HEALTH CARE FRAUD IN NURSING HOMES—PART II

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

FIRST SESSION

JULY 10, 1997

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HEALTH CARE FRAUD IN NURSING HOMES—PART II

THURSDAY, JULY 10, 1997

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

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

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

Staff present: Lawrence J. Halloran, staff director and counsel; Marcia Sayer, professional staff member; R. Jared Carpenter, clerk; Cherri Branson, minority counsel; and Ellen Rayner, minority chief clerk.

Mr. SHAYS. I would like to call this hearing to order. I am sorry for the delay. We had a bit of computer problems.

This is our second hearing on health care fraud in nursing homes. On April 16, State Medicaid officials, the Health and Human Services [HHS], Department's Inspector General and the General Accounting Office [GAO], described the absurdly complex system of eligibility and reimbursement rules that governs $45 billion of annual Federal long-term care expenditures.

It is a system that invites exploitation. In the nursing home setting, patients are an accessible, almost captive audience. Overlapping eligibility for Medicaid and Medicare benefits creates opportunities for dual billing and cost shifting between programs. Unscrupulous providers know the chances of getting paid are very good, while the odds of getting caught are currently very low.

As a result, Medicare, Medicaid and the beneficiaries who rely on both programs are vulnerable to fraud, abuse, and waste in the form of unnecessary services, excessive prices, fraudulent billings, and poorly coordinated care driven by financial, not medical, considerations.

Today, we invite the Health Care Financing Administration, HCFA, and nursing home patient advocates to join our discussion of health care fraud in nursing homes and to suggest how vulnerable programs and vulnerable patients might be better protected.

Some aspects of the program can, and should, be addressed administratively. We asked HCFA and the HHS agency that pays Medicare claims and approves State Medicaid payment rules to describe current efforts to screen nursing home claims more effectively. Working with the IG, State Medicaid Fraud Control Units,

the Justice Department and State long-term care ombudsmen, HCFA proved in Operation Restore Trust that a coordinate effort can uproot some of the scams that have taken hold in the jurisdictional cracks and crevices of the Byzantine Federal long-term care system.

Other solutions to nursing home fraud require legislative action. Last year, this subcommittee was instrumental in advocating many of the antifraud provisions enacted in the Health Insurance Portability and Accountability Act, the act known as the Kassebaum-Kennedy bill. New criminal sanctions now protect all health care payers, public and private. Dedicated funding is now available for the coordinated antifraud enforcement efforts we know to be effective against increasingly sophisticated schemes.

Building on that foundation, Congress is considering additional steps to strengthen Medicare and Medicaid program safeguards.

One promising proposal calls for consolidated billing by the nursing home for all Medicare and Medicaid services to a patient. Currently, basic long-term care charges are paid by Medicaid, while Medicare Part A and Medicare Part B can be billed separately for ancillary services to the same nursing home patient. Consolidating all these charges should make it much easier to detect double billing, overcharges and cost shifting between payers. It should also improve the coordination and the quality of care provided to nursing home residents.

That is the bottom line to all our calculations about health care fraud in nursing homes: the quality of care.

This is not a victimless crime. Every time a bill is rendered for an unnecessary or never-provided service, someone is denied needed care. Every time a coffee klatch is billed as group therapy, nursing home patients suffer an incalculable loss, the loss of dignity. Every time Medicaid doesn't know what Medicare is paying, or vice versa, nursing home care becomes disjointed, dictated as much by the source of payment as the needs of the patient.

But many victims of fraud in nursing homes remain silent. Some cannot speak for themselves and must rely on family members or friends to protect them. Others, dependent and vulnerable, are reluctant to complain against those on whom they rely for the necessities of daily living. So we asked our witnesses today to put a human face on what might otherwise be considered merely an economic crime and to describe their efforts to give voice to the silent victims of nursing home fraud.

This subcommittee is delighted to have this hearing today. We welcome our witnesses, and we welcome our guests as well.

[The prepared statement of Hon. Christopher Shays follows:]

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Statement of Rep. Christopher Shays
July 10, 1997

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Some aspect of the problem can, and should, be addressed administratively. We asked HCFA, the HHS agency that pays Medicare claims and approves state Medicaid payment rules, to describe current efforts to screen nursing home claims more effectively. Working with the IG, state Medicaid Fraud Control Units, the Justice Department, and state long term care ombudsmen, HCFA proved in Operation Restore Trust that a coordinated effort can uproot some of the scams that have taken hold in the jurisdictional cracks and crevices of the byzantine federal long term care system.

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Welcome. The Subcommittee appreciates your testimony.

Mr. SHAYS. At this time I would call on my partner in this effort, Ed Towns, the ranking member of this subcommittee, if he has a statement.

Mr. TOWNS. Thank you very much, Mr. Chairman, for holding this hearing today, hearing on the questionable billing practices which surround dually eligible people. However, as we approach this subject, I am reminded of the words of Health and Human Services Inspector General June Gibbs Brown who testified before this subcommittee on March 18, 1987. In her testimony on fraud in medical equipment and supplies, she told this subcommittee that we must proceed cautiously to ensure that any measure to control the benefits do not harm those beneficiaries who truly need these services. I believe those words have special meaning today; and I would like to say, thank you, June Gibbs Brown.

Those people who are called dually eligible are eligible for both Medicare and Medicaid. As the General Accounting Office found, compared to the overall Medicare population, dual-eligibles are much more likely to be female, living alone or in institutions, a member of a minority group and have long-term, chronic illnesses. They are poor—and I mean poor. Eighty percent of the dual-eligibles have annual incomes of less than $10,000. By definition, these are the people who are most in need of accessible and compassionate health care assistance.

Yet this group of vulnerable beneficiaries is most likely to face access problems. As the Congress takes a second look at the billing procedures of skilled nursing care facilities and home health care services and as the States move toward managed care for Medicaid patients, this group of patients is most likely to fall through the cracks of any complicated system with unconnected coverage guidelines and confusing billing rules.

Therefore, Mr. Chairman, may I suggest that as we receive testimony here today we keep in mind that those who are eligible for benefits from both programs are not people taking advantage of a vulnerable system, but vulnerable people accessing benefits which Congress has rightfully provided.

Again, thank you for holding today's hearing, and I look forward to the testimony of the witnesses and taking this information and working with you to try and strengthen the system.

I yield back.

Mr. SHAYS. I thank the gentleman.

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

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OPENING STATEMENT
REP. EDOLPHUS TOWNS
RANKING DEMOCRATIC MEMBER
SUBCOMMITTEE ON HUMAN RESOURCES

JULY 10, 1997

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Therefore, Mr. Chairman, I suggest that as we receive testimony here today, we keep in in mind that those who are eligible for benefits from both programs are not people taking advantage of a vulnerable system but vulnerable people accessing benefits which Congress provided. Again, thank you for holding today's hearing and I look forward to hearing the testimony of the witnesses.

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Mr. SHAYS. At this time, I call on Mr. Kucinich.

Mr. KUCINICH. Thank you very much, Chairman Shays.

This hearing is of vital importance to the American public. The abuses that seem inherent in the system always affect those who are least able to protect themselves; and, as the chairman said, there is a necessity to put a human face on these hearings. Because waste, fraud and abuse involving Medicare or Medicaid involves people who were supposed to receive services, didn't get those services, perhaps were billed more than the services should have cost.

Any time that happens what it leads to is an overall attack on Medicare and Medicaid itself. Because these programs were set up by the Congress to help people who needed help and provide a health safety net for the people of this country; and anyone who is involved in waste, fraud and abuse in this program is helping to shred that safety net.

So there is great relevance to these hearings, and I congratulate the chairman for his interest and efforts in this regard.

There is anticipation now of structural changes in the Medicare program itself; and if we are successful in these hearings in pointing out the areas where we can correct waste, fraud and abuse, we can perhaps do much to rescue Medicare from many of the most serious changes which would be to the disadvantage of the beneficiaries.

The Department of Justice, Mr. Chairman, has estimated that perhaps up to 10 percent of the $35 billion in Medicare assets and Medicaid assets paid to—according to GAO, Federal Medicare and—Federal and State Medicare programs paid nursing home providers more than $35 billion in 1995, and the Department of Justice estimates about 10 percent of that is lost to fraud and abuse.

So this is a question that has enormous impact today; and, Mr. Chairman, as you know, in the future, with the change in demographics, we have a growth of the nursing home industry occurring. There will be an even greater number of people applying for nursing homes, greater demands on the system and, therefore, increased stress on the health care resources of this country. So as we go into these hearings, I am hopeful that it will help to point the way to remedying the deficiencies in the system which keep the system from realizing its full potential to serve those who need help the most.

Thank you, Mr. Chairman.

Mr. SHAYS. I thank the gentleman.

At this time, we will call on our first of two panels. The first panel is one individual, Mrs. Kathy Buto, Deputy Director, Center for Health Plans and Providers, from the Health Care Financing Administration. You are going to be accompanied, in the sense that there may be responses to questions, by whom else?

Ms. BUTO. Linda Ruiz.

Mr. SHAYS. Our custom is to swear in all witnesses, including Members of Congress. At this time, I would like you to stand and raise your right hand.

[Witnesses sworn.]

Mr. SHAYS. For the record, both witnesses have responded in the affirmative.

Before we receive your testimony, I just want to take care of some housekeeping things. I ask unanimous consent that all members of the subcommittee be permitted to place an opening statement in the record and that the record remain open for 3 days for that purpose. Without objection, so ordered. I ask further unanimous consent that all witnesses be permitted to include their written statement in the record; and, without objection, so ordered.

Let me say that we put the clock on for 5 minutes, but I am going to roll it over again. It is important that we receive your testimony, so you will have as much time as you need for your statement, especially since you are the only witness on this panel.

So, welcome. You may proceed.

STATEMENT OF KATHY BUTO, DEPUTY DIRECTOR, CENTER FOR HEALTH PLANS AND PROVIDERS, HEALTH CARE FINANCING ADMINISTRATION, ACCOMPANIED BY LINDA A. RUIZ, DIRECTOR, PROGRAM INTEGRITY GROUP, HEALTH CARE FINANCING ADMINISTRATION

Ms. BUTO. I actually will try to be brief, because I know there are a number of questions, and everyone has received my written testimony.

Mr. SHAYS. Let me just say, though, I want to make sure that, for the record, you put in some of that verbally, so feel free.

Ms. BUTO. Mr. Chairman, members of the subcommittee, I am pleased to be here to discuss HCFA's fraud and abuse prevention initiatives.

My testimony will focus on the type of fraud and abuse that occurs in nursing home settings. We must be increasingly vigilant in guarding against improper provider claims and billing, particularly as demand for services increase with the growth of the Medicare and Medicaid populations.

We have some innovative ways to fight this type of fraud and abuse which I will describe and have described in detail in my written testimony, and I will touch on in my statement here.

We have all heard the proverb "an ounce of prevention is worth a pound of cure." This is especially pertinent in the area of physical well-being. By guaranteeing the initial accuracy of both claims and payments, we avoid having to, what we call pay and chase, and we can prevent opportunities for fraud and abuse.

I think it is extremely important to note that some incorrectly billed claims can stem from confusion and misinformation about proper billing procedures, especially in the nursing home arena. For example, if there is a payer who is primary to Medicare, the Medicare contractor rejects the claim and submits to the appropriate primary payer. Where Medicare is primary, the contractor makes payment, then sends the paid claim to the supplemental insurer. For dually eligible Medicare and Medicaid beneficiaries, the Medicare contractor pays first and then sends the paid claims data to the Medicaid State agency as the payer of last resort.

The policies regarding priority and precedence of payers is one source of payment confusion.

HCFA uses many prepayment mechanisms, including our Medicare as secondary payer, or MSP activity, to determine not only the primary payer for benefits for a Medicare beneficiary, but to ensure

that every bill is properly submitted. Using these methods to ensure proper billing, we can concentrate our resources on locating and eliminating areas of fraud and abuse, as I will describe.

I would like to add, however, that we have heard many complaints that the Medicare/Medicaid payment methodologies are so complex that they invite error. This reflects the fact that current payment methods have evolved over 30 years into a variety of sophisticated methods covering a greater diversity of different kinds of services.

Adding to this complexity, especially in the case of nursing home services, is the fact that both Medicare and Medicaid finance care, often for the same individuals. Because of the different but sometimes overlapping benefits of the two programs, there are opportunities for "ping-ponging" patients from nursing homes to hospitals and back.

A typical instance is where the dual-eligible is transferred from a nursing facility to a hospital when there is an acute illness and then sent right back to the nursing home when the hospital determines that the admission is not needed. Although care could have been given in the nursing home, it was not provided because the opportunity to shift costs to Medicare for hospital costs is so great. The unfortunate results are a waste of Medicare and Medicaid dollars, as well as compromised quality of patient care. Let me stipulate some of our specific areas of concern.

We are targeting fraud and abuse of Medicare and Medicaid at a critical time when America is spending about 15 percent of the gross domestic product on health care. In 1995, the bill for nursing home care financed by Medicare and Medicaid programs combined reached $44 billion, which represents about 55 percent of all spending for nursing home care. Especially in the area of nursing home care, there are numerous opportunities for fraud, as we have already noted.

The nursing home population has a high percentage of patients who are incapable of monitoring their own bills and may not have family members to do this for them. This makes them easy prey for unscrupulous providers and suppliers. We are focusing on the following areas where there seems to be the greatest concentration of fraud and abuse.

First, for the dual eligibles generally in 1995, I think, as others have noted, there were about 6 million dually eligible beneficiaries in Medicare and Medicaid, of which about one-quarter reside in nursing homes. Individuals who are dually eligible for both Medicare and Medicaid are a diverse and particularly vulnerable population. Most problems arise when their benefits are covered by both programs but under somewhat different coverage rules, creating opportunities for confusion, billing errors, misdirected or duplicate payments and, in the worse cases, outright fraud.

Second is mental health services. A finding from the Inspector General's medical necessity review demonstrated that in 32 percent of Medicare records reviewed mental health services for nursing home residents had been ordered improperly or unnecessarily.

Another area is medical supplies. Providers of medical supplies, such as those required for wound care, incontinence and orthotic equipment may unreasonably inflate prices for these supplies or

may inaccurately describe the supplies in the bills in order to receive higher payment.

Hospice services: The Inspector General has found that there is considerable financial incentive to enroll nursing home facilities patients in the hospice benefit since Medicare makes an additional payment for these beneficiaries, while few additional services are provided.

Therapy services: Providers, we know, have been charging excessively more for Medicare therapy services provided under contract with nursing homes.

Let me mention just a couple of our important fraud and abuse prevention initiatives. My written testimony really details these, and the chairman has already alluded to some of them.

Operation Restore Trust, our Medicare Integrity Program, which is authorized under the Kassebaum-Kennedy provisions, and Medicare secondary payer initiative, which I have mentioned.

The President's budget contains a number of proposals to reduce waste, fraud and abuse in the Medicare program. These include, first, provisions to require insurance companies to report the insurance status of beneficiaries to ensure that we pay right the first time; second, to implement home health prospective payment services in Medicare that incorporates all services provided in the nursing home; third, that we require the nursing facility to bill for all services that its residents receive, which is not now current law—we call that consolidated billing, as the chairman noted; and, fourth, to link home health payments to the location where care is actually provided rather than the billing location.

We also propose to work with the medical community to develop objective criteria for determining the appropriate number of home health visits for specific conditions so that we can prevent excessive utilization in the area of home care.

In March, the President presented additional legislative proposals titled the Medicare and Medicaid Fraud, Abuse and Waste Prevention Amendments of 1997. These amendments address areas of hospice benefit modifications, partial hospitalization benefits, which are mental health benefits, the provider enrollment process, rural health clinic benefit reforms, and other important areas. We are pleased that both the House and Senate reconciliation bills include many of the proposals put forth by the President.

Neither bill, however, includes a provision that would authorize the development of a prospective payment system for rural health clinics services, nor do they include our proposal to clarify the partial hospitalization benefit, which is an area of rampant abuse. We hope these provisions are added in conference.

In conclusion, HCFA is firmly committed to aggressively fighting health care fraud and abuse; and by collaborating with our counterparts in government, the industry nonprofit organizations and advocates, we can build a powerful team that will prevent our Medicare and Medicaid resources from being lost. We look forward to working with Members of Congress, including this committee, on legislation to enact the proposals I mentioned today.

Thank you.

Mr. SHAYS. Thank you very much.

[The prepared statement of Ms. Buto follows:]

INTRODUCTION

Mr. Chairman and Members of the Subcommittee, I am pleased to be here today to discuss the Health Care Financing Administration's (HCFA) fraud and abuse prevention initiatives. My testimony today will focus on the type of fraud and abuse that occurs in nursing home settings, a particularly egregious crime which preys on some of the weakest and most vulnerable members of our society. Particularly as the Medicare and Medicaid population of the medically fragile elderly increases, we must be increasingly vigilant in guarding against improper provider claims and billing. At HCFA, we are strongly committed to acting aggressively against all forms of fraud and abuse in Medicare and Medicaid. As I will describe later, we have some innovative weapons in the war against fraud and abuse, and we have been working with the authorizing committees on proposals to reinforce these efforts.

Overview of HCFA's Fraud Prevention Policy

The annals of medicine are replete with case histories demonstrating that prevention is the best antidote to illness. This is equally true in the area of fiscal well-being: in order for our Medicare and Medicaid programs to remain both solvent and strong, we need to prevent improper or fraudulent claims which strain the fiscal and personnel resources of the system. By guaranteeing the initial accuracy of both claims and payments, we avoid having to "pay and chase," and we can prevent opportunities for fraud and abuse.

Incorrectly billed claims can stem not only from fraud, but from confusion and misinformation about the proper billing procedures. For example, if there is a payer primary to Medicare, the Medicare contractor will reject the claim for submission to the appropriate primary payer. Where Medicare is primary, the Medicare contractor will make payment, then send the paid claims data to the supplemental insurer. For dual Medicare and Medicaid eligibles, the Medicare contractor will pay first and then send paid claims data to Medicaid as the payer of last resort. Although one would not expect dual eligibles to have Medicare supplemental coverage, the Medicare contractor would send the paid claims information to the supplemental insurer, if one exists and where there is an established trading partner agreement.

HCFA uses many pre-payment mechanisms to determine not only the primary payer for benefits for a Medicare beneficiary, but to ensure that every bill is properly submitted. Some of these mechanisms are part of our Medicare as a Secondary Payer (MSP) Activity, and include an Initial Enrollment Questionnaire, contractor systems edits, IRS/SSA/HCFA Data Match, Voluntary Insurer/Employer Reporting, Hospital Admissions Procedures Review, First Claim Development, Trauma Code Development, and MSP Litigation Settlement, as well as unsolicited updates (i.e., phone calls and letters) from providers and beneficiaries. Using these methods to ensure proper billing, we can concentrate our resources on locating and eliminating areas of fraud and waste, as I will describe next.

Specific Areas of Concern

We are targeting fraud and abuse of Medicare and Medicaid at a critical time, when America is spending approximately 15% of the gross national product on health care. In 1995, the bill for nursing home care financed by the Medicare and Medicaid programs reached $44 billion, which represents 55% of all spending for nursing home care. Especially in the area of nursing home care, there are numerous opportunities for fraudulent claims. The nursing home population has a high percentage of patients who are incapable of monitoring their own bills, and may not have family members to do this for them; this makes them easy prey for unscrupulous providers and suppliers. The following are some of the areas we are especially concerned about in regard to fraud and abuse, and which are identified in several of the President's FY98 proposals. Under current law, we do not have adequate authority to address some of these concerns.

● **Dual Eligibles** - We estimate that in 1995 there were almost 6 million dually eligible beneficiaries in Medicare and Medicaid, of which approximately one-quarter resided in nursing homes. Individuals who are dually eligible for both Medicare and Medicaid are a diverse and particularly vulnerable population. The complexity of the Federal laws governing Medicare and Medicaid reimbursement often causes confusion and billing errors, even where there is no illicit intent. This is especially true in the area of dual eligibles, and the problems are particularly great for dual eligibles who reside in nursing homes.

- Coverage: Most problems arise when benefits are covered by both programs but under somewhat different coverage rules, creating opportunities for confusion, billing errors, misdirected or duplicate payments, and in the worst cases, outright fraud. Such opportunities are prevalent in particular for dual eligibles who reside in nursing homes. For example, both Medicare and Medicaid cover a nursing home benefit. The Medicare benefit is limited to no longer than 100 days, and is designed to serve Medicare beneficiaries who need relatively brief periods of rehabilitative care. While Medicaid also covers such short, rehabilitative stays if the patient is eligible only for Medicaid, its nursing home benefit also goes to persons needing longer term and mainly custodial care. It is sometimes difficult for providers or beneficiaries to predict, when a patient is admitted to a nursing home, which program will eventually pay. As a result, bills may be submitted to both programs, with the expectation that those paying the bills will sort things out.
- Payment: When a service is provided to a dual eligible who is covered by both Medicare and Medicaid, Medicare pays first. Medicaid pays only the beneficiary's Medicare beneficiary cost-sharing. When a service is provided to a dual eligible who is covered *only* by Medicaid, then Medicaid pays. Requirements and systems safeguards are in place at both the State and Federal levels to ensure that claims are paid by the appropriate program. However, given the difficulties described above in determining coverage, and given the natural desire of both programs to avoid making erroneous payments, delays in payments sometimes occur, creating more incentives for providers to "game" the system.

● **Mental Health Services** - Findings from the IG's medical necessity review demonstrated that in 32 per cent of Medicare records reviewed, mental health services for nursing home residents had been ordered improperly or unnecessarily. Specifically, there was no medical indication for mental health services for these patients, and medical necessity was questionable for an additional 16 per cent of patient records reviewed. The total amount of these services was $27 million in 1993.

● **Medical Supplies** - Providers of medical supplies such as those required for wound care, incontinence, and orthotic equipment may unreasonably inflate prices for these supplies or may inaccurately describe the supplies. For example, a seat cushion may be described as a "custom fitted orthotic body jacket" to obtain a larger Medicare or Medicaid reimbursement. Similarly, Medicare dollars have been lost or misspent when a higher price has been paid for supplies which could be more cost-effectively obtained through other sources. Some examples of this include I.V. poles, enteral nutrition supplies, and portable x-rays for patients. Also, providers are often charging separately for items such as aspirin, tape or cotton balls that should be included in the routine per diem rate.

● **Hospice Services** - Hospice care shifts the focus from curative to palliative care, to help the patient spend the remaining days of life as comfortably as possible; consequently, hospice care may be less costly to the nursing facility. Although hospices can provide services either at home or in a separate hospice facility, often patients in nursing homes may also receive "hospice services." For the nursing homes, the IG has found that there is a considerable financial incentive to enroll patients in the hospice benefit since Medicare makes an additional payment for these beneficiaries, while few additional services are provided.

The IG has estimated that as many as one-fifth of hospice patients residing in nursing homes may be erroneously enrolled under the Medicare hospice benefit. Audits of hospice patients in the fourth benefit period have shown that as many as two-thirds found to be ineligible were nursing home patients. Also, the IG found that they were receiving fewer services from hospices than at-home patients and that most services would have been available from the nursing home without the hospice designation. This is significant because a condition of enrollment in a hospice is that the patient forgo his rights to Medicare payment for curative care.

● **Therapy Services** - Specialized rehabilitation agencies often provide services such as speech-language pathology, occupational or physical therapy services to nursing home patients in both Medicare and Medicaid. The multi-layered structure of these organizations, which often use outside billing services, tend to complicate payment oversight. There have been Medicare salary equivalency guidelines for contracted physical therapy services and respiratory therapy since 1975 and 1978 respectively. However, in the past there were no established salary equivalency guidelines for contracted occupational and speech-language pathology therapy services, and therapists and therapy companies were able to bill providers for services based on exorbitant salaries and other administrative costs, resulting in charges of as much as $688 per hour for occupational and speech-language pathology therapy services. HCFA has proposed to limit excessive charges for Medicare therapy services; in the interim, intermediaries are applying the "prudent buyer concept" to ensure program payments are appropriate. On March 28, 1997, HCFA proposed new salary equivalency guidelines to combat these abuses. This proposal introduces guidelines for the contracted

speech-language pathology and occupational therapy services which in most instances limits excessive charges for therapy services in Medicare. The proposal also updates the physical and respiratory therapy guidelines amounts with a modest increase. We are just starting to review and prepare responses to the comments on the proposed regulation. Until we have reviewed and addressed all of the individual comments, we cannot indicate the details of the final guidelines.

HCFA's FRAUD AND ABUSE PREVENTION INITIATIVES

This Administration has been successful in taking aggressive measures to staunch the flow of Medicare and Medicaid funds to perpetrators of fraud and waste. In order to stay one step ahead of unscrupulous providers and suppliers, we need to step up our efforts, using innovative, state-of-the-art prevention and detection methods. However, in many areas we lack the authorization we need to create effective and thorough anti-fraud and abuse programs. With the support of the Congress to increase our authorization in these areas, we can reduce Medicare and Medicaid losses dramatically.

One of the ways we have already succeeded in reducing losses is through Operation Restore Trust (ORT), which has already shown an impressive return on resources invested in the program. The program integrity activities of the Medicare contractors initiate many of the cases subsequently developed by the Office of Inspector General and Federal Bureau of Investigation, and support their prosecution by the Department of Justice. In addition, using monies expand our successful efforts using the State survey agencies to be our "eyes and ears" in the field and report to the contractors whether providers are meeting Medicare billing requirements. We have used this model successfully with our expanded home health surveys in the 5 ORT States.

Operation Restore Trust

Operation Restore Trust provided valuable experience in fraud and abuse detection and prevention that is enabling HCFA to dramatically reduce waste of Medicare and Medicaid funds. The original ORT was a two-year demonstration project which concluded on March 31, 1997. It was launched by the President in May 1995 and was designed to demonstrate new partnerships and new approaches in finding and minimizing fraud. As a demonstration project, ORT targeted four areas of high spending growth: home health agencies, nursing homes, DME suppliers, and hospices. Since more than a third of all Medicare and Medicaid beneficiaries are located in New York, Florida, Illinois, Texas, and California, ORT efforts were targeted at these five states.

The ORT project was the first comprehensive effort at collaboration between HCFA and law enforcement agencies. Through HCFA's expanded efforts, approximately $1.8 million has been allocated to HCFA for "ORT Plus" through HIPAA's Fraud and Abuse Control Program, to enhance the program integrity activities and to integrate these activities into our certification surveys conducted by State agencies. Eighteen States will participate in a total of 26 HIPAA funded projects, allowing us to survey approximately 300 providers for both certification and reimbursement issues. These enhanced surveys will be made of providers of home health services, skilled nursing services,

outpatient physical therapy services, and laboratory services, as well as psychiatric services in both hospitals and community mental health centers. Many of these surveys will be modeled after the home health agency and skilled nursing facility surveys conducted during ORT. This collaboration, which was continued through the Fraud and Abuse Control Program established in HIPAA, establishes a funding stream for health care fraud activities, and requires DoJ and HHS to establish priorities jointly. Most importantly, HIPAA, through the Fraud and Abuse Control Account and MIP, is helping us to finance new ways of doing business in the future.

Medicare Integrity Program (MIP)

This program authorizes the Secretary to promote the integrity of the Medicare program by entering into contracts with eligible entities to carry out program integrity activities such as audits of cost reports, medical and utilization review, and payment determinations. Section 202 of P.L. 104-191 (the Medicare Integrity Program (MIP)) was enacted to strengthen the Secretary's ability to deter fraud and abuse in the Medicare program in a number of ways. First, it created a separate and stable long-term funding mechanism for MIP activities. Historically, Medicare contractor budgets had been subject to fluctuations of funding levels from year to year. Such variations in funding did not have anything to do with the underlying requirements for MIP activities. This instability made it difficult for HCFA to invest in innovative strategies to control fraud and abuse. Our contractors also found it difficult to attract, train, and retain qualified professional staff, including clinicians, auditors, and fraud investigators. A dependable funding source allows HCFA the flexibility to invest in new and innovative strategies to combat fraud and abuse. It will help HCFA to shift emphasis from post-payment recoveries on improper claims to pre-payment strategies designed to ensure that more claims are paid correctly the first time.

Second, by permitting the Secretary to use full and open competition rather than requiring that we contract only with the existing intermediaries and carriers to perform MIP functions, the government can seek to obtain the best value for its contracted services. Prior law limited the pool of contractors that could compete for contracts, thus, we have not always been able to negotiate the best deal for the government or take advantage of new ways to deter fraud and abuse. Using competitive procedures, as established in the Federal Acquisition Regulations (FAR), we expect to attract a variety of offerors who will propose innovative approaches to implement MIP.

Third, MIP permits HCFA to address potential conflict of interest situations. We will require our contractors to report situations which may constitute conflicts of interest, thus minimizing the number of instances where there is either an actual, or an apparent, conflict of interest. By invoking the FAR in establishing multi-year contracts with an expanded pool of contractors, we will be able to avoid potential conflicts of interest and obtain the best value. Also, by permitting us to develop methods to identify, evaluate and resolve conflicts of interest, we can create a process to ensure objectivity and impartiality when dealing with our contractors. This is a concern particularly when intermediaries and carriers are also private health insurance companies processing Medicare claims.

Other Initiatives

● **Medicare as a Second Payer Initiative** - This "front end" activity takes an active approach to identifying the correct payer before the claim is processed. There are multiple areas that are scrutinized to ensure that the appropriate payer is billed; these mechanisms include contractor systems edits, the Initial Enrollment Questionnaire, data matches and first claim development, as well as unsolicited updates (i.e., phone calls and letters) from providers and beneficiaries.

● **PACE and SHMO Demonstrations** - The Program for All-inclusive Care for the Elderly (PACE) and Social Health Maintenance Organization (SHMO) programs are two models that address the problem of fragmentation of Medicare and Medicaid benefits and health care services for dual eligibles. A lack of coordination between services and benefits increases opportunities for fraud in addition to jeopardizing quality of care. PACE and SHMO are prototypes that integrate acute and long-term care into a single system, which can then be closely monitored. The President's proposals would grant full permanent provider status for the PACE demonstration sites that currently meet the PACE protocol. Also, SHMO demonstrations would be extended until December 31, 2000. SHMOs enroll a cross-section of the elderly living in the community and provide standard Medicare benefits, together with limited long-term care benefits. These Congressionally-mandated demonstrations are currently set to expire on December 31, 1997. A three-year extension would provide additional time to evaluate this delivery model. Although these models may not be appropriate or workable in all settings, we believe that coordination of Medicare and Medicaid funding in these programs could reduce the possibility of fraud and abuse, while improving overall quality.

● **Durable Medical Equipment** - There is widespread concern that Medicare's payments for durable medical equipment are excessive. Medicare payments for DME are based on a fee schedule methodology established by Congress in Omnibus Budget Reconciliation Act (OBRA) 1987, and these fee schedule amounts were based on supplier's "reasonable charges" in the mid-1980s. Unless otherwise specified by Congress, these amounts have been increased annually by the Consumer Price Index-Urban (CPI-U) as required by statute. This statutorily prescribed payment methodology does not consider changes in technology or any other factors impacting suppliers' costs and as a result HCFA's payments for DME are often excessive.

It is essential that providers of durable medical equipment (DME) have proven track records of reliable and scrupulous business practices, given the potential for fraud and abuse in this area. By bonding these providers much in the same way that other businesses are bonded, there is greater control over the fly-by-night operations that seek to defraud the Medicare and Medicaid programs. A notice will be issued this summer by HCFA that will require that DME providers meet certain criteria, including putting up a surety bond for licensure, and greater proof of the bona fide existence of the business. This will prevent abuses such as the case of the Florida man who received a DME license, despite the fact that the only actual supplies he had in stock were stuffed alligator heads and other souvenirs he sold from his garage. He had applied for a DME certification to sell wheelchairs to complement his brother-in-law's business of installing wheelchair lifts in cars. Examples like this are a good argument for DME bonding.

● **Grants Program: Reforming Service Delivery for Dually Eligible Beneficiaries** - On May 22, 1997, we announced that HCFA is sponsoring a grants program to foster a more integrated and flexible service delivery system for persons entitled to both Medicare and Medicaid. Our principal interest is, of course, to develop better ways of serving this most vulnerable population. In addition, another very important and desirable outcome would be to reduce the kind of fragmentation and duplication that results from dual coverage and that so readily sets the stage for fraud and abuse.

● **Interagency Collaboration** - We are collaborating with similar efforts of other organizations and agencies, such as the Long Term Care Ombudsman Program funded by the Administration on Aging. This program sends ombudsmen to visit nursing homes and other sites of potential fraud and waste. In addition, programs such as Operation Restore Trust have used State Survey and Certification teams, Medicaid Fraud Control Units, Departments of State and Justice personnel, and law enforcement officials to complement and enhance oversight of Medicare and Medicaid providers.

THE PRESIDENT'S LEGISLATIVE PROPOSALS

The Health Insurance Portability and Accountability Act (HIPAA) legislation provided a solid foundation on which to build program integrity activities. To extend these efforts, the President proposed a number of additional fraud and abuse proposals in his FY98 Budget and the Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997.

Proposals Targeting Special Areas Of Concern

The President's budget contains a number of proposals to reduce waste, fraud and abuse in the Medicare program. They include provisions to require insurance companies to report the insurance status of beneficiaries in order to ensure that Medicare pays appropriately. Generally private insurance is the primary payer when Medicare or Medicaid beneficiaries have such coverage, and Medicare or Medicaid is required to be the secondary payer. Primary insurers should not be allowed to cost-shift to these two programs and evade their fiscal responsibilities.

Creating a single payer for services provided to Part A patients in skilled nursing facilities would dramatically streamline the Medicare billing process, enabling carriers to scrutinize bills for medical necessity documentation. Currently, Medicare pays room and board charges under Part A for up to 100 days of post-hospital skilled care, while certain therapy services may be contracted out and those providers paid separately under Part A cost reimbursement or Part B payments. In other cases, some nursing homes may provide supplies and services themselves and we pay the nursing homes directly. The broad range of variations creates confusion and stymies coordination of payments, thus providing a scenario ripe for abuse and fraud. The President's FY98 Budget includes a proposal to implement a PPS for SNF services provided to beneficiaries eligible for Medicare SNF care --- whether the services have been historically reimbursed under Part A or Part B. A consolidated billing requirement would create an incentive for skilled nursing facilities to monitor and control payments for therapy services not provided during a Medicare SNF stay.

We have several other proposals to prevent excessive and inappropriate billing for home health services. We are proposing to close a loophole in the current payment calculation by linking payments to the location where care is actually provided, rather than the billing location. When we implement a home health prospective payment system (PPS), we are proposing to eliminate home health agency (HHA) periodic interim payments, which were originally established to encourage HHAs to join Medicare by providing a smooth cash flow. Since over 100 new agencies join Medicare each month, such financial inducements are no longer needed. We also propose to work with the medical community to develop more objective criteria for determining the appropriate number of visits for specific conditions, so that we can prevent excessive utilization.

Medicare and Medicaid Fraud, Abuse And Waste Prevention Amendments of 1997

In March, the President presented an additional set of legislative proposals titled the "Medicare and Medicaid Fraud, Abuse, and Waste Prevention Amendments of 1997." Some of these proposals build on the provisions enacted in HIPAA. Others seek to close loopholes or weaknesses in the Medicare statute that allow providers to take advantage of Medicare payment. Provisions in the bill especially relevant to nursing homes include:

● **Hospice Benefit Modifications** - This proposal would revise Medicare hospice coverage and payment policies in certain cases. First, after the two initial 90-day periods this proposal would replace the current third and fourth hospice benefit periods with an unlimited number of thirty-day periods. This change would help HCFA ensure that the hospice benefit is used for those beneficiaries with a terminal illness, but it would not end hospice care for those fortunate to survive longer than expected. Thirty-day re-certifications would, in fact, help ensure that only terminally ill patients continue to receive hospice care. Second, as the President's FY98 budget bill proposed for home health, this proposal would link payment for hospice services to the geographic location of the site where the service was furnished. Third, this proposal would also limit beneficiary liability under hospice care. Currently, the major cause for denial of hospice claims is the fact that the beneficiary was not terminally ill within the meaning of the law (i.e., did not have a prognosis of six months or less of life at the time the services were rendered). If a hospice claim is denied because the patient was not terminally ill, the patient's liability for payment would be waived and the hospice would be liable for the overpayment unless it could prove that it did not know or have reason to know the claim would be disallowed. The standard of proof would be high since both the law and HCFA instructions are explicit as to the requirement and there are well established protocols for documentation of medical prognosis.

● **Clarify the Partial Hospitalization Benefit** -- Partial hospitalization services are intensive outpatient day programs which may include individual and group therapy, family counseling, occupational and activity therapy, diagnostic services, and drugs that cannot be self-administered. The Medicare benefit is intended for patients who would be likely to be hospitalized without these services.

This proposal would establish Medicare coverage requirements and limitations to minimize program abuse, and would also preclude providers from furnishing partial hospitalization services in a nursing home or in a residential setting. It would provide the Secretary broad authority to establish through regulation a prospective payment system for partial hospitalization services for Medicare that reflects appropriate payment levels for efficient providers of service and payment levels for similar services in other delivery systems. The current cost reimbursement system would stay in place until the Secretary exercises this payment authority. In addition, this proposal would provide authority for the Secretary to establish (through regulation) Medicare participation requirements, such as health and safety requirements and provider eligibility standards for community mental health centers (CMHCs). Additionally, it would provide authority for CMHCs to be surveyed upon request by state agencies to determine compliance with Federal requirements or investigate complaints. It would also prohibit *Medicare-only* CMHCs. Finally, the bill includes a provision to penalize physicians for false certification of partial hospitalization need which parallels the authority created in HIPAA for penalties for false certification of home health services. This provision would create a strong incentive for physicians to certify need for partial hospitalization services *only* for those individuals who meet Medicare requirements. Unfortunately, our proposal is not included in the House or Senate mark.

● **Improving the Provider Enrollment Process** - We propose to clarify the provider enrollment process, and strengthen HCFA's ability to combat fraud and abuse by not allowing "bad actors" to become Medicare providers and/or suppliers. These provisions would provide the Secretary the authority to deny Medicare entry for those provider applicants who have been convicted of a felony, and the authority to collect a fee for all Medicare and Medicaid applicants when they apply for enrollment or re-enrollment. The fee would cover administrative costs in processing applications and administering the HIPAA National Provider Identification program requirements. If an application is denied, a six-month waiting period must be completed before the provider could reapply.

● **New Fraud and Abuse Sanctions** - New sanctions on fraud and abuse will discourage those seeking opportunities to "game" the Medicare and Medicaid programs. By penalizing false certifications, barring kickbacks, and specifying civil monetary penalties, we will gain tighter control over the caliber of individuals providing health care for our beneficiaries.

● **Value of Capital When Ownership of an Institution Changes** - This proposal, which would apply to all providers, would deem the sales price of an asset to be its net book value. There have been instances in which SNFs or hospitals currently game the system by creating specious "losses" in order to be eligible for additional Medicare payments. For example, a seller might claim that a significant portion of the purchase price of a hospital is attributable not to the value of the hospital building and other capital assets, but to the value of the certificate of need, the already assembled hospital staff, or some other intangible asset. By minimizing the value attributable to the capital assets, the seller is able to record a lower sales price, and a greater "loss" on the sale. The seller is then entitled to partial reimbursement for the loss from Medicare. This existing loophole is especially problematic in the case of hospitals paid under PPS for capital because the prospective capital payments to the new owner are unaffected by the low valuation of the hospital. Prior to PPS, the new owner would be somewhat disadvantaged by the gaming because their cost-based capital payments

would have been lower because of the low sales price. Effectively, this proposal would eliminate the need for any payment adjustments for gains or losses.

● **Bankruptcy Provisions** - These proposals would protect Medicare and Medicaid interests in bankruptcy situations. - A provider would still be liable to refund overpayments and pay penalties and fines even if it filed for bankruptcy. Quality of care penalties could be imposed and collected, even if a provider were in bankruptcy, and Medicare suspensions and exclusions (including educational loan defaults) would still be in force even if a provider files for bankruptcy. Bankruptcy courts would not be able to re-adjudicate our coverage and/or payment decisions.

● **Rural Health Clinic (RHC) Benefit Reforms** - Recognizing the importance of the rural health clinics, reforms are needed to strengthen Medicare policy and better target assistance. It should be emphasized that the inclusion of RHC proposals in the Medicare and Medicaid Fraud and Abuse Prevention bill is not meant to imply that we believe these providers are engaged in fraudulent or abusive activities. We do believe, however, that the RHC program could be better targeted to serve truly under-served rural areas, and as such, we have included several proposals to address this issue. These proposals would hold provider-based RHCs to the same payment limits as independent RHCs, better target the placement of RHCs in under-served areas and still provide access to clinic services. We are pleased that both the House and Senate Reconciliation bills include these proposals. Neither bill, however, includes a provision that would authorize the development of a PPS system for RHC services. We hope that such a provision is added in Conference.

FUTURE CHALLENGES

We are witnessing both an increase in the elderly population, and an unprecedented rate of change in the health care environment. As innovative new health care arrangements flourish, the combination of these two phenomena may also create new opportunities for fraud. The vulnerability of skilled nursing facility patients encourages individuals seeking to defraud Medicare to target the very ill or elderly, who may not be able to monitor their own bills for fraudulent charges.

Another trend that will be increasing in the future is the concentration of large numbers of the elderly in specific geographic locations, and specific residential and care facilities. The changing demographics of our society indicate that not only a greater proportion of the national economy will be devoted to care of the elderly, but that this concentration of elderly will create territory that is ripe for exploitation by profiteers.

As new trends emerge on the health care horizon, we must be prepared to respond to them. For example, health care mega-corporations pose challenges for fraud detection and prevention: new mergers and acquisitions are resulting in ever-larger health care corporations, which will be more difficult to monitor for fraud and abuse. The challenge for HCFA and the Medicare and Medicaid programs will be to understand the relationships between health care entities in order to understand the potential for kickbacks and other illegal relationships. In the same way, new treatment protocols, rapidly advancing technology, and innovative payment systems are a boon to the health care industry,

but they also create new opportunities for fraud and abuse of Medicare and Medicaid monies. We need to be a step ahead of potential misuse of these allocated funds, which are essentially investments by taxpayers and which must be safeguarded for future generations

CONCLUSION

HCFA is firmly committed to aggressively fighting health care fraud and abuse. By collaborating with our counterparts in government, industry, and non-profit organizations, we can build a powerful team that will prevent our Medicare and Medicaid resources from being lost. I know that you share our goal of providing high quality medical care for nursing home residents, and for all Medicare and Medicaid beneficiaries. I look forward to working with Members of Congress, including this Committee, on legislation to enact the various proposals I mentioned today. With your help, we can implement policies which will strengthen our abilities to eliminate fraud and abuse.

Mr. SHAYS. Mr. Towns.

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

Let me begin by thanking you for your testimony and saying to you that we do look forward to working with you to try and see what we can do to eliminate waste, fraud and abuse of any sort.

Let me begin by saying, in your testimony, you discussed the billing confusion that results when someone is dually eligible. Can you tell me whether there is a way to eliminate the confusion without having the benefits delayed to those that are dually eligible?

Ms. BUTO. Yes. There are a number of different ways.

The most tangible way that I can describe is a way that we have worked out and that Congress, we believe, is very much in favor of, which is a combined Medicare and Medicaid payment for the care of the dually eligible. This would be a combined, capitated payment.

You may be familiar with the Program for the All-inclusive Care for the Elderly [PACE], for the frail elderly. This provides the right incentives to keep people out of institutions or provide them with the institutional care in a cost-effective way while also using the Medicare resources to cover their acute care, hospital-related, physician-related needs. This has been a very successful program. A number of the States are interested in this, and we look forward to expanding this kind of program.

There is another programmed called the Social HMO Program, which is also under a demonstration in our agency, which is similar but doesn't target necessarily the frail elderly, but really tries again to combine those payments between Medicare and Medicaid to make the best use of the combined payment. That, too, seems to be a much more efficient way for some individuals to receive their care.

Both of those are part of our legislative package.

Mr. TOWNS. Let me make certain that I understand this hospice care. A patient must be terminal in order to go into this, like life expectancy of maybe 6 months or less, generally.

Ms. BUTO. Right.

Mr. TOWNS. Is that what is really happening?

Because when you talked about hospice you indicated that some of the services in some instances were eliminated, which means even though they are able to bill and get paid at a high level, the point is that maybe some people might be put into a hospice that should not go in there. I sort of get the feeling that that might be happening. Are you saying that? Or what are you really saying? That is the question.

Ms. BUTO. Let me just try to divide it into two things.

One issue is are some people getting it who we do not think are really terminally ill. Hospice areas——

Mr. TOWNS. You are saying what I thought you were saying.

Ms. BUTO. There are some people getting it who are not terminally ill, and we think there are some people that are unscrupulous in certifying them.

In Operation Restore Trust, we targeted hospice services because we saw a lot of growth in that area. There are a number of provisions we have in the budget proposals to begin to tighten and really recertify people every 30 days after the first two benefit periods,

so that would really help us. Right now, the way the law is structured, there is a much more open-ended fourth benefit period. This would really help us tighten and recertify the eligibility.

But the other issue, and the one I talked about in my testimony, is the issue of both Medicare and Medicaid paying for an individual whose home is the nursing home, but who is getting Medicare-covered hospice services. Right now, that hospice is getting a Medicaid payment for some services that Medicaid would cover, like the relief of pain, for example. Medicare's hospice payment also pays for that, so there is some overlap.

The issue is, different States pay for different things, can we figure out what a reasonable payment is? We and the Inspector General are working on that issue to see if we can begin to audit how to pay more appropriately.

But I think there is an issue of are we—that we have really raised as part of our reviews, which is, should we be paying or modifying proposals, both in Medicaid and Medicare?

Mr. TOWNS. There has been a lot of talk about the Medicare Integrity Program. When is this going into effect?

Ms. BUTO. We have started the Medicare Integrity Program, which is an outgrowth of the Health Insurance Portability and Accountability Act, by whenever there is a contractor change——

For example, one of our large contractors in the West, Aetna, recently has decided to get out of the Medicare business. We have started to move toward what we call benefit integrity contract source. So when we have the opportunity that is what we are doing under current law.

But we are working now on a statement of work to really compete for a whole separate set of fewer contractors whose entire purpose it is to focus on benefit integrity issues, and we expect that to go into place in 1998.

Mr. TOWNS. Is there an incentive involved in this at all in terms of the contractor receiving an incentive payment for uncovering fraud and abuse?

Ms. BUTO. The incentive will be to get the business. But if I could just turn to my colleague who will be overseeing that, I will ask if she wants to elaborate.

Mr. SHAYS. If you could identify yourself for the record.

Ms. RUIZ. Certainly. My name is Linda Ruiz, Director of the Program Integrity Group.

We hope to offer contractors some incentives. They will not be directly related—for example, recovering a certain percentage of money based on moneys that they might recover from a provider or anything that would provide some kind of reason for the contractor to unnecessarily hassle providers—but we are looking for some legitimate ways to provide them with additional financial incentives to do the very best job for us they can.

Mr. TOWNS. So you have not finalized what these incentives would be?

Ms. RUIZ. No. We are experimenting. This is a tricky area.

Mr. TOWNS. I agree with that.

Let me just sort of ask one more question, Mr. Chairman, before I yield back.

Mr. SHAYS. Sure.

Mr. TOWNS. In your testimony, you described reforms to Medicare payments for durable medical equipment. Will you have a grandfather clause that will allow current equipment providers to participate in the programs without fulfilling the new requirements?

Ms. BUTO. I actually—some of the durable medical equipment provisions we are talking about—I am not sure whether this is what you are talking about or not—involve a bonding requirement. Is that what you are talking about?

Mr. TOWNS. That is what I am talking about, yes.

Ms. BUTO. That we are, I believe, planning to do through regulation, but I don't know that we have—the legislative staffer is informing me that there will not be a grandfather requirement for the existing suppliers, that they will all need to be recertified, so there won't be some sort of an exemption for them.

Mr. TOWNS. Will not be?

Ms. BUTO. Will not be.

Mr. TOWNS. Mr. Chairman, I would like to talk about that a little more later on.

Thank you very, very much. I yield back.

Mr. SHAYS. There is always this number of 10 percent of health care is waste, fraud and abuse. We have indications from the Inspector General that, in certain areas, health care fraud could be 15 percent. There are some who think it is 20 percent. It is an extraordinarily large number when we think of how much we spend.

You have outlined areas, and I would like you to go into a little more depth with each one. You outlined dually eligible, you outlined mental health services, medical supplies, hospice, therapy services and prospective rural health care plans. You mentioned one other at the end. Do you remember what that was—after rural—the two that you said that were not part of the proposal?

Ms. BUTO. Oh, we are hoping the conference agreement will pick up.

One is prospective payment for rural health clinics, which we thought would have a lot of support but has not been picked up in either the House or Senate.

The other is a proposal to address the issues involved with partial hospitalization.

These are the mental health benefits that I will be glad to elaborate on, but this is the outpatient mental health services where we really need to have some authority to impose standards on providers, No. 1.

No. 2, we have what we call right now Medicare-only providers. We think these should not be Medicare-only providers. They ought to be certified by States to provide services more broadly.

We have seen a lot of abuse in the billing patterns here. Nursing home patients are quite vulnerable in this area where they are provided, in a sense, a social service. They think they have had a recreational activity. It is billed as a mental health visit.

So that kind of behavior we need to get a handle on. We need to be able to screen providers, and that is called the partial hospitalization benefit. We will be glad to provide copies of the proposal to your staff.

Mr. SHAYS. OK. I am having a hard time understanding, and I want to appreciate it, the challenge the administration faces and also Congress, as to why we can't deal with the dually eligible problem. What are the policy issues that work in conflict?

My sense is that 6 million dually eligible Medicare, Medicare, one-fourth of those 6 million are in nursing homes. In our first hearing, it was very clear to me that you can rip off the system quite easily and not get caught. If you are caught, it is pay and chase. So why don't you talk to me first about dually eligible.

Ms. BUTO. OK. The dually eligible is an issue where we are dealing with people who are, as you can expect, certainly nursing home individuals who are the most vulnerable. Dually eligible are over-represented by people over 85, for example. They are also over-represented in the under-65 disabled population.

Mr. SHAYS. Tell me, are they dually eligible because——

Ms. BUTO. They are low-income Medicare beneficiaries. They cannot afford—for example, they meet the standards for either Medicare spend-down or the QMB provisions.

Mr. SHAYS. Wouldn't anyone in Title 19 be potentially dually eligible?

Ms. BUTO. No, because so many of the—I think it is two-thirds of the Title 19 population is mothers and children right now. They would not be——

Mr. SHAYS. I am talking about in the nursing homes. Anyone under Title 19 in nursing homes would be dually eligible.

Ms. BUTO. If they meet the Medicare requirements of Social Security. They have basically paid into Social Security. They are entitled to Social Security Medicare. But, yes, the vast majority would be eligible for both programs.

Mr. SHAYS. OK. So what makes it difficult to deal with this? On the surface, it seems like a no-brainer to me. There are two different programs. Admittedly, they have two different standards. So where is the problem?

Mr. Towns, you know, rightfully cautioned that we don't want people to be caught—hurt in the process——

Ms. BUTO. Yes.

Mr. SHAYS [continuing]. Of our dealing with this issue, the patients. But describe to me why this isn't an easy issue to deal with.

Ms. BUTO. Medicare covers mainly acute care services. The skilled nursing services that we cover are supposed to be post-hospital, related to a hospital stay. There is a 3-day requirement and so on.

Increasingly, the population, as Mr. Towns pointed out, is becoming more chronically ill. The demographics—people are living longer, they are more chronically ill, et cetera. So that post-hospital stay begins to, when they are in the nursing facility, turns into a chronic care management of some deterioration that occurred because they went in for a hip replacement or something else.

Medicaid pays for the so-called custodial care. When people are poor and they go into nursing facilities—and you have heard of people using all of their assets. They may have not been Medicaid eligible, but the nursing home costs $35,000 to $50,000 a year. After a couple of years, they use up all of their assets. They are poor. They are on Medicaid.

What they are doing at that point is not necessarily and usually not getting acute care followup, but they are there for a variety of other purposes having to do with their deterioration, such as Alzheimer's Disease or a variety of other conditions that make them eligible for nursing facility custodial care, which Medicare doesn't cover.

Now, the problem comes in when you have an individual who is custodial, who may have dementia, may have some other things that really make up a long-term nursing home patient. They are living there, and they fall or they have some acute episode which, in a legitimate sense, takes them back to the hospital. Medicare pays because it is hospital care, because it is doctor care. It is all the acute services covered by Medicare.

The problem comes in when the nursing facility sees that when somebody is ill, even though they could take care of the patient in the nursing home—they have the medication, they have the staff—but they would just as soon ship that patient off to a hospital, because it is now not their reimbursement issue. They have the financial incentive to, if you will, shift the patient.

It is those cases where it really shouldn't be done, not the cases where someone really needs to be hospitalized—they have a heart attack or need a bypass operation—where we have this problem of making sure that we know what is going on.

So that is one issue.

The other issue is for the nursing home patient who doesn't get admitted to the hospital but is getting a new wheelchair, wound care services, things that Medicare Part B covers that the nursing home, because it doesn't have to bill us for those, can really wash its hands of. You can have unscrupulous providers getting the patient's billing number and billing Medicare for those supplies, those therapy services, et cetera; and the nursing home is pretty, you know, indifferent in the sense that they are not on the hook or accountable; and it really is less cost for them if those services are provided by Medicare.

Mr. SHAYS. You are making an argument now why we need to deal with the problem. I am trying to understand why it is difficult to deal with the problem.

Ms. BUTO. I am sorry. OK, it is difficult because, in the case of Medicare, it has us working with 50 States and territories because each one of them has different rules for paying nursing homes. Some cover some things, some cover other things.

We are experimenting with the State of Minnesota in a very comprehensive way to pay together and to share data so that we know what we are paying for.

We also have begun to make our data available on who is eligible for what—at least let them know who the eligibles are—to States so that they can begin to, if you will, pay smarter when they pay Medicaid rates; and that has been difficult because of State rules of confidentiality of data and because again what they need and how they code things aren't necessarily compatible with ours.

We are experimenting with the State of Maine right now and have been with the New England States to begin to share data, but we found that we don't describe services the same way. They code

them differently, so it is hard to crosswalk those individuals. They may have different identifier numbers for people.

Mr. SHAYS. As you have started to describe this problem, do you have someone in your office who focuses only on trying to resolve this issue?

Ms. BUTO. There are people in our data shop who are dedicated to this—not entirely, they do other things—but who are working with the States on this issue of compatibility of data. So, yes, on that.

But we have people in other offices working on compatibility of policies, legislative proposals to make this work. We have an initiative that really talks about putting grants out to the States so that we can come up with common payment systems so we don't have both of us paying separately but we look to join our payment in ways that will get better care for the individuals. And that solicitation asking States to come forward with proposals that we can work with just went out.

Mr. SHAYS. We have a vote, and I am just going to try to move it along so we don't keep you waiting for 20 minutes.

We have a long list of areas, but we are still in the dually eligible. What I am hearing you say, the bottom line is that you have the Federal Medicare program. You—which is all Federal—you have Medicaid, which is 50–50 or 30–70, some mix of Federal and State or State/Federal.

You have, obviously, different kinds of programs run differently in each State. We have heard that before and we know it is just dumb. I know it is administrative, but it is also legislative, but I must be missing something. There must be something more that makes it more difficult to deal with this issue.

Is it a political problem? Who is saying, don't move forward? Or who is saying, if you do this you are going to hurt us, so don't do that? How would we be potentially hurting someone who is dually eligible? I just don't see it. It seems to me like it is our money, and we should——

Ms. BUTO. Yes. There is an issue between the States and the Federal Government that I guess really is a political issue which is that, first and foremost, these are Medicare beneficiaries. Medicare pays primary, Medicaid pays secondary.

The States feel, however, they are the most expensive beneficiaries; and they ought to have control over all of their health care costs. We don't agree, but the reason we have been able to work successfully with the States is that we have decided that the issue of who is in charge shouldn't be the issue, that we have to find a way to join the payments and jointly administer them.

We can do that. I don't think it is impossible. It is just time consuming and complicated because of the different payment mechanisms, coding, all of the technical issues involved in joining payments and having proposals that the States are willing to come to the table with us, to come with a pay to jointly fund these services.

Mr. SHAYS. Now, tell me what the negative impact is on us economically by our not dealing with dually eligible. What is happening? Give me some examples of what happens, where people, either through outright fraud or just through mistakes or inefficiencies, hurt us economically.

Ms. BUTO. What hurts us economically is having both programs sometimes paying for the same services and paying wastefully at times because, for example, the nursing home is not held accountable.

Mr. SHAYS. Tell me why, if it is a health care service paid out of Medicare Part A, you know, Medicare Part A is hospital—I am sorry.

Ms. BUTO. It is also skilled nursing.

Mr. SHAYS. So there is—skilled nursing in Part A would be in a nursing home, correct?

Ms. BUTO. Right.

Mr. SHAYS. So then tell me how a nursing home could possibly make a mistake without it being intentional to also bill Medicaid?

Ms. BUTO. Well, that is not—that is much less of a problem. When somebody is fully getting skilled nursing under Medicare, that is not the—the real problem comes when the person is really getting mainly Medicaid custodial nursing home care and then they bounce them back for a Part A hospital stay in Medicare or a Part B wound care service under Medicare. It is fragmented.

Mr. SHAYS. So a person might be sent back to the hospital, but they are still billing for them being in the nursing home and they aren't?

Ms. BUTO. When they discharge from the nursing home, they are not billing for the nursing home care per se; but the most wasteful part is that they could have provided that care and were supposed to under the rules, which, by the way, are also the Medicare nursing home rules.

Mr. SHAYS. And they also have hospitals in their—I am missing this part of it. If they are sending them out of the facility to the hospital, they are not their patient any more, period.

Ms. BUTO. Right. But the point is, sometimes they are sending people that don't need to be in the hospital.

Mr. SHAYS. OK. Well, that is one thing, but I don't think that that is the biggest problem.

We had lots of testimony last time that made it very clear that a number of nursing homes were double billing us, not that they were shifting them back to the hospital, which is inefficient and costly and wasteful, but not illegal.

Ms. BUTO. Yes. I think the double billing occurs on these supply issues as well as, in addition, on hospice care, where the nursing home really should be providing some of these hospice services maybe under the Medicaid rate. But the double billing really occurs in the medical equipment, in the therapy services where they are supposed to be providing those, and——

Mr. SHAYS. Let's talk about therapy services then.

Ms. BUTO [continuing]. Physical therapy, occupational therapy, speech therapy where we know of instances where the services—the therapy service providers are coming into the nursing home, basically getting services billed for Medicare beneficiaries who may or may not need them. The nursing home is not accountable. It doesn't, in a sense, take responsibility for whether those are needed services or not; and that is wasteful spending because we don't need to provide those services for individuals.

Mr. SHAYS. I am going to have to recess. As soon as Mr. Barrett gets in, he will just convene and ask questions. Thank you.

[Recess.]

Mr. SHAYS. My best-laid plan. No one came in my place. Sorry.

As I was going to vote, I was really thinking that I am not really satisfied yet with leaving dually eligible, because what I am hearing being said is that you have waste in that you are taking people out of nursing homes into hospitals when they could still be in the nursing home, admittedly at greater cost to the nursing home because they might require greater attention. But there is still nursing home responsibility. That clearly is wasteful.

The only potential kind of fraud is—that I have heard is that you have a dual-billing when you have a nursing home that is part of the overall charge, would include certain therapy or services, but also is billing for those therapy services to Medicare.

Ms. BUTO. Right. Supplies that are provided by both programs. The other thing——

Mr. SHAYS. Tell me, for the record, some kind of supplies that we are talking about.

Ms. BUTO. Incontinence supplies, wound dressings.

Mr. SHAYS. Those should be covered under the nursing care?

Ms. BUTO. Right, they really should be, because we actually have combined Medicare and Medicaid standards.

Mr. SHAYS. Why would there ever be a bill then for that kind of service if it is in a nursing home? Why wouldn't you throw it out right away? Because the Medicare people don't know that the person is in a nursing home?

Ms. BUTO. Well, that is part of the issue; and that is one reason why we are improving our sort of information on where things are being billed, if you will, and one reason why the new contracts that focus on fraud and abuse as a result of the legislation will help us focus on the providers and the suppliers in that area and the beneficiaries and what everybody is getting.

Mr. SHAYS. When you put a billing in for service, why wouldn't it say this person is in a nursing home? Why wouldn't we require that every time a person is in a nursing home? When a bill is submitted, you acknowledge that that person is in the nursing home. Why would that be so difficult? It is silly for you to sit back.

Ms. RUIZ. It is already on the bill.

Mr. SHAYS. If it is on the bill, why would we pay for any of that kind of service? Why would Medicare pay that?

Ms. RUIZ. We would not pay for something for DME, for example.

Mr. SHAYS. DME is?

Ms. RUIZ. Durable medical equipment, if the bill said the person was in a nursing home. However, lots of times that is not accurately reflected on the bill.

Mr. SHAYS. Is that viewed as fraud or what?

Ms. RUIZ. I think you would have to ask the IG. They would investigate whether it was intentional or not, but it frequently can be fraud.

Mr. SHAYS. I don't want to, you know, swallow camels and strain out gnats here, but I want to just get a simpler idea of—I still don't have a sense of where the difficulty is in dually eligible. It seems to me that if you are in a nursing home, there are certain services

you have no right to bill Medicare and that, if you did, it is just latent fraud. That is what it strikes me.

Are our systems so broken down that somehow a nursing home can feign that they didn't know? I mean——

Ms. BUTO. Well, let me just try to say that, because Medicaid, in the case of a nursing home patient who is there for the Medicaid stay, may pay for different items and services from one State to another, that nursing home should certainly know, and there should not be any confusion about that.

But State rates are not necessarily always that clear. They will pay a rate to a nursing home. Their benefit package of what is covered for a nursing stay should be known. What we cover for a skilled nursing facility or other supplies should also be known, but we are finding that one of the problems is deliberate fraud on the one hand and some misunderstanding or confusion, especially as the States have been changing what they pay for, which they have been doing under Medicaid.

So we need to do a better job of educating providers who really want to do the right thing so they understand when they are getting—when they ought not bill Medicare, if you will, or when they ought to just consider the charge covered by Medicaid. We are beginning to experiment in the home health area in both Connecticut and Massachusetts in doing that, but this is clearly another area.

Let me see if I can address the dual-eligibility. I was trying to understand where I thought you were going.

Mr. TOWNS. Would you identify——

Mr. SHAYS. It is silly for you to keep moving back and forth.

Ms. BUTO. My sense is what you are trying to understand is what is the most efficient way to pay for this service. It is one patient. Why can't we figure out how to pay appropriately? Why is there so much lack of coordination?

You know, clearly there have been proposals to either block grant the nursing home benefit entirely to the States. That has been one set of proposals on the Medicaid side. On the Medicare side, from time to time we have thought about what if we covered all of the cost of care for Medicare individuals in nursing homes. Unfortunately for Medicare, especially right now, Part A and the trust funds is a big issue; and if we take on an additional cost, even if we could get the States to maintain their effort, it would show up as an increase, big increase, especially with the demographic shift over the next 10 to 20 years in the Part A trust fund in financing.

So we are in that bad position where the States really don't want to take on the entire cost of care. They would like to control more of the care through managed care for people who are not in nursing homes and who are dually eligible, but they have not stepped up to the nursing home population except in a couple of States—Minnesota is one—to take on managing the Medicaid dollar in an efficient way under capitation.

So part of the difficulty is we are looking for some comprehensive solutions and—in some sense—because of the nature of Medicaid, we need those to be voluntary on the part of individual States. We are not in a position right now to mandate that States have to turn their money over to us so we can manage it or, vice versa, that we would want to turn all Medicare dollars over to the States because

their benefits are very different from ours. That is really the crux of the problem.

I wanted to make sure you understood that the PACE program, although it has been a small demonstration, that it looks like Congress is going to enact legislation that will make it widely available as a Medicare benefit as a provider type. We think that is very good, because the States want that and so does the Medicare program. So that is one area that we can begin to get at nursing home fraud and abuse.

Mr. SHAYS. OK. Let me recognize Mr. Barrett, and then I will come back. Mr. Towns, do you have more questions as well?

Mr. TOWNS. I have one. You go ahead.

Mr. BARRETT. I actually have no questions at this time since I just came in.

Mr. SHAYS. Mr. Towns.

Mr. TOWNS. Yes, let me—do you believe that it would be appropriate for nursing homes that receive Federal funds be charged a fee to pay for their inspection audit as a condition of receiving Federal funds? Because I get the impression that you don't have these audits too often, and there is a reason for it—probably is the cost and all of that. Have you thought about that?

Ms. BUTO. You are talking about user fees for nursing home—I believe we have thought of that. Don't we—for surveys. Yes, sir, I believe that we have, in a number of areas, really gotten some initial authority to charge user fees for inspections and surveys. It would certainly help in terms of the frequency. But we do nursing home audits more regularly than we do some other provider audits.

I think the complicated issue is, again, not just an audit of the Medicare costs, but of the joint spending and joint responsibility for Medicare and Medicaid. Until we get a way for all of the services provided to a person being billed to the nursing home under this consolidated billing arrangement, right now, some of those are suppliers or—you know, we have a bunch of different fragmented places to go to look at what is provided in that nursing home. That is why we feel we need this consolidated approach so that nursing home is accountable and we can go to that one place to look at the audit.

Mr. TOWNS. When you say more frequent, I guess I need to have—what do you mean by more frequent? I am not sure I understand that part. I don't want to be pushy either. But I am thinking that not a lot of audits are taking place, and if you are not looking to see what happens—and probably there is a reason for it, because once you get involved in this you are talking about costs.

Ms. BUTO. I am sorry. I was confusing two things. The survey I was talking about was the health and safety and those kinds of things. But the audits—especially under the new contracts where we have integrity contractors whose whole purpose is to look in areas for patterns and we have, I guess, a contract or an agreement with the Los Alamos lab to develop some software for us so we can begin to detect better patterns of fraud and abuse in these kinds of providers.

So we are definitely looking to improve the auditing and the frequency, and we are receptive to the notion of user fees to finance more of those audits. But I think a first step will be to have these

benefit integrity contractors really begin to focus in on all of the providers in an area like nursing homes, to look for comprehensive patterns and to use this more sophisticated technology.

Mr. TOWNS. Well, I am very concerned. Because I come from New York, and that is an area—you probably remember years ago in terms of the nursing home scandals, I want to make certain that we do not go back to this. That is a problem for me. You need to have some way to check to find out what is going on, and I think that we have to be a little bit more aggressive in looking.

Ms. BUTO. We agree.

Mr. TOWNS. Because people are living longer, of course; and we need to make certain that, in their later years, that they are not being abused.

Ms. BUTO. The other thing I wanted to mention is that the Kassebaum-Kennedy legislation for the first time actually sets aside dedicated funding for these kinds of reviews. Before, it has always been the issue of how much we could spend on these kind of audits was subject to a budget process. This will use trust fund dollars to—over quite a long period of time we have dedicated funding for this purpose—to look at fraud and abuse and benefit integrity; and that is really a vast improvement over what existed before.

Mr. TOWNS. Thank you very much, Mr. Chairman. I yield back.

Mr. SHAYS. I thank you. Mr. Pappas.

Mr. PAPPAS. Thank you, Mr. Chairman.

My question centers around the coordination between Federal and State inspections. Is there uniformity amongst the 50 States? And what kind of coordination or sharing of information is there between your agency and any of the State agencies that do inspect?

Ms. BUTO. Let me start, and then I will ask Linda to chime in.

The coordination varies. I think Operation Restore Trust was the beginning of real collaboration with the States as well as with the Justice Department and other investigative agencies. We have developed an investigative data base that we share with the States as well as with our Medicare contractors that gives us all a common understanding of the investigations and what is going on.

But we expect that with this expansion of our Operation Restore Trust kinds of efforts to target high-risk providers and suppliers that we are going to be in an even better position to share information and work with States to get at these areas of abuse.

Some States have started getting Medicare data from us and that has been—I mentioned earlier a task to make sure we are talking apples and apples when we talk about services. But the process has started.

There are five or six States now that are working with us to join those data bases together so they can do a better job of seeing what Medicare is paying for and what they are paying for, and I think both that and the target investigations and the investigative data base all will help make that collaboration better.

Linda, I am going to let you——

Ms. RUIZ. Ms. Buto has, I think, adequately described what we are doing in terms of law enforcement investigations. I just want to be sure that your question was not referring to initial or subsequent surveys for quality purposes in the nursing homes.

Mr. PAPPAS. It is kind of both. Certainly one of the primary concerns that many people have is over specific incidents, but specific incidents could be prevented if there are adequate regular inspections. Again, this sharing of information and when it is appropriate—and sometimes it may not be conducive to any kind of positive application of information that may be passed from a State inspector to a Federal agency, but sometimes there is. The professionals themselves, I think, are best able to assess what is necessary information or helpful information.

Ms. BUTO. The other thing I just wanted to add—and I don't know if this is what you were going to say, Linda—but we are beginning to get data. We will start getting data on the quality of care being provided, the nature of services being provided to people in nursing homes that will enable both us and the States to, from a quality standpoint, make sure that we are not getting shoddy results or poor care for the money that is being paid out.

Ms. RUIZ. I guess what I was going to say was we contract with the State survey and certification agencies to do the bulk of the surveys, and they always share the information coming out of those surveys with us.

We do have some Federal surveyors. They do not do the bulk of the work. On occasion, they go in where there is a complaint made or there is some lack of resources on the part of the State to go in on an immediate basis. Sometimes they may go in to do sort of a check on what was already done. That information is always shared between the State and the Federal agency.

Mr. PAPPAS. Is there any difference, generally speaking—I am looking for generalities—any difference between for-profit, not-for-profit or government owned and operated nursing home facilities?

Ms. BUTO. In terms of performance? We have seen a lot of growth in the for-profit area in terms of the numbers. But in terms of performance, we hold them all to the same standards; and for those that do not comply, there are a series of intermediate sanctions that apply; and they are treated all the same. I would be glad to take a look at the data, but I don't believe that we see any patterns of differences in the behavior or compliance.

Mr. PAPPAS. One last question, is there anything that you think that we in the Congress could do to help you folks do what you are being expected to do?

Ms. BUTO. Yes, we have a long list of proposals that we would like to enact. Just in brief, in the nursing home area, I think nursing facility prospective payment and consolidated billing are really key to getting the payment accountability to where it should be. There are a series of different sanctions that we have asked for, some sanction authority.

We particularly would like to get the Social Security numbers of, basically, the folks who own and operate these suppliers and providers so that we have some way of making sure they don't get out of one bad business and move to another State and get a different provider number. It is very hard to track them. We have asked for that, plus the employer identifier number. Both of those are very important to us.

Mr. TOWNS. Will the gentleman yield?

Mr. PAPPAS. Certainly.

Mr. TOWNS. Do you have a Federal data base?

Ms. BUTO. Yes.

Mr. TOWNS. You do?

Ms. BUTO. You mean generally on what we paid for?

Mr. TOWNS. No, in terms of where you had—if a home had been cited for abuse, sanitary conditions or whatever it might be, that I would be able to plug into your data base to get information on a specific home, whether or not they have been cited for this or cited for that?

Ms. RUIZ. We do have a data base that indicates certification citations. It is not available to the public, however. It is used by HCFA.

Mr. TOWNS. Well, you know, I guess, just to personalize this thing for a moment, I was thinking that maybe we should have something like that in case my children want to put me in a nursing home. They would know whether or not the nursing home has been abusive or not. That, to me, seems to be information that one would need.

Ms. RUIZ. I would believe that most States have that kind of information available to consumers, but we could check on that.

Ms. BUTO. Let me just mention, we did—and I believe it is still under development because it causes problems. We did try to develop, if you will, a nursing home report card kind of document at one time. The problem with it is that often by the time you develop the report card instrument the institution has corrected its problems. Often the problems are not health and safety problems. They may be technical issues of not having good documentation in one area, which they then are able to fix. So the issue of how you do those kinds of things is difficult.

But I think we are looking for ways to make information better available to consumers so they can have some benchmark to figure out what facilities are doing.

The one thing we can say is that where there are serious issues of health and safety or patient care, we do move against facilities either to terminate the provider contracts or to not allow—there are a series of sanctions that we can apply to not allow them to sign new people up, et cetera. So there are a variety of things we can do. It is difficult to do the information in a way that is current and that is fair both to the people who are trying to figure out which nursing home and to the facilities as well.

Mr. TOWNS. I don't want to put you in a spot. I am really a nice guy. But suppose we come forward with legislation. What do you think the reaction would be from the agency?

Ms. BUTO. Legislation to?

Mr. TOWNS. Talk about a Federal data base that would have specific kinds of information in it where I could push the button to find out if that is where I would like to put my mother or father.

Ms. BUTO. I think the reaction would be—the first reaction would probably be, gee, that sounds like a great idea. The reaction of a lot of people would get very critical, though, if the data base was inaccurate or out of date; and I can imagine providers who felt they were unfairly identified. So I think the reaction is going to vary.

Consumers who go to one that looks good in the data base and then it turns out there has been a recent complaint that they think

is serious—so, I think the initial reaction is probably positive. It sounds like information consumers should have. But it is really going to depend on how accurate, how reliable and how valid that information is and whether people feel they can really rely on it. I think the credibility of the data base is critical to whether or not that going to be well-received down the road.

Mr. TOWNS. Thank you very much.

Mr. Chairman, I think we should talk.

Mr. SHAYS. We talk a lot.

This committee was responsible for Title II being inserted in the Kassebaum-Kennedy bill, and we were responsible because we had extraordinary cooperation from the administration. Much of what was included were suggestions by the administration. So I want to say for the record we have been grateful to work with your office. You have been very cooperative and very helpful, and I think we have made lots of progress.

I am just aware of the fact that we are focused on so many things in Congress—balancing the budget, slowing the growth of Medicare—which, obviously, one way you do it is save money in fraud and waste and abuse. I am also aware that things don't happen because you have committees of jurisdiction that may be jealous if another committee gets involved.

You have all of these things. I am really trying to sort out why you think it may take so long or why it is taking so long to move forward on some of these things. If I asked you what the most important thing to deal with dually eligible patients was, the most important reform, what would that be?

Ms. BUTO. I would have to say one thing as a caveat up front. There are distinctly different groups. The young disabled have a whole set of issues that are very different from the elderly in nursing homes, and so there are really different——

Mr. SHAYS. I think I know what the answer is that I would be looking for. I am curious, and then I would tell you what I would put down.

Ms. BUTO. I have to say from my personal experience from having looked at this area, for the dually eligible and especially for the elderly, the big issue——

Mr. SHAYS. The biggest reform we could put that would enable us not to be making double payments.

Ms. BUTO. OK. That is a different question. Some sort of combined payment approach——

Mr. SHAYS. Some kind of coordinated billing.

Ms. BUTO [continuing]. For nursing home patients.

Mr. SHAYS. Let me not spend a lot of time on some of these issues. Let me focus on that one issue, and say what do we do—what is going to be required to do it? Is it administrative or legislative or a combination of both? Just give me a sense much what it would take to do coordinated billing.

Ms. BUTO. It would take a willingness on the part of States to do it, No. 1.

Mr. SHAYS. So we need their buy-in.

Ms. BUTO. No. 2, there is a real question as to how you actually combine the payment. Because nursing home patients range from hip fracture recovery to somebody who has got dementia and is to-

tally dependent on the nursing home. How do you make those payments the right amount to make sure that they are getting decent quality of care without overpaying? So the issues of how you figure that out are not real simple, quite frankly.

I guess the third thing would be to have an accountable nursing home so that the nursing home that is providing care should be accountable in a way that we can properly sanction them, that we can properly reduce payments where they are not——

Let's assume for a moment that they are combined payments, that we can figure that out. Then when you reduce payments you have to figure out who gets the savings. I assume we would have to figure a way of splitting Medicare and Medicaid savings so that States got some of the savings and the Federal Government got the rest.

Mr. SHAYS. It strikes me that there is a lack of incentive. There is an incentive for Medicaid to basically send that patient to the hospital so it is Medicare, even though it may be more expensive; and there needs to be some way to have an incentive that we do the most cost-effective thing.

Ms. BUTO. Yes. There is one intermediate thing that we are trying that I think helps, which is Medicare case management of the nursing home patient. Medicare goes in and has somebody, a nurse or somebody, whose job it is to make sure that that tradeoff of care between what the nursing home is providing and what Medicare would provide is appropriate. That is a service we are looking at. Because there you have got an individual whose job it is to be the person's advocate and to worry about total dollars, not just one or the other. So that is a model we are taking a look at as well.

Mr. SHAYS. I am having a little sensitivity on why it may be difficult to be a senior in a nursing home. Because I have needed to get my glasses fixed, my reading glasses that combine with long distance. Finally, it was going to take a week. I didn't want to buy a second pair, so I gave them my glasses. I have been frustrated this entire hearing trying to read and look up.

But lots of what I want to be able to do is just read some of your testimony in which you outline extraordinary abuse—your testimony is fine testimony—extraordinary abuse, much of it pointed out by the IG's office.

But in one instance it says where you have a physician who billed $350,000 over a 2-year period for comprehensive examinations and never once examined the person. If a doctor or someone giving therapy comes to a nursing home, do they have to get the nursing home to sign off that they did what they said they did?

Ms. BUTO. I don't know the answer to that. We can get that for the record.

Ms. RUIZ. The answer is no. There ought to be a record in the patient records of the visit. But there is no requirement that somebody responsible in the nursing home certify that the physician visited.

Mr. SHAYS. I would think one way we could deal with this issue is that any time a service is provided in a nursing home, the nursing home has to agree that that service was provided. You walk in our building, you cannot bill for that unless it is certified by the nursing home that you did it. What would be the problem with

doing that? I will be asking others, but what would you think would be the problem?

Ms. BUTO. I cannot think of one right off the bat. I think that that is a reasonable—it is kind of what we had in mind when we talked about consolidated billing. The nursing home in a sense has to sign off on everything that is provided and billed for.

Mr. SHAYS. Why don't I conclude by having you tell me more about PACE and how that works. You are saying that you would be doing something like that under that program.

Ms. BUTO. Under PACE?

Mr. SHAYS. Not under PACE. What was the program that you made reference to? The case management?

Ms. BUTO. I am sorry, case management.

Mr. SHAYS. I confused you. You don't need to apologize. I apologize to you.

Ms. BUTO. I am beginning to feel like I need new glasses.

The case management program I am talking about is one where we have already experimented. The earlier version we used, basically, nurse practitioners and nurses to manage a lot of the primary care and sort of under a capitated arrangement managed the services provided to nursing home patients.

What we want to do, though—and that was pretty much limited to capitation of the Medicare service. We found that it had a lot of potential to limit unnecessary bouncing to the hospital or the outpatient department, et cetera, because the nurse practitioner was managing and making sure that the nursing home did its job and was paying appropriately, and we were paying that person to watch over the case.

The other sort of variation on that that we are taking a look at is for people who are basically Medicaid nursing home patients—there is some possibility again for the nurse to manage the Medicare part but also the Medicaid services involved under a primary care kind of approach. We pay the nurse under Medicare, and they try to manage the whole set of services the patient is getting.

It is less focused on just the Medicare service and more focused on the comprehensive care that is being provided. That has some real potential again to avoid the bouncing around that patients face, if somebody is managing the case, especially for a vulnerable person who is not able to fend for themselves.

Mr. SHAYS. OK.

Ms. BUTO. So those are demonstrations again. We don't really have that kind of authority under Medicare now, and we need to know whether it is cost-effective and it works or whether it just adds cost to the system. But a number of people have suggested we look at that, and we think it is worth looking into.

Mr. SHAYS. My regret is that we haven't taken full advantage of your testimony before the committee. I think what is going to happen is your continued dialog with this committee staff. But I would like some kind of sense of a time line of what we want to achieve and when we want to achieve it. I have this sense that we are having a pilot program here, we are having another program here, and it is a good-faith effort to try to get at this problem, with no sense that you would not come before us next year and we wouldn't be just having a continued dialog.

I guess we will try to deal with this in our report on this issue. But I would love to see legislation that we would be pushing, I would love to see administrative changes that you would be doing, and I would love to see some kind of outline of some goals that we said we would achieve by this. It might help us provide maybe a sense of urgency to some parts of this.

I don't know, I am just thinking out loud a bit, but I just have a feeling like we are just a lot of good people trying to do some good things, but we will be doing this forever unless we kind of put some time line and deadlines to this. Do you have deadlines?

Ms. BUTO. Well, yes we do.

Mr. SHAYS. Can you give me an example of that?

Ms. BUTO. I guess I am aware of a couple of things—that it takes time, especially with this population. We put out in May basically a call to the States that said, we want to work with any State that wants to work with us around this population to come up with innovative ways to serve them better and—especially nursing home patients—and to pay for the services jointly rather than to have this disaggregated payment system. We put that out in May, and the proposals are due this summer.

That, we hope, will produce something that will come up with some approaches that we can use beyond the ones that we have already started. We think the States have some good ideas, and we have some good ideas, and we ought to try to do that. I know that that is going to produce something.

We have three demonstration projects that will take us a long way in this area. One is Minnesota. There is a proposal now from six New England States including Connecticut, a concept paper to talk about serving the dual-eligibles in the six New England States.

Mr. SHAYS. As one unit?

Ms. BUTO. No, each of the States will come in with its own proposals, although they have a number of common elements. The data collection will be common. There will be a number of things that the States want to do jointly. We are sharing data with all of them. That is very seriously probably coming to a head again this summer with specific proposals.

Maine and Massachusetts are the two that are in the position to really go forward fastest. I think we are going to learn some important things there about how we can collaborate.

We have some limited lessons in other areas; and, again, PACE has a permanent part of the Medicaid program as an option which it looks like it will be—as a result of the reconciliation process will be a major advance in Medicare. We have never had that dual-eligible option available, if you will. I don't think we are running in place or playing at the margins. I think there are some big things going on.

I am also mindful of the fact that, after this Congress, HCFA will be—there is a tremendous amount work coming our way, and this is one of the things that we have already started. I expect we will continue, and PACE is part of that, but there will be a tremendous workload associated with the new reconciliation.

Mr. SHAYS. I think that we will probably get to the next panel.

Mr. Pappas. Is there anything that you want to say?

Closing comments from both of you before we go to the next panel?

Ms. BUTO. The only thing I would like to say—I have said this before—I think that the dual-eligibles are both the hardest population to deal with and provide the most opportunity for us to do the right thing. They also represent—since they are such a large share of spending both in Medicare and Medicaid, if we can responsibly address these issues I think we will go a long way toward ensuring a better future for Medicare and Medicaid.

Mr. SHAYS. Ms. Ruiz.

Ms. RUIZ. I have nothing. Thank you.

Mr. SHAYS. Thank you both for being here.

Mr. SHAYS. Our next panel: Ms. Faith Fish, a long-term care ombudsman from New York; Ms. Pat Safford, California Advocates for Nursing Home Reform; and Ms. Tess Canja, Board of Directors, American Association of Retired Persons.

If all three of you would come forward and remain standing, we will swear you in.

[Witnesses sworn.]

Mr. SHAYS. If we could, we will go in the order I called you, beginning first with you, Ms. Fish, and then we will go to you, Ms. Safford, and then Ms. Canja.

We welcome you here. If you would first present your testimony and make the comments you want to make, feel free to do that, and I will roll the clock. But the first pass is 5 minutes, and then I will give you a little bit more time if you need it.

STATEMENTS OF FAITH FISH, LONG-TERM CARE OMBUDSMAN, NEW YORK; PAT SAFFORD, CALIFORNIA ADVOCATES FOR NURSING HOME REFORM; AND TESS CANJA, BOARD OF DIRECTORS, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. FISH. Thank you very much.

Excuse me, much of my written testimony, as a matter of fact, will relate to specific questions that you did ask; and I also have incorporated some examples that I brought of actual cases that we worked on to give you an idea of what is happening in New York State and across the country.

First, I thank you for giving me the opportunity to come here and to talk about the New York State long-term care ombudsman program and also the successful efforts of Operation Restore Trust.

In New York State, I represent over 140,000 New York State long-term care residents. In the Nation, we are talking about——

Mr. SHAYS. How many did you say?

Ms. FISH. 140,000 long-term care residents in nursing homes and adult homes. In the country, there are 1.6 million. Today they are not here to speak before you because of many reasons: They may be ill, reasons of finance, and also fear of retaliation for coming to speak with their voices. So I come here to speak on behalf of them.

Now what is the role of the ombudsman? What do we do? The ombudsman is there to support and protect the residents. We are there to ensure that they get quality care and that—we talk about quality of life, something that you have all been talking about in your opening statements.

In New York State, we have over 550 volunteers that are trained—duly trained and authorized to go into nursing homes. Upon certification, what happens is ombudsmen are actually assigned to a facility. When you are assigned to a facility, you are there somewhere between 4 to 6 hours a week.

Mr. SHAYS. These are volunteers you said?

Ms. FISH. Right. These are volunteers that are trained, and they are trained in the 36-hour training certification program.

When they are trained, they go in 4 to 6 hours a week. Now this is very different than regulatory agencies that go in once every 18 months or upon situations of neglect and abuse. So we feel that our constant presence there does a couple of things. One is, we are able to deal on the spot with complaints and resolution of complaints. But, second, it is also a prevention. When you are there on a regular basis what tends to happen is abuses do not tend to occur as much.

Let me give you an example—a short example of a case that one of our ombudsmen wrote up. It is a very, very short summary.

In this particular nursing home, approximately 2 months ago a resident developed a small sore on his toe. Due to the lack of aggressiveness in treatment, medical treatment, the resident now has blackened legs to the knees and a giant hole in one hip and one developing in the other. The resident went from ambulating freely and independently to a bedridden person with severe pain.

Despite constant reporting of pain and sore sizes and growth, we feel nursing was very lacking in seeking prompt care and didn't aggressively contact the doctor. The above resident is scheduled for a bilateral amputation. A good quality of life, pain free, could have been accomplished if treatment was sought sooner. That is one example.

Now, the ombudsmen, as I said before, are the only advocates that are in nursing and adult homes on a regular basis. This is one of the reasons why we became and were sought after as partners in Operation Restore Trust. In May 1995, we became very involved with this.

But I know you know all about Operation Restore Trust, so I am not going to go into any of the details about that. But I want to tell you specifically about the model that we have in New York State, because I think it speaks or addresses some of the issues that you asked before.

Under the leadership and the guidance of Governor George Pataki, a State work group was developed; and this State work group was a coordinated effort with the Attorney General's office, the State Department of Health, the State Department of Social Services, and the Division of Criminal Justice, with the State Office for Aging ombudsman program heading it up.

The purpose was to bring all of these agencies together. One interesting thing that we found—you talked about what are some of the barriers of people coordinating these efforts—is we found that people weren't talking. They simply weren't talking to each other.

So let me tell you some of the things that we did that have been used as an example for the rest of the country, and they are using some of the things that we have done in New York State.

We approached it with three steps. We approached it with education and outreach. We decided that—how do you best find out about fraud and abuse? You best find out about fraud and abuse by actually educating people and teaching them what to look for. That is one thing. So we went out and we trained all of our ombudsman volunteers to, in fact, go out and look for certain things. We taught them certain red flags to look for.

Then we looked at systemic changes. Well, if you find a complaint and you resolved it, what about the systems that we are talking about? What about the dual payments that we are talking about?

Well, during one of our meetings, the State work group met with the Federal work group. When they both came together the Department of Social Services, Medicaid Division, started talking to the people in Medicare. What happened is that they said—we never really talked before—Medicaid people said, how about if we start sending you some of the things that we think are dual payments?

They did, and now we have a system that is being used in New York State where the people in Medicaid are talking to the people in Medicare, and in one quarter they found over $1.1 million in dual payments, dual billings that are taking place. Something as simple as talking, getting together, communicating.

So that is one of the answers that I would give to you is communication, people sitting down and working it out. That is one of the things.

Mr. SHAYS. I just want to be clear. Who is talking?

Ms. FISH. OK. The State work group, which consisted of the State agencies I talked about—the State Department of Social Services; State Department of Health, OK, with HCFA, the Administration on Aging; and the Office of Inspector General. Those are the three Federal partners. I am sorry. I forgot to mention that. That was the systemic part of it, looking at those services.

Now the third part was complaint handling, and I was happy to hear about talk about quality care. While making the system more efficient is important, we also want to make the system responsive, so I want to talk about the cases.

When we first became involved in Operation Restore Trust, I was not a believer. I could not understand how an ombudsman volunteer could go in and start becoming an investigator until I came home. I came home, and we began to find a number of cases after we trained our volunteers, cases like this:

A podiatrist wanted to make molds on every resident's feet and make custom shoes, whether the resident could walk or not. Many were in wheelchairs. A family complained to the ombudsman about being billed for hundreds of dollars of bandages 1 month. Bandages for a scratch on this person's leg was $300, and the resident was responsible for paying $127 of this.

One of the other things you talked about, therapists. We found that when we went into nursing homes that there would be group therapy. Instead of giving the individual therapy that Medicare and Medicaid were being billed for and that the residents should be getting, they had what they called "wave therapy." Wave therapy is when a therapist walks into a room with a group of people,

they wave, and they walk out and bill individually. That is called wave therapy.

We found an example of an administrator, after we trained our ombudsman—an ombudsman goes in and sits on a residents council; and the administrator comes in and says, look at the explanation of benefits that the person was supposed to have received. It is too confusing to nursing home residents. They don't understand. So what we are going to do is we are going to keep them.

And the ombudsman said, you can't do that. First of all, there is a copayment; and that person has a right to see that. Second, there is an ombudsman in there to discuss it with them. Third, it is a violation of a patient's rights to keep their mail.

So what happened was that the residents now have the ability—continue to have the ability to review the explanation of medical benefits.

Another case, where a family member comes in and finds their mother crying hysterically. The ombudsman walks in, and the person reaches out and hands the ombudsman a sheet of paper, an explanation of medical benefits, and said, my granddaughter just opened this. I am so ashamed. I am so embarrassed.

The explanation of medical benefits read that Medicare was being billed for this person for alcohol rehabilitation. This woman was never an alcoholic and was not a drinker, but her granddaughter opened this up and began to say—it was just humiliating, absolutely humiliating to the person.

Mr. SHAYS. Let me get to our next witness soon, so if you would kind of conclude. You have given us some very good examples, so I am grateful to you.

Ms. FISH. OK. I will conclude with one last statement. I urge to you support and expand on Operation Restore Trust. The momentum has to continue in this case.

My last statement is this: Ombudsmen deal with many frustrations while working with agencies and families. Sometimes I wonder why volunteer ombudsmen wish to continue trying to overcome the obstacles they face. Then I speak to a volunteer and hear a story about a resident that he or she has helped, and every one in this room will remember a face of someone who needed help or a story that touches our hearts.

Most ombudsman residents cannot be here today to talk with you, but they silently watch and wait for your help. My testimony today is on behalf of over a million voices asking not to be forgotten.

I would be glad to answer any questions when the time comes; and I thank you very much.

[The prepared statement of Ms. Fish follows:]

I thank you for this opportunity to speak to you today about the New York State Long Term Care Ombudsman Program and its role in the successful efforts of Operation Restore Trust in New York State.

Our Office of the State Ombudsman represents over 140,000 New York residents who reside in nursing and adult homes. I come before you today as a voice for all residents of long term care facilities who are unable to come before committees such as this to express their concerns. This population constitutes the most vulnerable segment of our society and are most often the victims of Medicare and Medicaid waste, fraud and abuse.

The role of the Long Term Care Ombudsman Program is to advocate on behalf of individuals residing in nursing and adult homes. This program, unlike any other, has as its sole purpose supporting and protecting the residents of long term care facilities. Our concern is the quality of care and the quality of life that residents have living in these restrictive settings.

In New York State, the State Office for Aging, under the direction of Walter G. Hoefer, administers the Ombudsman Program. The Office of the State Ombudsman has direct responsibility for 59 local programs with over 550 volunteers. Upon completing a 36-hour training and receiving certification from the Office of the State Ombudsman, local volunteers are assigned to a facility

where they visit with residents 4-6 hours per week. Upon receiving this certification a duly certified Ombudsman has unrestricted access to nursing and adult homes. This allows citizen volunteers to maintain a constant presence in the facilities. In doing so, Ombudsmen volunteers form a strong rapport with the residents which enables them to express their concerns with greater ease.

The purpose of the Ombudsman Program is to ensure that the voice of the resident is heard. With the approval of the resident, Ombudsmen act on these concerns and on any violations of the rights of residents. In addition to resolving individual problems, Ombudsman casework lays the foundation for systemic change within the long term care system.

The Older Americans Act clearly supports a wide-range of Ombudsman responsibilities for residents in long term care facilities which includes advocating for residents' rights. Ombudsmen are not regulators, nor do we have the administrative authority to enforce the law. We are independent advocates whose purpose is to ensure that the system is responsive to the residents' rights and needs. We achieve our purpose by working cooperatively with other agencies and providers (i.e., doctors, therapists) to ensure that residents are being heard.

Ombudsmen are the only advocates that are in nursing and adult homes on a regular basis. Volunteer Ombudsmen are the only ones that have regular contact with residents and families. It is for this reason that Ombudsmen were asked to become partners with the Office of Inspector General and the Health Care Financing Administration in Operation Restore Trust (ORT).

Operation Restore Trust, implemented in May, 1995, is a federal/state partnership designed to combat waste, fraud and abuse in Medicare and Medicaid programs. It targets provider fraud and abuse in nursing homes, home health care services, including hospice care, and in the durable medical equipment industry. It began in the five demonstration states where 40 percent of Medicare and Medicaid dollars are expended -- New York, Florida, Texas, Illinois and California. Because of its initial success the program has recently been expanded to twelve additional states -- Arizona, Colorado, Georgia, Louisiana, Massachusetts, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, Virginia and Washington.

Each of the five original ORT states decided to initiate an approach that is unique. I am here today to tell you about New York State's model approach.

Under the leadership of Governor George E. Pataki, a State Operation Restore Trust Workgroup was convened in August, 1995.

I was pleased that the Governor appointed me to coordinate this Statewide effort. State participants include the Office for the Aging, the Attorney General's Office - Medicaid Fraud and Abuse Unit, the departments of Health and Social Services and the Division of Criminal Justice Services. Our federal partners include the Administration on Aging, the Office of Inspector General and the Health Care Financing Administration.

Governor Pataki's objective is to provide quality care to residents of New York State that are in need of medical care. Under the direction of Walter G. Hoefer, Director of the New York State Office for the Aging, I was instructed to develop a work plan with the State Workgroup that would meet this objective.

For a process, we used a three-step approach:

1. Education and Outreach - Staff from each agency in the federal/state workgroup participated in the development and training of over 650 volunteer Ombudsmen and Health Insurance Information, Counseling and Assistance Program (HIICAP) volunteers across the state, presented information at community forums, and developed a training for senior center staff in New York City. Our education and outreach goal was and continues to be reaching as many senior volunteers as possible to educate them on potential Medicare and Medicaid fraud and abuse. Training manuals, videos, and other training materials are available for

use in the training of new Ombudsmen, HIICAP and senior center volunteers and community forums. Many of the training materials developed in New York State are being utilized in other states.

2. Systemic Changes - Systemic issues are examined in order to make changes in the current system that would allow New York State to provide quality health care services with greater efficiency. For example, there have been over 70 referrals of double billings totaling over $1.1 million from the New York State Department of Social Services Medicaid Division to the Medicare's Durable Medical Equipment Carrier (DMERC). The DMERC is responsible for processing Medicare claims for durable medical equipment, such as wheelchairs and other medical equipment. Before the establishment of Operation Restore Trust, the New York State Department of Social Services made no referrals to the regional DMERC.

Under Operation Restore Trust, the interagency workgroup created by Governor Pataki, provides a vehicle for direct communication with the participating state and federal agencies to identify barriers to providing quality care to individuals receiving Medicaid and/or Medicare. Operation Restore Trust combines the efforts of three federal agencies within the Department of Health and Human Services: the Office of Inspector General, the Health Care Financing Administration and the Administration of Aging.

The New York State federal and state partnerships coordinate all activities within these two workgroups. By coordinating activities and sharing information among its investigatory, entitlement and advocacy agencies, New York has strengthened its ability to identify, investigate and prosecute Medicaid/Medicare fraud and abuse. This ability to coordinate activities will also serve as a strong deterrent against future fraud and abuse.

3. Complaint Handling - Volunteer Ombudsmen receive complaints concerning potential Medicare or Medicaid fraud and abuse. Many complaints are received regarding the interpretation of material presented on the Explanation of Medical Benefits (EOMB) form. This form contains a description of what services have or have not been provided to a beneficiary.

As the only trained advocate that maintains a regular presence, Ombudsman have an unexpected role in reducing Medicare and Medicaid fraud and abuse. We may hear residents complain of never having the opportunity to talk with their physician, yet Medicaid may be billed for nonexistent visits. A podiatrist wants to make molds of every resident's feet and provide custom shoes whether the resident is able to walk or not. A family complains to the Ombudsman about being billed for hundreds of dollars for bandages when the resident has a scratch on her leg. Wheelchairs not needed for ambulatory residents start being used, and the resident losses muscle strength.

An example of our complaint handling skills was highlighted when an administrator of a nursing home decided not to deliver any mail that included an Explanation of Medical Benefits. This decision was a direct violation of the Resident's Bill of Rights. It also sent up a red flag that there may be a reason that an administrator may not want anyone to see the Explanation of Medical Benefits. As a result of our specialized training on fraud and abuse, the volunteer Ombudsman was able to stop the administrator from keeping the residents' mail. Residents now have the ability to review their Explanation of Medical Benefits to identify fraud and abuse. This capacity is critical in Operation Restore Trust.

A potential fraud situation was identified when a resident gave the Ombudsman a copy of an Explanation of Medical Benefits showing that she was receiving rehabilitation services for alcohol abuse. This resident was humiliated and extremely upset. The resident was not an alcoholic and had never received any services. This case has been referred to the Office of the Inspector General and is now under investigation.

Another fraud and possible abuse situation occurred when an active and alert resident received a wheel chair even though she did not need one. Because it was in her room, she began to sit in it. Its presence convinced her that maybe she did need the wheelchair. Within a few months she was unable to move without

it. The wheelchair was billed as a needed item. There were two unnecessary costs associated with this incident -- the cost of the wheelchair, but more important -- the long term personal cost due to the resident's lost independence. For sake of profit, the person could no longer walk. Her independence was sacrificed for greed.

In coordination with our federal partners, the New York State Operation Restore Trust Project has identified over $25 million in Medicaid and Medicare fraud by increasing communication between participating federal and state agencies. This Project is still in its infancy. I believe that a phenomenal increase in savings would result with the expansion of Operation Restore Trust to all fifty states.

There are over 7,000 Long Term Care Ombudsmen volunteers in the United States. The Long Term Care Ombudsman Program provides one of the most cost effective services available to seniors today because most Ombudsmen (and HIICAP) are unpaid volunteers. With additional resources for training more volunteers, we could expand our outreach and educational capacity. This ability would multiply our savings in fraud and abuse detection and provide our volunteers with the knowledge necessary for them to act on behalf of nursing and adult home residents. The volunteers would empower the elderly to recognize potential fraud and abuse. The savings in dollars to Medicaid and Medicare would increase

substantially.

I urge you to continue to support and expand Operation Restore Trust. A relatively small investment of federal dollars can save millions of dollars that are currently being lost to fraud and abuse. One potential means of providing the needed financial support would be to allow each state Operation Restore Trust Project to retain a percent of the savings that it identifies as an incentive to broaden its operation. In cooperation with the Administration of Aging, the State Units on Aging, local Ombudsmen, HIICAP volunteers, local offices for the aging and senior centers could utilize this increased funding for legitimate services needed by the public.

This momentum must continue to move forward to provide quality care and prevent fraud and abuse by ensuring federal, state and local dollars are spent for services needed by the elderly. The New York State Office for the Aging in cooperation with the Administration on Aging has established a viable access to the vulnerable senior population at risk of becoming victims of Medicare and Medicaid fraud and abuse. Efforts in New York State have served as a model in other states but the momentum must continue. Unless this occurs we may never be able to replicate these achievements again.

Ombudsmen deal with many frustrations while working with agencies, families, facilities and providers. Sometimes I wonder why volunteer ombudsmen wish to continue trying to overcome some of the obstacles that they face. Then I speak to a volunteer and hear a story about a resident that he/she just helped. We all remember a face of someone who needed help or a story that touches our heart. Most nursing home residents cannot be here today because of lack of funds or illness. They silently watch and wait for our help. My testimony today is on behalf of over a million voices asking not to be forgotten. We have an opportunity today to address the needs of the elderly by deciding to continue and build on the success of Operation Restore Trust. The people who contact us are the fathers, mothers, grandmothers, grandfathers, aunts, uncles, and elderly neighbors in our communities.

I would be happy to respond to any questions you may have regarding the New York State Ombudsman Program or New York State's efforts in Operation Restore Trust.

Thank you again for inviting me to speak with you today on the role of New York State Long Term Care Ombudsman in protecting of our most vulnerable population and the detection of Medicare and Medicaid waste, fraud and abuse under Operation Restore Trust.

A first year Accomplishments

Health Care Fraud Prevention

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MISSION STATEMENT

The mission of the New York State Operation Restore Trust Work Group is to establish a coordinated state-federal approach to prevent fraud and abuse in the Medicare/Medicaid programs. This mission will help to ensure that beneficiaries of these programs receive both quality care and appropriate services. Further, this will enhance the public's confidence and trust in the administration of the Medicare and Medicaid programs.

STATE WORK GROUP STAFF

Convener:

Governor George E. Pataki

Chairperson:

New York State Office for the Aging
Faith E. Fish, State Long Term Care Ombudsman

Participants:

New York State Office for the Aging
Honorable Walter G. Hoefer, Director
Nicholas J. Rogone, Director of Program Implementation & Evaluation
Mark P. Manfredi, Ombudsman Program Representative

New York State Office of Attorney General
Dennis Vacco, Attorney General
Stephen Spahr, Deputy Attorney General, Medicaid Fraud Control

New York State Department of Health
Barbara A. DeBuono, M.D., M.P.H., Commissioner
Robert Dougherty, Assistant Director, Bureau of Home Health Care Services
Robert Welch, Health Program Administrator II

New York State Department of Social Services
Brian J. Wing, Acting Commissioner
James White, Director, Bureau of Program Integrity
Mark Ives, Director, Fraud and Abuse Activities
David Dorpfeld, Chief Cost Containment I

New York State Division of Criminal Justice Services
Paul Shechtman, Director of Criminal Justice & Commissioner
F. William Kervan, Associate Training Technician (POLICE)

Federal Liaison:

Office of Inspector General
U.S. Department of Health & Human Services
Linda Little, New York State ORT Coordinator

Operation Restore Trust in New York has far exceeded our expectations. Our ability to protect the integrity of federal health care programs has been greatly enhanced by the involvement of New York State agencies. During the period that this report covers we have identified questionable billings of over 17 million dollars in federal and state funds. New York State has taken unprecedented steps toward removing barriers to information and data sharing through joint federal/state initiatives that benefit both state and federal programs. The federal and state work groups have shown tremendous commitment to these initiatives. Operation Restore Trust will end as a demonstration project in a few months but it will live on in New York State as our work has only just begun.

Linda Little
New York State Coordinator
Operation Restore Trust

INTRODUCTION/OVERVIEW:

Operation Restore Trust (ORT), implemented in May 1995, is a federal/state partnership to combat fraud and abuse in the Medicare and Medicaid programs. It targets provider fraud and abuse in nursing and adult homes, home health care services, including hospice care, and in the durable medical equipment (DME) industry in the five states where 40 percent of Medicare and Medicaid dollars are expended -- New York, Florida, Texas, Illinois, and California.

Governor George E. Pataki, Governor, convened a state work group chaired by the State Long Term Care Ombudsman to coordinate our statewide effort. State participants are: Attorney General's Office (AG) - Medicaid Fraud Control Unit; Office for the Aging (SOFA); Department of Health (DOH); Department of Social Services (DSS); and Division of Criminal Justice Services (DCJS).

Operation Restore Trust combines the efforts of three federal agencies within the U.S. Department of Health and Human Services: the Office of the Inspector General (OIG); the Health Care Financing Administration (HCFA); and the Administration on Aging (AoA). The State Work Group is represented at each federal ORT monthly meeting by the State Long Term Care Ombudsman.

By coordinating activities and sharing information among its investigatory, entitlement, and advocacy agencies, New York has strengthened its ability to identify, investigate and prosecute fraud and abuse of Medicare and Medicaid as well as develop strong deterrents. Systemic issues are also being examined for the purpose of making recommendations for permanent changes in our current system which will allow New York State to provide quality health care services with greater efficiency.

The purpose of this report is to provide a summary of the accomplishments for the period of May 1, 1995 to April 30, 1996. In addition, the ORT Work Group has provided a list of recommendations and future activities.

In New York State, over $17 million in fraud or questionable billings have been identified by our federal and state partners under Operation Restore Trust during the first year of operation (5/1/95 - 4/30/96). These include:

- $2,676,559 in questionable Medicaid payments identified by State Department of Social Services. A project to identify duplicate (Medicare/Medicaid) payments for durable medical equipment for dual eligible skilled nursing home residents involves unprecedented coordination and cooperation between the New York State Department of Social Services and the Medicare Region A Durable Medical Equipment Carrier. To date, the New York State Department of Social Services has referred approximately $1,000,000 in Medicare over-payments to the Medicare Region A Durable Medical Equipment Carrier;

- $2,000,000 (approx.) in Medicaid payments identified as questionable billings by the Attorney General's Office for Medicaid Fraud Control;

- $600,000 (approx.) in Medicaid funds recovered or in the process of recovery by the Attorney General's Office for Medicaid Fraud Control;
- Over-payments totalling $5,000,000 to 70 portable x-ray suppliers performing services to skilled nursing facility residents have been identified. One provider, who accounts for $3.3 million of the over-payments, is under criminal investigation by the Office of Inspector General. The remainder are involved in over-payment recoupment through the New York Medicare carrier;
- $384,436 in court ordered criminal restitution and fines;
- $6,822,214 in civil settlements and civil monetary penalties;
- 63 potential Medicare fraud cases opened since March 1, 1995;
- 39 Medicaid fraud cases currently under investigation;
- 13 Medicare fraud convictions; and
- 7 Medicare civil judgements.

In addition to financial recovery, significant strides have been made in the areas of public education and outreach. The Long Term Care Ombudsman Program has coordinated a series of 11 statewide regional trainings for over 650 citizen ombudsmen and health insurance information counseling and assistance program counselors (HIICAP), to help them identify and report potential fraud and abuse. This training not only coordinates the involvement of many levels of government, but also seeks the help of older New Yorkers themselves to help in the fight against health care fraud.

This unprecedented state and federal partnership has been successful in identifying or recovering a substantial amount of funds largely as a result of newly established cooperative working relationships and joint efforts. These efforts will continue as we develop creative ways to ensure that consumers are not victimized and work to recover scarce health care funds.

STATE INITIATIVES:

During the past year, the State ORT Work Group has served to increase communication between participating state and federal agencies. This has resulted in expediting resolution of ongoing cases and identifying potential fraud and abuse. The state efforts have been in the areas of financial audits and investigations, education and outreach, survey activity and the development of new partnerships. The following highlights activities in each of these areas:

FINANCIAL AUDITS AND INVESTIGATIONS:

Attorney General's Office

Since May 1995, the Attorney General's Office has opened 62 cases for investigation, of which 39 are still open.

Status: These cases are in various stages of investigation, for example:

- one case within a nursing home has combined Medicaid payments of approximately $250,000 with related Medicare payments in excess of $1.3 million.
- There are eight home health cases that have a combined Medicaid billing in excess of $55 million. Of these eight cases, two cases have initial audit findings of approximately $300,000, and two cases have identified several procedure codes for an in depth audit review totalling $610,000. The remaining four cases are at a very early stage of their audit/investigation and have a combined billing in excess of $39 million.
- Twenty Durable Medical Equipment (DME) cases are open that have a combined Medicaid billing in excess of $15.5 million. Of these 20 cases, five cases have initial audit finding of approximately $620,000, and two cases have identified several procedure codes on issues for an in depth audit review totalling in excess of $180,000. The remaining 13 cases are at a very early stage of time audit/investigation and have a combined billing in excess of $12 million.

* See Appendix B for further information on the Attorney General's Office for Medicaid Fraud Control.

New York State Department Of Social Services

The Office of Quality Assurance and Audit of the Department of Social Services has commenced 23 field audits of durable medical equipment and medical and surgical supply providers since May 1, 1995. These providers had prior year billings of over $18 million. For most of these audits, the audit process is still ongoing but one recently completed audit resulted in an overpayment assessment of $450,000. In addition, final reports issued to DME providers since ORT started contained over-payment assessments of $4.7 million. (Most of the assignments supporting these reports commenced prior to May 1, 1995).

Increased audit activity often translates into decreased program expenditures in the future. For instance, projected expenditures for durable medical equipment in the current state fiscal year are down by nearly $600,000 compared to the prior year. The office has also developed computer programs that identify improper payments to providers for DME and medical and surgical supplies, "billed for dates," when recipients are residents of nursing homes. For the most part, Medicaid does not pay for these items on a fee-for-service basis because the facilities are reimbursed for them through a daily rate. Some of these payments were for Medicare co-payments made on behalf of dual eligible clients. Over $2 million in suspected Medicaid over-payments were identified for almost 200 providers during calendar years 1991-1994. Collections of approximately $250,000 have been realized to date. An additional $2.5 million in associated Medicare payments have also been identified as questionable.

Once final reports are issued for the Medicaid overpayment (Medicare co-payments), the providers are referred to the Medicare carrier for collection. **There have been 71 referrals to Region A Durable Medical Equipment Carrier (DMERC) totalling over $1 million. In addition, two cases were referred to the New York State Attorney General's Medicaid Fraud Control Unit.**

New York Office for the Aging, State Long Term Care Ombudsman Program

For nearly two decades the New York State Office for the Aging has supported a statewide Long Term Care Ombudsman Program (LTCOP) that provides a community presence in long term care facilities. Today there are 49 local ombudsman programs, with over 550 volunteer ombudsmen serving more than 140,000 residents in 642 nursing homes and approximately 1,289 level I & III adult care facilities. **By maintaining a constant presence in nursing and adult homes, the ombudsman program has referred a number of potential Medicaid and Medicare fraud cases to state and federal level investigatory agencies.** These cases include identifying questionable billing practices and unnecessary treatments and supplies. These cases are in various stages of the investigation and recovery process.

New York State Department of Health

A Medicaid Management Information System (MMIS) computer audit has been implemented to identify possible duplication of day treatment services being provided to nursing home residents.

EDUCATION AND OUTREACH:

New York State Office for the Aging, Long Term Care Ombudsman Program

The State Long Term Care Ombudsman Program plays a valuable role in educating senior groups, long term care residents and families to identify possible fraud and abuse. A number of activities were conducted during the report period. A few examples include:

- In 1996, a series of 11 regional meetings were held by the Long Term Care Ombudsman Program throughout New York State with assistance by the state and federal ORT participants. These meetings targeted over 650 citizen ombudsmen and health insurance information counselors training them to recognize possible Medicaid and Medicare fraud. This has resulted in a number of cases being referred to the Office of Inspector General and the Attorney General's Office.

- **In October 1995, a comprehensive Operation Restore Trust (ORT) training manual was developed by the New York State Long Term Care Ombudsman Program with assistance from state and federal partners. The manual received national recognition and is used as a model curriculum for a number of other states.** As part of this effort, a protocol for handling complaints has been developed for fraud and abuse referrals.

- In October 1995, a three-day statewide training was held for local LTCOP coordinators on identifying, reporting and preventing Medicaid and Medicare fraud.

- A community forum was held in Ulster County with over 100 participants which included professionals, community representatives, county officials and consumers.

- A state and federal conference was held in November 1995, to bring together key staff from each of the participating agencies in the project.

- In November 1995, the Long Term Care Ombudsman Program assisted in planning a joint ORT conference to improve communication between the federal and state agencies. A number of recommendations which resulted from this session are included in Section VI.

New York State Department of Health

In March 1996, staff from the Health Care Financing Administration (HCFA) Region II conducted a training session in ORT survey protocols for key long term care staff from the Department of Health's central office and each of the department's six area offices: Northeastern; Buffalo; Rochester; Syracuse; New Rochelle; and New York City. During HCFA's presentation, long term care survey staff were advised that a resident interview instrument had been developed by ABT Associates, under contract with HCFA. Twenty-five nursing homes in New York State were selected for the ORT resident survey protocol. The ORT resident interview instrument was part of New York State protocol for the selected facilities between March 1996 and September 1996. Upon completion of the nursing home survey, all ORT-related materials are separated from the standard survey forms and sent directly to HCFA Region II for further analysis.

The Bureau of Home Health Care Services (BHHCS) survey activities during the demonstration period have focused on Certified Home Health Agencies (CHHA) Medicare reviews. A surveillance protocol for fraud detection was developed jointly with HCFA. Results of these reviews were forwarded to HCFA to better target comprehensive program audits. Five such surveys were conducted in the first year of the demonstration and 14 in the second year.

- The Bureau of Home Health Care Services staff have participated in several provider association forums to increase awareness of Operation Restore Trust activities and to provide information on unauthorized billing practices.

New York State Department of Social Services

The Office of Quality Assurance and Audit (QA&A) participated in the 11 one-day fraud and abuse training sessions sponsored by the State Office for Aging for local ombudsmen in various areas throughout the state. QA&A's role was to give the participants an overview of the Medicaid program, explain how Medicaid pays for services and items provided to recipients in nursing homes and explain to participants how fraud and abuse can occur in nursing homes.

PARTNERSHIPS:

New York State is strengthening enforcement by sharing information between agencies to help identify, investigate and prosecute fraud in addition to developing strong deterrents. ORT combines the efforts of state programs and agencies with federal partners to:

- increase the awareness of fraudulent and abusive practices;
- reduce and prevent the incidence of such practices;
- detect and punish wrong-doing;
- encourage self monitoring and reporting of fraud and abuse by provider companies; and
- recommending systemic changes in government practices to increase efficiency and delivery of services to the public.

Linkages and increased communication between the state and federal partners have been strengthened during the demonstration program in the following manner:

- The Department of Social Services (DSS) and the Medicare Region A Durable Medical Equipment Regional Carrier (DMERC) have established a coordinated system to identify duplicate (Medicaid/Medicare) payments for dual eligible skilled nursing home residents. To date, DSS has supplied approximately $1,000,000 in Medicare over-payments to the DMERC. The process for referrals has been a direct result of the efforts of the State Work Group
- From the vantage point of the Medicaid Fraud Control Unit, where 75 percent of funding comes from Health and Human Services, Office of Inspector General, and where efficient lines of communication with sister state agencies such as DOH are integral to the success of fraud and patient abuse perpetrators, ORT serves as the springboard for an enhanced cooperative effort.

- State Department of Health, Bureau of Home Care Services staff have worked with HCFA and the fiscal intermediary, United Government Services, to develop criteria for targeting certified home health agencies (CHHAs) and hospice agency outliers for focused surveys.

- State Department of Health staff have interacted cooperatively with other state agency representatives as part of the State Work Group to share information and gain knowledge of the broad spectrum of functions performed by governmental units as it relates to the Medicare and Medicaid programs. The knowledge gained provides a framework for developing better relationships and systems for detecting fraud and avoiding duplication of efforts.

SYSTEM WIDE RECOMMENDATIONS: STATE AND FEDERAL:

The State Work Group met monthly during this period (5/1/95 - 4/30/96) to determine the issues needed to improve our communication network. There are a number of concerns which will need the continued involvement on the state and federal levels to achieve the goals of ORT. The following recommendations were developed by the ORT Work Group. We plan to continue to meet to prioritize the issues and develop procedures over the next year.

- Explore the feasibility of implementing the use of a single claim for dual eligible Medicare/Medicaid recipients. This will help prevent duplicate payments and result in improved coordination of claims for dual eligible beneficiaries.

- Promote enhanced provider and consumer oriented anti-fraud and abuse public relations initiatives. This would empower the public to become more active in the identification of fraudulent and abusive situations. The development of a brochure providing information to patients will increase their awareness of the appropriate utilization of health care services.

- Review current Medicaid reimbursement rates on Durable Medical Equipment and prosthetics for possible adjustments. Technological advancements have resulted in significant reductions in cost of certain reimbursable items; these rates have not been significantly modified since first established.

- Require greater scrutiny and responsibility of physicians in signing for orders of reimbursable items. The physician's review of care plans will help to ensure that unneeded reimbursable items are not provided.

- Explore the feasibility of increased use of targeted mailings of Medicaid Explanations of Medical Benefit statements to recipients. This would encourage beneficiary's to report questionable charges and promote greater accountability.

- Conduct MMIS audit to identify possible duplication of day treatment services provided to nursing home residents.

- Conduct aggressive outreach with consumers and health care providers to expand efforts to identify, prevent and detect health care fraud. It has been proven that education and outreach activities provide major dividends to prevent health care fraud and abuse.

- Explore increased computer data base linkages between Medicaid and Medicare and exchanges.

- Identify staff resources, federal and state, to improve fraud detection and inefficient utilization of health care resources.

Target available state resources on Medicaid programs considering the potential for revenue recovery. Reliance on federal efforts for Medicare purposes may not be consistent with state priorities for detecting Medicaid fraud and over-utilization.

Design better state and federal reporting systems for tracking Medicare and Medicaid costs, both on a provider specific and patient specific basis. These products should be targeted to assist in earlier identification of provider outliers and allow for review of total health care expenditures on individual patients.

PROPOSED FUTURE ACTIVITIES FOR THE STATE WORK GROUP:

The State Work Group has identified some activities that would provide information to the public about Medicaid and Medicare fraud and abuse. They will continue to request federal funding to implement the following activities, as part of a joint state and federal initiative.

- Focus on prioritizing the recommendations (in the previous section) developed by the State Work Group. Meetings will be held every two months, inviting our federal partners to address joint issues on Medicare. Other state agencies will be invited to participate as necessary.

- Develop a work plan to implement changes to the health care system to make it more efficient and responsive to the public. This work plan will include all participating agencies and any additional ones that are identified in the development of this plan.

- Develop an outreach plan that includes:
  - A public service anti-fraud announcement which will include the federal and state hot line numbers as well as any others that the State Work Group identifies. The calls will have to be screened as either informational or complaints that should be referred to the State Attorney General, Medicaid Fraud Control Unit and the Federal Office of Inspector General, or both.

  - An ORT brochure for dissemination throughout New York State. This would include the names and phone numbers for the public to report potential fraud and abuse.

  - Exploring feasibility for a New York State hot line for reporting public benefit fraud and abuse. Currently there is a federal hot line, 1-800-HHS-TIPS. The state referrals have been originating with the volunteer ombudsmen in the community. Educating the public will increase the number of referrals, but will also increase the number of incoming calls that are just informational. A mechanism will have to be developed to receive and respond to these calls. The Work Group will have to explore current resources to determine if there is a system in place that can be responsive to this concern.

  - Informational packets to be used for community forums to include brochures, videos on fraud and abuse (currently available) and other informational matters that would help the public identify fraud and abuse.

  - Community education forums to target nursing home and adult home residents and family councils.

  - Community education forums to target senior citizens in senior centers and housing projects. The Division of Criminal Justice Service has offered to work through law enforcement agencies that provide outreach to seniors. This is one resource that will allow us to provide information to a number of elderly and their families.

APPENDIX A

AGENCY/PARTICIPANT OVERVIEWS

Attorney General's Office of Medicaid Fraud Control

The Medicaid Fraud Control Unit is, under federal statute, the single, identifiable entity within New York State government having authority to prosecute participating Medicaid providers for criminal violations, as well as any individuals for criminal violations arising therefrom. The Medicaid Fraud Control Unit is also responsible for the investigation and prosecution of patient abuse in Medicaid funded facilities.

The unit is the largest component within the Office of the Attorney General, and is the largest unit of its kind in the nation.

The unit personnel participating in the ORT work group are representatives from unit headquarters located in New York City.

Division of Criminal Justice Services

The New York State Division of Criminal Justice Services was assigned its responsibilities pursuant to the Executive Law of New York State. The mission of the agency is to plan for and to provide quality services in support of programs to promote public safety and to improve the administration of justice in New York State. The mission is accomplished by:

- Conducting research and developing, monitoring and evaluating criminal justice programs;
- Maintaining a computerized criminal history and statistical data file available to federal, state and local agencies;
- Providing training and management services to municipal police, peace officers, security guards and campus security officers; and
- Strengthening the capacity and performance of local criminal justice agencies.

In support of Operation Restore Trust activities, the Division of Criminal Justice Services, while not directly involved in the investigation of illicit activities of health care providers, can provide peripheral support to investigative efforts of the Attorney General, the Inspector General, state and local police. In line with agency policy and mission, the division will fulfill requests from law enforcement and the Attorney General with regard to criminal histories of individuals who may become the focus of Operation Restore Trust investigations. In addition to providing investigative background information of the enforcement community, DCJS, as required by law, will process the records of any arrests generated by Operation Restore Trust.

New York State Office for the Aging, Long Term Care Ombudsman Program

The Long Term Care Ombudsman Program, charged in the Federal Older Americans' Act with protecting the health, welfare, safety and rights of long term care residents, is administered by the NYS Office for the Aging, Division of Policy and Program Development. The State Long Term Care Ombudsman Program supervises 49 county-based ombudsman programs with over 550 certified citizen ombudsmen throughout New York State. This program receives, investigates and resolves resident concerns for over 140,000 residents living in long term care facilities. Because of their work in nursing and adult care facilities, the State Long Term Care Ombudsman Program are part of the core interdisciplinary team for the five state Operation Restore Trust demonstration project. Ombudsman staff, composed primarily of trained volunteers, provide a regular presence in long term care facilities. By maintaining a constant presence in nursing and adult homes, ombudsmen, during the course of investigating complaints, have become pivotal sources of information for enforcement agencies involved in fraud control.

New York State Department of Social Services

The New York State Department of Social Services, until October 1996, administered the Medicaid Program. Within the department, the Office of Quality Assurance and Audit (QA&A) conducts audits and investigations of Medicaid providers. When appropriate, the office refers cases of potential fraud for investigation and/or prosecution. These cases are most often referred to the New York State Office of the Attorney General Medicaid Fraud Control Unit; however, in some cases referrals are also made to the Federal Bureau of Investigation or Health and Human Services, Inspector General, Office of Investigations. The office's audit activities resulted in cost avoidance of almost $200 million and cash collections of $22 million in state fiscal year 95/96.

New York State Department of Health

The major focus of the Department of Health (DOH) efforts associated with Operation Restore Trust (ORT) were carried out by the bureaus within the Division of Health Care Standards and Surveillance (DHCSS). DHCSS is responsible for the oversight of institutional and non-institutional health care providers for the quality of care that is provided to the public. On-site state surveillance presence allows observation of both the quality of care and an ability to detect over utilization and/or fraud.

Bureau of Home Health Care Services (BHHCS) - Certified home care and hospice activities. "The Bureau of Health Care Services is responsible for certification, licensure and oversight of the quality of patient services delivered by over 1,000 home care and hospice providers servicing more that 500,000 patients annually. Assurance that these agencies meet federal and state standards for the delivery of such care in a qualitative manner is monitored through onsite surveillance and investigation of patient care complaints. The Bureau also oversees a process to review organizations authorized to provide such services to determine that the character and competence of these organizations is adequate."

Bureau of Medicaid Management Information Services (MMIS) - Durable Medical Equipment activities (DME) - The Bureau of Medicaid Management Information Services within the New York State Health Department provides consultation to federal auditors regarding New York State Medicaid policy, proper procedure coding, and the clinical appropriateness of questionable services which Operation Restore Trust identifies. The Bureau also provides expert witness testimony to the United States Attorney's Office in the federal prosecution of fraud cases involving New York State Medicaid.

Bureau of Long Term Care (LTC) - Residential health care facilities activities (RHCF). The Bureau of Long Term Care Services surveys and certifies 660 nursing homes in the state, encompassing 115,000 beds. Surveys are conducted by staff in six regional offices of the department's Office of Health Systems Management. Facilities are surveyed for compliance with standards contained in Article 8 of the Public Health Law, and Title 18 and 19 of the U.S. Social Security Act. Virtually all nursing homes in the state participate in the federal Medicare and Medicaid programs. In addition, the department's LTC staff investigate complaints of abuse, mistreatment and neglect pursuant to the role under Section 2803-d of the New York State Public Health Law.

APPENDIX B

ATTORNEY GENERAL'S OFFICE
MEDICAID FRAUD CONTROL UNIT

CASES OPENED
By Region
May 1, 1995 - April 30, 1996

REGION	NH/OTHER	HOME HEALTH	DME	TOTAL
Buffalo	2	2	4	8
Happauge	4	5	3	12
NYC	10	2	3	15
Pearl River	1	3	7	11
Syracuse	3		4	7
Rochester		4	3	7
Albany			2	2
Total Cases Opened:	20	16	26	62
Cases Closed:	<9>	<8>	<6>	<23>
	11	**8**	**20**	**39**

ATTORNEY GENERAL'S OFFICE
MEDICAID FRAUD CONTROL UNIT

SUMMARY OF PROSECUTION AND CIVIL SETTLEMENT
By Type of Case
May 1, 1995 - April 30, 1996

	Prosecution	Civil Settlement	TOTAL
Nursing Homes		5	5
Other			
Home Health	16	5	21
DME	7	2	9
	23	12	35

SUMMARY OF RESTITUTION ORDERED
BY TYPE OF CASE
May 1, 1995 - April 30, 1996

	Medicaid	3rd Party Recovery	Fines Caused	Legal Cost's Recovery	TOTAL
NH	24,247.17	66,136.07			90,383.24
Home Health	333,290.81	8,449.72	4,680.00	285.00	346,705.53
DME	165,394.25	_____	10,000.00	155.00	175,549.25
TOTAL	522,932.23	74,585.79	14,680.00	440.00	612,638.02

Mr. SHAYS. Let me ask you, before we go to Ms. Safford, are the ombudsmen not paid just in New York?

Ms. FISH. The ombudsman program is different in every State, and in New York State they are all volunteers. They are not paid. In some States, they are paid a small stipend; and in other States they are just paid mileage to get to and from.

Mr. SHAYS. I have been in public office 20 years, and I did not know they were volunteers. I am amazed.

Ms. FISH. Most States are trying to get more volunteers. There are 7,000 volunteer ombudsmen in the United States, and you could have 21,000 with additional funding. There are people out there who are more than willing to give their time.

Mr. SHAYS. That is amazing to me. It certainly qualifies for a point of light.

Mr. SHAYS. Ms. Safford.

Ms. SAFFORD. Mr. Chairman, subcommittee members, I would like to thank you for the opportunity to testify today about health care fraud in California.

California Advocates for Nursing Home Reform was founded in 1983——

Mr. SHAYS. I am going to have you lower the mic just slightly. I think that would be good.

Ms. SAFFORD [continuing]. Founded in 1983 by Pat McGinnis. She was determined to create an organization independent of Federal funding or funding from the industry, of course, so we are mainly a membership organization. We do get some fees for—as far as buying our materials and quite a bit of foundation grants. Only recently we have accepted a Federal grant to provide pension counseling for California consumers.

We have a program of community education, outreach and advocacy; and it is our goal to provide consumers with up-to-date information to help them make choices about nursing home placement. To that end, we have information compiled from the Department of Health Services in California as well as from HCFA on all 1,450 nursing homes in California. We have this data available to any consumer who calls on our 800 line.

We also now have it on the Internet so people—we have a web page so people can call up that information.

We also put out—we have legal services, the legal services in California. We provide support service as far as nursing home patient rights. We provide assistance with legal and financial issues. We have organized family councils throughout the State, and we have community workshops as well as putting out an annual report card.

The report card on the facilities in California lists the bottom 50, the ones with the most violations; and it also lists those with the best records. To keep apples and apples being compared, we make sure that the ones on the "best" list also accept Medi-Cal. Because it is easy to provide great care when you charge people exorbitant fees. It is quite another thing to stay within the budget. We have some very good nursing homes in that category, too.

The data base helps us in a number of ways. In addition to providing consumers with information, it helps us to compile information about the nursing homes, about the ownership, too.

We worked hard over the years to try to change the enforcement system in California, which, by the way, was put in place in 1974 with a lot of input from the industry. It has an awful lot of safeguards for them, and it really has not worked in California.

To that end, we had a bill, AB 1133, which had made it through the State assembly and was on its way to the Health Committee in the Senate; and just last week Governor Wilson managed to make an end run and kill it. What we know from talking to those people is that they are as frustrated as we are about trying to get some changes made and trying to get the nursing homes to be responsible and try to correct problems; but, for now, effectively it killed the bill this year. It did, however, make us more determined to have more reform and a bigger bill for next year.

In 1996, California got a large share of the Medicare and Medicaid pie. We call it Medi-Cal in California. We have—over $4 billion income came to California nursing homes. Seventy-five percent of that is directly from the taxpayers through Medi-Cal, Medicare or through the Department of Mental Health Services. So the majority is tax dollars, and the problem is there is really no accountability for it.

We started a number of years ago studying costs. Our first report came from OSPHD, Office of Statewide Health Planning and Development. They come out yearly with a report, usually about a year and a half late, of all the costs for every nursing home. But the problem with this is that it is self-reported, and the auditing they do is simply to see if the numbers add up and if they filled out every category.

Starting last year, we have ordered all of the audits that have been done by the State Department of Health Services. They have an audit and investigation division. Unfortunately, they only audit 15 percent of the nursing homes a year; but what we found there was pretty startling, at least to me anyway.

With a one-in-seven chance of ever being audited—and they never audit chains as a whole—the chances of getting caught are almost nil. In addition to that, even if the audits find some horrendous overcharge, it doesn't automatically get turned over to an investigation division because the audits division of DHS mainly concentrates on beneficiary fraud. They are not looking at provider fraud particularly. They are looking at people who applied for Medi-Cal who shouldn't have, who filled out the application paper and had assets. That is their focus instead of focusing on the provider fraud, the bigger area.

I have brought these along. One Inglewood facility claimed $109,000 in expenses for home health care, and they don't provide it. This is very common.

One facility claimed half a million dollars for lease and rental expense. They own the facility. This is clearly a subsidiary company, and that is what they do. They pay rent to themselves, and this goes around and around. Often they will take both lease expense and the mortgage interest, so they are taking doubly.

This is fairly easy to spot in a cost report. But when it is spotted, it doesn't automatically go to investigations. It is just essentially they set the rate. The only purpose of the audit division is to set the daily reimbursement rate. No other reason.

I have a few other examples, one where the owner's airplane expense was listed as patient care. That was disallowed, obviously.

Anyway, for-profit chains routinely form subsidiary groups. They are related corporations. The State is aware of some of these but not all of them. There is a morass out there.

We had a project about 3 years ago called Who Owns Nursing Homes. You may or may not be aware that violations with the nursing home stay with the facility. They don't stay with the owner or the licensee. They essentially don't stay with the persons responsible for the violations. That is why when the lady from HCFA was talking about the report card, why we have to be so careful. We have to try to identify the current owner. Who was responsible when these violations occurred?

What consistently happens in California is if you get into too much trouble and the State or Federal Government is breathing down your neck you simply sell out to someone else, move somewhere else, obtain a new corporate name and continue on and take that new facility and drive it into the ground. That is why it is really important to try to identify the owners and the chains and to take a look at these costs State-wide, not just one individual facility. Because if they are improperly taking costs in one facility, you can be sure they are doing it, you know, right across the board.

Right now, the California Attorney General's Bureau of Medi-Cal Fraud and Patient Abuse is responsible for investigating Medi-Cal fraud. There has been very little activity in this area, by the way. I tried to get statistics this week about how many cases. They didn't have any.

I know a year ago they started a patient abuse in nursing home—I mean, they have one unit just for that; and the report they issued about a month ago showed they had 10 convictions last year. I know this is 10 more than we ever had before, but this is minuscule compared to what goes on every day in the nursing homes in California where we have 125,000 residents.

In 1996, the California Department of Health Services issued what they call a WFM citation. It is welfare falsification of medical records. Every single one of these cases reported treatments and therapies and services that were not provided. So the Department of Health Services doesn't turn that over to a fraud unit, but they issue a citation for fraudulent recordkeeping.

Medicare was billed for many of these. Medicare is billed for doctor visits. They are called gang visits; and even if they do visit the facility, they visit the chart, not the patient. They sit there and take a group of them. Particularly it is the medical director of the facility. They will get everyone's chart; and even if you look at them, they say the same thing month after month after month. We have cases where someone deteriorated to the point where they died; but their chart looks just fine, very stable. Essentially, they are not looking at the patient.

It is also difficult for consumers to spot fraud. As she was saying, they often do not get the explanation of benefits. In our family council meetings, we try to have the people to bring their bills. It is very easy to spot. Many are billed for things they never receive.

Some of the cases that we saw—a Nevada company was billing for psychotherapy services for one facility. No one had gotten those

services. This is probably where they were then given a diagnosis of mental illness which they didn't have.

Lotion was being billed at $150 a month from another company; $75 for discharge instructions when it was a mimeographed sheet of paper saying what to do when you get out of the hospital. Another $10 for talcum powder. This is not unusual.

A bill I brought in with me was a complaint I received just before I left was $40 for 4 ounces of baby lotion, and that was being billed throughout the chain.

Mr. SHAYS. What was that?

Ms. SAFFORD. $40 for a 4 ounce bottle of baby lotion. Pretty expensive.

Anyway, we have a number of recommendations. We have tried to beef up protections, but one of the main problems we have is fear of retaliation. In a group in San Mateo County I met with 2 weeks ago, people said they wanted to do things, but they were afraid to complain because administrators could identify who was complaining by who they investigated. If the State came in to look at a patient, there is retaliation going on.

In California, there is a $1,000 fine for retaliation; but it is difficult to prove and hardly ever is cited. If your mother now has to wait for an hour for a call bell, how can you prove it is because you complained? It is hard to get consumers to come forward and family members to come forward.

We need stronger ownership disclosure and conflict of interest. These subsidiary companies, they should report every way that they are getting income. In some places, they are charging us for outside x-ray equipment that is being used. It is their own x-ray equipment. This is not outsiders coming in. It should be a lower rate.

Mr. SHAYS. You need to conclude your comments.

Ms. SAFFORD. Finally, we believe that there should be a Federal ownership data base to coordinate ownership throughout the country so that when these bad operators go from California to Nevada to New York we will be able to provide those regulatory agencies with their background. We are not able to do that right now.

[The prepared statement of Ms. Safford follows:]

Hearing before Subcommittee on Human Resources
Committee on Government Reform and Oversight
July 10, 1997
Washington, D.C.
Testimony of Patricia Safford
California Advocates for Nursing Home Reform

Mr. Chairman, Subcommittee members, I would like to thank you for this opportunity to testify regarding health care fraud in California's nursing homes. While Medicare and Medicaid fraud affects all U.S. citizens, those who have the most to lose are nursing home residents whose Medicare is billed for services they never receive or who suffer the consequences of substandard care that results from redirecting Medicare or Medicaid reimbursements from patient care into owner or management pockets.

California Advocates for Nursing Home Reform (CANHR), a non-profit membership organization, was started by Pat McGinnis in 1983 for the purpose of improving the quality of care in nursing homes and other long term care facilities in California. Determined to create an organization indepedent of the political influence of the nursing home industry, Ms. McGinnis eschewed federal and state funding, and CANHR has been supported primarily through foundation grants, consumer contributions and sales of its materials. Only recently has CANHR accepted a federal grant to provide pension counseling to California consumers.

Through community education, outreach and advocacy, it has been CANHR's goal to provide consumers with the most up-to-date information necessary to make informed choices about placement and to remind policy makers of the problems that result from inadequate oversight and accountability.

CANHR provides a number of direct services to California consumers, including a toll-free statewide consumer hotline for pre-placement counseling, legal services support, pension counseling, assistance with legal and financial issues, family council organizing, community workshops for consumers, as well as providers, and an annual "report card" on California nursing homes. CANHR currently receives over 2,000 calls per month from consumers throughout California.

Consumer Information System

In 1986 CANHR developed a data base which includes individual profiles of all 1,450 nursing facilities in California. Information is gathered from a number of sources, including the Department of Health Services' ACLAIMS system and HCFA. In addition to survey and enforcement information such as citations and penalties assessed, consumer complaints and deficiencies issued, the profiles include information on staff, services, costs and ownership.

This data base has not only served to provide consumers with timely quality of care information on individual facilities, but has provided CANHR with statistical

information for statewide reports and policy issues, particularly the enforcement system.

CANHR has worked hard to change the nursing home enforcement system in which the majority of fines assessed for abuse and neglect of residents are waived, reduced or otherwise dismissed. Since 1990, over $20 million in fines assessed against nursing homes in California have been automatically waived or otherwise not collected. Just last week, Governor Wilson announced his opposition to AB 1133, a CANHR sponsored bill, which would have eliminated the automatic waiver of fines and the numerous opportunities to pay reduced fines for neglect and abuse of residents.

Calling for yet another "study" of the enforcement system and stating that nursing homes should not have to pay fines for "minor" violations, the Governor's opposition has effectively killed any reform efforts for 1997. These "minor" violations range from sexual and physical abuse to amputation of limbs due to gangrenous bedsores and are often so severe that residents die or are permanently injured.

In 1996 California expended over $2.3 billion in Medi-Cal reimbursements to nursing homes. Of the $4+ billion in total nursing home revenues in 1996 in California, over 75% comes directly from the taxpayers through Medi-Cal, Medicare or Department of Mental Health funds. With little

accountability of how the money is spent and with fines for patient neglect and abuse rarely paid, California, in essence, has written a blank check to the nursing home industry. Nothing illustrates this better than the cost reports submitted by facilities.

Cost Reports

Tired of listening to the nursing home industry excuse substandard care on the basis of inadequate reimbursement, CANHR started studying the cost reports in earnest over seven years ago. Although annual cost reports for Medi-Cal certified facilities are required to be filed with the Office of Statewide Health Planning and Development (OSHPD), these costs are self-reported by the facilities. The reports are verified as "audited" by OSPHD, but that simply means that they've checked to ensure that the numbers add up and that each category has an entry.

The Audits Section of the Department of Health Services is responsible for actual audits of facility cost reports. However, only 15% of California nursing homes are audited annually. Facilities are picked at random, **and chains are never audited as a group.** When auditors find irregularities, they disallow these costs, but facilities rarely have to return misspent Medi-Cal funds. The results of the audit are utilized solely to set Medi-Cal reimbursement rates in California.

With a one in seven chance of ever being audited, for-profit nursing homes, in particular, routinely hide profits in cost categories such as owner's compensation and administrative costs. Millions of dollars are allocated to management fees, and investments in real estate, buildings, bonuses and stock options, whether or not they have anything to do with nursing home care, are written off as "expenses."

- One Inglewood facility claimed $109,351 in home health care expenses which were disallowed because the facility doesn't provide home health care.

- A Long Beach facility has been charged with an overpayment of $4.2 million in Medi-Cal funds when an audit revealed no documentation of expenses.

- A Paradise facility claimed $537,920 in lease and rental expenses when they owned the facility.

- In a Lodi facility, where the administrator is the son of the owners, over $340,000 in owner/administrator compensation, IRAs and vacation pay was charged to expenses. Cellular phone and car expenses for the administrator's parents were also disallowed. A total of $108,000 was eventually disallowed in administrative expenses alone.

- A property tax assessment for a facility owner's airplane was disallowed.

Home office costs, leases and rental expenses are routinely overcharged and, when audited, disallowed. It is difficult to hold a facility accountable when you don't even know who owns it.

For-profit chains routinely form subsidiary corporations for each individual facility, which then pays millions in leases, rents, management fees and home office costs back to the parent corporation. Since the license is held in the name of the subsidiary corporation, the true ownership is often not known to the state or the federal governments.

These examples represent only the tip of the iceberg. Millions of Medi-Cal dollars are diverted annually from patient care, and, **although costs may be "disallowed" for the purposes of the audit, they are not reallocated to patient care.** Cost reports are signed under penalty of perjury, and improper or undocumented expenses will reduce a facility's audited costs per day, but they will rarely trigger scrutiny by other agencies charged with investigating possible fraud.

The California Attorney General's Bureau of Medi-Cal Fraud and Patient Abuse is responsible for investigating and prosecuting cases of Medi-Cal fraud and the neglect and abuse of residents in Medi-Cal-certified facilities.While few patient abuse cases are prosecuted, even fewer nursing home fraud cases are investigated, much less prosecuted. When the Audits Section finds fraudulent record keeping, the case is

referred to the Attorney General's Office. The Attorney General's office has not been able to provide any statistics or even case samples of any Medi-Cal fraud case that has been prosecuted.

California's Department of Health Services spends millions of dollars each year to detect and prosecute beneficiary fraud, and even more to place liens and estate claims on the homes of those unfortunate enough to end up poor and sick in a nursing home. No liens, however, are ever placed on the property of the nursing home owners who provide substandard care, submit erroneous cost reports and defraud the Medicare and Medi-Cal programs.

Medicare Fraud

In 1996, California's Department of Health Services issued dozens of citations and deficiencies to nursing homes for willful falsification of medical records. In most of these cases, facilities recorded giving treatments, medications or therapies to residents when they were not provided. Medicare was billed and paid for many of these bogus services.

Medicare is generally billed for doctors' visits to nursing homes whether or not the doctor actually sees the patient. Gang visits are still common, whereby the treating physician, often in a dual role as the facility's Medical Director, visits the medical records rather than the

patients, but Medicare and Medi-Cal are billed for patient visits.

Medicare fraud is particularly difficult in that many consumers don't even recognize it when they see it. Since the Medicare itemizations are not "bills," they are rarely scrutinized to determine whether or not the services were actually provided. In addition, fear of retaliation, which our experience has shown is justified, has prevented many consumers from coming forward with complaints of fraud. Years of lax enforcement and little oversight by the federal government has not helped. When consumers did file complaints of alleged fraud, nothing was done. In fact, few consumers ever received a response.

- One Northern California woman was shocked to find her mother's Medicare being billed $150 per month for a skin lotion that was already paid for under the Medi-Cal program and that cost $5 in the local drugstore. The company that sold the cream was out of North Tampa, Florida and had forged an alliance with a 7-facility nursing home chain in California where most of the residents were on Medi-Cal. Notices were sent by the North Tampa company to all of the residents or their representatives asking them to authorize billing the cost of the lotion to Medicare. It's safe to assume that numerous patients signed the form. No response has yet been received to the complaint filed in 1993.

• A company out of Nevada was billing Medicare for psychotherapy services in California which the residents never received.

•A Northern California facility recently billed Medicare $75 for discharge instructions - a standard, xeroxed list of bathing and activities instructions.

•A Southern California facility charged $300/month to keep an electric wheelchair recharged for one patient.

• Routine supplies of talcum powder were billed to Medicare at $10 each at one facility, and prescription drugs from a subsidiary company billed to Medi-Cal were marked up 100% over the price at the local drugstore.

The Impact of Fraud and Abuse

The impact on patient care as a result of Medicare and Medi-Cal fraud and abuse cannot be overstated. Millions of Medicaid dollars are allocated to cost centers that have nothing to do with patient care. Nursing home residents do not receive the therapies, range of motion or ambulation services prescribed, and instead, decline in health, which requires additional, more expensive, care.

Cost shifting and game playing with cost reports benefits no one except the facilties' owners. It is these facilities that are routinely understaffed, where staff is underpaid and overworked and where all the residents, whether Medi-Cal or private pay, suffer from substandard care. Our

statistics show a strong correlation between neglect of nursing home residents and misuse of public funds. By cutting the costs of staffing, food services, activities programs or of needed repairs to the facility, the owners may increase their net profits, but they violate the public trust and their legal duty under the Medicare and Medicaid programs.

The Medicare notice may state that "this is not a bill," but Medicare and Medicaid fraud results in a bill for all taxpayers, and it is our elders and disabled citizens in nursing homes who suffer the most adverse consequences.

Action and Advocacy

CANHR has attempted to address the problem of waste, fraud and abuse by trying to educate consumers to detect and report fraud and abuse. In Family Support meetings with relatives of nursing home residents, we review Medicare billings and ask family members to check to make certain the items billed were items delivered.

We have tried and failed to beef up protections for consumers and residents who report fraud or abuse of residents. As long as consumers fear retaliation, they will fail to report fraud and abuse.

For the past three years, CANHR has recommended that California's audit system be changed to audit nursing home chains as a group, rather than random, individual audits. We have called for the full enforcement of fraud and abuse laws, including an automatic review process when clear cost-shifting has occurred and the return to the taxpayers of all monies not directly related to patient care.

Clearly, much more needs to be done at the federal level as well.

We need stronger ownership disclosure and conflict of interest disclosures on all related health care companies, and an investigation into their true administrative and management costs.

We need closer coordination with the state and federal governments to track repeat violators and substandard care providers and stop them from repeating their abuses in other states.

We need a federal ownership data base to coordinate ownership and enforcement information and to provide information to the states on new provider applications.

The appropriate state and federal agencies charged with the investigation and prosecution of Medicare and Medicaid fraud should establish a quarterly report system and make these reports available to the public.

And, finally, we need to encourage consumers to report fraud. To do this, we need to assure that those who dare to

retaliate against nursing home residents because they or their family members report fraud or abuse are criminally prosecuted for elder abuse. We need strong federal and state laws that protect residents from such retaliation. Until we can guarantee the safety of these residents, nursing home residents and their family members will continue to be silenced by fear.

Thank you.

Mr. SHAYS. And your organization again is?

Ms. SAFFORD. California Advocates for Nursing Home Reform, otherwise known as CANHR.

Mr. SHAYS. How are you funded?

Ms. SAFFORD. Mostly through membership and by foundation grants. We sell publications, generally for cost.

We are lucky if we make our costs. For instance, we have all of the facilities by county. We charge $2 for the list for every facility in the county and their record for the last few years. It costs about 78 cents to send it out.

Mr. SHAYS. Are you an ombudsman in California?

Ms. SAFFORD. No. I was for 4 years an ombudsman in upper California and handled over 100 cases of abuse. I was disgusted at what I found about the system and how it doesn't work for the patients and decided I wanted to work in a more direct way to try and change some of these abuses.

Mr. SHAYS. It raises an interesting question of whether we can do what you all are doing in some measure, to have the ombudsmen be people who are really well-versed in bills.

Ms. SAFFORD. In California, we have some staff—generally, each district may have one or one-and-a-half staff members, very understaffed. The rest are all volunteers.

One of the problems that we found is that we need two different types of ombudsmen. I was in Tehama County, the only ombudsman in that county. But we need one person that goes out and is the eyes and ears for the office. The second is one that has some investigatory skills.

Also, we found that the problem in the ombudsman program in California, as it is with the Department of Health Services over all, is that money talks and the industry is very powerful. This is a billion-dollar industry. So they stop reforms often before they get started.

Mr. SHAYS. I am having some dentist bills, and the bills sometime come in 6 months after because they go to the insurance company. So I thought I would pay the bill if I have it. So, finally, I asked them to give me all the billing that I have had, because it struck me that I was paying a lot. I can tell you I cannot decipher one line of that bill, not one line. So I am going to have a visit with my dentist. But it is awkward, because he is a friend. Yet I am finding it is just a good experience for me to have to go through that, because I have a sense of what it must be like for people.

Mr. SHAYS. Ms. Canja.

Ms. CANJA. Thank you. Good morning. I am Tess Canja from Port Charlotte, FL, and vice president of AARP.

I was asked to testify today about the results of a survey that we conducted recently on public attitudes toward health care fraud. I appreciate that opportunity and commend you for holding this hearing and for your genuine interest in finding ways to make inroads against fraud and abuse in nursing homes.

Based on the results of our survey, AARP believes that older Americans and their families want to help correct the problems of fraud in all areas of the health care system, including nursing homes. The stumbling blocks for consumers are in identifying fraud and in knowing what actions to take.

Of course, consumers can't do the job alone. They need to feel confident that Congress and the Health Care Financing Administration are doing their part to protect consumers and to spend taxpayer dollars wisely.

Our survey also reveals a widely held misconception that stopping health care fraud can solve all of the financial problems of our health care system. However, we know that stopping fraud alone cannot keep the Medicare program solvent or repair the problems with the Medicaid program, but it is an essential first step.

Fraud and abuse, especially in nursing homes, directly affect consumers in two basic ways—in their pocketbooks and in the quality of the care they receive. Indeed, fraud and abuse affect all Americans by increasing the cost of the Medicaid and Medicare programs. The most serious impact is on consumers who depend on these programs for their health and long-term care.

AARP's health care fraud survey sheds light on how the public views fraud and its impact on health care costs and the delivery of quality care. Here is what the survey found.

Americans believe that health care fraud is a major, widespread and growing issue. Interestingly, when asked who is responsible for health care fraud, respondents mentioned doctors, consumers or patients and insurance companies, those people they are most familiar with. Respondents were unaware of any efforts to reduce fraud, but the survey underscores that Americans are optimistic that something can be done about it.

Almost all respondents agreed that it is their personal responsibility to report suspected health care fraud. Eighty-five percent indicate they would be more inclined to report fraud if only they knew more about it; and, in addition, 70 percent of respondents indicated they would not be more likely to report suspected fraudulent behavior if a reward or monetary incentive was offered.

Finally, a solid two-thirds approved spending more public and nonpublic funds to fight health care fraud.

The results of this survey demonstrate that the American public believes there is a significant problem with fraud and abuse in our health care system. The results also clearly underscore the need to provide the public with more information about how to recognize and report fraud and about ongoing efforts to fight it.

Clearly, there is a need and a desire for greater public education on health care fraud. If consumers were aware of the types of fraud being perpetrated, if they knew what to look for when reviewing their claims and if they knew whom to call when they suspect fraud, their chance of being unwitting participants in a scam would be greatly reduced. Equally as important, they would become valuable partners in the fight to reduce health care fraud.

AARP believes there are several simple things that consumers can do to prevent fraud: One, protect your Medicare card the same way you protect your credit card. Two, Medicare does not make house calls. Beware of anyone who contacts you claiming to be from the Medicare program. Three, be cautious of any offer of free medical services or supplies.

The standards set by government to hold providers accountable and the coordinated enforcement efforts of Federal, State and local authorities are essential to reducing fraud and abuse in nursing

homes as well as in the rest of the health care system. However, these efforts cannot be successful unless Congress provides adequate financial resources and continues to develop legislative policies that support enforcement efforts.

Moreover, nursing home owners and operators themselves are important players in the fight against fraud. It is incumbent on them to take more responsibility for their actions and for the actions of other providers in their facilities to follow their own code of ethics and to set standards for their industry.

Thank you for the opportunity to testify.

[Note.—The AARP survey entitled, "America Speaks Out On Health Care Fraud," can be found in subcommittee files, or obtained from AARP by calling (202) 434–2277.]

[The prepared statement of Ms. Canja follows:]

Good morning. I am Tess Canja from Port Charlotte, Florida. As a member of the AARP Board of Directors, I appreciate the opportunity to testify today about the results of a survey that we conducted recently on public attitudes toward health care fraud.

Based on the results of this survey, AARP believes that older Americans and their families want to help correct the problems of fraud and abuse in all areas of the health care system, including nursing homes. The stumbling blocks for consumers are in identifying fraud and in knowing what actions to take.

Of course, consumers can't do the job alone. They need to feel confident that Congress and the Health Care Financing Administration (HCFA) are doing their part to protect consumers and to spend taxpayer dollars wisely. Equally as important, consumers need to know that owners and operators of nursing homes deserve their confidence. They are, after all, the stewards of public and private funds, and the providers of care to the loved ones entrusted to them.

Our survey also reveals a widely-held misconception that stopping health care fraud can solve all of the financial problems of our health care system. However, we know that

stopping fraud alone cannot keep the Medicare program solvent or repair the problems with the Medicaid program -- but it is an essential first step.

THE PROBLEM OF FRAUD AND ABUSE

Fraud and abuse, especially in nursing homes, directly affects consumers in two basic ways -- in their pocketbooks and in the quality of the care they receive. Fraud and abuse in nursing homes can encompass a broad range of improper practices such as the nursing home overcharging for services, not providing necessary medical treatment, and transferring or prematurely discharging residents to maximize their profits. Fraudulent and abusive activities affect the entire health care system. For example, recent estimates show that fraud, waste, and abuse may absorb ten to twelve percent of each Medicare dollar spent. Such improper practices place an additional burden on this essential program that is already under great financial stress.

Fraud and abuse affects all Americans by increasing the cost of the Medicaid and Medicare programs. The most serious impact is on consumers who depend on the programs for their health and long-term care. Understandably, they may fear that they are being subjected to unnecessary tests and treatments. People enrolled in managed care fear that they are not receiving necessary services. People in nursing homes fear that they will receive poor quality of care. They know that their out-of-pocket expenses are increasing each year, in part because of fraud and abuse.

Fraud and abuse also diminish beneficiary confidence in the integrity of their health care providers. Fraud and abuse undermine the trust and confidence that a family should have in a nursing home or other provider, creating an atmosphere of suspicion and mistrust rather than the sense of confidence that is essential for the well-being of Medicare and Medicaid beneficiaries placed in their care.

AARP HEALTH CARE FRAUD SURVEY

AARP's Health Care Fraud Survey sheds light on how the public views fraud and its impact on health care costs and the delivery of quality care. The survey also explores public attitudes toward government and the private entities that administer health care programs, and what the public thinks should be done to address fraud. The survey, the most in-depth to date on this topic, was conducted in November and December, 1996, by the ICR Survey Research Group. It interviewed by telephone two thousand adults age 18 and over from across the country. Respondents represent all income levels, educational backgrounds, and all types of insurance coverage. Here is what the survey found:

- *Health care fraud was considered a major issue by 41 percent of respondents.* Thirty percent (30 percent) considered it a minor issue, while 28 percent did not consider it an issue at all. Notably, personal interest in the health care fraud issue was strongly related to the extent of health care fraud they perceived. That is, people who believed

health care fraud to be extremely widespread were much more likely to say it was a major issue for them (64 percent).

- *Ninety-three percent (93 percent) believe fraud is either somewhat or extremely widespread. More than half (53 percent) of respondents believe that health care fraud is increasing,* a third (34 percent) thinks it is staying the same, while very few (6 percent) believe it is decreasing.

- *An open-ended question about whom the respondents thought were most responsible for the level of health care fraud in this country resulted in "top-of-mind" responses with which the respondents were most familiar, such as doctors (31 percent), consumers or patients (15 percent), and insurance companies (11 percent).* Interestingly, the respondents overlooked or gave very low scores to certain providers where, according to enforcement officials, the potential for fraud is very high. For example, nursing homes, durable medical equipment suppliers, medical laboratories, and home health agencies are not high on the respondents' list, while enforcement authorities see these areas as "particularly susceptible to fraud."

- *Nearly 80 percent of respondents were unaware of any efforts to reduce fraud.* Of the 20 percent who were aware, only 52 percent believed that these efforts actually reduced health care fraud, 31 percent thought these efforts had no effect, and one in ten thought these efforts actually increased fraud.

- *While they may disagree about the efficacy of current oversight, Americans are optimistic that something can be done about fraud.* Almost 8 in 10 people agree that something "can be done to reduce health care fraud." In a related question, nearly 8 in 10 people disagreed with the statement that fraud is a natural part of the health care system and nothing can be done about it.

- *Survey respondents indicate they consider themselves to be partners in the fight against health care fraud.* Almost all respondents (90 percent) agree that "It's my personal responsibility to report suspected health care fraud." Eighty-five percent (85 percent) indicate they would be more inclined to report fraud "if they only knew more about it." In addition, 70 percent of respondents indicated they would not be more likely to report suspected fraudulent behavior if a reward or monetary incentive was offered.

- *All respondents were asked whether more public and nonpublic funds should be used to fight health care fraud.* A solid two-thirds approved spending more public funds (66 percent) and nonpublic funds (69 percent.)

The results of this survey demonstrate that the American public believes there is a significant problem with fraud and abuse in our health care system, especially in the Medicare and Medicaid programs. The results also clearly underscore the need to provide the public with more information about how to recognize and report fraud, and

about ongoing efforts to fight it. Despite the major drive by enforcement authorities in recent years, most Americans (8 in 10) are unaware of any efforts to combat health care fraud. Of the people who are aware, nearly one-third believe that such efforts have had no effect. Compounding the problem, many people do not know whom they would trust most to reduce health care fraud.

However, the American consumer does believe that something can be done to reduce fraud and advocates spending more money by the government and the private insurance sector to rid the health care system of unscrupulous providers.

American consumers are eager to join in this fight because they believe that costs would decrease and the quality of care would improve if fraud were reduced or eliminated. Nearly 85 percent said they would be more inclined to report health care fraud if they knew more about it. For example: How is fraud practiced? What are some of the different types of fraud? Interestingly, however, they said that offering a reward or monetary incentive does little to increase the likelihood that consumers would report suspected fraudulent behavior. Consumers believe reporting fraud is their personal responsibility.

THE ROLE OF THE CONSUMER IN FIGHTING FRAUD

Clearly, there is a need and a desire for greater public education on health care fraud and abuse. If consumers were aware of the types of fraud being perpetrated, if they knew what to look for when reviewing their claims, and if they knew whom to call when they suspect fraud, their chance of avoiding being unwitting participants in a scam would be greatly improved. Equally as important, they would also become valuable partners in the fight to reduce health care fraud and abuse.

AARP believes there are several simple things that consumers can do to prevent fraud:

1. Protect your Medicare card the same way you protect your credit card. Never give your Medicare number to anyone who contacts you over the phone or in person, or to someone who is not a known provider. If your Medicare card is lost, contact the Medicare program immediately. Just as with a credit card, you don't want your Medicare card number to fall into the wrong hands. The Medicare program could be billed millions of dollars for services that were never provided.

2. Medicare does not make "house calls." Representatives of the Medicare program will never knock on your door or call you on the phone. Beware of anyone who contacts you claiming to be from the Medicare program.

3. Be cautious of any offer of free medical services or supplies. Such services and supplies are offered by unscrupulous "providers," often set up in malls, bogus store fronts, or mobile "offices." They will ask you for your name and Medicare number in exchange for "valuable" medical services or supplies that won't cost you anything, but could cost the Medicare program millions.

THE ROLE OF GOVERNMENT

The standards set by government to hold providers accountable and the coordinated enforcement efforts of federal, state and local authorities are essential to reducing fraud and abuse in nursing homes, as well as in the rest of the health care system. These efforts, however, cannot be successful unless Congress provides adequate financial resources. Additionally, legislative policies that support enforcement efforts should continue to be developed.

THE ROLE OF THE INDUSTRY

While consumers and enforcement authorities are major players in the fight against health care fraud, an important factor in eradicating fraud and abuse in nursing homes are the owners and operators, themselves.

THE ROLE OF THE INDUSTRY

While consumers and enforcement authorities are major players in the fight against health care fraud, an important factor in eradicating fraud and abuse in nursing homes are the owners and operators, themselves.

There are many responsible leaders in this industry. It is incumbent on them to take more responsibility for their actions, to follow their own code of ethics, and to set standards for their industry. Though we have made significant progress in eliminating many of the past problems with nursing homes, today's problems with fraud and abuse, while often more subtle, are just as costly to residents, families, and the American public.

CONCLUSION

Thank you for the opportunity to testify. We hope that you find our survey useful. We believe that educating Americans about the extent of health care fraud and abuse, and what they can do about it, is a good first step in fighting the on-going battle to reduce health care costs.

In compliance with House Rule XI, clause 2(g) regarding information of public witnesses, attached is AARP's statement disclosing federal grants and contracts by source and amount received in the current and preceding two years.

AARP Statement of Federal Grants & Contracts Pursuant to Rule XI, Clause 2(g)

On December 19, 1995, the President signed into law the Lobbying Reform Disclosure Act of 1995 which prohibited 501(c)(4) organizations that lobby from receiving federal funds. Although the lobbying act only applies to new grants, AARP transferred its grant programs (staff, funds, and administration) to the AARP Foundation, a 501(c)(3) nonpartisan, charitable corporation established in the District of Columbia in 1961. These transfers, effective January 1, 1996, were approved by all of the federal funding agencies.

	AARP	AARP Foundation	
	1995	1996	1997
Revenues	Actual	Actual	Projected
Department of Labor: AARP Senior Community Services Employment Program (SCSEP) (1)	$50,993,000	$46,155,000	$50,600,000
Environmental Protection Agency: AARP Senior Environmental Employment (SEE) Program (2)	24,050,000	21,126,000	24,000,000
Internal Revenue Service: AARP Tax-Aide (3)	3,468,000	3,327,000	3,200,000
Housing and Urban Development: AARP Home Equity Information Center	234,000	257,000	357,000
Health & Human Services:			
AARP Early Detection and Control of Breast Cancer Project	235,000	253,000	375,000
AARP National Legal Assistance Support Project	154,000	40,000	135,000
AARP Technical Assistance Project for Statewide Legal Hotlines	100,000	40,000	125,000
AARP SSA Outreach Demonstration Program	98,000	0	
AARP National Eldercare Institute	28,000	0	0
White House Conference on Aging	6,000	0	
AARP Suicide Evaluation and Prevention Project	0	0	50,000
AARP Ombudsman Training and Technical Assistance	2,000	51,000	50,000
AARP Improving Early Access to Mental Health Services Project	0	87,000	49,000
Department of Justice	58,000	0	0
Corp for National Community Service	1,000	0	0
Total Federal Grants	$79,427,000	$71,336,000	$78,941,000

Three Largest Programs:

(1) The AARP SCSEP is a work-training program authorized under the Older Americans Act of 1965. Eligible program applicants must be at least 55 years of age, physically able to work, and have income at or below the poverty level. This program operates in 102 locations in 35 states. For the grant-year ending June 30, 1996, the program served over 13,000 individuals and had an unsubsidized placement rate of 44%.

(2) The AARP SEE Program places retired, or unemployed individuals, 55 or older, in technical assistance roles with the EPA. For the last grant year, participants were enrolled in 33 locations throughout the United States. Multi-year cooperative agreements were projected originally to result in payments of $24 million for 1997. Because this program may end before the end of 1997, a lower amount may be received in the current year.

(3) The AARP Tax-Aide Program provides free tax counseling for low and middle-income individuals, 60 and over, through a network of more than 10,000 sites and 30,000 volunteers. In 1996, this program helped over 1.5 million taxpayers.

5/7/97

THE AARP FOUNDATION
History and Role

The AARP Foundation was established in the District of Columbia in 1961 as a 501(c)(3) nonpartisan charitable corporation, contributions to which are tax deductible. As an affiliate of AARP, the corporation was originally named the Retirement Research and Welfare Association and was set up to engage in the study and discussion of issues affecting aging persons.

In 1983, the Retirement Research and Welfare Association changed its name to the AARP Foundation and shifted its emphasis to promoting projects and community service endeavors related to the social welfare, maintenance, and improvement of health and educational services for older persons. During the 1980s and early 1990s, the Foundation received grants for various AARP projects and also awarded small grants to a variety of community service, educational, and social welfare groups.

On December 19, 1995, the President signed into law the Lobbying Disclosure Act of 1995 which prohibited 501(c)(4) organizations that lobby from receiving federal funds. Although the lobbying act only applies to new grants, AARP transferred its grant programs (staff, funds, and administration) to the AARP Foundation. These transfers were approved by all of the federal funding agencies.

The AARP Foundation administers educational, employment, community service, and advocacy programs funded by both private and federal grants totaling about $80 million and employs about 200 staff. Major programs of the Foundation include the AARP Senior Community Service Employment program, the AARP Tax-Aide Program, and the Washington, DC based advocacy programs funded through Legal Counsel for the Elderly. The AARP Foundation's five-member Board of Directors is appointed by the AARP Board of Directors and provides oversight and guidance to the Foundation's management. Anne Harvey serves as Foundation Administrator, supervising the administrative, financial, and professional activities of the Foundation. Under a service agreement, AARP provides the Foundation with support services and specialized skills needed to carry out some of the grant-funded programs.

AARP Foundation Administrator's Office

Revised May 14, 1997

Mr. SHAYS. Thank you, all three of you. Your testimony is very helpful and valuable because it may get us to think outside the box a little bit.

We tried last year—we, in this case, the majority party—tried to, in our Medicare reform bill, provide a bounty provision; and we weren't able to set a number.

But I remember one time I spoke before a group at AARP, and a woman came and gave me a stack of envelopes. They were Medicare bills. She said, they all came in 1 week, she said, over like a 2- to 3-day period. She wanted to know why they couldn't have all been in one envelope. I was trying to look through these envelopes, but there were something like 30 of them. This is just this bill of the $40 for the lotion. I mean, you know, fortunately, it is registered down as baby L-T-N.

Ms. SAFFORD. Lotion.

Mr. SHAYS. Yes, but they could have put a code number. They could have just put some code, and you wouldn't have known.

Ms. SAFFORD. Did you also notice the $400 for gauze for 1 month?

Mr. SHAYS. The dressing is $402.

Ms. SAFFORD. Yes, for 179 little gauze bandages.

Mr. SHAYS. But what you could do very quickly is, it seems to me, you could have the beneficiary, if they have a bill that they think is wrong, that they get to keep 10 percent of it.

Ms. SAFFORD. That would be great.

Mr. SHAYS. Or even more. But it could be 10 percent. We would get 90 percent. Because in most cases we wouldn't catch it.

Ms. SAFFORD. Just 90 percent more than we would get otherwise.

Mr. SHAYS. Yes. But the bottom line is, on the $402, they would get $40.

Ms. SAFFORD. I have one other quick comment.

We found a real strong correlation in California between those operators that have the most cases of violations and fraud. They seem to go together. They cut their costs by cutting back on staff and services and activities, by not providing what they are contracted to do. So I would like to see some way to put these two together, because they are joined.

Mr. SHAYS. What I want to ask, though, is what is the downside of paying a beneficiary a certain sum?

Because the interesting thing about my dentist bill is, I can tell you this, that if I didn't pay it, I wouldn't care. That is a horrible thing. I wouldn't have noticed. I have to pay it. My insurance doesn't cover it. I mean, it covers like 10 cents on the dollar, so it matters to me.

But to someone who has Medicare, Medigap, Medicaid, it is simply not going to really show up, other than the fact they just, as American citizens, become outraged. If they have to pay a portion of it, they would become more concerned. But if they were given a bounty, what would be the negative on that?

Ms. SAFFORD. Retaliation. For nursing home residents, money isn't the issue. The issue is, if you reported that it was fraud or misbilling and you were afraid that your vulnerable relative in a nursing home is going to suffer for it, you wouldn't say a word. That is the downside.

Ms. CANJA. Our survey showed that that really doesn't help, that people didn't feel that they would be more inclined to report it if they had a bounty.

The other side is, my mother was in a nursing home for 2½ years, so I have some experience with some of this. I thought I detected fraud; but, you know, there is small amounts, like the doctor that didn't see her. Well, 10 percent would have been $4. The podiatrist that cut her nails and gave this inflated bill, that would have been $6, $7, $8.

Mr. SHAYS. Was the bill paid?

Ms. CANJA. The bills were paid by Medicare. They were paid.

Mr. SHAYS. So maybe we give them 50 percent.

Ms. CANJA. No, would I have? Yes, I did report one of them. Would I have done it for the money and what would the administrative cost have been to give me the $6 and the $8 and the $4? I don't know. I am just answering your question.

Mr. SHAYS. I am not trying to have you answer the way I want. I want you to answer the way you feel.

Ms. CANJA. Yes. I don't know. But if there were larger amounts of money—I am wondering if they were mainly small, accumulative kinds of things that add up to a lot of money in the aggregate.

Mr. SHAYS. Ms. Fish.

Ms. FISH. Yes. I think it would be an incentive. But we have done with our volunteers an enormous amount of education and outreach, teaching them to read the bills, teaching them to talk with the residents. We have found that when the residents have found out that they were victimized, just the thought that they were victimized, it didn't even have to do with the fact of the money, that they had to pay it or didn't pay it, but that they were outraged, and the families and residents are now beginning to come forward. Resident councils as a group are being educated on how to read these bills.

So, to me, the answer is, yes, I think it could be an incentive; but I think the real focus has to be on getting out to the public, the way we have been doing, on reaching out and educating not only ombudsmen, but now we are going into senior centers.

You have right now existing all the tools you need to do exactly what you need to do. You have the ombudsman program, which has a whole cadre of volunteers throughout the country. You have organizations like the National Citizens Coalition for Nursing Home Reform right here in Washington, which is a base organization, which has distribution to all the nursing home residents across the country, to do education and outreach.

You would be amazed at the outrage that you would hear out in the public. People would say, I am not going to take it any more, and they are going to mean it. They really are going to mean it.

In New York State, we have found in the first year, as a result of our coordinated efforts in getting the word out to the community, we have identified over $25 million in overpayments, overbillings, with people coming forward.

Mr. SHAYS. The fact that it would inhibit you is just the personal relationship you have with the people who have submitted the bills. They are your friends, they are caring for you, and questioning them would be kind of difficult, I would think. It is difficult

for me. I would think it would clearly be difficult for someone in a nursing home.

Ms. SAFFORD. Is there a way to take it out of that personal range or even worrying about retaliation and have like an automatic review, you know, like just so many—that you actually have a readout?

Right now, Medicare just gets a summary bill. They don't even handle these charges. They would spot in a minute something is wrong with $40 worth of baby lotion, but they are not. They are just getting a package. But isn't there some way in the billing system that we could use to help find these problems? It seems to me that that would be a start.

Mr. SHAYS. OK. Mr. Towns.

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

You have been extremely helpful in so many ways. Let me begin with you, Ms. Canja. Do you believe that patients who are called dual eligibles—you have been listening to the discussion that we have had this morning—are more vulnerable than those who receive Medicare or private insurance coverage? Do you feel they are more vulnerable?

Ms. CANJA. I would have to speak from my personal experience, because my mother was in both of those situations. I did feel she was more vulnerable when she was a dual-eligible, just because she was more dependent on other resources. I am not aware that because she was dual-eligible that there was fraud involved. I am not aware in her situation that she received a lower level of care, although I know of many situations where that did happen.

Mr. TOWNS. Thank you. Feel free to talk. We are really trying to come up with some ways to—there is a problem out there, and I think we all are saying that, and I think that we want to make certain that we get as much information as possible to be able to fix the problem.

I think that, as Members of Congress, you are there on the firing line, and you have been out there working in this area and have some very valuable information, and that is what we are really looking for. So feel free to share that, because we want to be helpful in every way.

Yes.

Ms. SAFFORD. We have found that there is a big impact on the people who have both Medicaid and Medicare. I will tell you a typical call I get at least twice a week. They say, oh, all of a sudden you are told you don't need skilled nursing anymore. You have been in here 2½ weeks. I say, are you now qualified for Medicare? Invariably, they say, yes. The facility says, sorry, you don't need care anymore; get out.

That is what happens to those people in California. It is not proper, it is not legal, but it happens. So I think they suffer.

Mr. TOWNS. Ms. Fish, it appears that the ombudsman in your program have an extremely important oversight responsibility. There is no question about that. Since you operate with volunteers, is there some concern about the turnover rate? Consistency in this business is very, very important.

Ms. FISH. Turnover, yes. There is definitely burnout, because this type of work you are dealing constantly with a very serious prob-

lem. But we have volunteers who have been volunteers for 10, 15 years because of their dedication. We hand-select volunteers, and they are usually people who have some background in this work, and they are very committed.

I would say that probably there is at least a 10 percent turnover every year, 10 to 20 percent turnover every year, but I don't think any more than that right now. It depends on the type of support the State is giving the volunteer program, I think.

Mr. TOWNS. You mentioned communication or coordination—I am not sure which one it was—but I remember hearing communication or coordination of the various agencies that are providing services and have responsibility for oversight. What is your office's relationship with State and local prosecution in terms of police authorities and when you file a complaint? What happens there? You didn't talk about that.

Ms. FISH. Right. When the Governor convened the first State work group, we brought on board the Attorney General's Office, but we also worked with the Office of Inspector General. We developed a system where, when an ombudsman saw a red flag in one of the facilities, saw something happening, a therapist not giving treatment, whatever, we would then make the referral directly to the Office of Inspector General and HCFA and also the State Attorney General's Office.

If it was Medicaid, the State Attorney General's Office handled it. If it was Medicare, HCFA and the Office of Inspector General would handle it. Then they would get back to us, and we would get back to the complainant.

But that is basically how it worked. We were very involved with all of the law enforcement. We continue to be.

Mr. TOWNS. Ms. Safford indicated instances of physical abuse of residents. Have you found any such instances in New York?

Ms. FISH. Of physical abuse?

Mr. TOWNS. Yes.

Ms. FISH. Oh, yes. I can't right now give you the number, but I can tell you last year our figures. We have reported over 5,000 cases. That is reported. We know that could be tripled if people would, you know, the ombudsman actually did the paperwork. But out of our work, the majority of cases is resident care, and within that category is patient abuse and neglect. I mean, there is still a question. That case I gave you is the first example. I wish I could say it wasn't really typical, but it does happen. It happens frequently.

Mr. TOWNS. Let me just ask you one other question, also, picking up on Ms. Safford's testimony, about an extensive data base established by her group which includes important information about complaints and penalties imposed on nursing home facilities. Can you tell me whether your office keeps a similar data base?

Ms. FISH. We keep a data base of all of our cases that we get in regards to that. We have a reporting system, an ombudsman reporting system, but we also take a look at the data that our health department has. But, no, we really don't have. Does that respond to your question?

Mr. TOWNS. Yes. Sometimes my staff will say to me that you are barking up the wrong tree. I just think that if you have informa-

tion, then it helps in a lot of ways. If people know that this information is coming in a very coordinated fashion, they would even behave differently in terms of being responsible for providing service.

Ms. FISH. You are right.

As a matter of fact, you had said something earlier, and I wanted to address that question, when you talked about how do you know where the quality nursing homes are. Is there a listing, if I wanted to look at a data base or whatever?

I can tell you that in other States—and we are going to start doing this in New York State. In other States, what they have done is they have taken the survey reports and in their annual report they list the top 10 nursing homes in terms of compliance. You know, they have been complying, but they also list the top 10 worst in terms of compliance.

You will be amazed at how many people want to get on the top 10 list; and that automatically will start having facilities raise their standards to not just minimum standards, not just compliance. What we are talking about is a good nursing home goes above minimum standards. They say, we don't just need to be in compliance. We need to provide quality care to people. We go above that standard.

Ms. CANJA. I did want to comment. I can tell you in Florida that nursing homes are rated and that their compliance record has to be posted for residents and families to see.

Ms. FISH. We do have in New York State, too. They do have to post it in the nursing home.

Ms. SAFFORD. The last survey has to be available. We have about 2,000 calls a month. We tell them to go to the facility and ask for that survey, take a look at it.

Mr. SHAYS. It wouldn't be on the Internet?

Ms. SAFFORD. No, no, the survey of each individual facility. You know, all 1,450 have to make them available.

Mr. SHAYS. Why wouldn't there be one central source that someone could just turn to?

Ms. SAFFORD. It would be 25, 30 pages for each facility. We put it on the Internet. The State doesn't.

Mr. SHAYS. That is what I say. It is on the Internet, though?

Ms. SAFFORD. The survey results?

Mr. SHAYS. Yours.

Ms. SAFFORD. In Department of Health Services? Ours are, yes—I am sorry—but the results from the Department of Health services are not. They are just in each facility.

Ms. FISH. But the interesting think about that is that in New York State, I think it is, there is a one-page compliance report that is supposed to be posted; but unless you know you would never know to go over to the administrator and say, can I see the entire report. You have to be informed to know that. That is part of what the ombudsman does, is to inform them.

Mr. TOWNS. Last quick question. Ms. Safford, Operation Restore Trust, has it made any difference in California?

Ms. SAFFORD. Well, I was just talking with Ms. Buto earlier. I will give you an example. When I get calls that involve Medicare

fraud—I have several pending right now—it has to go to the carrier. An insurance carrier investigates it.

One case in point. A man in Orange County, who is very motivated to get this investigated, has made 10 calls, but Mutual of Omaha is the carrier. They have not been able to make contact. Ms. Buto said that is going to change. They are going to have new investigators. But, right now, it is a real problem to get the consumer, who does want to complain, to get the person together with an investigator. That has been our experience.

Mr. SHAYS. I just have one question before our vote, and I am not looking for a long answer. Just give me a few key characteristics of a good nursing home.

Ms. FISH. Well, OK. I will go back to a statement I made earlier.

To me, in my experience, 31 years experience, my definition of a good nursing home is not—when you are looking at regulations and you want to make sure you are compliant to each and every regulation when the survey agency comes, that is one thing. It doesn't necessarily mean you are a good facility.

A good facility rises above that. A good facility says, how are we going to go above the minimum, the very, very, very minimum qualifications? How are we going to do that? And there are many facilities who do that in New York State and all over.

Mr. SHAYS. Ms. Safford.

Ms. SAFFORD. Looking to patient care, No. 1, as a mandate for your operation and profit being—coming in second is a key to us. When you are looking at the net profit first, patient care generally suffers. You can see that again and again. So it is what your focus is. Are you looking at providing care or looking at making big bucks?

Ms. CANJA. I would say all of that. If a nursing home goes in with a real concern for the dignity of their patients, a lot of other things fall in place.

Mr. SHAYS. You opened the door for us to just see and to understand more about ombudsmen and what they do. It is just an extraordinary thing in this country I think; and it is very moving to think that there are so many people who are willing to, in fact, volunteer and commit to being somewhere at a certain time and doing it on a weekly basis. I really am surprised that I wasn't more aware of this.

So we will be doing a little more work here in seeing how we can use the ombudsmen more effectively in dealing with waste, fraud and abuse as well as quality care. Thank you very much.

This hearing is adjourned.

[Whereupon, at 12:45 p.m., the subcommittee was adjourned.]

[Additional information submitted for the hearing record follows:]

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IV. Conclusion

The following statement is submitted to the House of Representatives Committee on Governmental Reform and Oversight, Subcommittee on Human Resources on behalf of the Health Industry Distributors Association (HIDA). HIDA is the national trade association of home care companies and medical products distribution firms. Created in 1902, HIDA represents more than 700 companies with approximately 2000 locations nationwide. HIDA members provide value-added services to virtually every hospital, physician office, nursing home, clinic, and other health care sites in the country, and to a growing number of home care patients. As the intermediary between medical products manufacturers and Medicare providers, HIDA Members are able to provide unique "ground level" recommendations to aid efforts to combat fraud and abuse in the Medicare Program.

HIDA wholeheartedly supports the rigorous enforcement of laws that ensure that Medicare pays reasonable reimbursement amounts for medically necessary DMEPOS services on behalf of Medicare beneficiaries. HIDA has long advocated the responsible administration of the Medicare program, and has repeatedly identified specific abusive or illegal practices occurring in the marketplace to assist the government's anti-fraud efforts. HIDA fully supports the development of additional targeted policies designed to aid the government in the administration of the Medicare program. This statement will focus on two such policies, nursing facility consolidated billing and additional Medicare Part B supplier standards.

POLICY RECOMMENDATION NUMBER ONE: NURSING FACILITY CONSOLIDATED BILLING

The House and Senate Medicare Reconciliation bills both contain legislative proposals prohibiting any entity other than a nursing facility from billing Medicare for the medical supplies and services provided to nursing facility residents. These 'consolidated billing' proposals do not distinguish between reimbursements for services covered by Medicare Part A versus Part B.

HIDA supports consolidated billing for nursing facility residents who are covered by Medicare Part A. We understand that Part A consolidated billing is needed to gather the information that the Health Care Financing Administration (HCFA) needs to develop a nursing facility prospective payment system. However, HIDA believes that nursing facilities should retain their ability to use outside suppliers of medically necessary Part B services when the resident is not covered under the 100-day Part A stay. This choice is more efficient and economical for many nursing facilities.

Medical products suppliers such as my company provide nursing facilities with a number of services that promote positive health outcomes. Value-added services provided by medical suppliers including storage, inventory management, clinical services (e.g., respiratory therapy, nutritional assessments, support for wound care protocols), billing and collection, and outcomes support. Many nursing facilities (small, independent facilities, in particular) do not have the administrative staffing, physical space, or other resources to ensure that adequate quantities of the appropriate products are available to meet each patient's needs, especially since some patients require products on an emergency basis or have frequently changing needs. By removing these suppliers from the distribution chain, beneficiaries could be denied access to the wide range of high quality, medically necessary products are services that are currently available.

HIDA opposes consolidated billing for nursing facility residents who are not covered by Medicare Part A for the following reasons:

I. Concerns Relating To Fraudulent Billing Are Not Applicable After The 100 Day Part A Stay: Some argue that consolidated billing is needed to eliminate the opportunity for fraudulent simultaneous "double billing" of Medicare Part A and Part B. The fact is, these concerns can be addressed through Part A consolidated billing - simultaneous billing of Part A and Part B is not feasible for residents who are not covered by Part A.

   In addition, the new Durable Medical Equipment Regional Carriers (DMERCs) have instituted tight controls over the Part B benefit. With full time Medical Directors developing and implementing strict guidelines defining medical necessity and utilization of medical

supplies, the DMERCs have been highly effective in combating fraudulent billing practices. In fact, a recent report from the HHS Office of the Inspector General confirms the effectiveness of the DMERCs. This report, *Medicare Allowances for Incontinence Supplies* (number OEI-03-94-00773, March 1997), asserts that "there have been aggressive efforts by HCFA ... the DMERCs, and the OIG to prevent questionable allowances for incontinence supplies." The report stresses the fact that the DMERCs have, "made billing for questionable supplies more difficult." In the end, the report concludes that, "abusive billings for incontinence supplies have all but disappeared."

HIDA is confident the OIG would find that the DMERCs have been equally effective in reducing fraudulent billings for the vast majority of DMEPOS services. For this reason, HIDA believes that any irregularities in the Part B billings of outside suppliers providing DMEPOS services to nursing facility residents are readily apparent under the current system.

Consolidated Billing Would Impose New Cost Burdens On Nursing Facilities: By requiring fully consolidated billing, even when beneficiaries are not under a Part A stay, many nursing facilities that previously utilized outside suppliers to provide their residents with medically necessary supplies and services would be required to provide these services themselves, to directly bill for these supplies and services, and to assume other responsibilities that are currently fulfilled by outside suppliers. These responsibilities and services would add significant administrative costs to a nursing facility. Importantly, current law allows a nursing facility to act as a Part B supplier; presumably those facilities who choose to do so now would continue this practice in the future if it is their best option.

Consolidated Billing Is, At Best, Budget Neutral: The Congressional Budget Office has traditionally characterized this proposed legislative prohibition against the use of outside suppliers as a revenue neutral billing requirement. In reality, fully consolidated billing would likely increase costs to the health care system, since the supplier community provides valuable billing expertise, inventory control, staff education and clinical services which the facilities will need to replace.

Consolidated Billing Is Not Necessary For Prospective Payment: It is argued that consolidated billing is necessary to collect the data needed to construct a prospective payment system for nursing facilities. However, every prospective payment proposal before Congress applies solely to the Part A benefit. The Part B benefit will continue to exist under a prospective payment system, unless Congress specifically eliminates it.

In fact, the Prospective Payment Assessment Commission (ProPAC), an organization founded by Congress to provide policy recommendations on improvements to the Medicare Program, supports consolidated billing for Part A only. In their March 1, 1997 *Report and Recommendations to the Congress,* ProPAC states that, "the Secretary should require consolidated billing for all services furnished to beneficiaries during a Part A stay." ProPAC does not recommend consolidated billing for Part B items and services supplied to residents who are not covered by Part A. HIDA supports the ProPAC recommendation because it, too, would allow nursing facilities to maintain their ability to utilize outside suppliers of Part B items and services for residents who are not under a Part A stay.

POLICY RECOMMENDATION NUMBER TWO: SUPPLIER STANDARDS

help rid the industry of the few illegitimate players which jeopardize patient care, tarnish the ıstry, and unfairly distort the market for medical products and services, HIDA urges Congress the Health Care Financing Administration (HCFA) to require that all Medicare Part B pliers comply with additional standards that will assure Medicare beneficiaries receive a sistent quality of DMEPOS services. The following recommended supplier standards result n a widespread consensus that the current Medicare Supplier Standards (42 CFR 424.57 et.) are simply insufficient. Importantly, it is not just the *de minimus* nature of the standards that eficient, but also the process Medicare uses to determine whether a provider actually meets

those standards. The following recommended standards therefore would inject some substantive meaning into the notion of being a Medicare provider of DMEPOS services.

These new standards are intended to build upon those currently administered through the Medicare National Supplier Clearinghouse (NSC). These standards would therefore apply to all firms that have or apply for a Medicare Part B supplier number in order to provide DMEPOS services and bill Medicare on behalf of beneficiaries. They reflect the consensus of a wide array industry leaders, national associations, state associations, HIDA Members, and other constituent interests.

If the NSC adopts the recommended standards and changes the process by which it determines whether a provider actually meets the standards, Medicare will realize an immediate benefit by ensuring that beneficiaries receive DMEPOS items and services only from legitimate firms. If an effective screening process is used, unscrupulous firms will never have an opportunity to engage in abusive behavior because they will never be able to bill the Medicare program on behalf of beneficiaries. Consequently, the standards will significantly contribute to reducing fraud and abuse in the Medicare program. For these reasons alone, Congress should require HCFA to adopt these Supplier Standards.

ORGANIZATION OF STANDARDS:

1. Basic Business Standards—would apply to all firms applying for a Medicare Part B Supplier/Provider number and any firm that currently has a Part B supplier number issued by the National Supplier Clearinghouse.

2. Standards for Providers of Respiratory Products—would apply to all firms providing respiratory products and services to Medicare beneficiaries, and billing Part B for those products.

3. Standards for Providers of Home Infusion Therapy—would apply to all providers of home infusion therapy, and billing Medicare Part B for these products.

4. Supplier Enrollment/Application Procedures and Verification—describes a new process by which suppliers would receive a Medicare Part B supplier/provider number. The process includes verification of information submitted to Medicare, and an on-site visit to the firm.

Following are the recommended Part B Supplier Standards:

BASIC BUSINESS STANDARDS FOR PART B SUPPLIERS

The Basis Business Standards would apply to all providers/suppliers that apply for a Medicare Supplier number, and that are in the business of providing medically necessary durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to Medicare beneficiaries either in their home or in a nursing facility.

STANDARD BB-1:

AS PART OF THE APPLICATION PROCESS, THE PROVIDER/SUPPLIER MUST PROVIDE BASIC INFORMATION, INCLUDING:

1. Name
   A. Registration/business license
   B. D/B/A ("doing business as")
2. Tax identification number
3. Address verification
4. Proof of insurance
   A. General product liability insurance
   B. Professional liability insurance (if company has health care professionals as employee(s))

STANDARD BB-2:

Provider/supplier must comply with all federal, state and local regulatory requirements (e.g., licensure), and show proof of compliance when applicable.

Standard BB-3:

Provider/supplier must provide evidence of financial soundness. May be demonstrated in many different ways, for example by:

A. Bank references
B. Insurance—property, liability
C. Trade credit references
D. Etc. (Dun & Bradstreet or other credit reports)

STANDARD BB-4:

Provider/supplier must have policies and procedures to cover basic scope of services for appropriate product lines.

STANDARD BB-5:

Provider/supplier must maintain all professional and business licenses and certifications, and show proof when applicable.

STANDARD BB-6:

Provider/supplier must have 24-hour a day, 7 day a week service availability for appropriate products and response to emergency situations.

STANDARD BB-7:

Provider/supplier routinely monitors the quality and appropriateness of services, equipment and supplies provided.

STANDARD BB-8:

Provider/supplier has a corporate compliance program.

Standard BB-9

Provider/suppliers (owners and officers) shall not have been convicted of violations of Medicare and/or Medicaid rules and regulations.

Standard BB-10:

Provider/supplier attests that it is knowledgeable of the Medicare laws, regulations and policies pertaining to the billing of the applicable services, equipment and supplies provided.

Standard BB-11:

Provider/supplier has the capability (either directly or through contractual arrangements with other entities) to service customer locations, as evidenced by product inventory, distribution systems, and emergency backup systems.

Standard BB-12:

Provider/supplier provides its customers with educational resources relative to the products and services provided such as assistance with understanding Medicare regulations, provision of Medicare's toll free beneficiary help line, equipment inservices (if applicable), and product information.

Standard BB-13:

Provider/supplier has policies and procedure to document and resolve customer complaints and inquiries.

Standard BB-14:

Provider/supplier maintains regular business hours.

Standard BB-15:

Provider/supplier maintains a physical business location with its business name evidently displayed.

Standard BB-16:
Provider/supplier has procedures to document maintenance and repair programs for equipment as applicable.

Standard BB-17
The patient/caregiver must be informed of the provider's compliance with all applicable HME Federal and State laws, regulations and Standards.

Standard BB-18
The provider/supplier must assure that all the necessary and appropriate patient/caregiver education has been provided or arranged for with respect to the services, equipment, and supplies provided.

Standard BB-19
The provider/supplier must provide patient/caregiver training in the safe and proper use of equipment, with a follow-up demonstration.

Standard BB-20
The provider/supplier must inform, in general terms, the patient/caregiver of his/her financial responsibilities.

Standard BB-21
The provider/supplier will assure that environmental considerations are addressed such that the continuing needs of the patient/caregiver are met in the safest possible manner.

Standard BB-22
The provider/supplier only uses equipment and supplies that conform to generally accepted industry manufacturing standards.

Standard BB-23
The provider must have a valid, current and accurate prescription for all equipment and supplies provided.

Standard BB-24
The provider/supplier must notify the prescribing physician of apparent patient non-compliance.

SUPPLIER STANDARDS FOR PROVIDERS OF RESPIRATORY PRODUCTS

These provider standards would apply to providers of respiratory products (in addition to the Basis Business Standards described above).

STANDARD RESP-1:
All patient/caregiver information must be kept in confidence (except when required to be released, for example, by JCAHO; and provider will first obtain client's permission).

Standard Resp-2:
Providers may only provide respiratory therapy equipment for which it is an authorized dealer.

Standard Resp-3:
The provider must perform and document scheduled in-home routine preventative maintenance of provider-owned (i.e., rental, loaner) equipment.

Standard Resp-4:
Either directly or through contracting with another entity, the provider must perform and document manufacturers' scheduled maintenance of provider-owned (i.e., rental, loaner) equipment.

Standard Resp-5:

Provider cleans, stores, and transports respiratory therapy equipment in accordance with the manufacturer's recommendations and all applicable Federal and local laws ad regulations.

Standard Resp-6:

The provider must have a valid, current and accurate prescription for all respiratory therapy equipment dispensed.

Standard Resp-7:

The provider must secure physician approval, either through a change in the prescription or through physician-approved protocols, before respiratory therapy equipment modality substitutions are made.

Standard Resp-8:

The provider only utilizes the services of personnel who are appropriately trained, qualified, and competent for their scope of services.

Standard Resp-9:

The provider utilizes services of health care professionals that adhere to all Federal and State laws, rules, and regulations.

Standard Resp-10:

Providers providing life supporting or life sustaining respiratory therapy equipment assume the responsibility to directly provide or arrange for the services of a respiratory therapist or equivalent.

SUPPLIER STANDARDS FOR PROVIDERS OF HOME INFUSION THERAPY

These provider standards would apply to providers of home infusion products (in addition to the Basis Business Standards described above).

PERFORMANCE STANDARDS

Standard IV-1

Provider has competent staff:

A. Provider has trained, competent technical staff
B. Provider has access to qualified health professionals

Standard IV-2

Provider performs client assessments, which includes:

A. Appropriateness of therapy
B. Safety of home environment
C. Development of plan of care to establish product and service needs

Standard IV-3

Provider coordinates client care with other providers and practitioners:

A. Communication and interaction with other providers and practitioners
   a. Patient assessment/service plan
   b. Changes in patient's needs
   c. Changes in patient's care regimen

Standard IV-4

Provider has a valid, current and accurate prescription for all products dispensed.

Standard IV-5

Provider schedules activities, including

A. Who does what and when

Standard IV-6

Provider performs patient/caregiver training which includes:

A. Indication for therapy
B. Administration of medications or formula
C. Operation and maintenance of pump
D. Inventory storage and management
E. Self-monitoring
F. Emergency response

Standard IV-7

Provider delivers, sets up and pickup equipment and supplies.

Standard IV-8

Provider performs ongoing monitoring and follow-up, including:

A. Assess response
B. Assess functioning of therapy delivery system
C. Assess product utilization, patient compliance
D. Assess continuing need for therapy (with others)
E. Equipment tracking, cleaning, maintenance and repair

Standard IV-9

Provider provides access to emergency response services

A. Services are available 24 hours a day, 365 days a year
B. Provider responds within reasonable time
C. Provider provides intervention as indicated.
   a. Technical
   b. Clinical—provide instruction, visit or contact other provider

INFORMATION MANAGEMENT

Standard IV-10

Provider manages the following information related to the client:

A. Maintain clinical records
B. Patient satisfaction/grievances
C. Complications
D. Unscheduled deliveries and visits
E. Utilization data by service, by patient
F. Goals of therapy, patient needs

APPLICATION PROCESS -- FOR A MEDICARE PART B SUPPLIER NUMBER

The verification that a provider/supplier meets the Medicare supplier standards is vitally important to the supplier industry, beneficiaries, and the Medicare Program to ensure that only viable suppliers provide medically necessary DMEPOS items and services to Medicare beneficiaries.

HIDA recommends that non-governmental independent organizations verify that suppliers comply with the Medicare supplier standards, both initially and on an ongoing basis. This recommendation is similar to the structure used world wide by the International Standards Organization (ISO). This process would be simple, minimize bureaucracy and paperwork, and most importantly, ensure the suppliers comply with the standards.

1. National Supplier Clearinghouse (NSC) would certify organizations that wish to verify suppliers meet the Medicare supplier standards.

2. These organizations would verify compliance based solely on the Medicare supplier standards. Verification would include:
   A complete review of the application,
   Written follow-up on questionable areas

On-site visit to verify/check remaining questionable areas

3. There would be a time limit to complete the review process (no more than 90 days)

4. The provider/supplier pays the fee to the verification organization (a portion of which may go to the NSC to cover administrative costs).

5. There would be a three year cycle for renewal of Medicare supplier number to ensure ongoing compliance with the Medicare supplier standards. The fee would cover the three year cycle.

Note: HIDA supports a reasonable application fee to cover costs of verification. The recommendation is made with the understanding that these verification procedures will actually weed out the "bad actors;" non-legitimate companies would not be able to get a Medicare supplier number because of the rigorous screening of all applicants.

CONCLUSION

HIDA appreciates the opportunity to submit these recommendations to the Subcommittee. We urge Congress and HCFA to strengthen the Medicare program by requiring nursing facility consolidated billing during the 100-day Part A benefit and implementing rigorous Medicare Part B supplier standards. These two recommendations will aid in the ongoing effort to combat Medicare fraud, waste, and abuse while promoting the provision of consistent, high quality services to Medicare beneficiaries.