible for the detection, investigation, and prosecution of health care fraud.

MISSION STATEMENT

Purpose: To improve the detection, investigation, civil and criminal prosecution, and prevention of health care fraud.

- Goals:**
- Establish and maintain a pro-active stance in the fight against health care fraud.
 - Conduct national seminars to educate the public and private sectors in effective methods of combatting health care fraud.
 - Expand the investigative capabilities of health care reimbursement organizations through education in the detection, investigation, prosecution, and prevention of health care fraud.
 - Provide an information-sharing network, with appropriate safeguards, to aid in the investigation of health care fraud.
 - Assist law enforcement agencies in their investigation and prosecution of health care fraud.

ANNUAL TRAINING CONFERENCE

Each year, NHCAA conducts a 3-day educational conference featuring training workshops on a wide variety of anti-fraud topics and addresses by prominent leaders in the field. Future Annual Training Conferences are scheduled as follows:

- | | |
|------------------------|--|
| 1995: November 12 - 15 | Marriott Hotel - Marco Island, Florida |
| 1996: November 20 - 23 | Marriott World Center - Orlando, Florida |

MEMBERSHIP

Corporate Membership is open to private for-profit or not-for-profit health care reimbursement organizations approved for membership by the NHCAA Board of Governors. Individual Membership is open to persons occupying managerial, supervisory or professional positions in such reimbursement organizations; in local, state or federal law enforcement, prosecutorial or regulatory agencies; or in professional associations or professional disciplinary organizations approved for membership by the Board of Governors.

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 Blue Cross of Washington & Alaska
 Blue Cross of Western Pennsylvania
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 The United States Life Insurance Co.
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 US Department of Defense,
 Office of Inspector General

US Dept. of Health & Human Services
 • Health Care Financing
 Administration
 • Office of Inspector General

US Postal Inspection Service
 US Office of Personnel Management,
 Office of Inspector General

Agencies represented by Law Enforcement Liaisons

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US Department of Treasury -
 Internal Revenue Service,
 Criminal Investigation

INDIVIDUAL MEMBERS

NHCAA has more than 700 individual members from private insurance carriers, not-for-profit health insurance plans, health care reimbursement organizations, and state and federal law enforcement and regulatory agencies.

HEALTH BENEFITS PAID

In 1993 NHCAA Corporate Members accounted for an estimated **\$110 BILLION** in private-sector group and individual health benefits paid, not including benefits paid on behalf of self-insured or government programs.

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NHCAA

NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

GUIDELINES TO HEALTH CARE FRAUD

ADOPTED BY THE
NHCAA BOARD OF GOVERNORS

NOVEMBER 19, 1991

Health care fraud is an intentional deception or misrepresentation that the individual or entity makes knowing that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party.

The most common kind of fraud involves a false statement, misrepresentation or deliberate omission that is critical to the determination of benefits payable. Fraudulent activities are almost invariably criminal, although the specific nature or degree of the criminal acts may vary from state to state.

The variety of fraudulent reimbursement and billing practices in the health care area is potentially infinite. The most common fraudulent acts include, but are not limited to:

1. Billing for services, procedures and/or supplies that were not provided.
2. The intentional misrepresentation of any of the following for purposes of manipulating the benefits payable:
 - a. The nature of services, procedures and/or supplies provided;
 - b. The dates on which the services and/or treatments were rendered;
 - c. The medical record of service and/or treatment provided;
 - d. The condition treated or diagnosis made;
 - e. The charges or reimbursement for services, procedures, and/or supplies provided;
 - f. The identity of the provider or the recipient of services, procedures and/or supplies.
3. The deliberate performance of unwarranted/non-medically necessary services for the purpose of financial gain.

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APPENDIX II

NHCAA

NATIONAL HEALTH CARE ANTI-FRAUD ASSOCIATION

U.S. HEALTH CARE SPENDING & THE IMPACT OF HEALTH CARE FRAUD

—U.S. Health Care Spending

Health care expenditures in the United States totalled well over \$800 billion in 1992. The US Department of Health & Human Services placed the expenditure at \$808.9 billion, broken down as follows:

Hospital spending	\$ 313.9 bil.	Durable Products	\$ 16.1 bil.
Physician/Lab Services	165.5 bil.	Nursing Home Care	64.9 bil.
Dental Services	38.6 bil.	Workplace Care	14.9 bil.
Other Professionals	38.7 bil.	Admin. of govt. health programs & net cost of health insurance	45.9 bil.
(includes private duty nurses, chiropractors, podiatrists, speech & occupational therapists, midwives & optometrists)		Public Health Research	21.2 bil.
Home Health Care	8.5 bil.	Construction	13.3 bil.
Pharmaceuticals & Sundries	55.5 bil.	TOTAL	\$808.9 Bil.

The US Department of Commerce, meanwhile, placed the nation's total 1992 health care expenditure at \$838.5 billion, or some 14% of total US economic output, and the 1993 expenditure at 939.9 billion.

The Commerce Department estimates our 1994 expenditure at \$1.006 trillion.

—Estimated Loss to Fraud

By its nature, the amount lost to health care fraud can never be quantified to the dollar. Rather, it can only be estimated, and such estimates vary widely.

In May, 1992, citing health insurance industry sources, the US General Accounting Office (GAO) reported to Congress that the loss amounts to an estimated 10 % of the nation's total annual health care expenditure, or as much as \$84 billion in 1992, and as much as \$94 billion in 1993. Unless checked in the meantime, the GAO warned, health care fraud will consume \$100 billion per year by 1995.

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APPENDIX III

Most NHCAA Members, when asked their estimates of the amount lost to outright fraud, place that loss at between 3% to 5% of what the United States spends on health care each year—in 1994, then, from between \$31 billion to \$53 billion. Some, however, place the estimated loss as high as 10% of all spending, or as much as \$106 billion in 1994 alone.

The bottom line: By whatever measure—even the lowest estimates—health care fraud is an enormous and intolerable drain on both our private and public health care systems.

—Nature of Health Care Fraud

Although any party to the health care delivery and payment system might commit fraud, NHCAA's primary focus is on fraud committed by health care providers.

NHCAA believes, and emphasizes, that the overwhelming majority of health care providers are honest and ethical providers. Members estimate that no more than 1% to 2% engage in deliberate and systematic criminal attempts to defraud the private and public payment systems.

Fraud schemes range from those perpetrated by individuals acting alone to broad-based activities by institutions or groups of individuals, sometimes employing sophisticated telemarketing and other promotional techniques to lure consumers into serving as the unwitting tools in the schemes. Seldom do perpetrators target only one insurer or either the private or public sector exclusively. Rather, most are found to be defrauding several private- and/or public sector victims simultaneously.

According to a 1993 survey by the Health Insurance Association of America (HIAA) of private insurers' health care fraud investigations, overall health care fraud activity broke down as follows:

43%	Fraudulent Diagnosis
34%	Billing for Services not Rendered
21%	Waiver of Patient Deductible/Co-payment
2%	Other

—NHCAA Anti-Fraud Activity

The National Health Care Anti-Fraud Association (NHCAA) represents a national cooperative effort by private-sector health insurers and public-sector law enforcement agencies to improve the detection, investigation, civil and criminal prosecution and prevention of health care fraud. It pursues that mission by conducting formal anti-fraud education and professional interaction, by providing a medium through which members may share information on health care frauds, and by assisting law enforcement agencies in the investigation and prosecution of health care fraud.

Executive Summary**Fraud
In
Managed Health Care
Delivery and Payment**

**Report to the
National Health Care Anti-Fraud Association
Board of Governors**

**by the
NHCAA Task Force On Fraud In Managed Care**

December, 1994

As the United States' health care delivery and financing system continues its move toward more and different kinds of "managed" care, how are these market evolutions affecting health care fraud? And how must health care payers—private and public—change their fraud-investigation capabilities to best deal with this new system? In order to address these questions, in March 1994 the National Health Care Anti-Fraud Association created a special Task Force on Fraud in Managed Care. This Executive Summary provides an overview of the Task Force's findings.

In order to understand how the concept of "managed care" affects opportunities to defraud the health care system, it is critical to understand the types of financial relationships that exist in a managed-care environment, and how these arrangements differ from historical models of health care delivery. Traditionally, health care has been provided and paid for on a "fee-for-service" basis, in which benefits are provided not in services, but in the form of monetary payments, made either directly to a health care provider as payment for services rendered to the insured party, or to the insured party as reimbursement for medical expenses incurred.

APPENDIX IV

As costs in this environment skyrocketed, health care payers developed various mechanisms to "manage" the care provided to insureds—for example, pre- or post-treatment review and authorization and other controls on costs and/or utilization of services. In addition, various cooperative mechanisms have developed between providers and payers to effect these cost-control measures. In Preferred Provider Organizations (PPOs), for example, various providers contract with a given payer to treat the payer's insureds at agreed-upon (and usually discounted) rates and to comply with the payer's utilization review and other payment and/or practice guidelines. In return, the payer designates those providers as its "preferred" providers, and it creates financial incentives (such as lower deductibles or co-payments) for its insureds to obtain health care services from that "network" of specific providers.

Other kinds of health care financing mechanisms, meanwhile, feature even more direct "management" of patient care and its cost. Whether it is a network model Health Maintenance Organization, where the HMO entity contracts with particular medical groups to provide care to the HMO members, or a point-of-service plan, where members are offered both managed-care and fee-for-service options within one health insurance plan, the need to control health care costs has spawned a wide variety of health care delivery products—all designed to distribute financial risk and cost-control incentives in a way that reduces overall health care expenditures.

**MANAGED CARE ALTERS, BUT
DOES NOT ELIMINATE FRAUD**

The NHCAA Task Force examination highlights various misconceptions about fraud in this new health care environment. Contrary to the perceptions of some in government and in the health care reform arena—and even in the health insurance industry—fraud does not disappear in a managed-care or "managed-competition" environment. "Managed" health care delivery still features many incentives and opportunities for unscrupulous health care providers to commit fraud. However, in many aspects, managed care does *alter* the fundamental nature of some frauds that dishonest providers can commit, and it does expand the opportunities for creative abuse of the health care financing system.

NHCAA's analysis also makes clear that fee-for-service transactions continue to figure significantly in virtually any managed-care system; there are few "pure" managed-care models in which every patient service is delivered on a pre-paid and/or fixed-cost basis.

PROVIDERS' FINANCIAL RISK IS A KEY GUIDEPOST TO FRAUD

Understanding the nature of fraud in this wide variety of managed-care models, however, presents an array of new challenges for payers and their fraud investigators. In that regard, establishing the degree to which health care providers assume direct financial risk for the cost of patient care is a central guidepost in assessing any managed-care plan's exposure to health care fraud and in evaluating the specific new types of fraud to which it is susceptible.

In the fee-for-service setting, for example, the incentive for the unscrupulous health care provider is to do more (or claim to do more) in order to bill more and, therefore, be paid more. This system relies primarily on the provider's medical judgment as the barometer of appropriate care, with no cost-control incentives placed on the provider.

In many managed-care settings, by contrast, sharing financial risk with providers becomes part of cost control. Where providers share in the risk of higher medical costs, the incentives for fraud change. For example, where a provider is paid a fixed "capitation" payment for potentially unlimited treatment of a given patient, the incentive for the unscrupulous provider is to provide *less* care in return for that payment—i.e., to *under-serve* the patient, because the cost of providing treatment eats away at the provider's "profit" from the fixed payment.

MANAGED-CARE FRAUDS ARE MORE SUBTLE AND DIFFICULT TO DETECT

In day-to-day patient dealings, fraud involving the deliberate underprovision of care might range from simple inadequate treatment, to "automatic" referral to providers outside the capitated network of sicker—and thus more costly—patients (perhaps in exchange for kickbacks from those outside providers), to more subtle acts such as the establishment of inconvenient service locations and/or appointment hours for managed-care patients, designed to suppress patient traffic.

Beyond the deliberate underprovision of care, managed-care plans also may be the targets of such frauds as:

- inflated reports of patient traffic and treatment costs, designed to induce payers to increase future per-patient capitation fees;
- false claims for services not covered by fixed capitation payments;
- falsification of quality of care and/or treatment-outcome data; and
- providers' misrepresentations of their credentials or qualifications for admission to a given payer's network of managed-care providers.

The most critical task for anti-fraud specialists is to develop an understanding of the *indicators* of these managed care-based types of fraud, and how they differ from familiar fraud indicators. For example, claims fraud by fee-for-service health care providers against indemnity-type health insurance plans might manifest itself through various specific indicators (e.g., certain tests performed and billed on an inordinate proportion of patients, regardless of their symptoms or diagnoses; a provider who never bills for less than an extended office visit).

In the managed-care environment—depending on a given plan's financial and risk-sharing structure—certain indemnity-fraud indicators will remain valid, because fee-for-service remains a factor in most health care plans. However, with the advent of managed care, other indicators will reveal the potential for fraud. Many of these indicators of potential fraud in managed-care dealings are less tangible (and in fact, they may be far more subtle).

MANAGED CARE PLACES NEW AND GREATER DEMANDS ON FRAUD INVESTIGATORS

As a result, the detection and investigation of fraud in managed-care operations will place new and far greater demands on fraud investigators. In all likelihood, the more subtle nature of managed-care fraud will also spell a need for more medical expertise either on or readily available to investigative staffs.

As a first general rule, investigators must develop a much more sophisticated understanding of the variety and complexity of contractual arrangements between managed-care payers and providers. Managed-care plans use a variety of means to pay providers and implement cost controls, including capitated payments; the withholding of a certain percentage of each claim payment as a hedge against excess costs; claims-basis payments; and others. In investigating a specific suspected

fraud, therefore, investigators must clearly understand the precise contractual terms and financial mechanics of the given managed-care plan involved, in order to assess the incentives and opportunities for fraud.

As a second general rule, many preliminary indicators of newer managed-care frauds will be statistical in nature—i.e., the fraud's broadest manifestation will take the form of quantitative anomalies in provider-performance data related to such things as number of patient encounters, number of referrals, patient-outcome and satisfaction statistics.

Due to the complexity of these managed-care issues and the ongoing evolution of payer-provider relationships in the health care marketplace, the analysis of fraud in managed care necessarily has just begun. NHCAA's Task Force on Fraud in Managed Care will continue its analysis and review, in order to improve the ability of health care payers to detect, investigate, prosecute and, ultimately, prevent fraud in managed care.

This Executive Summary and Report were prepared by the National Health Care Anti-Fraud Association Task Force on Fraud in Managed Care:

Joyce L. Hansen, Chairperson
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The CHAIRMAN. Thank you very much, Mr. Mahon.

I just have a couple of quick questions for both of you. What is the role that the beneficiary plays in the private sector? For example, we've heard it testified many times over going years back, Inspector Generals come before the Committee saying the real front line of defense is the beneficiary, and we count on the beneficiary to alert us to potential areas of fraud. As a result, we set up a 1-800 number, and so the Medicare and Medicaid beneficiaries can pick up that phone, call a toll free number, and report that abuse.

The problem we've had over the years with respect to the use of that 1-800 number is that they on the other end of that line don't get a very receptive response. They have people who either don't understand the nature of what they're complaining about; or, number two, don't care; or, number three, they care that they're being troubled over a trivial matter and I'll give you an example.

I recall the case of a man named Otto Twitchal who testified some years ago—he was from Wyoming, kind of the salt of the earth people that we like to count on and who pinches pennies—his, and he pinches the Federal pennies as well.

His daughter, as I recall, had contracted hepatitis. The family physician said everybody in the family should get a shot, and everyone got a shot, and he was away fishing in some remote part of Wyoming. His wife got a shot, the other daughter got a shot, two son-in-laws got shots, et cetera. I think it cost \$15 by the private physician and then some went to a clinic. One son-in-law I think went to a clinic and he received his shot or her shot for \$3, all within a permissible range. He was way up in the mountains fishing and got a letter from his wife saying get a shot. He went to a local clinic and they didn't give the shots. He went 15 miles further on to another area, and went and saw a doctor. The doctor took his blood pressure, checked his chest out and that was about the end of it. He got a shot, the nurse told him to wait 15 minutes to see if he had any ill effects from the shot, and the shock that he got was not from the shot itself but rather when he saw the bill that was in the neighborhood of \$417, as I recall, for that one shot.

So then he tried to complain about it, and he knew that it would be futile to call the hospital, which would have been a long-distance charge. Nonetheless, he called the 1-800 number right here in Washington, DC—it was a Medicaid hotline—and they said it was a local problem and not their concern, and he thought if it was a national program, it should be of concern, especially here in Washington, D.C., and they said we can't be bothered with it. So then he continued to try and he finally tried another 1-800 number—I think it was out in Denver. He got essentially a harangue against him saying you are a trouble maker, what are you worried about, somebody else is paying for this, it's not coming out of your pocket. And he had just about given up in despair until he finally called upon the local Congressman's office who initially the assistant said, well, it's in somebody else's district but when they looked at the bill finally said, well, we'll work on it and finally got HCFA, the Health Care Financing Administration, involved. And, eventually, he gave up hope, all hope, and he became the guilty party involved here. Finally, he received a statement some months later, 4 or 5 months after the Congressman got involved, in which the hospital said it

made a mistake. The charge was, I think, \$115 or \$116 and his amount, I think, was \$16.25 that they charged him for and he wrote the check out and sent it in. But then he spent his own money to come and testify before the Committee to reveal the kind of reaction that the average beneficiary sometimes—quite frequently—runs into.

Now is that true in the private sector as well, that if you have a 1-800, if you do, you depend upon the beneficiary to say, wait a minute, I didn't get three pairs of glasses. I got one pair of glasses. Are they treated the same way in saying, look, it's a minor matter and not your problem; it's being taken care of?

Mr. GRADISON. Mr. Chairman, at bottom the third-party reimbursement system, whether it's reimbursed privately or publicly complicates this issue enormously. You have heard earlier that in many cases the beneficiary doesn't even know of the payment request that has gone in for services that may or may not have been given to that beneficiary. So the first thing is the beneficiary needs to know.

Second, the beneficiary needs to know this in an understandable fashion. This doesn't just relate to Medicare billing. Private billings can be extremely confusing in terms of figuring out what's in there. This next point, which is just my personal suggestion, is that I think there would be a whole lot greater response from beneficiaries if they had a financial stake in the ultimate recovery, even if it's 10 percent or something. I'm not talking about bounty hunters, but many companies in their private plans have provided that if an employee identifies excessive charges, that employee will get some part of the savings back from the employer, and that apparently has increased the frequency with which these bills are carefully examined by the beneficiary.

The CHAIRMAN. Well, it's a key point. This EOMB, which is not an executive branch of the OMB office but rather an explanation of medical benefits, I think if anyone looks at that, they would be hard-pressed to figure it out, number one. But, number two, most people aren't in a position to question whether a doctor's charges are legitimate, high-priced, or excessive. And, number three, there is usually a fear factor involved as well. Most people are reluctant to report—assuming they can detect that something seems wrong—but if they see three pairs of glasses, they know they got one. If they saw three MRIs, they knew they had one MRI. If they see something that really jogs their sense of responsibility and integrity, that's probably the rare case. But even when they do that, they are afraid to come forward because of the fear of the system, fear that they're trouble makers, fear that their other Medicare benefits will be terminated, fear that the insurance company may drop them, and so there is a good deal of education that we have to have, and it may be that some kind of financial reward is in order here.

There was another case where we had a woman from New Jersey. She was 81 years old, as I recall, and a woman called up on the telephone. Telemarketer is the fancy word for somebody doing business over the telephone, but she called up on the phone and said, did you realize that you are entitled to certain equipment, Dear Miss? And, by the way, do you have arthritis? That's kind of

a common question. You ask somebody who is 81 years old do you have arthritis—most people do starting at much earlier years—and the answer was yes. Well, just give me the name of your physician, and she gave the name of her physician. That particular caller went to the physician's office, got a certificate of medical and assessed fee stamped and approved for a 2-year period of time.

A short time thereafter along comes a package from UPS, and it's one of these thin wax baths that you can stick your elbow in, or whatever, your hand, fingers, feet, and apparently receive some relief from that. The problem was there's not much in the way of instruction in terms of not alerting you it can go up to 110 degrees or 140 degrees, I think, Fahrenheit. You can get some pretty severe burns out of this, but aside from that factor, she didn't want it. She didn't request it, she didn't need it, she didn't use it, and then she called up. When she found out that Medicare was billed for it, she called up and said I don't want this and they said it's too late. It's already been billed, it's been taken care of, and so then she started a series of calls, meeting with frustration. She finally turned to a senior volunteer, a retired person in a program, and he ran into a brick wall.

So, I mean, we really have to start putting—if we're going to have beneficiaries be the front line of defense, then we've got to give them the kind of tools necessary so they understand what is being billed to them that they will in fact have a fraud alert in their own minds, that a red light goes off and that they do make the calls. And then whether it be Medicare or the private insurer, then follow up on it because I don't know whether your experience is different than that in Federal system as such, but even when the calls come forward, there has been very little in the way of aggressive pursuit in chasing down what appears to be an abusive conduct, if not fraudulent conduct, on its face.

Mr. MAHON. I remember hearing Mr. Twitchal testify, Mr. Chairman, and for the treatment he got there is obviously no excuse. I remember that the GAO was quite critical of several intermediary carriers for not following up on beneficiary complaints. They also indicated that the Medicare beneficiaries were probably much more religious at scrutinizing those benefit statements than are those of us in the general population.

More recently, in the last 2 years some 30 States have enacted new laws pertaining to either insurance fraud generally or specifically to health care or worker's compensation insurance. In many cases, they are now requiring private insurers to place fraud-warning statements on both their claims forms and their benefit statements. I've noticed in recent weeks statements from two insurers in my own dealings that say "If you suspect health care fraud, call 1-800, et cetera." One would hope that in the private sector if they are doing it on their own volition, they're going to have a response that matches the interest they're trying to elicit from the insured person who reports the suspected fraud.

In reality, most companies who maintain hotlines on their own volition will tell you that probably fewer than 10 percent of the calls they get have any basis in suspected fraud, and even fewer turn out to be actual fraud cases. However, those who do apparently consider it worthwhile to do so, but we do have to rely on the

consumer or the insured person as someone who has a direct interest in the cost of health care and health insurance. And, to the extent that we sound the alarms for years here in Washington or throughout the country but then don't follow through at the level of the dealing with the individual person, then we're not doing the job.

I would note too that the benefit statement, confusing as many of them are now, is one of the things that is lost in the translation from paper to electronic. Then it becomes a straight deal between the provider and the payer, and unless the consumer is somehow copied on the electronic transaction, he or she has no clue as to what is being billed.

The CHAIRMAN. I want to thank both of you for coming forward and hope that we can continue to work together to fashion this legislation, which I am optimistic we will see passed and signed into law this year.






Thank you very much for coming, and the Committee will now stand adjourned.

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. MAHON. Thank you, Mr. Chairman.

[Whereupon, at 1:05 p.m., the Committee adjourned, to reconvene at the call of the Chair.]

APPENDIX

	Upcoding	Prescription Drug Diversion	Billing for "Professional Patients"	Inflating Charges for Ambulance and Taxi Services	Paying Kickbacks for Referrals	
Unbundling	 <h2>GAMING THE HEALTH CARE SYSTEM</h2> <hr/> <h3>Billions of Dollars Lost to Fraud & Abuse Each Year</h3>					Phony Medical Billing Services
Billing for Excessive or Unnecessary Services						Untrained Home Care Workers
"Obstet" Patients						Targeting Nursing Home Residents
Billing for Items Never Provided						Money Laundering
Billing for Inferior Products						Falsifying Prescriptions for Supplies
	Exorbitant Prices for Supplies	"Phantom" Therapy Sessions	Falsifying Diagnoses	Making False Claims	Fraudulent Providers	

INVESTIGATIVE STAFF REPORT of Senator William S. Cohen

Senate Special Committee on Aging
July 7, 1994

* This report includes the findings and recommendations of the Minority Staff of the Senate Special Committee on Aging. It does not represent either findings or recommendations formally adopted by this Committee.

Gaming the Health Care System: Billions of Dollars Lost Each Year to Fraud and Abuse

EXECUTIVE SUMMARY

For the past year, the Minority Staff of the Senate Special Committee on Aging under my direction has investigated the explosion of fraud and abuse in the U.S. health care system. This report examines emerging trends, patterns of abuse, and types of tactics used by fraudulent providers, unscrupulous suppliers, and "professional" patients who game the system in order to reap billions of dollars in reimbursements by Medicare, Medicaid, and private insurers.

The consequences of fraud and abuse to the health care system are staggering: as much as 10 percent of U.S. health care spending, or \$100 billion, is lost each year to health care fraud and abuse. Over the last five years, estimated losses from these fraudulent activities totaled about \$418 billion -- or almost four times as much as the cost of the entire savings and loan crisis to date.

Our investigation revealed that vulnerabilities to fraud exist throughout the entire health care system and that patterns of fraud within some provider groups have become particularly problematic. Major patterns of abuse that plague the system are overbilling, billing for services not rendered, "unbundling" (whereby one item, for example a wheelchair, is billed as many separate component parts), "upcoding" services to receive higher reimbursements, providing inferior products to patients, paying kickbacks and inducements for referrals of patients, falsifying claims and medical records to fraudulently certify an individual for government benefits, and billing for "ghost" patients or "phantom" sessions or services.

This report provides 50 case examples of scams that have recently infiltrated our health care system. While these are but a small sampling of schemes that were reviewed during this investigation, they serve to illustrate how our health care system is rife with abuse, and how Medicare, Medicaid and private insurers have left their doors wide open to fraud.

Patients -- and, in the case of Medicare and Medicaid, taxpayers -- pay a high price for health care fraud and abuse in the form of higher health care costs, higher premiums, and at times, serious risks to patients' health and safety. For example,

- physician-owners of a clinic in New York stole over \$1.3 million from the State Medicaid program by fraudulently billing for over 50,000 "phantom" psychotherapy sessions never given to Medicaid recipients;
- a speech therapist submitted false claims to Medicare for services "rendered to patients" several days after they had died;
- a home health care company stole more than \$4.6 million from Medicaid by billing for home care provided by unqualified home care aides. In addition to cheating Medicaid, elderly and disabled individuals were at risk from untrained and unsupervised aides;
- nursing home operators charged personal items such as swimming pools, jewelry, and the family nanny to Medicaid cost reports;
- 1500 workers lost their prescription drug coverage because a scam drove up the cost of the insurance plan for their employer. The scam involved a pharmacist who stole over \$370,000 from Medicaid and private health insurance plans by billing over one thousand times for prescription drugs that he did not actually dispense;
- large quantities of sample and expired drugs were dispensed to nursing home patients and pharmacy customers without their knowledge. When complaints were received from nursing home staff and patient relatives regarding the ineffectiveness of the medications, one of the scam artists stated "those people are old, they'll never know the difference and they'll be dead soon anyway";
- durable medical equipment suppliers stole \$1.45 million from the New York State Medicaid program by repeatedly billing for expensive orthotic back supports that were never prescribed by physicians;

- a scheme involved the distribution of \$6 million worth of reused pacemakers and mislabeled pacemakers intended for "animal use only." The scheme involved kickbacks to cardiologists and surgeons to induce them to use pacemakers that had already expired; and
- a clinical psychologist was indicted for having sexual intercourse with some of his patients and then seeking reimbursement from a federal health plan for these encounters as "therapy" sessions.

Our investigation found that scams such as these are perpetrated against both public and private health plans, and that health care fraud schemes have become more complex and sophisticated, often involving regional or national corporations and other organized entities. No part of the health care system is exempt from these fraudulent practices, however, we found that major patterns of fraud and abuse have infiltrated the following health care sectors: ambulance and taxi services, clinical laboratories, durable medical equipment suppliers, home health care, nursing homes, physicians, psychiatric services, and rehabilitative services in nursing homes. Our investigation further concludes that fraud and abuse is particularly rampant in Medicaid, and that many of the fraudulent schemes that have preyed on the Medicare program in recent years are now targeting the Medicaid program for further abuse.

Greater Opportunities For Fraud Will Exist Under Health Care Reform

As our health care system moves toward a managed care model, opportunities for fraud and abuse will increase unless enforcement efforts and tools are strengthened. The structure and incentives of a managed care system will result in a concentration of particular types of schemes, such as the failure to provide services and quality of care deficiencies in order to cut costs. In addition, while efforts toward simplification and electronic filing of health care claims offer tremendous savings, they also pose particular opportunities for abuse. Thus, it is crucial that any such system be designed with safeguards built in to detect and deter fraud and abuse.

Findings of Investigation

Deficiencies in the Current System Expose Billions of Health Care Dollars to Fraud and Abuse

A. Current Criminal and Civil Statutes Are Inadequate to Effectively Sanction and Deter Health Care Fraud

Federal prosecutors now use traditional fraud statutes, such as the mail and wire fraud statutes, the False Claims Act, false statement statutes, and money laundering statute to prosecute health care fraud. Our investigation found that the lack of a specific federal health care fraud criminal statute, inadequate tools available to prosecutors, and weak sanctions have significantly hampered law enforcement's efforts to combat health care fraud. Inordinate time and resources are lost in pursuing these cases under indirect federal statutes. Often, even when law enforcement shuts down a fraudulent scheme, the same players resurface and continue their fraud in another part of the health care system.

This cumbersome federal response to health care fraud has resulted in a system whereby the mouse has outsmarted the mousetrap. Those defrauding the system are ingenious and motivated, while the government and private sector responses to these perpetrators have not kept pace with the sophistication and extent of those they must pursue.

B. The Fragmentation of Health Care Fraud Enforcement Allows Fraud to Flourish

Despite the multiplicity of Federal, State and local law enforcement agencies, and private health insurers and health plans involved in the investigation and prosecution of health care fraud, these enforcement efforts are inadequately coordinated, allowing health care fraud to permeate the system. While some strides have been made in coordinating law enforcement efforts, immediate steps must be taken to streamline and toughen our response to health care fraud.

Recommendations

Based on our investigation and findings, we recommend the following to reduce fraud and abuse throughout the health care system:

1. Establish an all-payer fraud and abuse program to coordinate the functions of the Attorney General, Department of Health and Human Services, and other organizations to prevent, detect, and control fraud and abuse; to coordinate investigations; and to share data and resources with Federal, State, and local law enforcement and health plans.

2. Establish an all-payer fraud and abuse trust fund to finance enforcement efforts. Fines, penalties, assessments, and forfeitures collected from health care fraud offenders would be deposited in this fund, which would in turn be used to fund additional investigations, audits, and prosecutions.

3. Toughen federal criminal laws and enforcement tools for intentional health care fraud.

4. Improve the anti-kickback statute and extend prohibitions of Medicare and Medicaid to private payers.

5. Provide a greater range of enforcement remedies to private sector health plans, such as civil penalties.

6. Establish a national health care fraud data base which includes information on final adverse actions taken against health care providers. Such a data base should contain strong safeguards in order to ensure the confidentiality and accuracy of the information data contained in the data base.

7. Design a simplified, uniform claims form for reimbursement and an electronic billing system, with tough anti-fraud controls incorporated into these designs.

8. Take several steps to better protect Medicare from fraudulent and abusive provider billing practices and excessive payments by Medicare. Specifically,

- revise and strengthen national standards that suppliers and other providers must meet in order to obtain or renew a Medicare provider number;
- prohibit Medicare from issuing more than one provider billing number to an individual or entity (except in specified circumstances), in order to prevent providers from "jumping" from one billing number to another in order to double-bill or avoid detection by auditors;
- require Medicare to establish more uniform national coverage and utilization policies for what is reimbursed under Medicare, so that providers cannot "forum shop" in order to seek out the Medicare carrier who will pay a higher reimbursement rate;
- require the Health Care Financing Administration to review and revise its billing codes for supplies, equipment and services in order to guard against egregious overpayments for inferior quality items or services; and
- as we revise the health care system, give guidance to health care providers on how to do business properly and how to avoid fraud.

Adoption of these recommendations will go far in shoring up our defenses against unscrupulous providers, patients, and suppliers who are bleeding billions of dollars from our health care system through fraud and abuse. Since Medicare and Medicaid lose as much as \$31 billion annually to fraud and abuse, the savings from reducing fraud in these programs would go far toward paying for much needed reforms in our health care system, such as providing access to health care coverage for the uninsured, prescription drug benefits for the elderly, or long-term care for the elderly and individuals with disabilities.

We must not wait to fix these serious problems in the health care system until we see what form health care reform takes. We are losing as much as \$275 million each day to health care fraud, and effective steps can be taken within the current system to curb this abuse. With billions of dollars and millions of lives at stake, we can no longer afford to wait.

William S. Cohen
United States Senator
July 7, 1994

I. Introduction and Scope of Investigation

When the Senate Special Committee on Aging sought an expert on health care fraud in 1981, it turned to a cardiologist from Philadelphia. His credentials were impeccable: a noted physician, he was also a convicted felon who had defrauded both public and private health insurers in three states for more than \$500,000 by submitting \$1.5 million in claims for medical services he had never performed.

"The problem is that nobody is watching," the doctor testified. "Because of the nature of the system, I was able to do what I did. The system is extremely easy to evade. The forms I sent in were absolutely outrageous. I was astounded when some of those payments were made."

Apparently, we did not learn much from this doctor's testimony. For now, thirteen years later, he is allegedly still up to his old tricks. Last month, he was arrested by FBI agents in Philadelphia and charged once again with defrauding health insurers for millions of dollars by filing claims for procedures that were never performed. Bail was set at \$2 million, and he is currently awaiting trial.

According to the U.S. Attorney in Philadelphia, since 1974, this physician has had a total of seven arrests and five convictions for fraud in New York, Connecticut, and Texas. Despite his record, four years ago he was able to get his Pennsylvania physician's license reinstated. He might very well still be in business today if a former patient, who was angry about the false billings, hadn't agreed to go undercover.

How was this physician, with his long record of arrests and convictions for fraud, able to continue to perpetrate the same kinds of schemes against the health care system? Why weren't his blatantly fraudulent activities detected earlier? How could he get a previously suspended license reinstated in one state when he had been convicted for fraud in three others?

The vast majority of health care providers are honest and dedicated professionals, but the alleged activities of this physician is typical of the "bad apples" that threaten to corrupt the entire system.

Therefore, as Congress continues its work on omnibus crime legislation and crafts health care reform, the answers to these questions reveal flaws in our health care system that we simply cannot afford to ignore.

For the past year, under my direction the Minority Staff of the Senate Special Committee on Aging has investigated the growth of fraud and abuse in the U.S. health care system and has worked to identify deficiencies in current federal, state, and private sector efforts to combat these crimes. To demonstrate the scope of the outrageous fraudulent behavior currently plaguing the health care system, this report will detail recent cases in which individuals and companies have been either indicted, convicted or fined. Those cases that have been adjudicated represent the tip of the iceberg of what has come to light -- many more go undetected or are still under investigation. For example, in the area of home health care fraud, the New York Special Prosecutor states that "We've just scratched the surface." The Minority staff is continuing its investigation of the areas of abuse identified in this report, and will issue a series of reports on particular industries engaged in abusive practices.

In addition, this report will examine emerging trends, patterns of abuse, and types of tactics used by fraudulent providers; the inadequacy of current law and enforcement resources and the need for better coordination; and how the move toward managed care presents new and different opportunities for unscrupulous providers to defraud the system. And finally, the report will offer recommendations for correcting the current deficiencies in the system that allow fraud and abuse to flourish.

According to the General Accounting Office, each year as much as 10 percent of total health care costs are lost to fraud and abuse. With annual health care costs in the United States now exceeding \$1 trillion, fraud and abuse is costing taxpayers and policyholders about \$100 billion each year. Over the last five years, estimated losses from health care fraud and abuse totaled about \$418 billion -- or almost four times as much as the entire savings and loan crisis has cost to date. With amounts this large at stake, we simply cannot afford to wait any longer to toughen our response to health care fraud.

We would like to thank, among others, the Office of Inspector General of the Department of Health and Human Services, the Department of Justice, the Federal Bureau of Investigation, the Drug Enforcement Administration, the Postal Inspection Service, the National Association of Attorneys General, the Medicaid Fraud Control Units, and the General Accounting Office, as well as numerous health care industry representatives, for their assistance with this investigation and report.

II. Background

Current Law: How the Government Investigates and Prosecutes Health Care Fraud and Abuse Violations

A. Brief Overview of Health Care Fraud and Abuse Statutes

A number of Government health care programs are regular targets for fraud. Medicaid is financed jointly by the federal and state governments with states contributing up to 50 percent of the program's funding. Medicare is a federal program financed by a combination of federal payroll taxes, general revenues and beneficiary premiums. Other government-sponsored programs include benefits provided to federal employees, retired and active military and dependents, and veterans. Although government health care programs are often targeted, many unscrupulous providers are indiscriminate about who pays.

As this report illustrates, health care fraud and abuse encompasses a wide range of practices including overcharging for services, billing for services not rendered, and rendering services that are unnecessary or inappropriate. Paying kickbacks to physicians for referring patients and routinely waiving copayments or deductibles from patients are also considered fraudulent activities by the Medicare and Medicaid programs. Because kickbacks constitute payments to induce services, they increase insurers' vulnerability to claims for unnecessary services. By forgiving patient copayments and billing an insurer directly, unscrupulous providers may be able to misrepresent services rendered without the patient's knowledge.

While there currently is no specific federal health care fraud statute, Justice Department prosecutors do use traditional criminal and civil authorities, including mail and wire fraud statutes, the False Claims Act, and false statements statutes to prosecute health care fraud and abuse.

There are also criminal statutes directed specifically to prevent fraud and abuse within Federal health care programs. Such authorities include criminal penalties for false claims and statements specifically involving the Medicare and Medicaid programs, and the Medicare and Medicaid anti-kickback statute. The anti-kickback statute prohibits an individual or entity from offering, paying, soliciting, or receiving remuneration with the intent to induce Medicare or Medicaid program business.

The Department of Health and Human Services' (HHS) Inspector General (IG) is responsible for imposing the majority of health care administrative sanctions authorized under the Social Security Act. The Omnibus Budget Reconciliation Act of 1981 specifically authorized the IG, acting on behalf of the Department, to impose civil monetary penalties and assessments against health care providers who have filed false or improper claims for reimbursement under the Medicare, Medicaid, or Maternal and Child Health Block Grant programs. The law authorizes penalties of up to \$2,000 for each false claim, and an assessment of up to twice the amount improperly claimed by the health care provider. The law provides a major deterrent to fraudulent and abusive activity.

The Medicare and Medicaid Patient and Program Protection Act of 1987 further increased the Department's authority to exclude both individuals and entities from participation in Medicare and State health care programs for fraudulent activities. It amended the existing mandatory and enacted new discretionary (permissive) exclusion authorities. The mandatory provisions cover program-related and patient abuse convictions and require program exclusions of no less than 5 years.

The permissive provisions cover a variety of offenses including convictions for fraud, loss of a license, and kickbacks. Once a decision has been made to impose an exclusion, the provider is given notice and advised of the right to request a hearing before an administrative law judge (ALJ). If the provider is dissatisfied with the ALJ's decision, he may request review by the Departmental Appeals Board and, if still dissatisfied, may take his case to U.S. District Court.

Program exclusions or civil penalties are often the appropriate remedy to be utilized to address health care fraud and abuse.

The HHS Inspector General refers investigative findings directly to the Department of Justice or individual U.S. Attorneys for possible criminal or civil prosecution. Once the Department of Justice has completed or declined criminal or civil prosecution, HHS can consider imposing administrative sanctions. Successful prosecutions may take years, involve an investment of considerable staff time and resources and, in some cases, may never result in actual recovery of federal health care dollars lost to fraud.

**B. "Divided We Fall"
Law Enforcement Agencies Suffer from Overlapping and
Unclear Jurisdiction**

The responsibility for investigating and prosecuting health care fraud and abuse is currently dispersed among many agencies at both the federal and state levels. The HHS IG and the FBI, the two federal law enforcement agencies with primary jurisdiction in health care anti-fraud efforts, each devote between 222 and 228 full-time equivalent (FTE) positions to health care fraud investigations.

More than 4 billion claims are processed annually. Although the IG has authority over only federal health programs, the FBI has plenary authority for all health care plans -- that means less than 450 federal FTE's are devoted to investigating alleged improprieties in federal public health programs, which represent 40 percent of the nation's health care bill, and to investigating over 1,000 private payers. Thus, the two predominant health care anti-fraud enforcement agencies have only one FTE per approximately 8,690,000 claims. Agencies with some jurisdiction in anti-fraud and abuse enforcement efforts are as follows:

- The Inspector General of the Department of Health and Human Services audits and investigates health care providers accused of fraud against federally-sponsored programs, primarily Medicare and Medicaid. It is authorized to conduct civil, administrative and criminal investigations of frauds associated with the federal program.
- The Federal Bureau of Investigation has plenary authority to investigate all health care fraud offenses and includes all victims of the crime, whether against Federal programs or private insurance companies, business entities or individuals. Allegations of criminal conduct in the health care industry, at the onset, are presented to the U.S. Attorney's office for a prosecutive opinion. Based on the U.S. Attorney's decision, the FBI either proceeds with the investigation or closes the case.
- The Drug Enforcement Administration monitors and investigates the diversion, misuse, and abuse of pharmaceutically controlled narcotic substances.
- The Department of Justice combats health care fraud by pursuing criminal or civil proceedings when appropriate. Even if health care fraud does not constitute criminal activity, the Justice Department may try to recover damages by seeking the payment of civil penalties and restitution. Exclusions, suspensions or administrative civil penalties are still within the purview of the Department of Health and Human Services' Inspector General.
- The Food and Drug Administration regulates the prescription drug market for noncontrolled prescription medications as well as certain medical devices.
- The Postal Inspection Service enforces a number of statutes which allow them to take action against fraudulent practices involving the use of the mails (the criminal mail fraud statute and the civil postal false representations statute). Since the majority of claims filed by providers (as well as subsequent payments) flow through the mail, the Postal Inspection Service is an active component of health care fraud investigations.
- The Inspector General of the Department of Labor investigates cases involving workmen's compensation claims or fraud in health plans administered by labor unions.
- The Inspector General of the Office of Personnel Management investigates when fraud is suspected in federal employee health plans, to which the federal government contributes billions of dollars annually.
- The Defense Criminal Investigative Service seeks to ensure the integrity of all Department of Defense programs, including the military health care system (CHAMPUS).
- The Inspector General of the Railroad Retirement Board Office handles cases regarding railroad workers fraud.
- Forty-two States currently operate special Medicaid Fraud Control Units.

The Minority committee staff finds that agencies authorized with primary enforcement duty, such as the HHS IG, are seriously underfunded and are urgently in need of additional resources in order to keep pace with the growth in the health fraud crime problem. Many of the agencies dedicated to this effort are stretched thin and are unable to keep pace with the growing number of claims and the evolving relationships of providers and entities as our health care system moves more toward a managed care environment. The committee staff is concerned about the lack of coordination and unnecessary duplication of efforts among agencies with overlapping jurisdiction.

Historically, turf battles have existed, potentially undermining investigations and cases. A muddled chain of command and the decentralized nature of some health care fraud investigations allow many fraudulent actors to perpetrate their schemes without detection. Recently, health care fraud working groups have formed at the national, regional and local levels. Many of these groups include federal and state prosecutors and investigators from FBI, HHS IG, Medicaid Fraud Control Units, and other agencies. We have found that where a task force or working group exists to coordinate investigations of a specific fraudulent or abusive practice, the overall investigation and prosecutorial effort are positively affected.

III. "Tip of the Iceberg"

Select Cases of Fraudulent and Abusive Schemes

As stated above, the GAO estimates that fraud and abuse accounts for as much as 10 percent of U.S. health care spending. With health care costs approaching \$1 trillion, approximately \$100 billion will be lost to fraud and abuse annually. The FBI calculates that fraud accounts for between 3 percent and as much as 15 percent of total health care spending, costing the United States tens of billions of dollars each year. Despite the enormity of the problem, GAO concludes that *only a small fraction of the fraud and abuse committed against the health care system is identified.*

Those instances that have been detected have involved substantial sums of money, risked patients' health and lives, diverted scarce resources, and contributed significantly to national health care costs. In addition to these tangible costs, health care fraud and abuse by providers can dangerously erode the trust of patients in the quality and integrity of the health care system. The cases described in this report are cases which are based on either recent convictions, indictments or fines so as to not disrupt or prejudice ongoing investigations which may result in future convictions. The committee staff is, however, continuing its investigation of ongoing cases.

A. Durable Medical Equipment (DME)

Over the past several years, the durable medical equipment industry has been repeatedly cited as a major source of fraudulent and abusive practices in the health care system. Ongoing investigations by the Minority committee staff revealed shocking evidence of unscrupulous DME sales practices, often resulting in the sale of unnecessary, overpriced, and even dangerous equipment to Medicare beneficiaries.

While the DME industry has recently taken steps to stamp out abuse, our current investigation of health care fraud cases has concluded, unfortunately, that major abuses continue to occur within this industry. The overwhelming majority of the nation's more than 160,000 DME suppliers are dedicated and honest professionals, but the rapid growth and sheer size of the industry has greatly increased the potential for fraud and abuse. Our investigation reveals that not only do these problems continue to plague the Medicare program, but they are being replicated not only in Medicaid, but in private insurance programs as well.

DME providers are not required to be certified or licensed. In fact, until recently, they have not had to meet any kind of standards whatsoever. Medicare carrier oversight of suppliers has also been lax. Most carriers do not keep track of their suppliers, and their billing numbers are rarely cancelled, even when the supplier has been excluded from the Medicare program. Insufficient carrier oversight also enables suppliers to be issued multiple billing numbers, allowing them to double bill, overbill, or avoid being caught for fraudulent activities.

Largely as a result of Congressional pressure, the Health Care Financing Administration (HCFA) has taken some action to curb fraud and abuse in the Medicare DME program. HCFA has reduced the number of Medicare carriers processing DME claims from 34 to 4, which should bring greater uniformity and consistency to coverage and payment decisions. In addition, all claims must now be submitted to the carrier serving the area where the beneficiary resides and uses the item, thus eliminating the ability of suppliers to engage in "carrier shopping" to locate the carriers paying the highest reimbursement rates in order to get the best price for their overpriced items.

These new requirements are a step in the right direction, however, Medicare and Medicaid clearly remain vulnerable to abuse, and there is more that we can and should do to strengthen the participation requirements and administrative and payment policies for durable medical equipment.

Specific areas of abuse by DME suppliers include billing Medicare and Medicaid for inferior products, billing for items never provided, paying kickbacks to physicians for referring patients to DME suppliers, forging physician signatures or falsifying prescriptions for equipment, and tasting health care products.

INFERIOR PRODUCTS: The problem of selling inferior products at inflated prices is an ongoing problem that this industry still has not cleaned up.

- A DME supplier in Texas defrauded Medicare of over \$1 million by charging Medicare for "body jackets," when what he actually provided were wheelchair pads. Legitimate custom-fit orthotic body jackets are used to treat injuries such as vertebra fractures and compressions or to aid in healing following surgery on the spine. A wheelchair pad is a cushioned seating support for the wheelchair. This supplier billed Medicare close to \$1,300 for each pad, which actually cost between \$50 to \$100 to manufacture -- representing a mark-up to Medicare of as much as 2,500 percent.
- Body jacket scams have become increasingly popular, prompting the HHS IG recently to conduct an inspection to determine whether Medicare was being appropriately billed for orthotic body jackets. The Medicare claims paid remained relatively steady until 1990. Then, the number of claims submitted to Medicare skyrocketed 6,400 percent by the end of FY 1992 -- from 275 claims in 1990 to 17,910 claims in 1992. Total allowed charges also increased significantly, from \$217,000 in 1990 to \$18 million in 1992 -- an 8,200 percent increase.

The IG found that 95 percent of the jacket claims filed in a one year period were for "jackets" which did not meet the construction and medical necessity requirements to be reimbursed by Medicare. According to the IG, an orthotic body jacket costs only approximately \$100 to manufacture, while Medicare pays approximately \$800 for this item. In 1991, total Medicare payments for jackets that did not meet construction and medical necessity requirements exceeded \$7 million.

Medicare requires that a patient's physician complete a prescription -- known as a "Certificate of Medical Necessity" (CMN) before a DME can be approved for payment. The IG found that the body jackets were marketed by salespersons before the CMN's were completed by physicians. Typically, DME salespersons marketed their devices to nursing homes for use by their residents.

The IG found that salespersons presented their products to nursing home directors and physical therapists as restraint alternatives to help patients sit upright in wheelchairs. When a patient agreed to purchase a device, salesmen either completed the CMN or gave nursing home staff the proper wording to use and they completed the CMN. The nursing home staff then sent it to a physician for signature. This practice in itself is strictly illegal because, under current law, physicians -- not suppliers -- are required to complete the CMN.

To market this non-legitimate device as an "orthotic body jacket," DME suppliers took advantage of nursing homes' desires for restraint alternatives. They also took advantage of the fact that these primarily Medicare and Medicaid patients did not have to pay out-of-pocket for the products and also of the fact that physicians are often far too lax in their attention to the CMN requirements.

BILLING FOR ITEMS NEVER PROVIDED: Our investigation found that there are still many cases of sham companies billing for products that are never delivered. This is particularly a problem when nursing home residents are targeted for the sale of items that they never receive and, in some instances, never even ordered.

- The manager of a California DME company billed Medi-Cal, in just less than seven months, for more than \$500,000 for merchandise allegedly delivered to needy beneficiaries. In fact, the company was supplying nothing and the beneficiaries had no actual medical need for any of the supplies. An audit revealed that the operation was a virtual sham from its inception, and that the company had never even purchased an inventory of supplies from which deliveries could have been made. All Medi-Cal monies that were received were pocketed by the owner who used the funds to support a heavy gambling habit.
- A search warrant was recently issued in New York after a number of Medicare beneficiaries complained to their local carrier that they never received durable medical equipment listed on their Explanation of Medicare Benefits form as having been delivered to them by a New York DME company. Instead the company often provided non-reimbursable substitute items, such as angora underwear, power massagers, air conditioners and microwaves, in order to induce the beneficiaries to give them their Medicare number.

Medicare beneficiaries would contact the DME company and its sales representatives to learn how they could obtain the "free" household items. After receiving telephone calls from the beneficiaries, the sales representatives would then visit them in their homes and show them household items from a catalog. More expensive reimbursable durable medical equipment, such as hospital beds, wheelchairs, and patient lifts, which were never delivered would then be billed to the carrier using the beneficiaries' Medicare numbers.

It is estimated that Medicare overpaid \$1.5 million for the items, but this figure is only based on those beneficiaries who complained to their carrier. The DME company is also accused of conducting an elaborate money laundering scheme in order to obscure the proceeds of the Medicare fraud.

KICKBACKS: Under the Medicare and Medicaid anti-kickback statute, it is illegal to offer or pay a profit distribution to physicians to deliberately induce them to refer business under Medicare or any State health care program. However, the practice continues.

- A cardiologist has been charged with receiving \$125,000 in kickbacks from a DME company for referrals that enabled the company, which supplied oxygen and respiratory aids, to bill government programs for hundreds of thousands of dollars. The indictment claims the doctor received kickbacks in the form of cash payments, jewelry, and other gifts in exchange for referrals.
- A group of Florida DME companies supplied respiratory equipment to Medicare beneficiaries without any prior physical examinations of the patients or authorization for the equipment. After the companies delivered the equipment, they paid kickbacks to physicians who agreed to write prescriptions for the equipment and medication, without ever seeing the patients. The companies then used the prescriptions as supporting documentation to obtain over \$5.2 million in Medicare reimbursements.

ITEM NOT MEDICALLY NECESSARY/FORGING OR FALSIFYING CERTIFICATES OF MEDICAL NECESSITY: Durable medical equipment is reimbursable by Medicare and Medicaid only if prescribed by physicians as medically necessary. Unscrupulous suppliers circumvent this requirement through aggressive sales practices such as telemarketing, pressuring physicians into signing CMN's, persuading physicians to act in complicity with a fraudulent scheme, or forging physician signatures.

- Two New York DME owners stole \$1.45 million from the New York State Medicaid program by repeatedly billing for expensive orthotic back supports that were never prescribed by physicians. The DME sales force used an aggressive personal solicitation and telemarketing campaign, offering free "angora underwear" to Russian immigrants in Brooklyn, in exchange for their Medicaid ID numbers. The State was then charged for costly medical supplies that were never authorized by doctors and only rarely, if ever, delivered to patients. As described in a previous case, angora underwear was again used as an inducement to obtain beneficiaries' Medicaid numbers.

The sales team recruited the Medicaid recipients in the streets with promises of the free underclothes, and then billed Medicaid for high-priced, medically unnecessary orthotic back supports -- charging nearly \$400 per claim. One of the owners also pleaded guilty to stealing an additional \$300,000 over two years by submitting numerous false reimbursement claims from another DME company by stating that the company had provided hundreds of Medicaid patients with oxygen concentrators and nebulizers that were similarly, in fact, never ordered by physicians.

- The owner of a DME company in New York was sentenced to five months in jail for Medicare fraud and ordered to pay \$100,000 in restitution for falsifying blood tests to justify claims for oxygen equipment and inflating hours of oxygen use to obtain higher reimbursement.
- In Florida, an investigation of physicians, middlemen and DME companies involved in selling and buying Certificates of Medical Necessity led to indictments and imprisonment. One physician was sentenced for selling the certificates for patients he neither examined nor treated, knowing full well they would be used in filing Medicare claims. Other individuals and companies are also under indictment as part of the overall investigation.

B. Other Practices of Suppliers

UNBUNDLING AND UPCODING: Unbundling is the practice through which providers submit bills piecemeal rather than for the procedure or product as a whole. These illegal practices add enormous costs to the public health care programs. Upcoding is the process of billing for a service by using a reimbursement code for a similar but more complicated service. This results in a higher reimbursement to the provider.

- The case of a Pennsylvania DME company illustrates how providers have used the techniques of "unbundling" and "upcoding" to defraud Medicaid. The DME company billed Medicaid for "incontinence liners" when it was in fact providing residents of a youth home and elderly nuns in a convalescent home with disposable washcloths. The supply company misrepresented the products supplied in order to receive a higher reimbursement. During interviews at the homes, investigators also discovered considerable amounts of durable medical equipment supplied by the same DME outfit, including wheelchairs, geriatric chairs, and accessories.

A review of the Medicaid bills submitted revealed that the wheelchairs, particularly the motorized ones, had been "unbundled": the supplier was billing separately for components of a wheelchair that are generally provided as standard items. The supplier also billed for more expensive equipment than was actually provided. Company owners were convicted for this fraud.

- Our investigation revealed several fraudulent billing schemes involving reimbursement for incontinence supplies. For example, a husband and wife in Michigan allegedly stole more than \$25 million from Medicare in false claims for providing incontinence supplies for nursing home patients. Each time the Medicare carrier initiated proceedings to review claims before paying them, the couple allegedly incorporated a new billing company in order to avoid detection by Medicare.

TAINTING OF HEALTH CARE PRODUCTS: Our investigation also revealed instances in which Medicare and private insurers have been billed for products that pose potentially serious risks to patients, such as through the sale of "tainted" products.

- A former pharmaceutical salesman who was the owner of a company that distributed human heart cardiac pulse generators and human heart pulse generator leads was convicted of altering and misbranding expired pacemaker boxes to make the product appear new. By the owner's estimate, over an eight-year period, he sold about \$6 million worth of pacemakers.

Former employees testified he often acquired low cost older models that were near expiration and relabeled them -- a process that meant not only implanting pacemakers with older batteries but also jeopardizing the devices' sterility and putting the patient at risk of infection. In addition, accounts stated when authorities raided the owner's office, they found a number of bloody pacemakers, raising suspicions he was reselling devices that had been surgically removed from other patients or even from corpses. One former employee said she saw him wash off a pacemaker battery with tap water. Other problems discovered included implanting devices with lapsed expiration dates, improper sterilization, recycling pacemakers, mislabeling pacemakers intended for "animal use only" and mislabeling standard units as "high output" units.

The owner also provided a variety of kickbacks to attending physicians, cardiologists and surgeons to induce them to implant adulterated, misbranded, or expired pacemakers into their patients. The physicians were given entertainment tickets, vacation trips, office medical equipment, the services of prostitutes and cash for using the heart devices.

According to the Department of Health and Human Services' Inspector General, a retired electrician from Chicago had a "mystery pacemaker" implanted in his chest. The brand, serial number, and even the expiration date of his pacemaker or the lead attached to his heart could not be determined. The patient did not know his pacemaker was subject to failure, which might require a pacemaker replacement operation with all the accompanying risks of further surgery. The patient's cardiologist admitted that he received the services of a prostitute, a trip to Hawaii and other types of kickbacks from the pacemaker dealer. To date, ten individuals have pleaded guilty to the scheme and the owner has been given a 6 year term of imprisonment.

C. Psychiatric Services

Our investigation has concluded that a growing area of health care fraud exists in the delivery of psychiatric and psychotherapy services, including those provided by hospitals, clinics and private practitioners. Our review of recently completed and ongoing criminal investigations indicates that psychiatric and psychological services are rife with abuse, particularly in the following areas: billing for "phantom" psychotherapy sessions; billing for excessively long hospital stays for inpatient psychiatric care; providing kickbacks to physicians; and grossly inflating the number of psychotherapy hours provided in order to reap thousands of dollars in overpayments from Medicare or private insurers.

PHANTOM SESSIONS: We have found a significant increase in cases involving the illegal practice of billing for psychiatric and psychotherapy sessions that never took place.

- A New York Community Center director was indicted for stealing almost \$800,000 by fraudulently billing the State for over 25,000 "phantom" psychotherapy sessions Medicaid recipients never actually participated in and for falsifying patients' medical records to cover up the theft. To perpetrate the scheme, the center director offered inducements like free food to attract thousands of Medicaid beneficiaries to the Center.

After obtaining the Medicaid recipients' names and I.D. numbers, the director allegedly used the Medicaid provider number of a psychiatrist to bill for tens of thousands of these "phantom" sessions. The billings were so excessive that the staff psychiatrist would have had to work well over 24 hours a day to handle the number of visits claimed, yet the scheme continued for over three years before being detected and stopped.

- In a similar case, physician-owners of a psychiatric clinic in New York were sentenced for stealing more than \$1.3 million from the State Medicaid program by fraudulently billing the State for over 50,000 "phantom" psychotherapy sessions never given to Medicaid recipients. They were also charged with conspiring to falsify patient medical records to cover up the theft.

The doctors had paid neighborhood "steerers" illegal kickbacks of \$10 to \$15 per session to bring in new patients. Once inside the clinic, the Medicaid beneficiaries (often drug addicts) would sit together in a big room, watch television, fill out so-called homework assignments, eat a meal, sometimes talk briefly to a doctor, and then, before leaving, receive a few dollars cash and prescriptions for drugs like Valium. The physicians saw patients on a twice-weekly basis, but billed Medicaid for four to seven visits per week, as well as for dates before the recipients ever even set foot in the clinic. They also billed for visits when the only licensed psychiatrist on staff was absent from the office — often on vacation in France and California.

BILLING FOR EXCESSIVE OR UNNECESSARY SESSIONS:

- A Minnesota psychiatrist was sentenced to prison for defrauding Medicare, Medicaid and the Department of Veterans Affairs by billing for extensive psychotherapy sessions with individual patients in nursing homes and board and care facilities when he either did not see them or saw them only in groups at meals. In addition, his medical license had been suspended for sexual improprieties with patients and for overprescribing medications.
- A Hawaii clinical psychologist, working as a marriage and family counselor, was accused of defrauding the Civilian Medical Health Program of the Uniformed Services (CHAMPUS). He was indicted for having sexual intercourse with some of his patients and then seeking payment for these encounters as "therapy" sessions. He also claimed payment for therapy sessions which never took place; for billing individual sessions as joint sessions in order to receive higher reimbursements; and for falsely certifying to CHAMPUS that he billed and collected a required 20% copayment from his patients when he had, in fact, advised them they were not responsible for the fee. As a result, his patients had no incentive to scrutinize his billings, allowing him to continue his fraud against CHAMPUS.

- A Virginia psychiatrist was recently convicted for billing different insurers for patient counseling sessions that never occurred or whose length was inflated on reimbursement claims. He is accused of defrauding seven insurers including Medicare, Medicaid and CHAMPUS. He was sentenced to home confinement for six months, ordered to perform community service, fined \$10,000 and put on probation.
- A record \$379 million in fines, damages and penalties will be paid by a large health care corporation for kickbacks and fraud at its psychiatric and substance abuse hospitals in over 30 states. The corporation agreed to plead guilty to six counts of making unlawful payment to induce doctors to refer Medicare and Medicaid patients to the hospitals and one count of conspiracy to defraud the United States. Fraudulent practices included admitting and treating patients unnecessarily, keeping patients hospitalized longer than necessary in order to use up insurance coverage, billing insurance programs multiple times for the same service and billing when no service was actually provided, and billing Medicare for payments made to doctors that were solely intended to induce referrals of patients to the facilities.

D. Nursing Homes

The investigation revealed a considerable number of cases involving direct targeting of nursing home patients in which both the industries that supply products and services to the homes and the owners and administrators of the home are involved in fraudulent and abusive practices. Nursing home owners have been convicted of charging personal luxury items like swimming pools to Medicaid cost reports. HCFA, the HHS IG, and the Minority committee staff are continuing to investigate nursing homes and the providers of rehabilitative services to nursing homes.

- A Minnesota speech therapist submitted false claims to Medicare for services provided to nursing home residents. The therapist also received Medicaid payments for speech therapy he never actually performed -- and the investigation revealed that he had been paid for services "rendered to patients" several days after they had died. He was also observed using flash cards with a blind resident, and then billing for reimbursement.
- The owner of a Pennsylvania rehabilitation service was indicted for allegedly operating a scheme to defraud Medicare by submitting false claims for speech therapy provided to patients in nursing homes. The owner allegedly told speech therapists to recruit Medicare clients even though he knew their therapy would not be covered under Medicare.

Before submitting the paperwork for reimbursement, the speech therapists would rewrite their patient reports so that they would appear to be medically necessary rehabilitation services. The employees then allegedly falsified bills submitted to Medicare, including certifications by doctors that patients needed continued speech therapy, and also falsified patients' medical records.

- A Connecticut nursing home owner allegedly overstated expenses in reports for Medicaid reimbursement over a five-year period resulting in an overpayment by the State of almost \$400,000. The nursing home owner allegedly arranged a beneficial financial arrangement with a leasing corporation to procure equipment. The leasing company then sold or leased the equipment back to the owner for a far greater cost than its purchase price. The nursing home was accused of passing on these costs to the State by submitting inflated cost figures and in order to obtain a higher rate of Medicaid reimbursement.
- A supply company in California billed Medicare for \$5 million for post-surgery surgical dressings for nursing home patients who had never even had surgery. Medicare paid numerous nursing homes in several States for the surgical dressings, and the homes, in turn, paid a percentage to the supply company.
- Nursing home operators in North Carolina and Pennsylvania have been convicted of charging personal items such as swimming pools, jewelry, and the family nanny to Medicaid cost reports.

E. Clinical Laboratories

Some of the largest health care fraud convictions and settlements to date have involved major national clinical laboratories. These providers have come under intense scrutiny by the FBI, the HHS IG, the Medicaid fraud units, and private insurers for such practices as "sink testing," by which patients' lab samples are dumped down the sink without having had the requisite tests performed, providing and billing for bogus test results; performing extra tests in order to obtain excessive reimbursements; providing kickbacks to physicians for patient referrals; and "unbundling" so that Medicare will pay individually for each test that should be billed as part of a series of tests. Our investigation reveals that clinical labs continue to be a major potential area of abuse, posing the threat of significant losses to Medicare, Medicaid, CHAMPUS, and private insurers, as well as a threat to patients' health care due to faulty or unperformed lab tests.

- Three of the nation's largest clinical laboratories paid over \$150 million to settle allegations that they submitted claims for unnecessary blood tests. Part of these cases arose from allegations by a whistleblower who charged that the three companies had submitted thousands of false Medicare and Medicaid claims. The labs were accused of manipulating doctors into ordering additional medically unnecessary tests when the doctors ordered basic automated blood tests. This probe is continuing and several other lab companies have acknowledged receiving subpoenas.

One of the labs, which pleaded guilty to the submission of false claims to the CHAMPUS program and to Medi-Cal, was accused of revising its order form so that doctors ordered additional tests as part of a standard test without realizing that Medicare would be charged separately for them. The unnecessary tests allegedly cost Medicare millions of dollars.

- In New York, a laboratory that had billed Medicaid more than \$39 million over six years was indicted for fraudulently billing for bogus ultrasound and blood tests. It was also indicted for illegally laundering over \$1 million in Medicaid profits through the lab in order to generate kickback money. The sales manager of the lab was accused of submitting thousands of false reimbursement claims stating that blood tests and sonograms had been provided to Medicaid recipients, when, in fact, the tests were never medically required. Further, to the extent that services were actually provided, they were done solely to maximize the Medicaid reimbursements.

The lab sales manager then allegedly laundered the Medicaid proceeds by writing checks to fictitious employees and converting the funds to cash in order to pay kickbacks to others and also to make the fraud more difficult for Medicaid to detect.

F. Physicians/Practitioners

When physicians and health care practitioners engage in fraudulent practices they not only violate their own code of ethics but also deceive their patients, add enormous costs to an already beleaguered system, possibly endanger lives and, ultimately, betray the public trust.

- A physician in Hawaii who specialized in internal medicine and oncology used fake diagnoses to justify billings for treatments never provided to patients. Some examples of the physician's billing practices included: billing for treatment of appendicitis in patients who previously had their appendixes removed; billing for office visits that never took place; and billing for laboratory tests that were not performed. The physician is currently under indictment.
- An Arizona physician who practiced as a radiologist is under indictment for obtaining admission into the Medicare Screening Mammography Program by falsely stating that he was certified in radiology by the American Board of Radiology, which is specifically required of interpreting physicians before admitting them to the program. This is done to ensure that a physician meets the requisite conditions for certification such as the necessary experience, continuing education, and written reports requirements.

The physician was also indicted for certain billing practices involving a mobile CT (computerized tomography) scanning service. In addition to performing CT scans of patients, the physician ordered technicians to perform reconstructions of the CT images. He is accused of directing the billing clerk to bill for reconstructions on all CT scans even when he knew that in many cases no reconstruction was done by the technicians.

- Over a two-year period, a Maryland physician's billing to Medicaid quadrupled, prompting an investigation. The physician was subsequently accused of double-dipping both Medicaid and the State Department of Social Services for giving physical examinations to disability applicants. Undercover investigators witnessed an office overflowing with drug addicts, disability papers in hand, being examined in four minute intervals. "Comprehensive" exams lasted no more than two to four minutes. Records showed that the physician sometimes saw upwards of 100 patients per day, even though he only spent six hours a day at his practice.

Patients were told to drop off disability forms one day and come back the next day to pick them up, and it was obvious that the forms were being completed before the patients even met with the physician. The physician was certifying "inability to work" without verifying or treating the complaints. He had a rubber stamp with the diagnosis "lumbar spine arthropathy" created to stamp all the "bad back" disabilities. By courting addicts and other potential disability recipients, the doctor built, in a very short time, a practice which billed Medicaid and the State Department of Social Services almost \$450,000 a year for services that were so superficial as to be relatively useless. In 1993, the physician filled out more than 9,900 disability forms. Another physician who at one time was in the same practice acknowledged the false certifications, stating that "these people could work."

Unfortunately, the poor care rendered by the physician as a result of his assembly line approach resulted in horror stories of poor patient care — one patient suffered a weight loss of fifty pounds in three months and received no treatment. The physician falsified the blood pressure readings of patients suffering hypertension and these patients often went untreated even though this dangerous problem existed. The physician was eventually convicted of Medicaid fraud and given a suspended sentence.

- Minority staff investigators found numerous cases involving kickbacks for sonograms, ultrasound, and other diagnostic imaging tests. For example, a New York radiologist allegedly stole more than \$1 million from the New York State Medicaid program during a two-year period by fraudulently billing for thousands of ultrasound tests he never reviewed. His Medicaid claims jumped from \$28,000 in one year to more than \$1 million two years later. The radiologist allegedly made kickbacks of 75 percent of his billings to so-called "salesmen" who regularly arrived at his office toting shopping bags full of sonograms collected at Medicaid clinics throughout the city.

The physician has been charged with billing Medicaid for reading and interpreting over 11,000 patients' sonograms and echocardiograms that, in fact, he never reviewed.

- A New York podiatrist stole more than \$200,000 from Medicaid by repeatedly billing for orthotics made from high-priced custom foot molds never provided to Medicaid patients. The podiatrist filed thousands of false reimbursement claims stating that Medicaid recipients had received expensive custom orthotics — foot molds reimbursable at \$46 each — fabricated from actual foot castings when, in fact, the doctor had furnished patients with cheaper devices which should have been reimbursed at only \$18 each.

This case is part of an ongoing statewide investigation into Medicaid abuse involving podiatrists, orthotic labs and orthopedic shoe vendors which has resulted in criminal charges against more than 200 individuals for stealing more than \$30 million from the New York Medicaid program. To date, 185 convictions have resulted in more than \$25 million in court-imposed fines and restitutions.

- A Georgia chiropractor, his wife and 15 former patients, were ordered to pay a total of \$3.2 million in fines after being convicted of Medicare and private insurer fraud. The couple recruited patients for their clinic by promising kickbacks of up to one third the amount that Medicare or the insurance companies reimbursed. Bills were submitted for patients and their families regardless of whether they had been treated. In one instance, bills were submitted for 169 patients supposedly treated in a single day.
- A Utah physician operating a clinic was charged with 34 counts of mail fraud and seven counts of false claims. He had previously been convicted of filing false Medicaid claims in the 1980's. He was to be suspended from the program for a period of ten years.

Following his conviction, however, there was no change in his billing practices. He continued to bill private insurance companies and Medicare and Medicaid (in the names of employed physicians) in the same excessive manner. When he was 'flagged' by insurance companies, he would then set up dummy billing companies to disguise his identity on claim forms. He was recently indicted on, among other things, unbundling services, identifying false diagnoses on claim forms, duplicate billings, misrepresenting the level of service, and billing for services without the knowledge or consent of patients. A jury convicted him on 32 counts.

- A Maryland physician-owned corporation was convicted of Medicaid fraud and ordered to pay \$190,000 in restitution for submitting false invoices to Medicaid. The corporation sought payment for several different types of medical services, including office visits and laboratory tests, which had not been done and were not medically necessary. The corporation billed Medicaid repeatedly for unnecessary laboratory tests.

In one instance, a young boy was rushed to the physician's office with a lacerated chin. The boy's chin was sutured but, in addition to this procedure, Medicaid was billed for a throat culture, a nasal culture, a non-specific culture, and three hearing tests, despite the fact that there was no reason to perform these services and that the boy's mother stated that none of the tests billed to Medicaid were performed by the physician. The investigation also revealed that the corporation had not purchased sufficient laboratory supplies to have been able to perform the laboratory tests for which Medicaid was billed.

- A Pennsylvania physician was convicted of illegally prescribing controlled substances. The physician, also known as "Dr. Xanax," prescribed prescriptions for non-legitimate medical purposes to abusers and dealers. It is estimated that he diverted in excess of 20,000 dosage units of controlled substances per month. He was convicted on 59 counts of illicit distribution of Valium, Adipex, Darvocet and Vicodin.
- A scheme in New York defrauded Medicaid by conducting unnecessary medical tests on drug addicts. The addicts, who were using multiple identities and Medicaid cards, were recruited from the street and given prescriptions for drugs they abused in exchange for participating in the tests.

The insurance billings generated from these tests were made possible by an agreement between the owners of the clinics and staff physicians. For the use of their provider numbers, the physicians received a 40 to 50 percent kickback for all accrued medical charges. Loss to the Medicare and Medicaid programs in this case is estimated at \$10 million. Twenty-one individuals, including seven physicians, have been charged or have entered plea agreements. This was one of the first health care fraud investigations in which Racketeer Influenced Corrupt Organizations (RICO) charges were levied. Money laundering violations served as the predicate offense for the RICO charge.

- A New York physician who operated a methadone treatment center stole more than \$1.5 million by fraudulently charging the State for over 25,000 methadone treatments never given to Medicaid recipients. In his illicit four-year billing scheme, the physician not only used the Medicaid numbers of patients who had not yet begun the program or had died, but brazenly appropriated the names and I.D. numbers of patients at a hospital with which he was affiliated who were neither in his care nor even on methadone.

The physician systematically filed thousands of false reimbursement claims stating that he had provided methadone maintenance treatment (reimbursable at almost \$60 per week) to over 1,100 Medicaid recipients at his office.

- In New York, nine persons involved in a conspiracy in which Medicaid was defrauded of more than \$8 million in a little over a year were given prison sentences. The owner of several medical clinics was sentenced to five years imprisonment and five other doctors were sentenced to lesser terms. The doctors were hired by the clinics for the sole purpose of using their Medicaid provider numbers.

The physicians wrote prescriptions for drugs that have a high street value and that ended up being diverted. The scam included rounding up "patients" for the clinics who had valid Medicaid cards, drawing blood and taking blood pressures, and then billing Medicaid for extensive diagnostic tests. The "patients" were also directed to specific pharmacists who filled prescriptions and billed Medicaid for drugs which were then sold on the street.

G. Non-Physician Providers and Professional Patients

PHARMACISTS AND PHARMACEUTICALS: The investigation has found that the diversion of prescription drugs continues to be a major criminal problem. The buying and selling of prescription drugs on the street poses enormous problems for law enforcement, already stretched to its limits, as well as adding immense costs to society by fueling an addicted population and facilitating illegal drug trafficking.

- In one of the largest fraud cases ever in New Hampshire, a pharmacist stole almost \$375,000 from the State's Medicaid program and private health insurance plans. Over a two-year period, the pharmacist systematically billed over one thousand times for prescription drugs that he did not actually dispense.

The pharmacist fabricated prescriptions to justify his billings. According to State officials, he used insurance information provided by his customers to submit false billings to their insurance companies and also double-billed Medicaid and private insurance for the same services.

This case illustrates how health care fraud can have devastating effects on insurance companies far beyond the actual losses. In addition to violating the trust and confidentiality of his customers, the acts of this pharmacist resulted in the loss of prescription drug benefits to many individuals: because the pharmacist's fraudulent activity caused a local company's health plan to incur high costs, the company was forced to drop its prescription drug coverage for about 1500 workers. The loss of the drug card benefit to hundreds of employees is a striking example of how health care fraud victimizes not only insurers, but also employers, employees and their families alike.

- In Michigan, several pharmacists obtained large quantities of sample and expired drugs and dispensed them to nursing home patients and pharmacy customers. Pharmacy technicians were instructed to remove sample drugs from their packages, scrape or rub off the word "sample" on the tablet, and place these drugs in the general stock for dispensing prescriptions. Expired drugs generally acquired from the purchase of other pharmacy inventories were handled in a similar manner. The samples and expired drugs were dispensed to nursing home patients and the Medicaid program was fraudulently billed.

Pharmacy technicians had received complaints from nursing home staff and patient relatives regarding the ineffectiveness of the medications delivered. According to testimony at trial, when the technicians confronted the pharmacy owner with these complaints, the owner stated "those people are old, they'll never know the difference and they'll be dead soon anyway."

- In Florida, a pharmacist was caught purchasing and selling diverted drugs that were samples provided to representatives of drug manufacturers. The pharmacist, the owner of a Broward County pharmacy, was accused of dispensing samples of Feldens, an arthritic drug, and Naprosyn, an anti-inflammatory drug, which had been adulterated by scraping off the mark "Sample" on the capsules. The pharmacist stated that he bought them for cash from a friend who delivered them in plastic bags on a weekly basis. This was in direct violation of the Prescription Drug Marketing Act which provides penalties for selling drug samples in order to ensure that the prescription drugs purchased by consumers are safe and effective.
- A black market scheme in New York has allegedly defrauded the Medicaid program by illegally buying and selling costly prescription drugs, including the AIDS medication AZT. The drug diverters are accused of warehousing an inventory of drugs pending resale for cash to pharmacies and other diverters at greatly discounted prices. The medications had originally been dispensed to Medicaid recipients in New Jersey and Connecticut.

In this illicit underground economy, Medicaid recipients -- often addicts who are seeking to abuse the system -- visit unscrupulous doctors and obtain prescriptions for a laundry list of costly brand name drugs. They then either sell the prescriptions to accommodating druggists or have the prescription filled and peddle their goods to street buyers who, in turn, recycle them to other pharmacies.

New York officials stated that this scam was particularly insidious because the ultimate users of the recycled goods -- the public -- could well be taking drugs that had lost their potency or had been improperly stored and handled. One of those arrested stated that he had just made a \$40,000 deal with a New Jersey pharmacy for similar prescription drugs. This case was part of a broader investigation into a vast network of physicians, pharmacists and Medicaid recipients who are engaged in dealing drugs and prescriptions for cash on the black market.

- An Illinois illegal narcotics distribution ring containing three ringleaders and a group of nineteen people was charged with diverting over 60,000 Dilaudid pills. According to the Drug Enforcement Administration, Dilaudid, a synthetic, morphine-like substance, is considered the most powerful prescription pain killer sold today.

The group diverted Dilaudid from legitimate channels by using professional patients who visited doctors on a daily basis. Some of the professional patients who were recruited had cancer. One ringleader collected the Dilaudid and then sold it to individuals who took it out of the State for resale. It costs approximately \$4.40 a tablet at the pharmacy counter, yet demands a street price of \$20 to \$80 a tablet depending on availability.

HOME HEALTH CARE: The aging of the population, the increasing preference for home and community-based long term care, and major advances in the development of out-patient technology has resulted in the explosive growth for the home care industry in the United States. Unfortunately, commensurate with the growth of this industry has been an increase in home care fraud. Our investigation has revealed that there are two major pockets where some abusive practices have become problematic: in the home health agencies and in home infusion companies (home infusion is an industry that provides intravenous drugs and nutritional therapy for patients who are receiving care at home).

Several patterns of fraud have emerged in home health agencies, such as billing for services not rendered, use of unlicensed or untrained staff, kickbacks to referring physicians, and falsified plans of care for patients. Home health care has tremendous potential to decrease costs of both acute and long-term care and to enhance patients' quality of life. It also, however, presents a disproportionate opportunity for abusive practices, hidden from medical professionals and overseers who cannot watch delivery of care at home.

The home infusion industry has been rocked with charges of kickbacks and overcharging. Some companies have allegedly charged patients fees as much as 2,000 percent higher than hospital charges. An examination by the HHS Inspector General has revealed three types of kickback schemes used by home infusion companies to defraud the federal government: direct payment of money to a physician for the referral of patients; stock bonuses based on the amount of referrals; and companies, through the use of recruiters, soliciting beneficiaries rather than doctors.

At the end of 1994, new legislation will prohibit Medicare payment for referrals by physicians to home infusion companies in which they have a financial interest. However, this payment prohibition only applies to physicians and will not correct the potential kickback violations with the referral of patients for IDPN, an infusion used for nutrition at the same time a patient is undergoing dialysis. The HHS IG has ongoing investigations in six regions targeting home infusion companies. In addition, it has a national case pending against one of the major home infusion companies in the nation. 1993 total revenues for home infusion therapy topped \$4 billion.

- The owners of a large New York home health care company stole more than \$4.6 million from the New York State Medicaid program by systematically billing, over a three-year period, for services rendered by untrained and unqualified home care aides. The company was accused of grossly inflating, by as much as 30,000 hours, the amount of time these employees actually worked. The company recruited untrained employees who were often immediately assigned to care for homebound Medicaid recipients, assisting them with such personal chores as bathing, dressing and feeding, and other support functions.

This scheme not only cheated Medicaid out of millions of dollars, but it also recklessly sent untrained health care workers -- including a 14 year-old girl to care for a 4-year old child with Down's syndrome -- into the homes of disabled and elderly residents. According to New York officials, home care has become the fastest-growing part of the New York Medicaid program -- ballooning from \$400 million to over \$2 billion a year since 1986.

- A vivid example of kickbacks for home care patient referrals involved a family in South Florida that established four companies to distribute liquid nutritional supplements, including a milk supplement, to Medicare beneficiaries. These nutritional supplements are reimbursable by Medicare if a physician signs a Certificate of Medical Necessity indicating that the supplement is appropriate for the patient. The companies hired recruiters to go into South Florida communities with heavy concentrations of elderly residents and offer "free medical milk." The senior residents then were signed on as new patients, monthly deliveries of nutritional supplements were made and Medicare was billed for these services.

The recruiters had made arrangements with Miami-area physicians to certify the medical need for the supplement. The company made kickback payments of \$100 to the recruiters for the "Certificate of Medical Necessity" obtained, and the recruiters, in turn, paid kickbacks to the physicians who had signed the certifications. In less than two years, the companies had billed Medicare for over \$14 million.

None of the elderly residents interviewed by the FBI during the investigation was qualified for the nutritional supplement, which is currently reimbursed by Medicare at a rate of \$600 per month per beneficiary. Twelve individuals, including several physicians were indicted.

- A Ohio girl who suffered from cerebral palsy was able to live at home with the help of intravenous drugs and nutritional therapy. Bills generated from her treatments ranged from \$95,000 to \$120,000 a month. The family filed a lawsuit against the home infusion company alleging overcharging and poor quality of care. In less than a year, the family's two private insurance policies' limit of \$1 million was used up. Comparisons showed that it cost close to \$1,000 a day more to treat the little girl at home than it would have cost to treat her in a hospital. When the insurance lapsed, a court order was needed to compel the supplier to keep the supply of treatment items coming to the house. The girl's mother was eventually forced to quit her job in order to qualify for Medicaid, ironically to pay for the treatment which was supposed to save money compared to the more expensive inpatient hospital fees.

MEDICAL BILLING SERVICES: The investigation found that the administrative complexity of the current health system has spawned a growth industry of billing companies to file reimbursement claims to both private insurers and federal health care programs. A consequence of this complexity is that billing firms at times falsify claims information with elaborate fraudulent schemes.

- The recent case of a California medical billing service illustrates how easy it is under the current health care system to be reimbursed for services which are never actually provided.

In August 1992, state and federal agents began an investigation into a sham medical billing service that was submitting claims to insurance companies nationwide for laboratory services. The owners of the billing service first gained entry to the system when they were previously employed by another billing service. Without the knowledge of their former employer or co-workers, the con artists photocopied and smuggled home hundreds of claim forms, doctors' billing numbers, and patients' medical information. Armed with this information, the operators set up their own phony billing service, and submitted over \$2.3 million in bogus claims for lab services that were never actually performed.

By the time federal investigators arrested the owners of this company, the operators had set up several "billing services," under at least five separate names. Each of these bogus entities had its own billing address and false business licenses.

Committee staff is concerned that the scheme only came to light after subscribers began to notify their insurance companies that they had received Explanations of Benefits (EOB) for services they had never received or for services performed by a physician they did not even know. Since many subscribers never reviewed their EOB's, some insurance companies continued to pay claims without question. As complaints from subscribers began to mount, however, insurance company investigators began to notice a pattern of fraud, and realized that the companies had each been paid hundreds of thousands of dollars in fraudulent billings.

At the time of arrest, the sham billing company's owners had stolen over \$1.5 million from insurance companies across the country, and had submitted additional false bills for a total of \$2.3 million in bogus bills.

AMBULANCE AND TAXI SERVICES: Medicaid-paid transportation services is an area ripe for abuse. For example, a common practice is routinely inflating the amounts billed to the program by overstating the miles travelled. There is also fierce competition among operators in these industries to obtain Medicaid business. In one Maryland operation, for example, an unscrupulous taxicab owner violently beat a competitor who was waiting outside a clinic looking for riders.

- In New York, Medicaid pays for a patient's transportation to a medical provider either when mass transit is unavailable in the recipient's area or when the patient, because of a debilitating physical or mental condition, cannot use mass transit.

The owner of a New York taxi firm allegedly stole over \$100,000 from the State by fraudulently billing for thousands of taxi rides never given to Medicaid patients. The president of the taxicab company was charged with filing more than 3,000 false reimbursement claims stating that his two taxi firms had provided over 300 Medicaid recipients with taxi service on days when, in fact, no transportation at all was provided.

This case is part of ongoing investigation of New York's medical transportation industry which, to date, has resulted in convictions against 66 individuals.

- The owner of a Massachusetts taxi company was recently indicted on Medicaid provider fraud and state tax violations. He is accused of charging Medicaid for separate rides when two or more recipients shared the same taxi. State Medicaid regulations require that taxi firms split the fare when two or more share the ride. Employees of the company were also indicted for failing to file tax returns over a three-year period.
- A Virginia Medicaid transportation service was convicted of a criminal violation of the federal False Claims Act. The owner of the company submitted claims to Medicaid with inflated mileage for transporting indigent patients to and from health care centers. The owner was sentenced to one year probation.

PROFESSIONAL PATIENTS: Our investigation found that health care providers are not the sole abusers of the health care system. Conversely, our investigation found significant abuse by so-called "professional patients" who scam the system by providing their own medical histories, blood or lab samples as the basis for fraudulent claims. In some instances these patients are provided kickbacks or inducements by health care providers to participate in schemes, while in other instances the patients themselves are the originators of the scams.

- The owner of a New York medical clinic was accused of submitting bills to Medicaid for medical services, blood analysis, drug prescriptions, and laboratory tests which were medically unnecessary. Physician assistants who worked at the clinic said that little medical treatment was actually administered at the clinic. A scheme was allegedly devised in which "patients" would routinely demand certain prescribed drugs, submit to a battery of unnecessary tests, and give blood in order to receive the drugs, which the "patients" would later sell on the street. The owner allegedly paid doctors and physician assistants five dollars per blood sample as a kickback. He then billed New York Medicaid to pay for the analysis the clinic conducted on the blood samples.
- A New York woman, who had four different aliases, was arrested on mail fraud charges for making false claims seeking reimbursement for medical treatment that was never actually rendered. Over a four-year period, the woman had submitted approximately 48 claims for direct reimbursement from her private insurance carrier. The carrier contacted the treating physicians named on the claims and learned that virtually all the claims were false. In one instance, she claimed that she was treated by a dermatologist on a date when he was actually on vacation.

IV. Findings of Investigation

Deficiencies in the Current System Impede Law Enforcement's Ability to Combat Health Care Fraud

While the cases included in this report represent only a small sample of fraud and abuse perpetrated against public and private health care programs, they serve to illustrate the vulnerability of our health care system. The investigation of these and other cases and our extensive review of current federal and state enforcement efforts lead us to conclude that major deficiencies exist in our defenses against health care fraud, allowing billions of dollars to be lost each year to fraud and abuse. We further conclude that as our health care system moves toward a managed care model, even greater opportunities for fraud will occur, exposing our health care system to even greater dollar losses.

A. Major Patterns of Fraud Exist Throughout the Entire Health Care System and Patterns of Fraud Within Some Provider Groups Have Become Particularly Problematic

Our investigation concluded that vulnerabilities to fraud exist throughout the entire system, affecting federal, state, and private health care plans alike. Major patterns of abuse that continue to plague the health care system are overbilling, billing for services not rendered, unbundling and upcoding services to receive higher reimbursements, providing inferior products, paying kickbacks and inducements for referrals of patients, falsifying claims and medical records to receive excessive reimbursement or to fraudulently certify a patient's eligibility for Medicaid, Social Security disability, or state welfare programs.

While these practices exist throughout the health care system and are perpetrated against both public and private health plans, our investigation found that health care schemes used to victimize payers and patients have become more complex and frequently involve regional or national corporations and other organized entities. No part of the health care system is exempt from these fraudulent practices, however, our investigation raises concerns that major patterns of fraud and abuse have existed in the following health care sectors: ambulance and taxi services, clinical laboratories, durable medical equipment suppliers, home health care, nursing homes, physicians, psychiatric services, and rehabilitative services in nursing homes. Our investigation further concludes that fraud and abuse is particularly rampant in Medicaid, and that many of the fraudulent schemes that have preyed on the Medicare program in recent years are now targeting the Medicaid program for further abuse.

We are continuing to investigate specific fraudulent schemes, particularly with regard to Medicaid and Medicare fraud.

B. Greater Opportunities For Fraud Will Exist Under Health Care Reform

As our health care system moves toward a managed care model, opportunities for fraud and abuse will increase unless enforcement efforts and tools are strengthened. Our investigation concludes that the structure and incentives of a managed care system will result in a concentration of particular types of schemes, such as failure to provide services; quality of care deficiencies; falsification or misrepresentation of professional credentials by providers; subcontractor fraud; submission of false cost data to obtain higher capitation rates; fraudulent or deceptive enrollment practices by health plans; and kickbacks, rebates, and other illegal economic arrangements to increase market share of health care services.

The experiences of several states' Medicaid programs illustrate that managed care systems often provide greater incentives and opportunities for providers to engage in health care fraud.

For example, the Arizona Health Care Cost Containment System Fraud Unit has found that Arizona's Medicaid managed care-style program has been subject to embezzlement of funds paid by the state for client services; fraudulent subcontractors; wire and mail fraud; fraudulent related party transactions; and kickbacks among physicians, osteopaths, home health care facilities, DME suppliers, and physical therapists.

The AHCCCS Fraud Unit concluded that the managed care structure of the Arizona Medicaid program offered opportunities for kickbacks and other types of health care fraud. Similarly, many other states' Medicaid Fraud Control Units have found that states which require their Medicaid beneficiaries to participate in managed care programs have experienced significant incidences of fraud, such as fraudulent marketing techniques and falsification of enrollments of new members to plans, reduced quality of care, improper disenrollment practices, deceptive marketing practices to potential enrollees, and providing substandard care to enrollees in the managed care plans.

These state experiences with HMO's and managed care plans illustrate that comprehensive health care reform incorporating the principles of managed care will exacerbate the opportunities and incentives for providers to engage in fraud and abuse.

Moreover, two other key aspects of health care reform could affect enforcement efforts. First, while uniform, standard claims forms will go far in reducing the complexity of the health care system, these revised claims forms must be designed with enforcement in mind, so that factors can be built in to detect fraud and abuse more easily. Second, electronic billing systems, while again reducing complexity, will eliminate the paper trail that enables law enforcement to track fraudulent practices. Any such system must be designed with safeguards built in to detect and deter fraud and abuse.

C. Current Criminal and Civil Statutes Are Inadequate to Effectively Sanction and Deter Health Care Fraud

Both the Department of Justice and the Department of Health and Human Services endorse strengthening the tools available to prosecute criminal and civil cases. Currently, Federal prosecutors use traditional fraud statutes, such as the mail and wire fraud statutes, the False Claims Act, false statement statutes, and money laundering statute to prosecute health care fraud.

Additional tools, such as penalties for false claims, anti-kickback statutes, and the authority to exclude providers from participation in Medicare and Medicaid, are now available to redress fraud and abuse in the Medicare and Medicaid programs.

Despite the availability of these criminal and civil remedies, our investigation has concluded that several deficiencies exist in the tools available to law enforcement to combat fraud and abuse most effectively in the health care system. For example:

Inordinate Time and Resources Are Devoted to Apply Traditional Fraud and Money Laundering Statutes to Health Care Fraud

While many egregious cases of health care fraud have been successfully prosecuted under the mail and wire fraud statutes, because there is currently no specific federal health care fraud criminal statute available to federal prosecutors, excessive time and resources must be devoted to developing a nexus to the mail and wire fraud statutes in order to pursue clear cases of fraud. Similarly, extensive resources are spent trying to track the cash flow from health care fraud schemes in order to prosecute under federal money laundering statutes. Relying on these more generic federal criminal statutes for prosecution results in an inefficient use of scarce law enforcement resources.

The case of the bogus medical billing service in California which stole over \$1.5 million from insurance companies nationwide before they were arrested by federal agents provides a prime example of how extensive resources are spent on proving a nexus to traditional fraud statutes: the FBI estimates that hundreds of additional investigative staff hours were devoted to proving the trail of expenditures in order to prove money laundering, because a federal health care fraud statute does not exist.

Creation of a new, general health care fraud offense prohibiting schemes to defraud federal or private health plans or persons in connection with the delivery of or payment for health care is necessary to provide a direct response to intentional acts to defraud the health care system.

In addition to providing a more efficient response to health care fraud, the establishment of a federal health care fraud offense sends an important message that health care fraud will be pursued with the same rigor as financial institution fraud, securities fraud, computer fraud, and other areas of white collar crime in which the federal government plays a prominent enforcement role. This type of provision is included in an amendment currently pending on the omnibus crime legislation, as well as in several comprehensive health care reform proposals.

D. Improvements Are Necessary in the Current Medicare and Medicaid Fraud Statutes

Based on our investigation, we find that additional tools are necessary to curb abuse in the Medicare and Medicaid programs. For example, the current remedies for violations of the anti-kickback statute (for kickbacks made to induce the referral of Medicare or Medicaid business) are criminal prosecution and exclusion from the Medicare and Medicaid programs.

It is important to deter kickbacks in order to deter overutilization of health care services, inappropriate "steering" of Medicare or Medicaid patients to more expensive, unqualified, or poorly equipped providers, and giving an unfair advantage to providers who offer kickbacks. When only criminal prosecution and exclusion from participation in Medicare and Medicaid are available as remedies, however, federal law enforcement may be reluctant to impose such sanctions, consequently allowing the illegal activity to go unaddressed.

Therefore, we conclude that civil monetary penalties should also be available as intermediate sanctions for anti-kickback violations in order to ensure that enforcement actions are taken against anti-kickback violations.

Similarly, it is important to provide a range of sanctions for other fraudulent or abusive activities against the Medicare or Medicaid programs, such routine waivers of copayments (except in appropriate circumstances), and the practice of knowingly submitting claims for a higher reimbursement rate than allowed under Medicare (so-called "upcoding"). Providing a full array of enforcement tools against health care fraud will better enable swift, fair responses to health care abuse.

E. Due to Flaws in Enforcement Efforts Of Private Payers, Billions of Health Care Dollars Are Vulnerable to Fraud and Abuse

While the federal government has many authorities available to it to combat fraud and abuse in the Medicare and Medicaid programs, private sector payers are at a greater disadvantage in fighting health care fraud, because they have a more limited set of tools available in their enforcement arsenal.

For example:

Generally, insurers do not have civil monetary penalties or false claims statutes available to them to sanction false claims submitted for reimbursement, false advertising, or false statements made to private health plans.

Further, despite the fact that kickbacks are a common element of many health care frauds against private insurers and health plans, many states do not have adequate anti-kickback statutes in place.

Another major obstacle facing private health plans is the lack of information available on whether a health care provider has been sanctioned for fraud in other parts of the health care system, thus leaving the plans exposed to further fraud and abuse. When a provider has been excluded from participation in Medicare or Medicaid for defrauding the programs, for example, they continue to participate -- and may continue fraudulent activities -- in private health plans.

Finally, private payers generally have less authority to recover overpayments than is available under the Medicare or Medicaid programs.

In addition to these statutory obstacles facing private enforcement efforts, the sheer number of different payers in the current health care system -- now numbering over 1,000 -- results in a multiplicity of different rules, reimbursement policies, claim forms, multiple identification numbers, coding systems, and billing procedures. The complexity of the current health care system allows fraud and abuse to flourish and go undetected, resulting in billions of health care dollars lost to fraud and abuse each year.

F. The Fragmentation of Current Health Care Fraud Enforcement Encourages Exploitation of the System By Fraudulent Providers

A multiplicity of Federal, State and local law enforcement agencies, as well as private health insurers and health plans, are involved in various aspects of the investigation or prosecution of health care fraud. Since fraudulent providers often infiltrate many different health care plans, it is crucial that law enforcement efforts be as coordinated as possible in order to detect emerging trends in health care fraud, fully shut down fraudulent schemes, and prevent them from recurring in other parts of the health care system.

Inadequate collaboration in combatting health care fraud takes a particular toll on the ability of private sector insurers to reduce fraud, and results in higher premiums for all insured. The costs for an individual insurer to investigate fraud and abuse act as a substantial disincentive to investigate -- instead, it is much simpler to increase the overall premiums to cover the losses from health care fraud.

Recently, major efforts have been undertaken to better coordinate federal and state agencies involved in combatting health care fraud and abuse. For example, the Department of Justice and the HHS Inspector General have established an Executive Level Health Care Fraud Policy Group to identify new methods to proceed against health care fraud, identify priority areas for fraud enforcement, and remove bureaucratic obstacles to enforcement efforts. Similarly, the Inspectors General from federal agencies have begun to better coordinate their responses to health care fraud in programs within their jurisdictions.

Our investigation concluded that substantial progress has been made toward coordinating health care fraud enforcement, but that additional steps are necessary to streamline enforcement procedures, share information among public and private health care agencies, and ensure that health care fraud is reported and referred for appropriate enforcement actions.

V. Recommendations

Based on our investigation and findings, we recommend that several reforms be adopted to reduce fraud and abuse throughout the health care system. Specifically, we recommend the following:

1. Establish an all-payer fraud and abuse program to coordinate the functions of the Attorney General, Department of Health and Human Services, and other organizations to prevent, detect, and control fraud and abuse, and to coordinate investigations, and share data and resources with federal, state, and local law enforcement and health plans.
2. Establish an all-payer fraud and abuse trust fund to finance enforcement efforts. Establishing a "revolving fund" to finance enforcement efforts would go far in addressing the current resource problems that plague federal health care fraud enforcement efforts. Fines, penalties, assessments, and forfeitures collected from health care fraud offenders would be deposited in this fund, which would in turn be used to fund additional investigations, audits, and prosecutions. Amounts in this fund would increase, not supplant, the operating budgets of federal law enforcement agencies with jurisdiction over health care fraud.
3. Toughen federal criminal laws and enforcement tools for intentional health care fraud. Specifically, create a federal health care fraud offense; provide criminal forfeiture and civil injunctive relief for health care fraud offenses; establish health care fraud as a predicate to the Racketeer Influenced Corrupt Organizations Act (RICO); and expand the civil False Claims Act to cover claims presented to health plans.
4. Improve the anti-kickback statute and extend prohibitions of Medicare and Medicaid to private payers. Specifically, expand current Medicare and Medicaid anti-kickback statute to private payers and to all federal health care programs; provide civil monetary penalties for anti-kickback violations; and provide injunctive relief for anti-kickback violations.
5. Provide a greater range of enforcement remedies to private sector health plans, such as civil penalties.
6. Establish a national health care fraud data base that includes information on final adverse actions taken against health care providers. Such a data base should contain strong safeguards in order to ensure the confidentiality and accuracy of information contained in this system.
7. Design a simplified, uniform claims form for reimbursement and an electronic billing system, with tough anti-fraud controls incorporated into these designs from their inception.
8. Take several steps to better protect Medicare from fraudulent provider billing practices, such as:
 - revise and strengthen national standards that suppliers and other providers must meet in order to obtain or renew a Medicare provider number;

- prohibit Medicare from issuing more than one provider billing number to an individual or entity (except in specified circumstances), in order to prevent providers from "jumping" from one billing number to another in order to double-bill or avoid detection by auditors;
- require Medicare to establish more uniform national coverage and utilization policies for what is reimbursed under Medicare, so that providers cannot "forum shop" in order to seek out the Medicare carrier who will pay a higher reimbursement rate;
- require the Health Care Financing Administration to review and revise its billing codes for supplies, equipment and services in order to update, clarify, and standardize billing codes. HCFA should be required to improve the descriptions used for reimbursement codes so that they accurately reflect the items being furnished and to make them sufficiently explicit to distinguish between items of varying quality and price. Such an updating of the billing codes used by HCFA would be a major step toward eliminating excessive reimbursements for poor quality items and Medicare reimbursements that far exceed a fair price for the item; and
- provide adequate guidance to health care providers on how to comply with anti-kickback and other health care fraud prohibitions. We recognize that due to the complexity of the health care market, many providers have difficulty interpreting reimbursement policies of public and private health plans, as well as difficulty in determining whether specific relationships with other providers or billing practices are prohibited under anti-fraud provisions. If comprehensive health care reform proposals are enacted, further confusion over what constitutes prohibited activity may result. Therefore, we recommend that the Secretary of HHS, working with the HHS Inspector General and the Department of Justice, develop a system to provide better guidance to health care providers on how to comply with anti-kickback and other health care fraud provisions.

Many of these recommendations are included in health care reform proposals now pending before Senate and House committees. Additionally, the Senate-passed version of omnibus crime legislation, now pending in conference, includes provisions to facilitate criminal prosecution of health care fraud.

While we are pleased that many of these proposals are now under consideration by the Congress, we are deeply concerned that the huge magnitude of health care fraud and the critical importance of improving enforcement efforts immediately has not received adequate attention during the course of the health care reform debate.

With over \$275 million being lost each day to health care fraud and abuse, we can no longer afford to wait to toughen our defenses against unscrupulous providers and others who are bleeding our health care system. Accordingly, we recommend a two-step process:

First, action should be taken immediately to strengthen criminal laws and enforcement tools to stop abuses of our current health care system. Too many dollars and lives are at stake to delay what can and should be done now to reduce health care fraud; and

Second, tough anti-fraud and abuse provisions must be built into the foundation of any health care reform plan enacted by the Congress so that unscrupulous providers will not take advantage of health care reform to further game the system.

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Association of American Physicians and Surgeons, Inc.

STATEMENT TO THE SENATE SPECIAL COMMITTEE ON AGING

HEARING ON HEALTH CARE FRAUD MARCH 21, 1995

PRESENTED BY THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

INTRODUCTION

The Association of American Physicians and Surgeons, Inc (AAPS), was founded in 1943 to preserve and promote private medicine and the sanctity of the patient/doctor relationship in the tradition of Hippocrates. AAPS has lead the fight to maintain honesty and integrity in the practice of medicine, and restrict unnecessary government intrusion in the practice of medicine.

On behalf of the public's right-to-know, AAPS successfully sued the White House to make public the records and deliberations of President Clinton's health care task force under government-in-sunshine laws.

AAPS represents physicians across the country on the front line of providing health care. Because of our commitment to the Hippocratic Oath, we are more concerned than any other parties about illegal and immoral billing practices in the provision of medical care.

As front line physicians, AAPS has first hand knowledge of the problems of the issue of health care fraud, and unique insight into the solutions which will create legitimate, effective reform of health care fraud.

CAUSES OF HEALTH CARE AND INSURANCE FRAUD

Willie Sutton robbed banks because "that's where the money is."

Today, government-run health programs and large managed-care plans are the functional equivalent of banks. To a lesser extent, so are private programs of prepayment for medical costs to insurance companies.

AAPS supports the efforts of the Senate Special Committee on Aging to target and reduce the costs of real abuse and fraud in the health care system.

(more)

But to put a stop to health care fraud, one must understand the cause and mechanism. AAPS suggests the following hypotheses:

1. Almost all fraudulent claims are "assigned"; that is, the "provider" is paid directly by the insurer, not by the patient.
2. A small fraction of fraud is related to the direct provision of lifesaving treatments to those who are seriously ill or injured. A large fraction is for screening tests, elective procedures, or for services and devices for persons who are not acutely ill.

A large fraction is also related to prepayment. First, a huge pool of money is collected, then some funds distributed for sickness care --only after a cut is removed for marketing, administration and profit.

PROBLEMS WITH CURRENT ENFORCEMENT/CODING PROCEDURES

The Investigative Staff Report of Senator William S. Cohen ("Gaming the Health Care System" July 7, 1994) acknowledges that "The vast majority of health care providers are honest and dedicated professionals..."

However, much of the current enforcement effort is directed at the coding practices of those honest individuals trying to make a living while abiding by ever changing and Byzantine regulations. The side effects:

1. Corruption in the system tends to protect the most egregious offenders; as demonstrated by the repeat offenses of the Philadelphia cardiologist cited in the investigative report, totalling millions over thirteen years.
2. The system of rewarding enforcers (incentives or "bounties," especially forfeiture) has led to outrageous abuse of power by government agents.
3. The system has become so terrifying that many physicians would be well advised to avoid participation. Factors include ambiguous rules, administrative law that deprives the accused of basic rights, paid informants, draconian fines for trivial errors and routine tactics of intimidation.

The Investigative Report of the Special Committee cites 50 case samples of true abuse. AAPS can match each of those with a case of an honest practitioner unfairly prosecuted for inadvertent mistakes or victimized because of inconsistent interpretation of coding regulations.

(More)

For example:

Edgardo Perez-DeLeon of Michigan. Mr. Perez-DeLeon, former office manager for his wife's internal medicine practice was convicted of 12 felony count of Medicaid False Claims and Health Care False Claims Offenses.

His crime? He coded patient visits as "office visits," even though there was no physical examination performed. The coding was the closest match available consistent with recommended manuals.

His punishment? One year in jail, while the family house was threatened with foreclosure and their children were sent back to Puerto Rico to live with family because they couldn't afford to support them. To this date, Mr. Perez-DeLeon has not been able to get a clarification of the official interpretation of "office visit."

PROPOSED SOLUTIONS

Current enforcement, while improved in cases of legitimate fraud, has been ineffective. Placing FBI officers or paid informants in every medical office would be tremendously expensive and oppressive, but without solving the basic problem.

AAPS agrees that the opportunity for fraud will increase under health care reform if a managed care model is adopted or strengthened. To paraphrase Sen. Robert Dole stated in his response to the Investigative Report, "Kind of scares you to think what would happen if we had a totally government-run (health-care) system,"

AAPS proposes these additional fraud prevention measures: for consideration:

1. Limit the moral hazard of insurance by restoring the principle of insurance as coverage for catastrophes, not prepayment for routine, budgetable expenses.

Remove the tax incentives that favor prepayment schemes which also punish those who choose to purchase true insurance plus self-insurance (i.e. Medical Savings Accounts) for smaller bills.
2. Pay benefits directly to beneficiaries, not providers.

CONCLUSION

AAPS supports the efforts of the Senate Special Committee on Aging to reduce fraud and abuse in the health care system if it includes provisions to eliminate the opportunities for fraud, not just step up enforcement.

If you want to stop the Willie Suttons from robbing the bank, stop giving them a blank check. Removing the incentive will work much better than retroactive enforcement. It will also preserve the rights of the innocent and reduce the cost of medical care.



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**Testimony
 of the
 American Health Care Association
 on
 Health Care Fraud, Abuse, and Waste
 Submitted to the
 Special Committee on Aging
 U.S. Senate
 March 21, 1995**

The American Health Care Association (AHCA) appreciates the opportunity to submit testimony on the issue of fraud, abuse and waste in the health care industry. AHCA is a federation of 51 affiliated associations representing over 11,000 non-profit and for-profit nursing facility, residential care, and subacute providers nationally.

As the largest association representing long term care providers, with over 1 million nursing facility residents nationwide, AHCA supports efforts to combat fraud and abuse in health care. We have had extensive discussions with the Aging Committee members and staff about this issue and support your work to eliminate this drain on our health care system. The intent of this testimony is to share with the Committee AHCA efforts to combat fraud, abuse and waste. We look forward to the opportunity when we can discuss specific legislative proposals to clamp down on fraud and abuse.

ENFORCEMENT

AHCA consistently supports efforts to increase fines and penalties against individuals who are convicted of committing intentional health care fraud. We further support provisions, such as those in The Health Care Fraud Prevention Act of 1995 (S.245), that increase the tools available to regulators to punish those who are responsible for committing health care fraud.

The Association also works to assist regulators uncover fraud and abuse. Numerous allegations of fraud and abuse have been reported to us by our members. We respond by putting them in touch with the proper authorities.

Additionally, AHCA publications periodically notify members how to report suspected acts of fraud.

EDUCATION

While enforcement activities are important in combating fraud and abuse, certain problems such as unintentional miscoding or improper billing instances that result from the complexity of the billing process can be remedied through guidance and education. Medicare and Medicaid regulations are extremely complex and compliance is not always easily determinable. For example, rules governing Medicare billing for therapy services are so complex and unclear that the Health Care Financing Administration (HCFA) had to issue additional guidance clarifying its original guidance to its fiscal intermediaries.

The breadth and lack of clarity of the current fraud and abuse laws also adds to the uncertainty for providers working to develop innovative, lawful arrangements for the delivery of long term care services. AHCA fundamentally believes that the vast majority of long term care providers seek to provide high quality services and operate within the law. Education and guidance will resolve many of the existing problems.

AHCA also believes that it must act in partnership with the Federal government to educate providers. AHCA reprints relevant Fraud Alerts issued by the Department of Health and Human Services (HHS) in our publications. We have found that the HHS's procedure for getting fraud alerts nationally is somewhat cumbersome and often slow, depending on where the potentially fraudulent practice is discovered or reported. AHCA encourages all of its members to forward fraud and abuse information to AHCA as soon as they are notified or made aware of such practices or schemes by their regional HCFA office, Medicare and Intermediary Fraud Unit or Medicaid Fraud Unit. This important information is then disseminated by the Association to provider members nationwide in a timely manner.

We also provide other types of guidance to our members so they can comply with current law and are aware of fraudulent schemes. They include:

- disseminating relevant Inspector General and General Accounting Office reports to AHCA leadership and state affiliates, and publicizing the reports to the membership;
- providing legal analysis and advice on compliance with new laws and regulations; and
- when identifying an area of potential fraud, publishing a comprehensive review of proper billing procedures (as was recently done on therapy billing practices).

IMPROVED BILLING SYSTEM

A small minority of long term care providers can commit health care fraud because Medicare's antiquated reimbursement system for skilled nursing facilities (SNFs) is riddled with uncertainty and ripe for exploitation. Services provided in SNFs are reimbursed under a patchwork of reimbursement systems and methodologies. For example, certain services such as nursing, that are billed under Part A and capped by the Routine Cost Limits, while other services are outside the limits. Physical Therapy services provided under contract are limited to Salary Equivalency Guidelines while other therapy services are not. Billing for therapy can occur by either the SNF or the supplier of a service. The list of complex billing procedures for SNF services is extensive.

A major step toward injecting rationality into SNF reimbursement is to implement a prospective payment system (PPS) for Medicare SNF services. Senator Pryor introduced an AHCA modeled PPS system in the 103rd Congress and we are working with his office on its reintroduction. While a PPS does not fix all the billing problems, it goes a long way toward creating a more uniform and accountable billing system. AHCA has advocated a PPS for years. Many states have taken this step. Congress has directed HCFA to develop a PPS and we welcome the Committee's support in making it a reality.

AHCA is also working with the other committees in Congress, and with HCFA on additional reimbursement changes. For example, we are working to develop a consolidated billing mechanism for all residents' Part B supplies and services through the nursing facility. Centralized billing will give nursing facilities greater accountability for services provided to its residents. It will also make it easier for HCFA to monitor the provision of Part B services.

RESIDENT EMPOWERMENT

The greatest tool to combat fraud, abuse, and waste is to give the residents of nursing facilities and their families a more powerful role in the delivery of care. To that end, AHCA is pursuing a Total Quality Management (TQM) program for facilities. The goal of this program is to eliminate the environment of isolation for residents that breeds fraud, abuse, and waste by fostering a climate that gives residents and their families a greater voice in the operation of nursing facilities.

Two years ago AHCA embarked on a quality initiative to create a new system for defining, measuring, and communicating information about the quality of long term care. The proposed system is rooted in the principles of TQM, and will rely on the use of customer satisfaction data to measure quality of life. AHCA has one full-time employee working with our state affiliates and nursing facility members to implement this initiative.

In addition, AHCA is working jointly with HCFA on a pilot program which substitutes the traditional survey process with TQM measurements of care in selected facilities nationwide for one year. This project will serve as a model for the nursing facility of the future where residents and their families are partners with the facility in assessing and redefining care. Such a dynamic system will create an environment where fraud, abuse, and waste can be easily detected and eliminated.

CONCLUSION

AHCA appreciates the opportunity to provide this testimony on our efforts to combat fraud, abuse, and waste in the long term care industry. AHCA supports greater enforcement by regulators and has directed our members, who uncover alleged fraudulent activity, to the proper authorities. To reduce the environment for health care fraud, AHCA is informing our members about proper billing procedures and fraudulent schemes, and is advocating a more rational Medicare reimbursement system. Finally, AHCA is working to eliminate fraud, abuse, and waste by promoting a TQM system for nursing facilities that give residents and their families a greater voice in the delivery of care. We look forward to working with the Committee on this and other issues.



STATEMENT OF THE
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION
TO THE
SPECIAL COMMITTEE ON AGING
U.S. SENATE
MARCH 21, 1995

The American Occupational Therapy Association (AOTA) appreciates the opportunity to submit testimony on the issue of fraud and abuse in the health care industry.

AOTA represents the professional interests of over 50,000 occupational therapy practitioners. Occupational therapy practitioners provide services to millions of people of all ages each year -- including Medicare beneficiaries -- in hospitals, nursing facilities, outpatient rehabilitation clinics, psychiatric facilities and school systems; through home health agencies and the office of independent practitioners.

AOTA strongly supports the efforts of Congress to eliminate fraud and abuse in the health care system and we applaud the Committee for holding hearings to focus attention on this serious problem. The Association would like to share with the Committee reports from our members over the past several months concerning allegations of fraud and abuse in the Medicare system; and actions the Association has taken to assist our members and appropriate authorities in dealing with these allegations.

Allegations of Fraud and Abuse

The Association has received a substantial number of reports from our members over the past 18 months concerning allegations of fraud and abuse in the Medicare system. Our members have written and called the Association with concerns about what they characterize as pressures from their employers to engage in activities which the member believes are inappropriate - because the member believes the requested action is unethical or illegal.

According to these member reports, employer requests have included: requirements to meet productivity standards without concern for the quality of care to be provided; pressure to provide inappropriate treatment; requests to falsify treatment records; inappropriate or inadequate supervision of staff; and extraordinarily high price "markups" on medical equipment and medical treatment. Although AOTA does not have the capacity to verify the accuracy of these complaints, we must assume that they are valid concerns of our members. As such they indicate troublesome developments in the delivery of health care services to the public that will adversely impact the Medicare program.

Many occupational therapy practitioners have contacted the Association to say that they have resigned from their positions because of "unethical billing or practice policies" while others are unable to leave their positions for financial reasons and are seeking assistance from the Association on how to respond to these problems. The following illustrates the types of incidences of fraudulent and unethical behavior reported by occupational therapy practitioners.

- ◆ Several AOTA members have described abuses that have occurred as a result of what they have termed the "profit motive" where their employers are focused on the number of units of care they can bill for rather than appropriate patient care. The therapy practitioner is pressured by the employer to "get their units up" or is reprimanded when their "units for this month are down." Reward systems are based on the number of units per month the practitioner bills for, rather than whether the practitioner provided appropriate care for a patient. Managers intervene to "identify" patients who need occupational therapy, if the practitioner does not identify enough patients. Some occupational therapists have observed that pressure to "get more units" has resulted in inaccurate reporting about the amount of time spent with patients, and evaluations for patients never seen.
- ◆ Similarly, several occupational therapy practitioners reported of incidences of "building a caseload" by using unsupervised assistants to deliver care and billing for these services as if they had been done by a licensed occupational therapist or under appropriate supervision, and of directions from the employer for the nursing facility to assign occupational therapy to patients the occupational therapists determined had no rehabilitation potential.
- ◆ Several occupational therapists described double billing practices. The skilled nursing facility (SNF) bills for services under Part A, Medicare, while the employer contracted by the SNF also bills for the same services under Medicare Part B. Several occupational therapy practitioners also reported the billing of inappropriate indirect costs.
- ◆ One incident of inappropriate use, and overpricing, of durable medical equipment was reported by an occupational therapist serving as a consultant to a nursing home regarding all splinting needs of the patients. A vendor of durable medical equipment offered to supply splints to the nursing home free of charge, billing Medicare directly. In this occupational therapist's professional judgment, the splints were inappropriately prescribed in many incidences and grossly overpriced (\$300 for a hand splint, \$500 for an elbow splint). The occupational therapist presented a case by case explanation to the director of nursing for incidences where the use of splints would be inappropriate for the patient, and in some cases harmful, but they were ordered anyway. The occupational therapist appealed to the administrator of the nursing home who referred the occupational therapist back to the director of nursing. This occupational therapist refuses to keep track of these devices in her reporting, so they are tracked and reported separately. In similar incidences, other occupational therapists have reported of instances where they have been required to order splints they have not prescribed, even for terminally ill patients.

AOTA is deeply concerned about these allegations. The Association strongly condemns exploitation of the Medicare program by dishonest or unscrupulous individuals or companies. We are hopeful that these individuals or companies represent a minority of the rehabilitation industry.

AOTA Responds to Members

AOTA has taken a number of actions to assist our members and appropriate authorities in dealing with these allegations. Among the steps the Association has taken:

- ◆ We have contacted the Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services to inform them of the allegations passed on to us and to seek advice on what our members should do when they are under pressure by their employers to engage in what they believe to be unethical, inappropriate or illegal activities relating to the Medicare program.

- ◆ The Association's leadership has met with officials from the Health Care Financing Administration (HCFA) to convey our deep concern about allegations of fraud and abuse. We have offered to assist the agency in any way possible to protect the Medicare program and beneficiaries from fraudulent and abusive activities and to assure quality of care.
- ◆ Under the direction of the Association's leadership and its Commission on Standards and Ethics (SEC), we have implemented a broad member education and assistance initiative to inform our members of this issue and to clarify their legal and ethical obligations as health care professionals. Through the Association's publications and continuing education events, we have widely disseminated fraud and abuse alerts and related materials from the national and regional offices of the HHS Office of Inspector General (OIG) and have had OIG representatives address the membership at our annual conference. We have also enhanced staff resources at the Association's national office dedicated to providing counsel to our members on ethics issues. The Association, through the SEC, has taken the position that along with the duty to deliver quality services, occupational therapy practitioners have an equal duty to assure that fees charged for services are both fair and equitable.
- ◆ To ensure maintenance of the Code of Ethics and adherence by AOTA members, the Commission on Standards and Ethics has developed procedures for the investigation and adjudication of alleged ethical violations. The American Occupational Therapy Certification Board (AOTCB), the national credentialing agency that certifies occupational therapists and occupational therapy assistants under the leadership of its Disciplinary Action Committee also has procedures for the investigation and adjudication of complaints regarding persons whose behavior reflects incompetence, unethical behavior and impairment. Both AOTA and AOTCB actively and expeditiously investigate cases brought to our attention alleging health care fraud and abuse by members of our profession.

Medicare System Changes are Required

When examining claims of fraud and abuse, the Committee must recognize that there are inherent problems in the Medicare system. Procedures for billing for Medicare services are extensive and complex. Formulas for billing vary depending on the type of services and settings in which they are provided. Some services are cost-based, while others are charge-based. Such variations inevitably lead to confusion and opportunities for abuse. The Association believes that these systems must be streamlined and simplified and that appropriate utilization review and cost containment mechanisms be imposed. Utilization review practices should involve skilled health care professionals, trained in the services provided, for monitoring appropriate patient care and ensuring adequate access to specialty care. The system must ensure consistency across health care settings for the patient. Mechanisms for coordinating the delivery of care among different providers, so as to enhance continuity of care for the patient, must be required. Cost containment incentives must ensure patient's receive appropriate and quality care.

Finally, the Medicare system, as well as all other payers of these health care services, should be required to have appropriate consumer safeguards in place. Empowering nursing home residents and their families by giving them a greater voice in the operation of the nursing facility, in understanding and deciding the services they receive, and in reviewing the billing for their services will go a long way to assist in scrutinizing the delivery of appropriate health care services.

The Association and our 50,000 members are committed to providing the public with quality occupational therapy services in a cost-effective manner. We are also committed to helping maintain the integrity of the Medicare system. We applaud efforts to combat Medicare fraud and abuse by the Congress. We appreciate the Senate Special Committee on Aging's attention to this issue. We will support and work to secure Congressional approval of constructive proposals to achieve those ends.

We appreciate the opportunity to submit this statement for the record, and look forward to working with the Committee on the issue of fraud and abuse in the health care industry.



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**Statement
of the
American Orthotic and Prosthetic Association
on
Health Care Fraud
submitted to the
Senate Special Committee on Aging
March 21, 1995**

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The American Orthotic and Prosthetic Association (AOPA) is pleased to submit this statement on the issue of health care fraud and abuse for the record of the March 21, 1995 Senate Special Committee on Aging hearing on "Gaming the Health Care System: Trends in Health Care Fraud." AOPA is the national membership organization representing the approximately 1,600 allied health care provider firms who serve the needs of the physically challenged throughout the United States. Orthotic and prosthetic (O&P) practitioners employed by AOPA member firms design and fit orthoses (braces) and prostheses (artificial limbs) which enable these physically challenged individuals to overcome often serious and crippling injuries and return to productive lives.

As the largest association representing orthotic and prosthetic providers, AOPA supports efforts to combat fraud and abuse in health care. Many O&P patients are Medicare beneficiaries and AOPA agrees with the belief that health care fraud and abuse, especially in the Medicare system, must be eradicated.

HHS OIG Report on Body Jackets

AOPA supports the findings of the Health and Human Services (HHS) Office of Inspector General (OIG) in its June, 1994 report on "Medicare Payments for Orthotic Body Jackets." We are extremely pleased that the OIG consulted with certified orthotists to determine the purpose of a body jacket and how one should be constructed.



BRONZE MEDAL SPONSOR

This report is referenced in the Inspector General's testimony before this Committee, as an example of the OIG's targeted reviews of specific items that have experienced a significant increase in claims and payments over a short period of time.

Unfortunately, the Inspector General failed to mention that 5% of the "orthotic body jackets" that were determined to be "legitimate" claims were provided by ABC-certified orthotists "whose primary occupation is supplying orthotic...devices to patients. The non-legitimate body jackets in our sample were supplied by Durable Medical Equipment (DME) suppliers that primarily supply DME equipment and supplies, not orthotics." OIG Report, page 4.

Orthotic and Prosthetic Certification

The critical difference between the DME and the O&P provider is the level of education and training needed to provide comprehensive O&P services. Comprehensive orthotic and prosthetic care requires highly specialized and trained practitioners who design, fit and fabricate a customized artificial limb or orthopedic brace for the particular needs of each patient.

These highly specialized services combine the disciplines of medicine and engineering unique in most areas of health care. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes and complex contours, is fundamentally different from most types of durable medical equipment which tend to be more generic, pre-fabricated, and less clinically intensive to provide.

The O&P profession has a defined body of clinical and technical knowledge. The profession consists of a core of over 3,000 certified practitioners with formalized education provided by well established baccalaureate and post-baccalaureate education programs offered at eight major American universities.

The American Board for Certification in Orthotics and Prosthetics (ABC) offers a high level of credentialing standards for orthotists and prosthetists. It is the most widely recognized credentialing organization for O&P services. ABC was founded in 1948 and conducts a comprehensive credentialing process for both orthotists and prosthetists as well as facilities in which they provide their clinical and technical services.

ABC-certified orthotists and prosthetists are the only O&P practitioners recognized by the American Medical Association (AMA) as true orthotic and prosthetic allied health professionals. ABC certification is required by the Department of Veterans Affairs (DVA), various state agencies and third party payers.

The ABC awards practitioner accreditation in three categories, Certified Orthotist (C.O.), Certified Prosthetist (C.P.) and Certified Prosthetist/Orthotist (C.P.O.). The current minimum entry level requirements for practitioner education and certification are:

- o a bachelor of science degree in orthotics and prosthetics or a bachelor of science degree in a related allied health or engineering field along with successful completion of specific undergraduate courses in orthotics and prosthetics at accredited schools;
- o a one year clinical residency in each discipline; and
- o successful completion of a comprehensive written, oral and clinical examination for practitioners administered by the American Board for Certification in Orthotics and Prosthetics.

ABC certification must be renewed every five years. Practitioners who maintain their skills and knowledge by attending continuing education courses are entitled to renew their certification.

These stringent standards help ensure that ABC certified O&P practitioners are competent to provide the full range of comprehensive O&P care to patients. The high level of education and training helps assure quality in the integral clinical service element of the delivery of O&P devices.

Conditions of Coverage

AOPA requests that the Special Committee consider the recognition of provider credentials in the delivery of quality O&P care when attempting to legislatively stem fraud and abuse in the Medicare program. We strongly believe one of the most effective ways to check the type of fraud and abuse found with orthotic body jackets would be to establish conditions of coverage for reimbursement under orthotic and prosthetic codes. If reimbursement of O&P services were limited to qualified orthotists and prosthetists who are certified to provide these services, HCFA would dramatically reduce the likelihood of future incidents of fraud and abuse similar to the body jacket situation.

Currently almost any provider who obtains a Medicare billing number can submit a claim for O&P reimbursement. But rather than limit access to the O&P codes to qualified O&P practitioners, in September, 1994, HCFA further expanded the range of providers eligible for reimbursement under the L-codes. HCFA now recognizes and allows "anyone credentialed by any certification organization in orthotics and prosthetics" to acquire an O&P provider specialty code and use the O&P codes in submitting O&P reimbursement claims.

It appears that HCFA has no substantive restrictions or apparent monitoring procedures as to who is qualified to submit O&P claims under the Medicare program. The recent Medicare policy change only increases the likelihood of fraud and abuse and provides little or no control to O&P code access.

For these reasons the organized field of orthotics and prosthetics recommends that conditions of coverage be established under Medicare for the provision of O&P products and services. A definitional standard similar to the one used by HCFA for physical therapists could be incorporated easily into HCFA administrative policies for orthotists and prosthetists.

In the alternative, HCFA could grant approval to all O&P facilities that meet the standards for ABC accreditation. Such accreditation includes physical facility requirements and the prerequisite that an ABC-certified practitioner be employed full time.

Conclusion

AOPA welcomes the opportunity to continue to work with the Special Committee on Aging to eliminate fraud and abuse in the health care system and to ensure the provision of the highest quality orthotic and prosthetic care. Thank you.



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WRITTEN TESTIMONY
OF THE
**NATIONAL ASSOCIATION FOR THE ADVANCEMENT OF
ORTHOTICS AND PROSTHETICS**

REGARDING FRAUD AND ABUSE IN
HEALTH CARE PROGRAMS

INTRODUCTION

The National Association for the Advancement of Orthotics and Prosthetics (NAAOP) is a national, non-profit organization comprised of orthotic and prosthetic health care practitioners (orthotists and prosthetists) who clinically and technically design, fit, and fabricate orthopedic braces and artificial limbs (orthotics and prosthetics) for this nation's two million amputees and other people with physical disabilities requiring orthotic and prosthetic care. Quality orthotic and prosthetic care can be extremely cost-effective by enabling people with disabilities to achieve high levels of independence and function in the workplace, in the home, and in all aspects of community life. Appropriate orthotic and prosthetic care also helps prevent secondary disabilities and decreases long term health and welfare costs to society.

NAAOP submits this testimony for the written record of this hearing on fraud and abuse in health care programs. Although our written remarks focus exclusively on the Medicare program, the statements and recommendations contained in this testimony apply throughout all health care programs, both public and private. Recently, Congressman Bill Thomas (R-CA), Chairman of the House Ways & Means Health Subcommittee, held hearings on the cost drivers in the Medicare program. The Office of Inspector General (OIG) testified that fraud and abuse was a significant factor for increased costs in the Medicare program and cited the OIG investigation of orthotic body jackets as a prime example.

NAAOP specifically requests this Committee to recognize the differences between durable medical equipment and orthotics and prosthetics when attempting to ferret out fraud and abuse in health care programs. Orthotic and prosthetic services are reimbursed under Part B of the Medicare program through a fee schedule known as the "L-codes." Although the four recently-created Durable Medical Equipment Regional Carriers (DMERCs) currently administer reimbursements for orthotics and prosthetics under the Medicare program, there is a major distinction between durable medical equipment (DME) and orthotic and prosthetic (O&P) services that justifies separate consideration and treatment when regulating these sectors of the health care field.

NAAOP's written testimony addresses this important distinction by highlighting the following issues:

- (a) the importance of ABC certification and accreditation in the delivery of quality, comprehensive O&P services,
- (b) the importance of legislative and regulatory separation of durable medical equipment from orthotics and prosthetics,
- (c) the inappropriate reclassification of orthotic seating system L-codes to durable medical equipment K-codes,
- (d) NAAOP's perspective on the OIG report regarding orthotic body jackets,
- (e) the importance of conditions of coverage to qualify for coverage and reimbursement under the Medicare program.

ENSURING QUALITY ORTHOTIC AND PROSTHETIC CARE

Practitioner Education

A critical distinction between the provision of durable medical equipment and the provision of orthotic and prosthetic services entails the level of education and training necessary to provide comprehensive O&P services. Comprehensive orthotic and prosthetic care requires highly specialized and trained practitioners in order to design, fit and fabricate a customized artificial limb or orthopedic brace for the particular needs of each patient. These highly specialized services combine the disciplines of medicine and engineering like almost no other area of health care. The successful custom replication and restoration of functional human body parts, which are in a multitude of shapes, sizes and complex contours, is fundamentally different from most types of durable medical equipment which tend to be more generic, pre-fabricated, and less clinically intensive to provide.

In addition, significant variation exists in the delivery of quality orthotic and prosthetic services, primarily due to the range of physical disabilities orthotic and prosthetic care can benefit and the explosion of technology over the past decade. To keep abreast of clinical and technological developments, individual practitioners participate in continuing education, research, and the frequent exchange of information among professionals. The orthotic and prosthetic profession has a defined body of clinical and technical knowledge and a core of over 3,000 specially credentialed practitioners with formalized education provided by well-established baccalaureate and post-baccalaureate education programs offered at eight major American universities.

Certification and Accreditation

Currently, the American Board for Certification in Orthotics and Prosthetics (ABC) offers the highest level of credentialing standards for orthotists and prosthetists and is the most widely recognized credentialing organization for orthotic and prosthetic services. ABC was founded in 1948 and conducts a comprehensive credentialing process for both orthotic and prosthetic practitioners as well as facilities in which they provide their clinical and technical services.

ABC-certified orthotists and prosthetists are the only orthotic and prosthetic practitioners recognized by the American Medical Association (AMA) as true orthotic and prosthetic allied health professionals. The education requirements for ABC certification are the only educational pathways recognized by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) and the U.S. Department of Education.

The ABC awards practitioner accreditation in three categories, Certified Orthotist (C.O.), Certified Prosthetist (C.P.), and Certified Prosthetist/Orthotist (C.P.O.). The minimum entry level requirements for practitioner education and certification are:

- (a) a bachelor of science degree in orthotics and prosthetics or a bachelor of science degree in a related allied health or engineering field along with successful completion of specific undergraduate courses in orthotics and prosthetics at accredited schools,
- (b) one year of clinical residency in each discipline, and
- (c) successful completion of a comprehensive written, oral, and clinical examination for practitioners administered by the American Board for Certification in Orthotics and Prosthetics.

These stringent standards help ensure that ABC-certified orthotic and prosthetic practitioners are competent to provide the full range of comprehensive O&P care to patients with a multitude of varying disabilities. This high level of education and training helps assure quality in the clinical service element inherent in the delivery of these highly technical customized devices.

The Service Element of Orthotic and Prosthetic Care

Quality orthotic and prosthetic care is as much a professional service as it is a device that results from this service. While there is a service component in the delivery of some types of durable medical equipment, such as the design of customized wheelchairs and the delivery of certain home health services, orthotic and prosthetic care is generally far more service-oriented and specialized to the needs of each patient. Yet, when Congress and the Health Care Financing Administration (HCFA) have regulated durable medical equipment in the past, through fraud and abuse and reimbursement reforms for instance, they have tended to blindly cast the same net over the very different fields of orthotics and prosthetics.

The lack of separate treatment between DME and O&P has resulted in widespread confusion and limited understanding of this small but critical component of rehabilitation in our health care delivery system. This failure to separately address DME and O&P often creates unintended consequences and unfairly punishes the orthotic and prosthetic fields for problems in other areas of the health care delivery system. Two recent examples of this is the inappropriate reclassification by HCFA of custom orthotic seating systems as "inexpensive/routinely purchased" DME and the fraud and abuse orthotic body jacket investigation conducted by the Office of Inspector General.

HCFA'S RECLASSIFICATION OF ORTHOTIC SEATING SYSTEMS AS DME

Custom orthotic seating systems are designed and fabricated to meet the unique needs of people with severe physical disabilities requiring seating support usually associated with long term wheelchair use. Custom orthotic seating systems are needed in this instance to avoid serious health complications--such as decubitus ulcers and spinal collapse--and to maintain functional activities of daily living. Depending upon the severity of the patient, these customized orthoses range in cost from a few hundred to several thousand dollars. Until recently, HCFA reimbursed these orthoses using an orthotic L-code and individually considered each device to determine a reasonable fee.

With the creation of Medicare's Durable Medical Equipment Regional Carriers, these custom seating orthoses were inappropriately reclassified as "inexpensive/routinely purchased" durable medical equipment and assigned three different "K-codes," obviously not part of the orthotic and prosthetic L-code system. Instead of individually considering the fee for each custom seating orthosis claim, HCFA and the DMERCs now reimburse claims for these devices at a fixed allowable fee, regardless of the level of complexity involved in designing and developing the individual orthosis. Despite the fact that the descriptions for these three new K-codes include the words, "orthotic" and "custom fabricated,"--which clearly demonstrate the propriety of reimbursing these devices under the L-code system--they continue to be treated as "one size fits all" durable medical equipment.

The DMERCs have recently stated that this action was taken because these custom orthotic seating systems are merely permanent accessories to wheelchairs and are not transferable. While custom orthotic seating systems are often fabricated to mount onto a wheelchair, the DMERC's rationale fails to consider the frequent use of these devices, particularly among children, as transferable between wheelchairs, as car seats, and in a variety of other situations, including allowing one to sit independently supported at a table to eat a meal.

HCFA and the DMERCs have been fully informed of this problem throughout the past several months, but have failed to remedy the situation to date. As a result, some of the very specialized orthotists who fit and fabricate these orthoses have begun to deny these services to Medicare beneficiaries. We point to this situation as an example of the problem of not recognizing the separate treatment of DME from orthotics and prosthetics. We request this Committee, HCFA, and the DMERCs to consider reincorporating these newly-created K-codes into the L-code system where custom orthotic seating systems truly belong and determining fees for these orthoses based on individual consideration of each claim.

THE OFFICE OF INSPECTOR GENERAL'S REPORT AND TESTIMONY

The Office of Inspector General (OIG) recently testified before the House Ways & Means Health Subcommittee on the issues of fraud and abuse in the area of durable medical equipment generally, and specifically as to the investigation of "orthotic body jackets." The OIG testified that "payments for [orthotic body jackets] went from \$217,000 in 1990 to \$18 million in 1992. We estimated that 95% of those payments were for devices more properly categorized as [prefabricated wheelchair] seat cushions, rather than body jackets."

Seat cushions are items of durable medical equipment that cost Medicare \$200 to \$300 per unit. An "orthotic body jacket" is a thoracic-lumbar-sacral orthosis (TLSO) designed for the treatment of spine or trunk musculoskeletal disorders such as fractures, spinal cord injuries, post surgical stabilization, scoliosis, congenital deformities, etc. The custom design and fitting of a TLSO requires sufficient medical knowledge of these complex disorders for one to possess the clinical and technical skills necessary to provide this complex and comprehensive orthotic service.

This type of orthotic body jacket is identified as L-0430 in the Medicare O&P reimbursement system and has a reimbursement value of approximately \$1,000 to \$1,200. According to the OIG report, unscrupulous providers began submitting claims for simple seat cushions using the L-0430 reimbursement code in 1990. By the time HCFA identified this fraud and abuse, \$18 million in fraudulent claims had been reimbursed under this L-code in 1992 alone.

What the Inspector General did not mention was that the 5% of "orthotic body jackets" that were deemed by the OIG report to be "legitimate" claims were, in almost every instance, provided by certified orthotists "whose primary occupation is supplying orthotic and prosthetic devices to patients. The non-legitimate body jackets in our sample were supplied by Durable Medical Equipment (DME) suppliers that primarily supply DME equipment and supplies, not orthotics." OIG Report , p.4.

THE IMPORTANCE OF CONDITIONS OF COVERAGE

Recognition of provider credentials in the delivery of quality orthotic and prosthetic care is a critical point that we strongly request this Committee consider when attempting to legislatively ferret out health care fraud and abuse in the Medicare program. NAAOP believes that an effective way to curb the type of fraud and abuse that occurred with orthotic body jackets would be to establish conditions of coverage for reimbursement under the orthotic and prosthetic L-codes. By limiting reimbursement of orthotic and prosthetic services to qualified orthotists and prosthetists who are certified to provide these services, HCFA could dramatically reduce the likelihood of this type of fraud and abuse in the future, as well as the additional costs of pursuing and adjudicating these fraudulent claims.

Currently, as a practical matter, any provider who obtains a Medicare billing number can submit a claim for orthotic and prosthetic reimbursement. Until 1992, HCFA's Medicare carriers manual on orthotics and prosthetics specifically referenced the ABC-certified orthotist and prosthetist regarding coverage and reimbursement. HCFA changed its policy to allow O&P reimbursement to any provider credentialed by a membership organization of the National Organization for Competency Assurance (NOCA). NOCA is not a credentialing organization, but rather a membership organization open to all organizations interested in credentialing issues.

HCFA realized its error in recognizing the NOCA, but instead of limiting reimbursement to practitioners qualified to provide comprehensive orthotic and prosthetic care, HCFA further expanded the range of providers eligible to provide O&P services reimbursable under the Medicare L-codes in September 1994. HCFA now recognizes and allows "anyone credentialed by any certification organization in orthotics and prosthetics" to acquire an O&P provider specialty code and use the L-code designations in submitting O&P reimbursement claims.

NAAOP believes the creation of orthotic and prosthetic conditions of coverage under the Medicare program would serve to promote quality control of orthotic and prosthetic health care services provided to Medicare beneficiaries and would lead to easy identification of fraudulent and abusive activities by unqualified providers. HCFA should consider reincorporating the ABC practitioner certification and facility accreditation standards into its conditions for O&P coverage and reimbursement. The certification and accreditation standards would include physical facility requirements and the prerequisite of supervision by an ABC-certified practitioner.

CONCLUSION

NAAOP welcomes the opportunity to work with this Committee, the Health Care Financing Administration, and the Durable Medical Equipment Regional Carriers to eliminate fraud and abuse in all public and private health care programs, to appropriately regulate orthotics and prosthetics separately from durable medical equipment, and to ensure the provision of the highest quality orthotic and prosthetic care to amputees and other individuals with disabilities.

Thank you.



Statement
of the
National Association for Medical Equipment Services
on
Health Care Fraud

The National Association Medical Equipment Services (NAMES) is pleased to submit this statement on fraud and abuse in the home medical equipment (HME) services industry for the record. NAMES members comprise more than 2,000 ethical home medical equipment (HME) companies which provide quality, cost-effective HME services and rehabilitation/assistive technology to patients in their homes, where they prefer to be. According to physician prescription, HME providers furnish an extremely wide array of HME and related services to patients in their home, ranging from more "traditional" HME items such as standard wheelchairs and hospital beds, to highly advanced services such as oxygen, nutrition, and intravenous antibiotic therapies; apnea monitors and ventilators; and specialized rehabilitation equipment customized for the unique needs of people with disabilities. Many of these patients are Medicare beneficiaries. NAMES wholeheartedly agrees with the opinion that health care fraud and abuse, especially in the Medicare system, must be eliminated. In testimony numerous times before Congress and this Committee over the last several years, NAMES has stated repeatedly that "even one unscrupulous home medical equipment provider is one too many."

NAMES firmly believes that even one company engaging in unethical business practices tarnishes the reputation of the legitimate HME services industry which truly helps make "homecomings" possible for many Americans. The vast majority of HME providers are reputable, ethical business leaders in their local communities, in whom Medicare beneficiaries can trust. They are not involved in abusive telemarketing or door-to-door schemes, such as delivering unwanted and unneeded equipment to Medicare beneficiaries. As such, NAMES members subscribe to a strict *Code of Ethics* and a *Guide for Conduct*.

According to the Department of Health and Human Services (HHS) Office of Inspector General (OIG) statistics, an extremely small percentage of HME providers were sanctioned by Medicare in recent years -- just 4 percent of total OIG sanctions as of June 1994; and none of them were NAMES members. In fact, former HHS Secretary Louis Sullivan noted in 1991 that the overwhelming majority of HME providers are ethical and legitimate businesses, and commended NAMES in particular for its efforts to curtail abusive business practices. NAMES participation with HCFA, AARP and the OIG in the publication in 1992 of a consumer pamphlet on Medicare fraud shows the HME services industry's commitment to working with the Administration and Congress to help eliminate fraudulent practices in the Medicare program. NAMES also published in 1990 two brochures which explain how consumers can safely rent or purchase HME. These consumer brochures have been widely distributed by HME providers to their clients and others.

NAMES also has been involved actively since 1992 in the National Health Care Anti-Fraud Association (NHCAA) as a member of its Advisory/Liaison Committee. We also work with the HHS OIG and FBI's Health Care Fraud Unit, in their investigation of health care fraud across the country and crimes against Medicare.

Due to the sensitive and personal nature of services provided to consumers by the health care industry, it is essential that every provider be above reproach in the delivery of quality products and services. Legitimate HME providers, who comprise the vast majority of the HME services industry, have a common interest with policymakers — to help stop all unethical HME business practices. This goal can only be achieved, however, through a comprehensive and targeted approach that supports legitimate providers by strengthening the HME industry while also making it extremely tough on “scam” operations to conduct business.

The HME services industry is virtually unique among health care providers in acknowledging problems in its own sector and proposing thoughtful legislative solutions. NAMES takes seriously its mission to promote access to quality HME services and rehab/assistive technology and has devoted significant resources to combat fraud and abuse. From the first public allegations of abusive business practices in the HME services industry, NAMES, through its Ethics Committee, has worked assiduously to eliminate the few unethical providers who damage the reputation of an otherwise upstanding industry.

NAMES worked very closely with the Health Care Financing Administration (HCFA) to establish the four durable medical equipment regional carriers (DMERCs) that now process Medicare DME, prosthetics, orthotics and supplies (DMEPOS) claims exclusively. NAMES efforts in this regard began before HCFA had even developed a Request for Proposal (RFP) for the DMERCs, when a special task force made up of industry experts developed a comprehensive set of recommendations and submitted them to HCFA.

A special component of the DMERCs was the establishment of the National Supplier Clearinghouse (NSC) which is solely responsible for providing supplier numbers necessary for suppliers to bill the Medicare program for DMEPOS. The NSC also conducts post-payment audits for all Medicare DMEPOS claims to detect fraudulent billing practices. NAMES continues to work closely with the NSC and HCFA to strengthen existing safeguards designed to obstruct fraudulent activity.

NAMES most visible legislative effort consisted of working during the 102nd Congress with Rep. Ben Cardin (D-MD), who introduced H.R. 2534, the *Ethics and Treatment of Home Medical Equipment Act of 1991*. This legislation, which was cosponsored by 112 Members of Congress, remains the most far-reaching of all subsequent HME bills introduced in Congress to date. Many provisions and concepts in H.R. 2534 were incorporated into legislation that passed the 102nd Congress in 1992, but were vetoed by then President Bush.

In the 103rd Congress NAMES helped Congress enact legislation — Social Security Act Amendments of 1994 — into law (H.R. 5252 & S.1668), that incorporates many of the provisions contained in HR 2534. Among other provisions, the Medicare Technical Amendments Act establishes national standards for HME suppliers; modifies the OBRA 1990 Certificate of Medical Necessity (CMN) Prohibition, enabling HME suppliers to complete certain paperwork required by HHS; requires advanced payment determinations for customized equipment; and requires HHS to develop standard national coverage and review criteria for most HME items.

NAMES efforts are long-term in nature but already are beginning to have a positive effect in Congress and the Administration. NAMES members have been cited publicly as representing “the most ethical component of the HME services industry.” Proudly, we note that NAMES has been cited for taking a “courageous” stand to rid the HME services industry of abusive business practices.

Over the last few years, NAMES has taken a number of positive steps to help educate providers in establishing compliance programs. In addition to helping develop strong ethics legislation, the following activities represent NAMES past and ongoing effort to combat unethical business practices:

- Established *Code of Ethics* in 1987 to set a high standard of conduct.
- Revitalized and strengthened Ethics Committee.
- Created *Guide for Conduct* in 1990.
- Developed sample Statement of Patient Rights and Responsibilities for use by members.
- Amended Bylaws to terminate membership upon:
 - conviction of a felony related to the business of retail, wholesale, rental or distribution of medical equipment, product, services or supplies for home use in the care and treatment of patients in the United States, and exclusion by the Department of Health and Human Services of a member from participation the Medicare or Medicaid programs.
 - a two-thirds vote of a quorum of the Board of Directors, upon recommendation from the Ethics Committee, following a violation of the Association’s Bylaws, Code of Ethics, or Guide for Conduct as initially determined by the Ethics Committee.

- Published consumer information brochures — *A Shopper's Guide to Home Medical Equipment and Check With Your Health Professional First.*
- Along with American Association of Retired People (AARP), worked with the HCFA, in conjunction with the HHS, OIG, on the publication of a consumer pamphlet on *Medicare and Home Medical Equipment.*
- Review Office of Inspector General (OIG) quarterly sanctions list.
- Publish OIG fraud hotline number, Fraud Alerts and articles about successful prosecutions or guilty pleas of unscrupulous suppliers.
- Met with the Federal Bureau of Investigation's (FBI) Health Care Fraud Unit on its commitment to investigating health care fraud.
- Published newsletter articles on: how to contact OIG or FBI Health Care Fraud Unit to report suspected cases of HME fraud; tracking an OIG investigation; Part B waiver; proper advertisement; anti-kickback statute; and Safe Harbor Regulations.
- Responded to federal rule on misuse of certain words in advertising, supporting OIG activities in this area.
- Invited OIG and FBI representatives to industry meetings to speak about current activities.
- Present educational programs to members on: joint venture; Safe Harbor regulations; anti-kickback statute; and OIG indictments.
- Participate as a members of the Advisory/Liaison Committee of the National Health Care Anti-fraud Association (NHCAA).
- Established a Consumer Advisory Council — comprised of a broad cross-section of national organizations — to help educate consumers about their rights and responsibilities in renting or purchasing HME products and services.
- Supported HME certification standards of practice under the Medicare program or accreditation by a duly authorized quality assurance organization.
- Testified numerous times before Congress on the efforts of the HME services industry to combat unethical business practices.

Unfortunately, a few HME providers are involved in unscrupulous action involving home care; fortunately, they are in the minority. In 1994 when HCFA implemented the four DMERCs to process Medicare claims for HME, all HME providers had to reapply to the NSC for a new Medicare provider numbers. The legitimate HME services industry believed that, under this new system, fraudulent applications for Medicare supplier numbers would be discovered by the government before they were issued. Unfortunately, that was not the case and many fraudulent Medicare provider number applications, especially in Florida, have slipped through the cracks and have been approved by the NSC. The process to identify all fraudulent applications must be improved.

NAMES has advocated for years that there must be stronger accreditation, certification and licensure requirements, potentially including on-site inspection. Despite the work of NAMES and HME providers to create a high level of service for individuals in need of care, formal Medicare certification standards for the provision of HME services still do not exist today. HCFA has no detailed specific requirements for beneficiaries receiving HME services. There are no provisions regarding type or frequency of services that should be rendered, record-keeping practice, emergency care, patient education, home safety assessments or infection control practices. We urge this Committee and Congress to work with the HME services industry to create minimum industry standards and require accountability measures in order to obtain a supplier number from HCFA.

We appreciate the opportunity to submit this statement for the record and look forward to continuing our work together to help exterminate fraud and abuse in the HME services industry. If you have any questions, please do not hesitate to contact Whitney Tannen, NAMES Director of Legislative Affairs, or NAMES President William D. Coughlan, CAE. Thank you.

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