DEFRAUDING MEDICARE: HOW EASY IS IT AND WHAT CAN WE DO TO STOP IT?

HEARING

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT MANAGEMENT, INFORMATION, AND TECHNOLOGY

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

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DEFRAUDING MEDICARE: HOW EASY IS IT AND WHAT CAN WE DO TO STOP IT?

TUESDAY, JULY 25, 2000

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON GOVERNMENT MANAGEMENT,
INFORMATION, AND TECHNOLOGY,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2154, Rayburn House Office Building, Hon. Stephen Horn (chairman of the subcommittee) presiding.

Present: Representatives Horn, Biggert, Ose, and Turner.

Staff present: J. Russell George, staff director and chief counsel; Randy Kaplan, counsel; Bonnie Heald, director of communications; Bryan Sisk, clerk; Elizabeth Seong, staff assistant; Will Ackerly and Davidson Hulfish, interns; Jim Brown, legislative assistant to representative biggert; Trey Henderson, minority counsel; and Jean Gosa, minority clerk.

Mr. HORN. A quorum being present, the Subcommittee on Government Management, Information, and Technology will come to order.

We are here today to examine the growing problem of fraud in the Medicare program. Medicare is the Nation's largest health insurer, covering nearly 40 million beneficiaries, including seniors and the disabled, at a cost of more than $200 billion a year.

At a March 2000 hearing before this subcommittee, we examine the Health Care Financing Administration's fiscal year 1999 financial statements. We learned that the Medicare program continues to be vulnerable to fraud, waste and misuse. At the hearing, the Health Care Financing Administration, the agency charged with managing Medicare, reported that in fiscal year 1999, the system paid out an estimated $13.5 billion in erroneous payments.

While the actual amount of fraud in the Medicare program is unclear, the General Accounting Office has reported that there is a growing trend in health care fraud in which sham providers are entering the Medicare system with the sole purpose of exploiting it. Both the General Accounting Office and the Department of Health and Human Services Inspector General have identified a number of schemes being used to defraud Medicare. Today we will hear from a variety of witnesses who will discuss those schemes and the reasons why career criminals and organized criminal groups are now targeting the health care system.

We will also discuss the ways in which the government can be more vigilant in combating health care fraud. One proposed solu-

tion is the Medicare Fraud Prevention and Enforcement Act, which was introduced in the Senate as S. 1231 by Senator Susan Collins from Maine, and in the House as H.R. 3461 by the subcommittee's vice chairwoman, Representative Judy Biggert from Illinois. I would like to commend my colleagues for their efforts.

In addition, we will hear testimony from individuals who were prosecuted, pleaded guilty and received sentences from their involvement in defrauding the Medicare program. Mr. Raymond Mederos will testify about a Medicare billing scheme he orchestrated and carried out. In addition to his sentence of 7 years and 3 months at a Federal institution, Mr. Mederos was ordered to pay restitution of $1.2 million. We will also hear testimony from Mr. Dennis Spencer, who owned a laboratory in southern California. He will discuss the pressures placed on laboratories to defraud the system. Mr. Spencer pleaded guilty to Medicaid fraud for falsifying laboratory test results and billing for tests that had not been performed.

We welcome our witnesses today, and look forward to their testimony.

I now yield to the ranking member of this subcommittee, the gentleman from Texas, Mr. Turner, for an opening statement.

[The prepared statement of Hon. Stephen Horn follows:]

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OPENING STATEMENT
Chairman Stephen Horn
"Defrauding Medicare: How easy is it? What can we do to stop it?"
Tuesday, July 25, 2000

A quorum being present, the Subcommittee on Government Management, Information, and Technology will come to order. We are here today to examine the growing problem of fraud in the Medicare program. Medicare is the Nation's largest health insurer, covering nearly 40 million beneficiaries, including seniors and the disabled, at a cost of more than $200 billion a year.

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We will also discuss the ways in which the Government can be more vigilant in combating health care fraud. One proposed solution is the "Medicare Fraud Prevention and Enforcement Act," which was introduced in the Senate as S. 1231 by Senator Susan Collins from Maine, and in the House as H.R. 3461 by the subcommittee's Vice Chairwoman, Representative Judy Biggert from Illinois. I would like to commend my colleagues for their efforts.

In addition, we will hear testimony from individuals who were prosecuted, pleaded guilty, and received sentences for their involvement in defrauding the Medicare program. Mr. Raymond Mederos will testify about a Medicare billing scheme he orchestrated and carried out. In addition to his sentence of seven years and three months at a Federal institution, Mr. Mederos was ordered to pay restitution of $1.2 million. We will also hear testimony from Mr. Denis Spencer who owned a laboratory in Southern California. He will discuss the pressures placed on laboratories to defraud the system. Mr. Spencer pleaded guilty to Medicare fraud for falsifying laboratory test results and billing for tests that had not been performed.

We welcome our witnesses today, and look forward to their testimony.

Mr. TURNER. Thank you, Mr. Chairman.

Senator, welcome this morning. We are glad to have you with us.

We know that this Medicare program, a $200 billion program managed by the Health Care Financing Administration, serves almost 40 million Americans. In fiscal year 1999, the Inspector General estimated that the program's potentially erroneous payments amounted to $13.5 billion, or 8 percent of the $170 billion fee-for-service program. The 8 percent error rate does not measure fraud, but it can include improper payments related to fraudulent conduct.

We all know that Congress is struggling trying to save the future of Medicare. It is our obligation to be sure that we do not tolerate any who attempt to cheat this very important and critical program.

I commend the chairman for having the hearing this morning. I commend Senator Collins and my colleague from Illinois Mrs. Biggert for their legislative efforts to crack down on fraud and waste and abuse in Medicare, and it is my hope that as a result of the hearing, we as a Congress will know what needs to be done to defend the program from those who siphon off moneys. Mr. Chairman, I look forward to the testimony today.

[The prepared statement of Hon. Jim Turner follows:]

Statement of the Honorable Jim Turner
GMIT: "Defrauding Medicare: How easy is it and what can we do to stop it?"
July 25, 2000

Thank you, Mr. Chairman. Medicare is the nation's largest health insurer. The $200 billion program, which is managed by the Health Care Financing Administration, serves about 39.2 million Americans. In fiscal year 1999, the Inspector General of HHS estimated that the program's potentially erroneous payments amounted to approximately $13.5 billion, or 8% of the $169.5 billion fee-for-service program. The 8% error rate does not measure fraud, but it can include improper payments related to fraudulent conduct. Previous investigations by the General Accounting Office (GAO) have provided evidence that, in addition to some legitimate healthcare and healthcare-related providers, career criminal and organized criminal groups have become involved in health care fraud across the country. Whatever these audits reveal or fail to reveal, we know that Medicare fraud is prevalent and that it represents a serious threat to the integrity of our healthcare system.

As many of you know, Congress is currently struggling to save the future of Medicare. Millions Americans rely on Medicare for primary health coverage. Therefore, we cannot afford, nor can we tolerate, those who seek to cheat this important program. I commend the Chairman for having this hearing and welcome the witnesses here this morning. Additionally, I want to commend Senator Collins and my colleague from Illinois, Congresswoman Biggert for their legislative efforts to crack down on waste, fraud, and abuse in Medicare. It is my hope, that as a result of this hearing we, as a Congress, will know what needs to be done to defend this program from those who siphon off dollars earmarked for the healthcare of our elderly and disabled.

Mr. HORN. I thank the gentleman and now call on the vice chair, the gentlewoman from Illinois.

Mrs. BIGGERT. Thank you, Mr. Chairman. Let me begin by thanking you, Mr. Chairman, for accommodating the request for a hearing on the disposition and extent of Medicare fraud and abuse.

I am hopeful that today's hearing will expose and explain how fraud and abuse are being perpetrated so that we in Congress might provide the tools to eradicate these practices.

Five years ago Citizens Against Government Waste equated the Medicare program to, "a Gucci-clad matron toting a flashing neon sign that says 'please rob me.'" It is 5 years later and the grand lady of health care is still toting that sign.

In fiscal year 1999, some $3.5 billion were drained from the trust fund as a result of waste, fraud and abuse. It is easy to see why the Medicare program is such an appealing target for theft. It is because, as Willie Sutton said when asked why he robbed banks, that's where the money is.

It is because Medicare is one of the Federal Government's largest programs and the Health Care Financing Administration, the entity responsible for managing Medicare and Medicaid, is the largest health care purchaser in the world.

Now, anyone closely involved with Medicare knows how difficult it is to determine what portion of the billions of dollars drained each year can be attributed to schemes such as deliberate forgery, kickbacks or fictitious medical providers. Nor is it easy to determine how much money is lost to human error and innocent mistakes, but that is not what the hearing is about. It is about the growing number of career criminals who are flocking to the Medicare program with the sole intent of defrauding the Medicare system and making a buck.

According to a GAO study, many of those currently perpetrating Medicare fraud had prior criminal histories for crimes unrelated to health care. Many of them had graduated from such small potato crimes as drug dealing, embezzling and credit card fraud and moving up to the big fry of Medicare fraud.

While I strongly condemn what they have done, I am pleased that the subcommittee will have an opportunity to hear directly from two individuals caught and convicted for gaming Medicare. They will give us a firsthand account of how easy it is to commit this kind of crime and they will speak to the loopholes that criminals are using to enter the program.

As for closing these loopholes, I am so pleased that Senator Susan Collins is here to tell us about companion legislation that she and I introduced to prevent these criminals from defrauding another cent out of this critical program. Our bill, the Medicare Fraud Prevention and Enforcement Act, is designed to prevent up front Medicare abuses and fraud by strengthening the program, enrollment process, expanding certain standards of participation and reducing erroneous payments. Most importantly, the bill gives law enforcement much needed tools to pursue health care swindlers. I hope today's hearing provides the momentum needed to get this legislation enacted into law.

Again, Mr. Chairman, I thank you for calling this important hearing and I trust it will lead to making the Medicare program

stronger and more secure so it continues to meet the needs of our growing elderly population.

Mr. HORN. I thank you and we now begin with our keynote witness here today and we are delighted to have Senator Susan Collins with us. She, as I said earlier, has been a true investigator on the Senate side and this is certainly one of the ones that mean a lot to millions of people. Thank you for coming.

STATEMENT OF HON. SUSAN M. COLLINS, A U.S. SENATOR FROM THE STATE OF MAINE

Senator COLLINS. Thank you very much, Mr. Chairman, for your gracious comments. It is a pleasure to be here this morning before you and the vice chair, Congresswoman Biggert, and other members of the committee.

I want to first of all start by applauding your efforts to combat fraud and abuse in the Medicare program and commend you for holding this morning's hearing. We have had the pleasure of working together on a variety of issues involving the inspectors general and other issues, and it has always been a pleasure to work with this subcommittee.

The Senate Permanent Subcommittee on Investigations, which I chair, has conducted an extensive investigation into Medicare fraud during the past 3 years, and I am pleased this morning to share some of our findings with you. I have a longer statement that I ask permission be included in the hearing record.

Mr. HORN. It is automatically in the record as well as your resume. That will take another volume.

Senator COLLINS. That will be the short part. In the interest of time, I will just summarize my comments this morning.

At the outset, I think it is important to emphasize, as both of you have done, that the vast majority of health care providers in this country are dedicated honest professionals whose top priority is the welfare of their patients. We are not talking about innocent mistakes or honest billing errors but complex deliberate schemes to defraud Medicare. Our investigation has revealed a dangerous and growing trend in which criminals pose as health care providers for the sole purpose of stealing from the Medicare program. Unlike traditional health care fraud where services are provided, albeit at an inflated and unjustified cost, what we are seeing is career criminals, completely bogus providers, entering the Medicare program, stealing all of the money for which they bill Medicare while providing inferior services or no services at all to our senior citizens. In fact, once they obtain a Medicare number, bogus providers have easy access to what one fellow who testified at a hearing I held described as a gold mine.

We learned about a community mental health center in such poor condition that the local health and fire departments condemned the building and evacuated all of the Medicare patients. In another case we learned that over $6 million in Medicare funds were sent to durable medical equipment companies that not only provided no services, they didn't even exist. One of these providers listed a fictitious address that, if real, would have placed the business in the middle of the runway at Miami International Airport.

And I mention that case, Mr. Chairman, because it shows how easily the system is ripped off. With just a little bit of due diligence one would think that the Health Care Financing Administration could have discovered that these businesses did not even exist.

In another example we found a criminal pretending that he had a doctor's office in Brooklyn that the actual physical address of turned out to be a Laundromat. So these are really blatant examples of fraud.

At my request the General Accounting Office investigated the nature and magnitude of fraudulent activity by career criminals posing as health care providers. In reviewing just seven cases of health care fraud, GAO found as many as 160 sham medical entities billing for services and equipment that was either not provided or not medically necessary. For the most part, these entities existed only on paper.

For example, the GAO examined one North Carolina case in which the crook stole beneficiaries' numbers from a Miami hospital, then used them to submit bogus Medicare claims for supplies and equipment. The fraud gang's leader had paid a relative $5 to $7 per patient to obtain beneficiary lists from the hospitals. That is something that we found was a common problem of criminals either gaining access to Medicare beneficiaries' numbers or stealing the numbers or tricking senior citizens into giving them to them.

In another case GAO analyzed a Florida Medicare fraud case that employed a rent-a-patient scam in which phony health care providers used recruiters to persuade real Medicare beneficiaries to obtain unnecessary medical services. In this case the beneficiaries were part of the scam and got a kickback for their cooperation. The beneficiaries understood that if they were really sick and needed a real doctor, they were to go elsewhere.

The impact of health care fraud perpetrated by these criminals is widespread. We know, as the chairman has indicated, that the Department of Health and Human Services Inspector General has estimated that improper payments, which obviously includes more than fraud, amount to an astounding $13.5 billion a year. That is money that could be put into providing a prescription drug benefit or improving payments to rural providers or in otherwise strengthening the solvency of the program. We must not lose sight of the fact that ultimately the taxpayers and Medicare beneficiaries are the ones who pay for fraudulent claims.

To address these problems, as the chairman has indicated, I have introduced Senate bill 1231, the Medicare Fraud Prevention and Enforcement Act, and I am delighted that the vice chairwoman of this committee has introduced the House companion bill. This would prevent scam artists from acquiring provider numbers by requiring a criminal background check to be performed on all Medicare applicants who are applying to providers. It also requires a site inspection for providers whose specialties have posed the greatest fraud risk to the Medicare program. Had there been site inspections in many cases I cited to you, it would have revealed that these were simply paper entities and not legitimate health care providers.

The bill assigns the unique identifying number to all Medicare billing agencies, and the legislation raises the stakes for commit-

ting Medicare fraud by making it a felony to purchase, sell or distribute beneficiary or provider numbers.

In closing, I want to thank you again for your leadership on this most important issue and for giving me the opportunity to testify here this morning. I have provided to the committee, in addition to my longer statement, a copy of the GAO report which I think you will find very helpful. We would also be happy to share our hearing records with you. I look forward to continuing to work with you to stem the tide of criminals waltzing in and stealing from the Medicare program.

Thank you very much, Mr. Chairman.

[The prepared statement of Hon. Susan Collins follows:]

STATEMENT FOR THE RECORD
OF
SENATOR SUSAN M. COLLINS

Hearing on Medicare Fraud
Subcommittee on Government Management, Information, and Technology
Committee on Government Reform
United States House of Representatives

July 25, 2000

Good morning, Chairman Horn, Vice Chairwoman Biggert, and members of the Subcommittee. I applaud your efforts to combat fraud and abuse in the Medicare program, and I commend you for holding this morning's hearing. As the Chairman of the Senate Permanent Subcommittee on Investigations, I have conducted an extensive investigation into waste, fraud, and abuse in the Medicare program, including an assessment of the new types of Medicare fraud.

My state has a slogan -- "Maine, the way life should be" – and it certainly is true when it comes to health care. I have had a lot of experience with health care providers in Maine. Most have been in business for many years and are well known in their communities. They provide high quality care and are committed to the health and welfare of their patients. My Maine experience in no way prepared me for what we found in our investigation.

Our investigation discovered a dangerous and growing trend in Medicare fraud. Career criminals and bogus providers with no background in health care are entering the system with the sole and explicit purpose of stealing hundreds of millions of dollars from the Medicare trust fund. One felon explained that the appeal of Medicare fraud is that it is easier and safer than selling drugs. Our investigation found that unlike traditional health care fraud, where services are provided albeit at an inflated cost, these career criminals steal all the money for which they bill Medicare while providing inferior services, or no services at all, to elderly Americans. In fact, once they obtain a Medicare number, bogus providers have easy access to what one felon called a "gold mine."

We learned about a community mental health center in such poor condition that the local health and fire departments condemned the building and evacuated all the Medicare patients. In another case, we heard that over $6 million in Medicare funds were sent to durable medical equipment companies that provided no services. One of these providers listed a fictitious address that, if real, would have placed the business in the middle of a runway at Miami International Airport.

To assist our investigation, I requested that the General Accounting Office ("GAO") investigate the nature and magnitude of illegal activity by career criminals posing as health care

providers for the purpose of defrauding federal, state, and private insurance systems. On November 4, 1999, Senator Dick Durbin and I announced the results of GAO's investigation, which are set forth in its report entitled, "Health Care Fraud: Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers." In this report, GAO confirmed that there is a growing trend in health care fraud in which sham providers are entering the health care system. In fact, the problem is even more pervasive than we had initially realized.

GAO closely examined seven cases of health care fraud. In just this small sample, GAO found as many as 160 sham medical entities billing for services and equipment not provided or not medically necessary. For the most part, these entities existed only on paper.

For example, GAO examined one North Carolina cases in which the crooks stole beneficiaries' numbers from a Miami hospital, then used them to submit bogus Medicare claims for supplies and equipment. The fraud gang's leader had paid a relative $5 to $7 per patient to obtain beneficiary lists from the hospital. In contrast, GAO analyzed a Florida Medicare fraud case that employed a "rent-a-patient" scam in which phony health care providers used "recruiters" to persuade real Medicare beneficiaries to obtain unnecessary medical services. The recruiters then paid the beneficiaries a "kick-back" for their cooperation. The beneficiaries understood that if they needed "a real doctor," they were to go elsewhere.

Under the "drop box" scheme, the criminals rented mailboxes, created bogus corporations, and opened phony bank accounts. They then stole, purchased, or otherwise obtained beneficiary and provider numbers to bill insurance plans for millions of dollars for medical services and equipment they never provided. During the Subcommittee's investigation, we discovered two physicians who, according to Medicare records, practiced out of a laundromat in New York City. Their "mail drop" scheme defrauded Medicare out of approximately $117,000.

The impact of health care fraud perpetrated by these criminals is widespread and affects more than just the Medicare program. Consumers pay increased health care costs and taxpayers pay for fraudulent claims. Moreover, these criminals threaten the quality of care provided to seniors and disabled citizens. In some cases, they fail to provide needed care. In others, beneficiaries risk acquiring false medical histories and exhausting their medical benefits.

I want to stress that the vast majority of providers are dedicated health care professionals whose top priority is the welfare of their patients. The Subcommittee's investigation and GAO's report are not about those legitimate health care professionals nor honest mistakes or billing errors. They are about career criminals who waltz into the Medicare program without being questioned and who steal hundreds of millions of dollars from the Trust Fund. We must crack down on bogus providers who have no business participating in a program vital to 38 million Americans.

To address this problem, we should not make entry into the Medicare program so difficult that the process deters legitimate health care providers. We must, however, have enough of a

deterrent so that these unscrupulous providers cannot enter the system and threaten the solvency of this vital health care program. The fact is, it is far easier to obtain a Medicare provider number than to obtain a Maine driver's license. The current process makes it far too easy for criminals to exploit a system that seems based on a philosophy of pay now, ask questions later. We owe it to the American people to strike this balance.

It was with this goal in mind that I introduced S. 1231, the Medicare Fraud Prevention and Enforcement Act of 1999. I am pleased that Vice Chairwoman Biggert has introduced the House companion to my bill, H.R. 3461. Although this legislation will not prevent all of the waste, fraud, and abuse that now plagues Medicare, it represents an important step toward a solution to a problem that threatens the financial integrity of this vital social program.

Unfortunately, there is no line item in the budget called "Medicare Waste, Fraud, and Abuse" that we can simply cut to eliminate this insidious problem. It is a complicated, difficult challenge to plug the holes that place Medicare at high risk for fraud and abuse. Nevertheless, S. 1231 seeks to stem the tide of criminals taking advantage of the loopholes by strengthening the Medicare enrollment process, expanding certain standards of participation, and reducing erroneous payments. Among other things, this legislation gives additional enforcement tools to the federal law enforcement agencies pursuing health care criminals.

One of the most important steps this bill takes is to prevent scam artists and criminals from securing the provider numbers that permit them to gain access to the Medicare system. Specifically, this bill requires background investigations to be conducted on all new providers to prevent career criminals from getting involved with Medicare in the first place. In addition, this bill requires site inspections of new durable medical equipment suppliers and community mental health centers prior to their being given a provider number. This will help close the system to those who apply for a provider number from a bogus or nonexistent location. Together, these provisions are designed to make it more difficult for unscrupulous individuals to obtain a Medicare provider number and begin submitting fraudulent claims.

In addition, this legislation requires community mental health centers to meet applicable certification or licensing requirements in their state before they are issued a provider number. It also permits the Secretary of Health and Human Services to establish additional standards for such centers to participate in the Medicare system.

My legislation requires each agency that bills Medicare on behalf of physicians or provider groups to register with the Health Care Financing Administration ("HCFA") and receive a unique registration number. Many billing companies receive a percentage of the claims they submit that are paid by Medicare. Unethical companies, therefore, have a financial incentive to inflate the cost or number of claims submitted. Because billing companies do not have a Medicare provider number, however, it is difficult for HCFA to sanction or exclude them from billing Medicare. Hence, there is little to deter unscrupulous billing companies from submitting inflated claims. This bill makes all companies accountable for their billings through a uniform registration system.

Under this legislation, providers also would be required to refund overpayments, even if they filed for bankruptcy, when the overpayments were incurred through fraudulent means. This money would then be deposited into the Medicare Trust Fund. Some bad actors have used bankruptcy as a shield against repaying Medicare. Essentially, unscrupulous individuals steal literally hundreds of thousands of dollars from the Medicare program, hide or spend it quickly, and then file for bankruptcy protection when they are caught, leaving the Medicare Trust Fund in debt. This bill intends to close this loophole.

This legislation also aims to halt trafficking in provider numbers by making it a felony to knowingly, purchase, sell, or distribute Medicare beneficiary or provider numbers with the intent to defraud. Our investigation revealed that there is a growing problem with unscrupulous providers using "recruiters" fraudulently to obtain Medicare beneficiary identification numbers, thereafter using these numbers to bill for services never delivered. This problem must be stopped.

In addition, the legislation requires the use of Universal Product Numbers ("UPNs") on claims forms for reimbursement under the Medicare program. These provisions of the legislation would require that a UPN uniquely identifying the item be affixed by the manufacturer to medical equipment and supplies. The UPNs would be based on commercially-accepted identification standards; however, customized equipment would not be required to comply with this requirement.

S. 1231 embodies my determination to improve the Medicare program by providing additional tools that are needed to combat the extensive waste, fraud, and abuse that plague our nation's most important health care program. The unscrupulous individuals who commit Medicare fraud drive legitimate providers out of business, cost taxpayers vast sums of money, deliver substandard services and equipment, and endanger our elderly by not providing needed services.

We must use common sense and cost-effective solutions to curtail the spreading infection of fraud that threatens the vitality of Medicare. We have a serious responsibility to older Americans across the country and to the nation's taxpayers to protect the Medicare program. I thus applaud your leadership on this most important issue, and I look forward to working with you to stem the tide of criminals who seek to take advantage of the Medicare program.

Mr. HORN. Thank you very much for your thorough exhaustion of all of the varieties of what goes on in this area. With all of that pot of money, it is going to be hard for some people to keep their hands off it. Without objection, all of the documents that you have given us as an exhibit will appear at this point in the record. Thank you for coming.

Senator COLLINS. Thank you, Mr. Chairman and members of the committee.

Mr. HORN. We now move to panel two and let me say for both panel two and three that the way we operate here is all members except Members of the Congress or the Senate take an oath that the testimony is going to be truthful and, No. 2, if you have a written statement, we put it automatically in the record when you are introduced. We would like to have you give an oral summary of that because what we are interested in is an opportunity for both the panelists and the Members of Congress to ask questions and to learn more about the problem. Panel two, Mr. Mederos and Mr. Spencer, come forward and raise your right hands.

[Witnesses sworn.]

Mr. HORN. The clerk will note that both witnesses have taken the oath and we will now begin with Mr. Raymond R. Mederos. Mr. Mederos is now at the Federal prison camp, Seymour Johnson Air Force Base in North Carolina, and we thank you for taking the time to come up here because your testimony can be very helpful to us in terms of how this process actually works in terms of Medicare. So thank you very much for coming.

Mr. MEDEROS. You are welcome.

Mr. HORN. Go ahead.

STATEMENTS OF RAYMOND R. MEDEROS, FEDERAL PRISON CAMP, SEYMOUR JOHNSON AIR FORCE BASE, NORTH CAROLINA; AND DENIS EDWIN SPENCER, "MY BREAK TRANSITIONAL CENTER," GARDEN GROVE, CA

Mr. MEDEROS. Mr. Chairman, members of the committee, I would like to thank you for the invitation to appear before this committee. It affords me an opportunity to in some small way make amends for my past wrongdoings. I am pleased to be able to help in any way possible by sharing with you any knowledge that I may possess as to how the Medicare program may be susceptible to fraud. Beyond legislative purposes, hearings such as this one are essential to educate the public about how they can help defeat Medicare fraud and ensure that the benefits are kept at an adequate level for those who need them.

In my opinion, the greatest vulnerability lies in the willingness of those responsible for policing the system to accept appearances in lieu of simple investigatory inquiries, as a company or person who identifies herself or himself as a provider and can talk the unique language of that arena is welcomed with open arms and very few questions. For instance, the legitimacy of the officers and owners of the companies that were used was never questioned.

In January 1994, I moved to the Fort Mills-Charlotte, NC area and started a medical billing service. I had learned of this business from a Miami, FL-based service. I was unable to make the business produce, and in May of that year I was offered a position as oper-

ations manager with the Miami billing service. I worked there until October 1994, when I returned to the Charlotte area.

The company I worked for in Miami had about 120 clients who received Medicare payments of approximately $150,000 to $200,000 per month for durable medical equipment services. My responsibility was to provide them with the best possible service, including the most expeditious way for them to receive prompt payment. But something appeared wrong in the way the clients conducted their business, and in July 1994 Medicare became aware that something strange was happening in Florida and all payments to Dade County-Miami providers were stopped.

Mr. OSE. Mr. Chairman, Mr. Mederos' testimony has been given to us in writing previously, and while I am confident Mrs. Biggert has read it and I have read it, I wonder if we can reduce the amount of time Mr. Mederos may read his testimony to us and go on to questions of these witnesses in lieu thereof.

Mr. HORN. Well, if the witness can summarize it, we would appreciate it. Don't read it because, as the Members say, we have read it. Go ahead and summarize it. Skip paragraphs, get the main point out, because that will help us and we can have an exchange of questions.

Mr. MEDEROS. Very well.

Mr. HORN. Thank you.

Mr. MEDEROS. So basically I thought, I could improve on what I had learned in Florida, and unfortunately I did. I started it and found it very easy to be able to obtain a Medicare provider number, do the billings and no questions were asked, although in many cases I used Florida patients being billed out of North Carolina, nobody questioned it. Eventually Medicare did realize that there was something strange and they questioned it. Beyond that, there were no questions asked, and it was not a very difficult thing to do.

In my opinion, after having had this experience, I would say that more should be done in the area of checking the applications that are received by Medicare, like obtaining a credit report on the officers or owners of the company in order to confirm that they exist, invest more money in aggressively advertising to the public and making them aware, the subscribers, that it is them, the only ones who can really stop fraud. Nobody else can because the system is so big. If it is possible to hire an advertising agency to do this and do it in a big way. That would be the best tool that the Medicare system could have, people who are aware of that, make it easier for the subscribers to understand what is being paid in their names. Right now what they receive is a copy of the statement that is sent to the provider and it is difficult for a layman to understand, and much more so for an elderly person.

Sometimes the simplest things will stop fraud from happening. Public awareness and educated subscribers would be the cornerstone of accountability in the Medicare program.

Finally, I would just like to point out that private insurance companies, it is not the committee's concern but they are much more

vulnerable to fraud than Medicare and those costs are passed on to the public directly, so something should be done by them about that, too.

I would like to thank you for giving me this opportunity.

[The prepared statement of Mr. Mederos follows:]

Statement to the Subcommittee on Government Management, Information, and Technology
Representative Stephen Horn, Chairman

July 25, 2000

Raymond Mederos

First I would like to thank you for the invitation to appear before this Committee. It is an opportunity for me to make up for my past wrongdoings, which have weighed heavily on my conscience. I am very pleased to be able to help in any possible way by providing information and knowledge that I may have on how the Medicare Program can be defrauded and what can be done to control it.

In January 1994, I moved to the Fort Mill, SC/ Charlotte, NC area and stated a Medical Billing Service. I have learned of this business from a Miami, FL, based service and, as a matter of fact, I obtained the know-how from them in exchange for an initial fee and future payments of a percentage of the gross revenue.

I was unable to make the business produce and in May of that year I was offered a position as Operations Manager with the Miami billing service. I worked there until October of 1994, when I returned to the Charlotte area.

During the months that I worked in Florida, I really learned the medical billing business since I was responsible for coordinating the billing clerks' work and also provided customer service.

The company I worked for had about 120 clients who received Medicare payment of approximately $150-200,000 per month for durable medical equipment services. My responsibility was to provide them the best possible service, including the most expeditious way for them to receive prompt payment. But something appeared wrong in the way the 'clients' conducted their business; they did not appear to be successful providers of durable medical equipment for Medicare recipients.

The in July 1994, Medicare become aware that something strange was happening in Florida and all payments to Dade County/Miami providers were stopped. I am not knowledgeable as to whether the freeze was local only or statewide. At about that time some of the 'clients' become more communicative and I leaned about how they really operated. And, regretfully, I saw an opportunity to make some quick money by improving on their system.

At this point I would like to mention that to my knowledge none of the people whom I knew of in Miami were ever apprehended or questioned by the investigating agency. And, to my knowledge, the billing services that handled the fraudulent oblongs were never questioned about their clients. I reached the conclusion that the investigations were not very thorough or run in an effective fashion.

In October of 1994, I returned to the Charlotte area. My oldest daughter had been taking of any inquiries or contact that came to the billing business. Since I needed to devote my time to the Medicare project, I sold my share of the billing business to a friend of theirs, and they were able later on to obtain some legitimate clients and make the business a successful one.

My main concern with the project was to keep my name out of any dealings, for obvious reasons. So I was able to get the services of two individuals, promising them a lump sum payment once the money began to be received. These individuals opened the first two mailboxes and bank accounts, and gave me some notarized forms for opening other boxes in the future. As soon as they were paid they were to leave the country.

Initially, I formed two corporations in their names. In the state of North Carolina all that is needed is a form duly signed and a $100 fee in order to incorporate. Also, the mailboxes were opened at the Mailboxes, Etc. (MBE) stores in the Charlotte area, thus providing a street address with a suite number, since Medicare does not accept a post office box as the primary address. Telephone answering services were contracted for each company.

In order to check messages and to make any needed phone calls related to the project, I contracted a cellular telephone using one of the individual's names for it. Also, the needed EIN's (Employer Identification Number) were obtained from the IRS via the telephone.

Applications for the two companies were sent to Medicare in Columbia, SC, by late October and approximately 3 weeks later the necessary Medicare Provider Number was received by telephone. I had been in contact with a medical billing service in Akron, Ohio, that belongs to a company that makes one of the computer billing programs for durable medical equipment billing. They were knowledgeable within a fortnight. The first payments from Medicare were received during the last week of December of 1994.

While in Florida, I had had access to all the patient data from the 'clients' that were serviced, and I used their demographics and just changed their address to the city of Charlotte, NC. Medicare never questioned this peculiarity initially, although around May of 1995 they did detect this anomaly. When that happened I was able to use names and data from patients in the Charlotte area since I had access to that information that was stored in my son-in-law's medical billing service. All I had to do was choose persons that were in their late sixties or above, since the type of billing that I was doing was related to tube feeding of nutrients, wheel chairs, hospital beds, urinary incontinence supplies, and other urological products.

In order to avoid suspicion, I limited each company's billing to about $500,000, which would result in that company receiving approximately $200-250,000 in payments, since Medicare only pays a certain percentage of the amount billed or what is indicated in their schedule of payments for each product or service involved. Some claims are not paid for various reasons. Therefore, I created other companies with different addresses,

using the forms that I had obtained from the initial individuals, whose identities were used to open them, always at a different MBE store. And the additional bank accounts were opened at the same branch of the initial bank by myself by telling the bank officer that I was their accountant and thus I was providing my clients a service by doing this. Checkbooks were purchased through the mail from some of the companies that offer that service.

At the end of each year tax returns were prepared for each company. Since that company had only operated for a few months, a loss was declared. Shortly after, the corporation was dissolved in the State of North Carolina and the IRS was informed accordingly. This was never questioned. Possibly because of the small amounts of income involved.

Also, a business license was needed. This was accomplished by obtaining it from the City Licensing Department. Even though the license was for a company using an accommodated address at an MBE store, the license was never questioned.

In order to avoid creating a corporation with the same person and especially to avoid any suspicions at the bank, other individuals' names were used to incorporate and open the bank accounts. These names were obtained from the patient rosters.

The physicians that supposedly provided the prescription for the products were real; those names were obtained from the phone book. Gastroenterologists and urologists were picked, and their UPIN (Unique Person Identification Number) was obtained from a Medicare directory that was available at the public library in Charlotte.

By the end of 1995, Medicare had become more difficult to deal with and I focused my attention on private insurance carriers. Using the same corporations that were still valid with bank accounts, fraudulent claims were processed for them. But this time no electronic billing was used. The claims were prepared using the standard HCFA form and mailed to each carrier. These were all psychiatric patients being billed for psychological evaluations and consultations while interned at a local hospital. The amounts of the claims were not high, and the insurance companies pay about 50% of the amount billed, thus they were not easily detectable. Also, it seems apparent that the private insurance companies were not that concerned with fraud being committed.

From time to time some private insurance companies would send a form letter advising that the patient claimed that the service was not provided. All that was needed was to send the insurance company a check covering the amount involved. No further questions were asked. Similar letters were received from Medicare; and again, I simply returned the amount of the money involved. No further questions were asked.

At one point, I believe three or four times, a letter from the Fraud Division of Medicare was received asking that someone should call them to clarify some things. Needless to say, any further billing was stopped and the company dissolved at the earliest possible date.

At this point I would like to take the liberty of offering some recommendations to the Committee on how to possibly avoid anyone from doing what I wrongly did. For this purpose, I would divide "Medicare Fraud" into two distinct areas:

1. "Paper companies" that bill Medicare but do not provide the services or products.
2. "Overbilling" by legitimate providers.

Of course, my experience has been with the first group and I offer the following suggestions:

1. Obtain a credit report for each officer and/or owner of the company; in order to confirm their existence, location, and history.
2. Carefully review any applications for Medicare Provider Numbers by **recently** incorporated companies and/or companies with only 2 or 3 persons involved.
3. Invest more money in an aggressively active and continuous advertising campaign aimed at creating awareness among all the subscribers, so that they may report to their Medicare Region as soon as possible any discrepancies that they may detect in the billing statements.
4. Develop fliers that could be included with the utility bills or bank statements
5. Use the back of the mild cartons to tell the subscribers that Medicare fraud can only be stopped with their help.
6. Use the Internet to reach some of the subscribers.
7. If possible, hire a professional advertising agency to handle this public outreach program.
8. Develop for the subscriber a simpler Notification of Benefits Paid form. Currently a copy of the payment schedule that is sent to the provider is sent to the subscriber, and honestly that form is difficult to understand by laymen, and much more difficult for an elderly person.
9. Join forces with the AARP group in order to reach their membership.
10. In bilingual areas, have the Notification of Benefits Paid form in other languages, at least in Spanish.
11. As soon as three notifications are received from subscribers that a certain company or individual has not provided a service or product, stop the payments immediately and launch an investigation on that entity.
12. Continue requiring that the Providers have a Bond covering their company.
13. If at all possible have a team in each Medicare Region responsible for conducting a personal interview with the company principals and especially visiting their facilities. This may sound like an impossible task, but it could be accomplished with the proper system and plan.
14. Have the computer system flag or call attention to billings involving persons receiving products or services in areas that are outside their geographical residence.

15. Make it more difficult t obtain a Medicare Provider Number. This will discourage the fraudulent companies. The legitimate companies will persist in going forward with the application.
16. In those cases where the principals cannot be reached on the telephone easily, a personal visit by an investigator should be arranged, since it is probably an answering service being used.
17. Over billing by legitimate providers is much more difficult to detect, but I am sure that it is not impossible. There, the Medicare system can almost only rely on the communication received from the subscribers, thus simplifying the Notification of Benefits Paid form and an aggressive advertising campaign against fraud would be of primary importance and effectiveness.

Sometimes what may seem like a very simple deterrent could be a most effective tool for preventing fraudulent claims.

I would like to point out that I was the only person who was actually involved in developing the system and carrying it out, and that no services or products were ever provided to anyone who may have been billed.

Again, I would like to thank the Committee for giving me this opportunity to help in some way. Should you have further questions, please do not hesitate to contact me. I will be most pleased to clarify anything.

Respectfully submitted,

Raymond R. Mederos
July 17, 2000

Mr. HORN. Since there are a lot of people watching this, on page 4, just run down those 17 points.

Mr. MEDEROS. Page 4 of my written statement?

Mr. HORN. That's correct.

Mr. MEDEROS. OK. I made the billing for each company that was used up to about $400,000, and that would make that company receive $200,000 to $250,000 because only a portion is paid of the amount billed. Some claims are simply not paid for whatever reason. Therefore, I created companies with different addresses and additional bank accounts were opened and checkbooks were purchased through the mail and at the end of the year a tax return was prepared for each company and since the companies operated for a few months, a loss was declared. Shortly after the corporation was dissolved in the State of North Carolina and the IRS informed accordingly. This was never questioned. And possibly because of the small amounts involved. A business license was required and it was obtained, no problem also there. The physicians' UPIN number, which is the unique personal identification number, was obtained from a directory available in the local library in Charlotte, NC, so there was no secrecy as to the uniqueness of the number at all.

Mr. HORN. Have you seen other groups that did exactly what your group has done? During the course of your activity, did you see other people doing similar things?

Mr. MEDEROS. Yes, when I was in Florida, out of the 120 companies. The billing service was a legitimate business. The companies, their clients, 119 of those 120 companies were fictitious companies. One of those had the address in the middle of the Miami airport. That company was a client of the billing service. The investigations must have gone on, but to my knowledge the billing companies were never questioned about their clients, not because a billing company was guilty but they had knowledge that was very factual about those clients and to my knowledge that was never done throughout the investigations in the State of Florida.

Mr. HORN. Well, I appreciate your very thorough statement. Let's move to the second witness now, Mr. Denis Spencer. He is at the "My Break Transitional Center" in Garden Grove, CA. We hope that you can reveal how this system works. Please go through your document and if you could, just give us a summary since Members have read it.

Mr. SPENCER. Right. I opened a laboratory doing blood gas testing in 1991 and continued that until closing it in 1998. During that period what a blood gas test does is qualify patients for oxygen, and we worked very closely with oxygen providers throughout a number of different States across the United States, not only just in California, where we were based, but throughout the Midwest as well, and the East Coast. What basically happens is if a patient is thought to need oxygen, the oxygen provider would go out and set up the oxygen and we would followup to do the testing to see if the patient qualifies for oxygen or not. The way that the system works is that they take two different values, either what is called an oximeter value, which is a measured probe or a blood test. This is actually where—one of the areas that we got in difficulty.

Our case involved two different aspects. One was the changing or altering of results in order to qualify the patient for oxygen; and the second was utilization of codes which were not appropriate to the testing. The two separate aspects, one was to benefit the oxygen company directly. There is no policing or mechanism by which these values are looked at. An oxygen company or a durable medical provider can use either one without being questioned by the government, and so we would provide the number that the oxygen company would need in order to bill their oxygen. The result was that we were used by a large number of durable medical equipment suppliers. They would get the numbers that they needed in order to keep the patient on oxygen, and at the same time we would stay in business.

The second aspect of changing or altering numbers, there are two different systems in the State of California. One is the State system, which is under the Medicaid regulations, which requires what we call a blood gas in order to qualify. The Medicare system does not, only requires the oximeter. Many of our technicians found it possible to just move the probe a little bit on the finger of the patient and the oxygen would qualify and we would report those values.

Mr. HORN. Any other points you want to make?

Mr. SPENCER. The question was asked of me approximately how many patients did we field during the period of time that were on oxygen or being provided oxygen as a result of this type of testing, and through the numbers that we went through during that period of time it was between 30 and 35 percent.

[The prepared statement of Mr. Spencer follows:]

NARRATIVE OF INVESTIGATION
Denis Spencer - STET Laboratories

This investigation was initiated based on evidence obtained during a search warrant of STET Laboratories (STET) in August 1996. Denis Spencer was the owner of STET. STET was an independent clinical laboratory whose primary purpose was to "independently" qualify patients for home oxygen. Medical supply companies typically referred Medicare and Medicaid patients to STET for independent laboratory testing. The Department of Health and Human Services Office of Inspector General (OIG) conducted a search warrant on STET on September 25, 1996. As a result, 172 boxes of evidence (documents, computer files, etc.) were seized.

This case began in approximately 1995, during a national investigation, conducted by the OIG, against "Home Americair" a durable medical equipment (DME) provider, who rented supplemental home oxygen equipment, such as concentrators, and portable oxygen tanks to predominately Medicare and Medicaid patients. Americair had between 33 and 45 independently owned franchises across the country, as well as their home office, in Newport Beach, California.

DME companies, typically, are for-profit organization, with large sales forces. Employee commissions were often based on equipment rentals to Medicare patients. However, in order for a patient to quality for home oxygen, and be reimbursed by Medicare, it was required that they receive a Certificate of Medical Necessity from the patients' physician, and to also have an oxygen saturation level of no higher than 88% or an arterial blood gas of 55 mm Hg. These tests however, must be performed by the physician, a hospital, or a laboratory that is completely independent of the medical supply company. The medical supply companies were not permitted to conduct qualification testing.

However, it was revealed in the investigation that Americair predominantly used STET, even for testing in other states. It was alleged that STET was altering laboratory test results in order to qualify beneficiaries for supplemental oxygen, for the benefit of medical supply companies, such as Medicare. The suspected altered test results included arterial blood gas (ABG) and pulse oximetries. Several DME companies, including Americair supply home oxygen. Once a patient qualifies, DME companies bill oxygen to Medicare independently. Clinical laboratories, such as STET, also bill Medicare for their testing. It is further alleged that STET is billing for laboratory tests they did not perform and were upcoding claims on other tests to obtain a higher reimbursement from Medicare.

On April 2, 1998, in the Central Judicial District of California, Home Americair of California, Inc. (Americair) entered into an civil agreement to pay $5 million in settlement of allegations of Medicare and Medicaid fraud. Americair is a Durable Medical Equipment (DME) company, primarily providing supplemental home oxygen equipment. The settlement is the result of on-going OIG investigation of Americair, and a "qui tam" lawsuit, in which it was alleged, among other items, that Americair: (1) submitted or caused to be submitted, Certificates of Medical Necessity (CMN) containing false or fraudulent information; (2) submitted for

reimbursement, oxygen equipment that was not medically reasonable and necessary; (3) encouraged its franchises to falsify laboratory test results to qualify Medicare and Medicaid patients for home oxygen; and **(4) conspired with so-called "independent" laboratories to insure that laboratory test results were sufficiently low enough to falsely qualify patients for Medicare or Medicaid coverage for supplemental oxygen.**

The settlement agreement specifically named Home Americair of California, Inc.; Thomas Frank, Americair's founder, owner, and president; Americair's billing company; two of Americair's franchises; (Florida Homecair, Inc. and Bates East Corporation) and Cynthia M. Bates, owner of the Bates East franchise. The named parties will jointly pay the $5 million. Americair also entered into an extensive corporate integrity agreement as part of the settlement. Americair has 33 independently owned franchises nationwide. The OIG continued its investigation of several independent laboratories, including STET, which allegedly falsified laboratory test results for the benefit of Americair.

STET was later charged with Medicare and Medicaid Fraud, including the falsifying of laboratory test results to qualify patients for supplemental oxygen; billing for tests not performed; and conducting tests without a required physician's order. Spencer pled guilty to one count of Medicare fraud.

Sales representatives, to qualify patients, for home oxygen place pressure on laboratory employees. The result is that oxygen equipment is provided to patients who, oftentimes, do not need it, resulting in millions of dollars of unnecessary Medicare expenditures. Laboratory technicians are receiving bonuses and commissions on the number of patients they qualify. Physicians are often circumvented, and DME companies are placed in a position to prescribe medical equipment, based on their own profit goals.

Mr. HORN. We thank you. We will now move to questions and I will ask the vice chairwoman, Mrs. Biggert, the gentlewoman from Illinois, to begin the questioning.

Mrs. BIGGERT. Thank you, Mr. Chairman.

Mr. Spencer, when you opened this lab, was it, you felt, a legitimate business at that time or was there an intent to falsify?

Mr. SPENCER. It was a legitimate business.

Mrs. BIGGERT. What happened to make that change into a fraudulent business?

Mr. SPENCER. In 1993, regulations changed at our intermediary that decreased our reimbursement from about $160 per patient to about $80 a patient, and so we got creative.

Mrs. BIGGERT. Was the intermediary the billing company or were you the billing company?

Mr. SPENCER. No, the intermediary was Transamerica. We sent out all of our—that was a very good question, but I am going to answer it in a little different way.

When we submitted bills, very often in the testing it isn't as black and white as one might think. There might be six codes for one type of test. What we would do is present the type of test to our billing company and they would check to see what reimbursement would be the highest for what code for that test. I am sure everybody knows what hemoglobin is. They would do the research and come up with the highest paying test. The intermediary is Medicare's provider that pays us the money, Transamerica.

Mrs. BIGGERT. So was the billing company involved in this in coming up with creative ways to bill or was it just your company?

Mr. SPENCER. It was a combination.

Mrs. BIGGERT. Part of this bill does include the third-party.

Mr. SPENCER. We relied on the expertise of the billing company to provide us with the information in order to see what billing codes could even be billed on a particular type of test. After determining that, we did really rely on the billing company to establish both the legality, was this a gray area or was this outright fraud. The person in charge of the particular billing company we used was an ex-employee of the intermediary. We relied on that expertise that that particular code, although not morally, necessarily the best code, was legal.

Mrs. BIGGERT. Thank you. Mr. Mederos, you said that you started—or you learned the business from another company. Was that a legitimate company?

Mr. MEDEROS. Yes, ma'am, it was a legitimate billing service in Miami.

Mrs. BIGGERT. Is it still in existence today?

Mr. MEDEROS. I don't believe so. No, because after what happened in Florida, there were no more clients, or very few.

Mrs. BIGGERT. After you left that company and started your own—so you were trained by the company. Did you start a legitimate business then or were you——

Mr. MEDEROS. Yes. I started a legitimate business, just that before I went to Florida I started the business. For 5 months I couldn't make a go of it. I couldn't get the clients. I couldn't make it go so I was offered a job in Miami. I needed it because I needed the income, and I went down there. That is when I learned why

I couldn't make a go of my business in North Carolina, because all their companies were fraudulent companies. And that way you can certainly have a lot of business and a lot of income coming in for the billing services because they charge a percentage of the amount collected, not billed, just collected. They get a percentage of it.

Mrs. BIGGERT. So you then started a business where there were really no clients but you were billing for them? Or you were just changing the amounts?

Mr. MEDEROS. No, no, no. I sold my share of the business, and they eventually made a go. The guy I sold to had friends that he could get the business from the hospitals for their billing service. What I did was I created paper companies, is what it was.

Mrs. BIGGERT. And you found that to be very easy.

Mr. MEDEROS. I don't know nowadays. This is 6 years ago. It was very easy. As a matter of fact, I got the first number within 5, 6 weeks of submitting the application, received the number and had already contacted a billing company in Akron, OH, that I knew of to do the billing for this new provider.

Mrs. BIGGERT. Did the billing company know that there were no legitimate clients?

Mr. MEDEROS. No. It was all done through the mail and they were not aware that this was a fraudulent company.

Mrs. BIGGERT. Did anyone ever come from HCFA to make a visit? Did they call?

Mr. MEDEROS. Initially at the beginning they didn't call. Afterwards, when I tried to obtain a provider number for another company, then they began to call but that could be circumvented very easily. I got a cellular phone and that is what they were calling.

Mrs. BIGGERT. So if someone called a couple of times you might close that business and start another one?

Mr. MEDEROS. Not necessarily. The way that it is done, if somebody from the Fraud Division of Medicare calls, then you stop the company. But if somebody from Medicare calls, there is no danger. So you just answer the question in a logical way and if they accept it, they just go on.

Mrs. BIGGERT. Thank you.

Mr. HORN. Let's move for 10 minutes, and then you can have 10 again. The gentleman from California, Mr. Ose.

Mr. OSE. Mr. Mederos and Mr. Spencer, you both have been convicted of fraud in the Medicare system, found guilty by a court of law and sentenced to some incarceration or penalty of some sort?

Mr. MEDEROS. Yes.

Mr. SPENCER. Yes.

Mr. OSE. One of the questions that I have, I have read both of your statements and I particularly appreciate the 17 suggestions that you have here, Mr. Mederos. Item 12, continue requiring that the providers have a bond covering their company. Did you have a bond?

Mr. MEDEROS. No. At the time that I did it, no bond was required. That happened in 1995, it is when Medicare began asking—it is simply $10,000 but you have to be sort of legitimate in order to get a bond. You can still get around it.

Mr. OSE. For a $10,000 bond, you pay about a 1 or 2 percent fee so it is $100 or $200, you shift a certain portion of the risk to the

bonding company for malfeasance or misfeasance or what have you. For $100 or $200 you get into the game, so to speak?

Mr. MEDEROS. But the benefit of the bond is you have to be a real person in order to get a bond.

Mr. OSE. I understand. Mr. Spencer, in your instance the fraud that occurred at STET laboratories, for how long did that fraudulent activity take place?

Mr. SPENCER. Three years.

Mr. OSE. What was the annual amount, in your opinion, of the total amount that STET was doing that was fraudulent?

Mr. SPENCER. It was around $175,000.

Mr. OSE. So $58,000 a year, $5,000 a month?

Mr. SPENCER. The tip of the iceberg is the laboratory billing. The oxygen and the durable medical equipment as a result of the testing was the significant amount.

Mr. OSE. Of the $170,000?

Mr. SPENCER. No, of the amount that the durable medical companies would be able to bill for oxygen as a result of the testing.

Mr. OSE. So the testing amount was $170-odd thousand?

Mr. SPENCER. That's correct.

Mr. OSE. And that would qualify the DME providers to then provide oxygen to patients, and the cost of that would then be——

Mr. SPENCER. A hundreds times that.

Mr. OSE. So $17 million?

Mr. SPENCER. Easily.

Mr. OSE. It is interesting, I went on the Internet last night and I tried to check out Americair. The average profit for Americair, which was a corporation, as I understand it, in different—it appears to be in different States from what I found last night—the annual profit for Americair, do you have any feel for what that was or any sense of that?

Mr. SPENCER. No, I don't.

Mr. OSE. What was your annual salary at STET?

Mr. SPENCER. Between $60,000 and $80,000 a year.

Mr. OSE. So some portion of STET's activities were legal and within the law and some without. Can you give us some sense of what that break was?

Mr. SPENCER. We responded a great deal to the pressure and—as a company and our employees, from the durable medical equipment companies. I would say it was more of a grass roots type feeling than responding to comments that if you don't provide the oxygen you are playing God. My employees and I responded to those types of things. We were playing God by providing the numbers. I am not sure that I am answering your question.

Mr. OSE. You are not. It is interesting testimony but you are not.

Let me go on. The penalty that was imposed upon the perpetrators of the fraud was an agreement to pay $5 million and that was paid by Americair and apparently one of their franchisees, the Bates East Corp. The question I have is what penalties did you end up suffering? You are incarcerated at the present time?

Mr. SPENCER. I am in a halfway house, yes.

Mr. OSE. You have never been in actual prison?

Mr. SPENCER. No.

Mr. OSE. Do you have a financial penalty?

Mr. SPENCER. Yes, I have restitution of $175,000.

Mr. OSE. You refer to Home Americair of California and founder, owner and president, Thomas Frank. Did Thomas Frank suffer any legal sanction under this action other than the $5 million——

Mr. SPENCER. I have no idea.

Mr. OSE [continuing]. Adjudicated settlement? You don't know whether Mr. Frank was prosecuted by the Department of Justice or anybody else for this other than the $5 million settlement?

Mr. SPENCER. I wasn't aware even of the $5 million settlement.

Mr. OSE. I am looking at the narrative, not your statement, all right.

STET laboratories, was there a bond requirement for you to participate in the Medicare system?

Mr. SPENCER. We had a bond. We were bonded. I don't know if it was a requirement. That was for liability insurance as well as to provide in the Medicaid system as well as the Medicare system.

Mr. OSE. What was the amount of the bond?

Mr. SPENCER. I believe it was $3 million aggregate and $1 million per incident.

Mr. OSE. Did Medicare make any claims against the bond when everything kind of melted down, to your knowledge?

Mr. SPENCER. To my knowledge, no.

Mr. OSE. So Medicare had a bond for performance for STET Laboratories' benefit, and you are not aware of any claim from Medicare or Medicaid having been made against that bond for all or part of the settlement that otherwise was adjudicated?

Mr. SPENCER. No, I am not aware of it at all. I don't think that it happened. When we closed down the laboratory in 1998, I pled guilty to the charges in December 1999.

Mr. OSE. I think we are onto something, Mr. Chairman. It seems like if you fold up the shop and your bond goes away, then Medicare's coverage evaporates.

Mr. Mederos, you have suggested here on item 10 that the notification of benefits paid be in at least other languages, and I presume you are suggesting that in the sense that demographically—for instance, in south Florida, we have a large Hispanic or Cuban population. They speak Spanish and why not print the notices in Spanish?

Mr. MEDEROS. Right. Many of the people would receive notification of payment and they have no idea what it says, and they would just throw it away.

Mr. OSE. Those are all of the questions that I have for these witnesses, Mr. Chairman. Thank you.

Mr. HORN. I thank the gentleman. I would like to get into one thing a little more. Mr. Spencer, you had both Medicare, and in California Medicare is Medi-Cal. What type of inspection was given to you on what time period by either the Medi-Cal department and inspectors and the Medicare inspectors?

Mr. SPENCER. Those are combined inspections in California and they are annual.

Mr. HORN. Do they let you know that they are coming?

Mr. SPENCER. No. They would just show up at the door, and they would go through our patient records and ensure that we are following all of our quality controls, that we are following guidelines

as to the types of procedures. It was fairly technical and not really——

Mr. HORN. They weren't looking for fraud at that point?

Mr. SPENCER. That's correct.

Mr. HORN. They were just seeing——

Mr. SPENCER. They would do everything.

Mr. HORN. And as long as you did that, it didn't matter to them anything else?

Mr. SPENCER. We used an outside billing company and they would have had to go to the billing company anyhow. Part of my suggestion, which I guess we do have the opportunity, is in any situation in the IRS or anything if you are doing taxes and you are relying on somebody from the outside, something has to be said about the person doing the taxes.

In the billing where we are relying on their expertise it can be anybody and anything and they can tell you anything that they want to tell you and there is no control or organization to it at all. We relied a great deal on their expertise.

Mr. HORN. In your case was there a random sample ever taken by Medi-Cal to check and see through what your papers had in terms of oxygen and what was actually had from the doctor, and not just the billing care but did they ever look at the doctor's records?

Mr. SPENCER. No. As a matter of fact when we would turn over our results to the oxygen company, they would throw out the ones that didn't qualify and they would keep just the ones that did. There is no system for saying OK, a blood gas was billed and yet we are not getting the results. There is no cross-check of that type of thing right now.

Mr. HORN. If they wanted to prevent fraud, what should they have been doing besides what you and I have been talking about here?

Mr. SPENCER. OK. There would be a cross-check system in the computer that says if a person has this type of test, that type of test is what is appearing on the CME.

Mr. HORN. What is CME?

Mr. SPENCER. I apologize. On the bill from the medical equipment company. The type of result is on that gross bill that matches the type of test that was billed for.

Mr. HORN. And they didn't do that?

Mr. SPENCER. That is still not being done. Most of the companies right to the day that I closed the door would scream at you for results of a different test than what should have been on the form.

Mr. HORN. What else could be done to cut out the fraud or at least minimize it?

Mr. SPENCER. Everything in the laboratory situation has to do with what is called by the CPT code. Everything is billed by a code with a description. The ability to come up with whatever codes that pay the highest, instead of here is a hemoglobin test, this pays this much, that would eliminate not only a great deal of fraud but the confusion for a legitimate firm trying to do business. I can't even tell you what the savings would be on that aspect.

Mr. HORN. What kind of kickbacks, if any, were given by your firm to doctors?

Mr. SPENCER. None.

Mr. HORN. Do you know of firms where there is a kickback to doctors?

Mr. SPENCER. It would be speculative. I know in my heart that when the grass is green, it got watered.

Mr. HORN. So there was a lot of green. And the water was dollar bills before Andrew Jackson got that big on a $20. What else would you suggest now that you have seen this from the inside?

Mr. SPENCER. I would suggest that the physicians—the power to control the patient, go back to the physician and not the oxygen company or the provider, that the physician now has the power of their patient back. In other words, the request for oxygen testing or any type of testing or for oxygen itself is not given to those people that are going to make money on it but to the physician who is ultimately responsible for the patient.

Mr. HORN. Mr. Mederos, do you have some suggestions as to what could be done to minimize the fraud on the Medicare and Medi-Cal, or Medicaid as it is in the rest of the Nation?

Mr. MEDEROS. The greatest system, an informed and educated subscriber is the one helping the program. Otherwise the program is wide open to over billing, which is what we have been talking about. That is more so than fraudulent companies. Billing twice or billing for something that hasn't been done by a doctor, a hospital, a clinic by anybody. That I think is the best suggestion I could make. Let the people be the ones who police the system itself. But they have to learn, they have to be educated. They have to be made aware of the importance of their role to do it.

Mr. HORN. I now yield 10 minutes to the gentlewoman from Illinois, Mrs. Biggert, for questioning.

Mrs. BIGGERT. Thank you, Mr. Chairman.

Mr. Spencer, you were doing the testing. How did your company get the names of the patients to use for your testing scheme?

Mr. SPENCER. We had a request form called or faxed from the durable medical equipment companies. That was 98 percent.

Mrs. BIGGERT. How did the durable medical equipment companies get the names?

Mr. SPENCER. Since a particular company was mentioned, I will use that company as an example. They would tell a group of physicians or a physician, look, we are going to, free of service, come in, survey all your patients that have certain diagnoses, and we will for free go out and test those patients to see if any need oxygen. At that point they would submit a request to us to go out and confirm their values.

Mrs. BIGGERT. When the durable medical equipment company went to the doctors, were any of the doctors involved in the scheme? Or were they legitimately seeking?

Mr. SPENCER. There might have been a few, but I would say the majority were responding. They were responding to an oxygen company saying, yes, if you are going to look at my patients for free, do it.

Mrs. BIGGERT. If the doctors and the durable medical equipment company and you and then the billing companies were all in collusion with this, would it be—how would the fraud be discovered?

Mr. SPENCER. It wouldn't. You are saying if the physician and the DME and the laboratory—there are not too many ways you are going to find out.

Mrs. BIGGERT. If there were inspection of all of those companies onsite, and it sounds to me when you talked before it was almost impossible to discover from your billing records if it was coded incorrectly, how could you discover that? For example, you gave the oxygen and it wasn't really the same test that was needed and you talked about the CMEs. If it goes back, the only way to find out that would be to ask the patients what tests they were going in for?

Mr. SPENCER. Certainly in the technology that we have available today in computers, it is very easy to cross-check the type of test that was done and the bill as well as the type of test that was reported on the CME. The billing company, depending on how much integrity, should be able to provide that in an easy formula of numbers. It is not being provided now, if that is what you are asking me.

Mrs. BIGGERT. Was the billing company involved in this? You said that you relied on their expertise. Did that mean that you relied on their expertise to——

Mr. SPENCER. If we were not in business, they weren't in business. So they were very helpful.

Mrs. BIGGERT. If you looked at the doctor's records then versus what was on the billing company's records, those were different?

Mr. SPENCER. Yes. There would be tests in the doctor's records that would not appear on the Medicare billing form.

Mrs. BIGGERT. How was the fraud discovered? What finally brought them to shut you down?

Mr. SPENCER. Essentially one of our main durable medical equipment companies, Americair, was being investigated and in investigating that company they saw our records and investigated us.

Mrs. BIGGERT. Who is they? Who investigated?

Mr. SPENCER. I don't know their name.

Mrs. BIGGERT. Was it——

Mr. SPENCER. It was the Inspector General's office.

Mrs. BIGGERT. How long did that investigation take?

Mr. SPENCER. Near the end of 1996 until the middle of 1999.

Mrs. BIGGERT. During that time did you still operate? During the investigation?

Mr. SPENCER. Yes. I didn't close down the lab until August 1998.

Mrs. BIGGERT. Did you declare bankruptcy?

Mr. SPENCER. Yes, I did.

Mrs. BIGGERT. So that alleviated paying part of the fine?

Mr. SPENCER. No.

Mrs. BIGGERT. Who is paying the $5 million?

Mr. SPENCER. I am not associated with Americair. My restitution is $175,000, and as the owner of the company I am responsible for $175,000.

Mrs. BIGGERT. Did the bond apply? Was there any use of that bond money?

Mr. SPENCER. No. The thought never occurred to me to use any of that money, and I don't think that it occurred to anybody else.

Mrs. BIGGERT. Mr. Mederos, what happened with your company? Did you shut it down when you were investigated?

Mr. MEDEROS. The provider——

Mrs. BIGGERT. All of the companies?

Mr. MEDEROS. Yes, ma'am. They were shut down and done away with. The investigation came about a year and a half later, after they had been closed.

Mrs. BIGGERT. Who conducted the investigation?

Mr. MEDEROS. One was the Postal Service and I don't know who else.

Mrs. BIGGERT. OK. And the Postal Service because you were using the mail?

Mr. MEDEROS. Right. Because of mail fraud.

Mrs. BIGGERT. How did they discover that?

Mr. MEDEROS. They were investigating—the addresses which I used were Mailboxes Et Cetera stores. I had opened a Mailboxes Et Cetera store in the Charlotte area and the one guy who owned the store remembered my face from a year and a half, 2 years before picking up mail. They investigated me and they came up in 1997 with the whole story.

Mrs. BIGGERT. Probably one time you would like to look like everybody else.

Mr. MEDEROS. That's right. In using the Mailboxes Et Cetera, you did have a street number with an apartment or suite number.

Mrs. BIGGERT. And then you used your cell phone to conduct business?

Mr. MEDEROS. To call Medicare back whenever they called asking about the company. What they did at that time was call the person applying for the number, the provider number, and went through the application asking the same questions and you were answering. I have no idea if they were recording the conversation or what but all you had to do was answer everything that was asked and that was it.

Mrs. BIGGERT. When you applied for a Medicare number and if you closed one business and started another one, would you use the same name?

Mr. MEDEROS. No. From the list of patients, you could just use anybody on that list. They never questioned it.

Mrs. BIGGERT. You would use a patient's name?

Mr. MEDEROS. Right.

Mrs. BIGGERT. And nobody ever verified the Social Security number?

Mr. MEDEROS. Right. In order to bill for the patient, you have to have the name, Social Security number and the date of birth. That is all the information you really need. With that, you can bill.

Mrs. BIGGERT. And you bill without providing your name?

Mr. MEDEROS. The billing is done electronically. You need the patient's name, address, weight, height, date of birth. The only things that are crucial are name, date of birth and Social Security number.

Mrs. BIGGERT. So under the current law anyone who has a Medicare provider number based on a patient, they can send a bill to Medicare or at least during the time you were in business?

Mr. MEDEROS. Yes. You had to be a Medicare provider with a number.

Mrs. BIGGERT. That is what I am driving at. How did you get the Medicare provider number?

Mr. MEDEROS. You incorporate, form a company. In the State of North Carolina, all you need is a one-page sheet with a $100 fee, mail it in, and 3, 4 weeks later you get your incorporation papers. Then you open a bank account with those incorporation papers. The banks seldom questions the person opening the account because it is a corporate account, so you don't have to ID yourself. They assume that the person going in is the one signing for the corporation.

Then you get a Medicare application form. You complete that by typing it in and mail it. And at that time about 2, 3 weeks later they would call you, review the application over the phone and 2 weeks later you call them again and they will give you a provider number over the phone.

Mrs. BIGGERT. Even though you had a different name to each corporation, did you still use your own name as one of the directors?

Mr. MEDEROS. No, I never did, because that would tie me directly to it.

Mrs. BIGGERT. So that was falsified, the names?

Mr. MEDEROS. That's correct.

Mrs. BIGGERT. Whose names did you use?

Mr. MEDEROS. Patients. Out of the patients I had, just picked some.

Mrs. BIGGERT. And you would have their Social Security number and address?

Mr. MEDEROS. That's correct.

Mrs. BIGGERT. Thank you, Mr. Chairman.

Mr. HORN. Mr. Ose, 10 minutes.

Mr. OSE. Thank you, Mr. Chairman. Mr. Spencer, I want to make sure that I understood your testimony. Was it your testimony that—let me ask it the other way. I am unclear on your testimony regarding who can authorize the use of durable medical equipment. Is it your testimony that only doctors can? Is it your testimony that the providers of DME can?

Mr. SPENCER. Only the doctors can actually sign the written order for durable medical equipment. It has to be signed by a physician.

Mr. OSE. If I understand your earlier testimony, the manufacturers or DME or sale organization or somebody would go to a doctor's office and say hey, have we got a deal for you. We will go through your patient files, pick out the people who are otherwise likely to need this service, we will test them for free in terms of the components in their bloodstream and the efficiency in which they are respirating, and we will give you a list of patients that you can examine for further purposes?

Mr. SPENCER. Except for the part where we will give you a list of the patients for you to examine. What they would do then is let the physician know that this particular patient did seem to qualify and they would call us to go out and do the testing.

Mr. OSE. Who would call you? The DME?

Mr. SPENCER. The DME company.

Mr. OSE. They would authorize the test of a patient and you would do that. Then what happens?

Mr. SPENCER. We would do the test. The results were sent to the oxygen company.

Mr. OSE. Who authorizes payment?

Mr. SPENCER. We would send a fax form to the doctor, prescription for the doctor to sign as far as for our records for the testing. Not for the oxygen equipment, for the testing.

Mr. OSE. Who authorizes the acquisition of the equipment?

Mr. SPENCER. Ultimately the doctor but it is a circle here. The oxygen company is asking us for the testing. We do the testing. Now the oxygen company has the testing to give to the doctor and the doctor will sign for durable medical equipment based upon the test.

Mr. OSE. Mr. Chairman, I am hopeful that for our later witnesses I will remember to ask them how it is that the doctor can authorize tests on the basis of a submittal from a durable medical equipment manufacturer. I find that very interesting.

The second question that I have, and this is for both of you, in terms of the bond requirement, you talked about the $10,000 bond and you talked about a bond of face value, which was $3 million with $1 million per incident coverage. Was the acquisition of that bond a make or break decision for your business? Was it so expensive that you couldn't acquire it?

Mr. SPENCER. It was very expensive. I can't remember the figures, but our insurance—it was high.

Mr. OSE. $300,000 a year or——

Mr. SPENCER. No. It was between $25,000 and $30,000 a year.

Mr. OSE. On a $3 million policy, of which $1 million was a per incident coverage. And you testified that there was a 1 or 2 percent fee for the $10,000 bond.

Mr. MEDEROS. I don't know how much the fee is because when I did what I did, the bond was not required. It came about after I stopped doing it.

Mr. OSE. So you are the guy that caused it?

Mr. MEDEROS. Possibly.

Mr. OSE. Mr. Mederos, when you had these various companies operating, I am kind of curious how you avoided detection for so long. Do you have this sixth sense when pressure is coming? Why and when did you close companies?

Mr. MEDEROS. On three or four occasions, a letter came from the Fraud Division of Medicare saying we would like someone from your company to call us to clarify something. That was a red flag.

Mr. OSE. That is when you packed it up.

Mr. MEDEROS. I didn't call them and the company was done away with. That was it.

Mr. OSE. You learned this, according to your statement, you learned this business from a Miami, FL based service?

Mr. MEDEROS. Right.

Mr. OSE. And then you go on to say that—I'm trying to find your exact words—none of the people whom I knew of in Miami were ever apprehended or questioned. Were they doing the same activity that you were doing?

Mr. MEDEROS. Certainly.

Mr. OSE. Do we know their names?

Mr. MEDEROS. I don't. It was a long time ago.

Mr. OSE. How long did you work for them?

Mr. MEDEROS. The Miami papers, there was a lot of——

Mr. OSE. When you worked for these people in Miami, FL, and learned this business, I mean, clearly you knew who they were then, right?

Mr. MEDEROS. No, not really. They were clients. The billing service was providing a service. When the Medicare freeze came, then the clients were very unsure of themselves and they were asking questions and then it dawned on me, I said this is strange. Something is going on.

Mr. OSE. I am trying to get at the issue of you having experience in the field in Miami, FL and learning a system.

Mr. MEDEROS. Right.

Mr. OSE. Which you have testified, I think your number, it was 119 out of 120 entities were involved in fraudulent activity. It would seem to me that there is a connection that the people in Miami, FL were engaged in fraudulent activities, and yet I can't find a name of any such individuals.

Mr. MEDEROS. I don't recall the name of companies that the billing service serviced. We are talking about 6 years ago. I'm sorry. It is 6 years ago.

Mr. OSE. Has anybody from the Fraud Division of HCFA ever examined this issue?

Mr. MEDEROS. I don't know.

Mr. OSE. It seems to me that you might be the nose of the camel under the tent?

Mr. MEDEROS. It is possible. But it is 6 years ago. Right now I think it is like looking for a needle in a haystack.

Mr. OSE. Apparently not. The provisions on the background check that are in the bill that Senator Collins and Congresswoman Biggert provide state that the Secretary shall conduct a background before providing a provider number to an individual or entity, shall include a search of criminal records and a background check and provide that such a background check is conducted without an unreasonable delay.

Do those thresholds provide the Medicare people, in your opinion, either individually or collectively with sufficient safeguards to identify those who might otherwise be in this for fraudulent purposes?

Mr. SPENCER. Yes.

Mr. OSE. They do provide——

Mr. SPENCER. If they are intending on getting it for that purpose, yes.

Mr. OSE. Mr. Mederos.

Mr. MEDEROS. See, I think the assumption is that a person who will commit fraud against Medicare is a criminal to begin with. Am I correct in assuming that? That is what is being said?

Mr. OSE. If someone is intending to commit crime——

Mr. MEDEROS. Not necessarily. Not necessarily. That is my opinion.

Mr. OSE. Let's move on beyond your opinion. Do these particular thresholds provide sufficient safeguards to prevent someone from

entering into the Medicare billing system and processing system to conduct fraud?

Mr. MEDEROS. They will help, but more so than that a physical inspection of the facilities will be very good and having knowledge of these people, who they are, will certainly be an advantage.

Mr. OSE. I know that the bill requires a site inspection. I think it calls out for one single site inspection. Are you suggesting that a series of inspections, not only a first one to essentially initially qualify but followon inspections are necessary?

Mr. MEDEROS. They should be. Like in the medical business, you have to recertify a patient every 3, 4 months. That should be an ongoing thing.

Mr. OSE. How many times did the Medicare fraud units come out to your individual locations for site inspections?

Mr. MEDEROS. In my case never.

Mr. SPENCER. Once.

Mr. OSE. In how many years?

Mr. SPENCER. 1991, and they came out in 1996.

Mr. OSE. Mr. Mederos, I notice that you had sold your business in North Carolina to your daughter and her husband, I believe.

Mr. MEDEROS. And a friend of theirs, right.

Mr. OSE. Were they initially involved—the suggestion here is, the way that you wrote it in your written statement, is that they were able later on to obtain some legitimate clients and make the business a successful one.

Mr. MEDEROS. Right.

Mr. OSE. "Some" legitimate clients?

Mr. MEDEROS. No, their clients were all legitimate. Their main client is a hospital called Charter Pines.

Mr. OSE. So "some" should be deleted from your testimony?

Mr. MEDEROS. Yes, they were implicated in my case by, I would say, for conspiracy because they knew what I was doing and that makes them a conspirator.

Mr. OSE. Mr. Chairman, my time is up. Are we going to go another round?

Mr. HORN. Will the gentlewoman from Illinois need more time for questioning?

Mrs. BIGGERT. No.

Mr. HORN. We could send some questions which they could answer.

We want to thank you very much for what you have provided here and we would like you to stay while we have panel three here, and if you have any thoughts on that, we will ask you what do you think of the testimony. This is primarily from individuals that have worked at trying to get at fraud, and you might have some additional suggestions.

We thank you. If you would just sit in the chairs back of the table. Then we will ask panel three to come before us, Mr. Hast, Mr. Hartwig, Ms. Thompson, Mr. Krayniak, and Mr. Lavin. I will swear in the witnesses.

[Witnesses sworn.]

Mr. HORN. The clerk will note all witnesses affirmed the oath and we will begin with Mr. Robert H. Hast, the Assistant Comp-

troller General for Special Investigations, Office of Special Investigations, U.S. General Accounting Office. Mr. Hast.

STATEMENTS OF ROBERT H. HAST, ASSISTANT COMPTROLLER GENERAL FOR SPECIAL INVESTIGATIONS, OFFICE OF SPECIAL INVESTIGATIONS, GENERAL ACCOUNTING OFFICE; JOHN E. HARTWIG, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES; PENNY THOMPSON, DIRECTOR, PROGRAM INTEGRITY, HEALTH CARE FINANCING ADMINISTRATION; JOHN KRAYNIAK, DEPUTY ATTORNEY GENERAL, DIRECTOR OF THE NEW JERSEY MEDICAID FRAUD CONTROL UNIT, OFFICE OF ATTORNEY GENERAL, STATE OF NEW JERSEY; AND JONATHAN LAVIN, EXECUTIVE DIRECTOR, SUBURBAN AREA AGENCY ON AGING, OAK PARK, IL

Mr. HAST. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss various schemes used to defraud Medicare and Medicaid and private insurance companies and how the proposed legislation contained in H.R. 3461 and S. 1231 could strengthen Federal and State health care programs.

As you are keenly aware, health care fraud is a serious financial drain on our health care system. The HHS Office of the Inspector General has reported that $13.5 billion of processed Medicare fee-for-service claims for fiscal year 1999 may have been improperly paid for reasons that range from inadvertent error to outright fraud and abuse.

Through our previous investigations, we have learned that health care fraud across the country is composed of not only some legitimate health care providers but also of an emergence of career criminals and organized criminal groups who generally have little or no medical or health care training or experience. Many group members have prior criminal histories unrelated to health care fraud, indicating that the individuals have moved from one field of criminal activity to another.

To perpetrate health care fraud, criminal groups and some legitimate providers have used variations of the following four schemes. The first scheme, the rent-a-patient scheme, has already been covered by Senator Collins.

In a similar scheme, the pill mill scheme, separate health care individuals and entities, usually including a pharmacy, collude to generate fraudulent claims to Medicaid. Patients allow their insurance identification numbers to be used for billing purposes in exchange for cash, drugs or other inducements. Brokers take the patients to clinics for unnecessary examinations and services and the clinics and laboratories bill the insurer who pays the claims. Pharmacists involved in the scheme bill the insurer for the prescriptions they fill for patients. The patients then sell the prescribed drugs to middle men or pill buyers in exchange for cash or illicit drugs. The middle men resell the drugs back to the pharmacies, and the drugs get recirculated in the system.

The proposed legislation will make it a felony for a person to purchase, sell or distribute two or more Medicaid or Medicare patient identification numbers. This may help to reduce the exchange of

such numbers between clinics, labs, and pharmacies who intend to defraud insurance entities, as in this pill mill scheme.

Another popular scheme is the mailbox scheme in which criminals or other unscrupulous individuals rent mailboxes at privately owned mailbox facilities. The drop boxes serve as the fraudulent health care entity's address, with a suite number being the mailbox numbers to which health care payments are sent. Perpetrators then set up medical-oriented corporations using drop numbers with the corporate mailing address. Criminals steal, purchase or otherwise obtain beneficiary and provider information and bill insurance plans for medical services and equipment not provided. A member of the group retrieves the insurance payment checks from the drop box and deposits them in controlled corporate bank accounts. Once deposited, the proceeds are quickly converted to cash or transferred to other accounts and moved out of the reach of authorities.

As mandated by H.R. 3461, site inspections to verify whether actual business is going on at a given address and whether the entity meets participation standards. Background checks should help eliminate those with criminal records from getting provider numbers.

The third-party billing scheme revolves around a third-party biller who prepares and remits claims for health care providers to Medicare, Medicaid, or other insurers. A third-party biller may defraud Medicare and others by adding claims without the provider's knowledge and keeping the remittances. Or the biller and the provider may collude to defraud Medicare, Medicaid, or private insurance. For example, criminals generate fraudulent Medicare claims by using the names and biographical data of recruited patients. The information is delivered to a third-party billing company, which may or may not be legitimate. The company then enters the information into its own computer and electronically forwards the data to Medicare. Medicare then sends the payment to the perpetrator's bank account. third-party billers involved in this scheme may benefit by receiving kickbacks or being paid a percentage of all Medicare payments received by the provider, including fraudulent payments.

Requiring all billing agencies to register with HCFA, as stated in H.R. 3461, would provide the Health Care Financing Administration with the ability to identify and sanction corrupt billers or exclude corrupt third-party billing companies from Medicare.

Finally, mandating full law enforcement authority to criminal investigators in the Health and Human Services Office of the Inspector General, as stated in H.R. 3461, should provide the investigators with the tools that they need, especially in light of the emergence of organized criminal groups in health care fraud.

Mr. Chairman, that concludes my prepared statement. I would be happy to answer any questions you or members of the subcommittee may have.

[The prepared statement of Mr. Hast follows:]

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Government Management, Information and Technology, Committee on Government Reform, House of Representatives

For Release on Delivery
Expected at 10 a.m., EDT
Tuesday,
July 25, 2000

HEALTH CARE FRAUD

Schemes to Defraud Medicare, Medicaid, and Private Health Care Insurers

Statement of Robert H. Hast, Assistant Comptroller General for Special Investigations
Office of Special Investigations

GAO/T-OSI-00-15

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss various schemes used to defraud the Medicare and Medicaid programs and private insurance companies and how the proposed legislation contained in H.R. 3461 and S. 1231 could strengthen federal and state health care programs. More specifically, I would like to focus on the schemes characterized as rent-a-patient, pill mill, drop box, and third-party billing that we have identified through our past investigations.

As you are keenly aware, health care fraud is a serious financial drain on our health care system. Large numbers of cases have been investigated and prosecuted, resulting in the recovery of large dollar amounts. We have designated health care fraud as a high-risk area. The Department of Health and Human Services' Office of Inspector General has reported that $13.5 billion of processed Medicare fee-for-service claim payments for fiscal year 1999 may have been improperly paid for reasons that ranged from inadvertent error to outright fraud and abuse.

Our previous investigations[1] have provided evidence that, in addition to some legitimate health care and health care-related providers, career criminal and organized criminal groups have become involved in health care fraud across the country. Indeed, the emergence of an organized class of criminals who specialize in defrauding and abusing Medicare and Medicaid has increased program vulnerabilities for the Health Care Financing Administration (HCFA). In general, career criminals and organized criminal groups have little or no medical or health care education, training, or experience. Many group members have prior criminal histories for criminal activity unrelated to health care fraud such as securities fraud, narcotics and weapons violations, grand theft auto, and forgery—indicating that the individuals have moved from one field of criminal activity to another.

To counter many of the fraudulent schemes used by such individuals, H.R. 3461 and S. 1231, both entitled "Medicare Fraud Prevention and Enforcement Act of 1999," were introduced to amend title XVIII of the Social Security Act. Both bills are designed to establish additional provisions to combat fraud, waste, and abuse within the Medicare program and for other purposes by strengthening the Medicare enrollment

[1] See *Medicare: Improper Third-Party Billing of Medicare by Behavioral Medical Systems, Inc.* (GAO/OSI-00-5R, Mar. 30, 2000); *Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers* (GAO/OSI-00-1R, Oct. 5, 1999); and *Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities* (GAO/HRD-93-118, Aug. 2, 1993).

process, expanding certain standards of participation, and reducing erroneous payments.

Results in Brief

In the rent-a-patient scheme, organizations pay for—or "rent"—individuals to go to clinics for unnecessary diagnostic tests and cursory examinations. Licensed physicians sometimes participate in the rent-a-patient scheme. Medicare, Medicaid, and other insurers are billed for those services and often for other services or medical equipment never provided. In a variation of this scheme, perpetrators merely buy individual health care insurance identification numbers for cash. Implementing the proposed legislation will make the purchase, sale, and distribution of two or more Medicare or Medicaid beneficiary identification numbers a felony and will establish universal product numbers (UPN) for identifying the specific type of medical equipment or supply provided.

Similarly, in the pill mill scheme, separate health care individuals and entities—usually including a pharmacy—collude to generate a flood of fraudulent claims that Medicaid pays. After a prescription is filled, the beneficiary[2] sells the medication to pill buyers on the street who then sell the drugs back to the pharmacy. Making the trafficking in Medicare and Medicaid numbers a felony would also likely help reduce the number of fraudulent claims submitted to insurance systems as part of pill mill schemes.

The drop box scheme uses a private mailbox facility as the fraudulent health care entity's address, with the entity's "suite" number actually being its mailbox number. The fraudulent health care entity then uses the address to submit fraudulent Medicare, Medicaid, and other insurance claims and to receive insurance checks. For example, while the insurer sends payments to "Suite 478" at a certain address, payments are actually going to "Box 478" at a privately owned mailbox facility. The perpetrator then retrieves the checks and deposits them into a commercial bank account that he/she has set up. Requiring on-site inspections of the entity's address and mandating background checks of the owners, as the legislation proposes, should reduce the number of criminals involved in the drop box scheme.

The third-party billing scheme revolves around a third-party biller—who may or may not be part of the scheme—who prepares and remits claims to Medicare or Medicaid (electronically or by paper) for health care

[2] Medicare-covered patients are most often referred to as "beneficiaries;" Medicaid-covered patients are referred to as "recipients;" and private insurance-covered patients are referred to as "insureds." For simplicity, we refer to all insured individuals, or patients, as beneficiaries.

providers. It is possible, however, for a third-party biller to defraud Medicare, Medicaid, and others by adding claims without the providers' knowledge and keeping the remittances or by allowing fraudulent claims to be billed to Medicare or Medicaid through its service. The proposed legislation will require unique HCFA billing numbers to reduce fraudulent claims filed by third-party billers.

The bills also give the Department of Health and Human Services' Office of Inspector General additional enforcement tools to pursue health care swindlers.

Rent-a-Patient Scheme

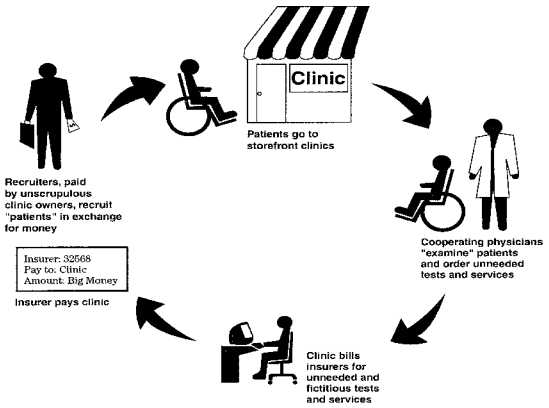
Under the rent-a-patient scheme, criminals pay "recruiters" to organize and recruit beneficiaries to visit clinics owned or operated by the criminals. (See fig. 1.) In other words, for a fee, recruiters "rent," or "broker," the beneficiaries to the criminals. Recruiters often enlist beneficiaries at low-income housing projects and retirement communities and drive them to area clinics. There the beneficiaries receive cursory examinations and testing, treatment, or durable medical equipment (DME) referrals. Recruiters generally receive $100 or more for each beneficiary they bring to a clinic. In turn, recruiters often pay a portion of their fee to each cooperating beneficiary. Cooperating beneficiaries participate to "make a few bucks" and understand that if they need "a real doctor," they are to go elsewhere. Medicare, Medicaid, or other insurance companies are later billed for the services that were provided and for other services or equipment that was not provided.

Even a few licensed medical doctors and medical school graduates—including physician assistants—collaborate with rent-a-patient clinics in exchange for money. Medical school graduates perform actual procedures on the beneficiaries, including noninvasive medical tests, and fill out medical charts. Licensed physicians are generally paid $50 or more per medical chart to periodically sign the chart for services they neither perform nor supervise or to provide certificates of medical necessity for medical equipment that is not needed.

Under the proposed legislation, Medicare claim forms will require a UPN for medical equipment and supplies instead of a billing code that covers a wide variety of items. Using the UPN, HCFA would be able to track the specific type of equipment that was allegedly provided to ensure that a lower-cost product had not been substituted. This provision may aid in reducing the number of claims submitted for medical equipment that is not provided as billed. Use of a UPN could also help investigators determine if a supplier had purchased sufficient stock of a particular item it supposedly supplied to beneficiaries.

In other instances, only beneficiary and/or identifying information is rented or brokered to the criminals. For example, some recruited beneficiaries provide only their insurance identification number in exchange for cash. Clinic owners nonetheless send blood samples—fraudulently labeled as being from the beneficiary—to labs for testing and the labs bill for the tests. The labs then kick back some of the payment they receive to the clinic owners. According to law enforcement officials, cooperating beneficiaries sometimes go to a private apartment to have x-rays taken with a portable x-ray unit or to have blood drawn. The beneficiaries receive cash or unneeded prescriptions, which they later fill and sell on the street. Their insurance plans are billed for x-rays, blood tests, or other unnecessary services or equipment. Under the proposed legislation, the purchase, sale, or distribution of two or more Medicare or Medicaid beneficiary identification numbers will be a felony.

Figure 1: Rent-a-Patient Scheme



Pill Mill Scheme

The pill mill scheme, a variation of the rent-a-patient scheme, is characterized by collusion between two or more entities—sometimes a network of clinics, pharmacies, physicians, laboratories, patient brokers, and middlemen distributors—to fraudulently divert prescription drugs and

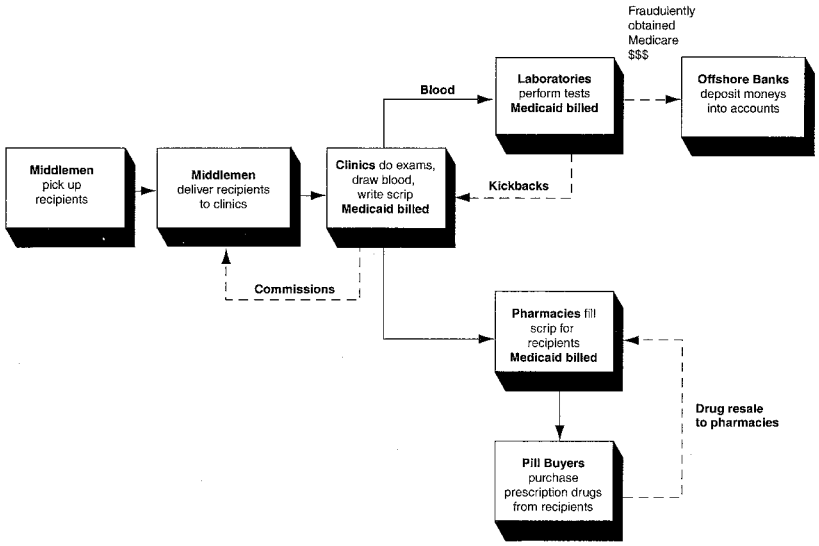
obtain unlawful reimbursement from insurers. Joint or related ownership of clinics, laboratories, and pharmacies is common. Beneficiaries often participate knowingly in this scheme, allowing their insurance identification numbers to be used for billing purposes in exchange for cash, drugs, or other inducements. Incentive for all parties to abuse an insurer's health benefit is considerable. Some medications have a substantial monetary value and profiteers can divert drugs for resale through illicit channels. (See fig. 2 for the overall structure of such a network.)

In general, the scheme works as follows. As in the rent-a-patient scheme, brokers locate beneficiaries who are often homeless or indigent individuals or drug addicts and take the beneficiaries to clinics for unnecessary examinations, blood tests, and prescriptions. Clinics and, subsequently, laboratories bill the insurer who pays the claims. In like manner, pharmacists involved in the scheme bill the insurer for the prescriptions they fill for the beneficiaries, and the beneficiaries sell the prescribed drugs to middlemen (pill buyers) in exchange for cash or illicit drugs. The middlemen, on behalf of the colluding parties, resell the drugs back to the pharmacies. Funds obtained through fraudulent billings are often moved to offshore banks to avoid recovery by law enforcement entities.

Then the cycle is repeated, with the diverted drugs being collected and resold at lower-than-wholesale prices to pharmacies. There they are repeatedly dispensed and billed to the insurer and may eventually be dispersed to legitimate patients, who could be subjected to potential harm through drugs that were not handled or stored properly or whose potency may have altered or expired.

The proposed legislation will make it a felony for a person to knowingly, intentionally, and with the intent to defraud, purchase, sell, or distribute two or more Medicare or Medicaid beneficiary identification numbers. This may aid in reducing the distribution of beneficiary identification numbers between clinics, laboratories, and other providers with the intention of defrauding insurance systems, as in the pill mill scheme.

Figure 2: Pill Mill Scheme



Drop Box Scheme

Another popular scheme is the drop box or mail drop scheme in which criminals or other unscrupulous individuals rent private mailboxes, or drop boxes, at privately owned commercial mail receiving agencies (CMRA). (See fig. 3.) In the drop box scheme, perpetrators set up medical-oriented corporations, using CMRA addresses as the providers' "official" addresses with the CMRA box numbers showing up as the providers' suite

numbers in the corporations' mailing addresses.[3] If the proposed legislation becomes law, site inspections would verify whether there is actual business going on at a given address and whether the entity meets participation standards. Background checks should help eliminate those with a criminal background from getting a provider number.

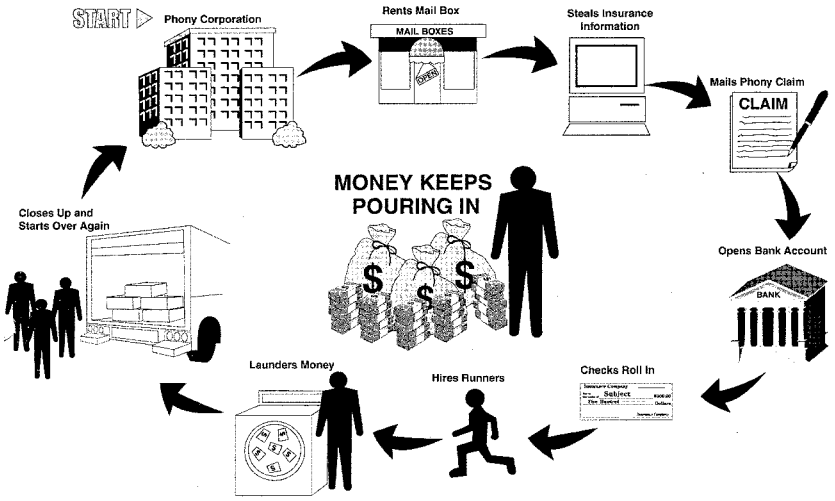
In furtherance of the drop box scheme, criminals also open corporate bank accounts to deposit insurance payments for the fraudulent health care claims they submit. They then steal, purchase, or otherwise obtain beneficiary and provider information and bill insurance plans for medical services and equipment that was not provided. A member of the group retrieves insurance payment checks from the drop boxes and deposits them in controlled bank accounts. Once deposited, proceeds are quickly converted to cash or transferred to other accounts and moved out of the reach of authorities.

While some drop boxes are set up using the name of a group leader or names of co-conspirators, others are set up with phony identification cards containing fictitious names or assumed identities together with the criminals' photographs. In another variation, criminals use the basic elements of a drop box scheme but receive the medical payments electronically in their bank accounts rather than through a private mailbox.

The proposed legislation will make the purchase, sale, or distribution of a Medicare or Medicaid provider number or two or more beneficiary identification numbers a felony. This proposal addresses the growing trend of the purchase, sale, and distribution of Medicare and Medicaid provider numbers and beneficiary identification numbers for the purpose of defrauding health insurance systems.

[3] A new CMRA regulation adopted by the U.S. Postal Service on Apr. 26, 1999, required that all mail delivered to CMRAs be identified on its face as a private mailbox, or PMB (39 C.F.R part 111 and *Domestic Mail Manual DO42.2.6*). This regulation is meant to keep criminals from using CMRA addresses for credit card fraud and other scams. All CMRA customers were required to be in compliance by Apr. 26, 2000. This deadline was extended until Aug. 26, 2000. Responding to concerns of small business and privacy advocates, the U.S. Postal Service also announced its plan to propose additional modifications to the CMRA regulations. They include the option for using "PMB" or the "#" sign in customer addresses and prohibiting the use of the terms "suite," "apartment," or any other designation that implies something other than a box.

Figure 3: Drop Box Scheme



Source: Florida Department of Insurance, Division of Insurance Fraud

Third-Party Billing Scheme

Perpetrators sometimes use third-party billing companies to file fraudulent claims and receive payment. For example, criminals generate fraudulent, computerized Medicare claims by using the names and biographical data of recruited beneficiaries. The information is downloaded to tapes and delivered to a third-party billing company that may or may not be aware that the claims are fraudulent. The third-party biller enters the information into its own computer and electronically forwards the data to Medicare. Medicare then sends the payment to the perpetrator's bank account. Third-party billers in collusion with providers may benefit from this scenario by receiving kickbacks from the provider or simply by virtue of the sheer volume of such billings, particularly when the third-party biller receives a percentage of all Medicare payments to the provider.

A variation of this scheme involves a company that represents itself as a health care provider but also functions as a broker of medical services. In other words, the company submits health insurance claims on behalf of contracted physicians through a legitimate third-party biller and adds claims for services not provided. The legitimate biller submits billings to the insurer. The insurer then sends claim payments and the explanation of benefits to the company owner who is acting as a broker. Since the physicians receive no explanation of benefits, they are unaware that the broker is adding fraudulent claims to services provided and keeping the additional money.

The proposed legislation requires that all billing entities be registered and have a unique HCFA billing number. This number will allow HCFA to identify the specific billing entities and make them more responsible for claims they file. This should act to reduce the number of upcoded,[4] unbundled,[5] and fictitious claims filed through billing agencies.

Finally, with the enactment of the legislation, criminal investigators in the Department of Health and Human Services' Office of Inspector General will have full law enforcement authority to conduct investigations; obtain and execute warrants; and, under certain circumstances, make arrests without warrant.

Mr. Chairman, that concludes my prepared statement. I would be happy to answer any questions that you or Members of the Subcommittee may have.

Contacts and Acknowledgements

For further information regarding this testimony, please contact Robert H. Hast or Steve Iannucci at (202) 512-6722. Mary Balberchak, Robert Gettings, Harvey Gold, and William Hamel made key contributions to this testimony.

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[4] Upcoded refers to billing for more expensive services at a higher service fee than was actually provided.

[5] Unbundled refers to billing separately for services that should be included in a single service fee.

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Mr. HORN. Thank you very much, Mr. Hast. We appreciate all of the fine work that you have done, and we now move to John E. Hartwig, the Deputy Inspector General for Investigations of the Department of Health and Human Services, with responsibility for the Health Care Financing Administration.

Mr. HARTWIG. Good morning, Mr. Chairman and members of the subcommittee. It is my pleasure to appear before you today to talk about our efforts and accomplishments in the continuing fight against Medicare fraud. We heard this morning about Willie Sutton and his solution to criminal targeting. Today health care is where the money is and today's Willie Suttons are lined up to target health care programs. They know where the fraud radar is and how to fly under it. Sound program oversight and well organized law enforcement are absolutely necessary.

As we heard, this hearing deals with the extreme end of the health care scale. That is individuals who set out to rob the Medicare program while providing little, if any, service to beneficiaries. We are talking about people who should never have been allowed to participate in Medicare, and I think we heard from two of them this morning. Our mission is to ensure that providers like these are never allowed in the program in the first place.

Provider numbers are still the keys to the bank. For many years the OIG has expressed its support for strengthening the process by which providers are allowed to participate in Medicare. We strongly support better controls at the front end of the Medicare payment system. Over the past few years with new legislation and oversight, much progress has been made to keep bad providers from entering the Medicare program. HCFA has begun site visits to potential providers, made DME providers reenroll, and disenrolled inactive provider numbers. But this is an area where we must be alert. Unscrupulous individuals will always adopt new methods and go to great lengths to get numbers.

We see a disturbing trend for the Willy Suttons to buy legitimate provider numbers for the purpose of committing fraud. We have seen this trend in laboratory investigations in California, clinic investigations in Florida and DME suppliers in New York. In Colorado, a chiropractor was charged with using a Medicare provider number of a deceased physician to bill for infusion therapy he did not render, and just last week a podiatrist who lost his license to practice was convicted of a scheme using numerous provider numbers from recruited podiatrists.

If provider numbers are the keys to the bank, then beneficiary identification numbers are the combination to the vault. Obtaining and selling of beneficiary numbers is a new growth industry in health care fraud. In New York two individuals visited senior citizens' apartments conducting health fairs where they coaxed beneficiaries into giving them their Medicare numbers and these numbers were then marketed to medical equipment suppliers, which were able to bill for DME. In Los Angeles we have a number of investigations underway involving fraudulent health care operations.

In conducting these ongoing investigations, we found some very disturbing patterns. Many beneficiaries showed very high Medicare service rates, some of these rates 250 times the average beneficiary billing. As an example of one DME's history, as demonstrated by

the chart on the side, and you can see the amount of DME billed to this beneficiary. Our investigation revealed beneficiaries' billing information was being traded and sold to alleged Medicare providers. We found some beneficiaries were enticed into schemes by cash and gratuity. Unfortunately, others were medically handicapped and homeless.

In February 1999, with the cooperation of Health Care Financing Administration and its contractors, prepayment edits were instituted on 40 beneficiary numbers denying all Medicare claims payments, and there were no complaints. I have another chart that illustrates the Medicare savings for 4 months on just 10 of these beneficiary numbers where we stopped payments, and if technology agrees, you can see it was almost a quarter of a million dollars.

In August 1999, an additional 120 beneficiary numbers were placed on payment denial. Again there were no beneficiary complaints. To date the contractor estimates that it has denied $7.3 million in claims, and we anticipate adding more Medicare beneficiary numbers to this project.

We do appreciate the hard work of this subcommittee and Congresswoman Biggert and Senator Collins in crafting legislation designed to protect the Medicare program and aid the law enforcement community.

One provision I would like to highlight now would be the grant of law enforcement authority to my office by statute. This has been a top priority for the Office of Inspector General. We appreciate the recognition that this legislation gives to this very important issue. Currently we operate through temporary grants of law enforcement conferred by the U.S. Marshals Service. Our office conducts lengthy and complex investigations that require the exercise of law enforcement authorities. In order to carry out these responsibilities, we need a permanent, not a conditional grant of law enforcement authority. In support of law enforcement authority earlier this year, the administration submitted to Congress a proposal to amend the Inspector General Act to grant law enforcement powers to 23 Presidentially appointed Inspectors General that currently operate under a temporary grant law enforcement authority from the U.S. Marshals Service.

Again, I greatly appreciate the opportunity you have given me today, and I would be happy to answer any questions.

[The prepared statement of Mr. Hartwig follows:]

Medicare Fraud:
Continuing Efforts

Statement of John E. Hartwig
Deputy Inspector General, Office of Investigations

Office of Inspector General
Department of Health and Human Services

Hearing Before:
House Subcommittee on Government Management, Information and Technology, Government Reform and Oversight

July 25, 2000

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

Testimony of
John E. Hartwig
Deputy Inspector General for Investigations
Department of Health and Human Services

Good morning Mr. Chairman and Members of the Subcommittee. I am John E. Hartwig, Deputy Inspector General for Investigations in the Office of Inspector General. Thank you for the invitation to appear today to discuss our efforts and accomplishments in our ongoing fight against waste, fraud and abuse in the Medicare program as well as the challenges that continue to face us. We have made substantial progress in combating these problems but the challenges that confront us are still daunting. We appreciate the interest and support of the Subcommittee and Congress in helping to provide the tools and resources we need to address the problem of Medicare.

Over the years we have made numerous recommendations in our reports that would help prevent fraud and abuse against the Department's programs and strengthen the hand of the Department to detect and prosecute each fraud. Congresswoman Judy Biggert and Senator Susan Collins have both introduced bills which contain provisions designed to support our work and recommendations. We very much appreciate this support for health care fraud enforcement and thank Congresswoman Biggert, Senator Collins and the various cosponsors for introducing these bills. We also appreciate the fact that the need for legislative action is being considered by this Subcommittee today. My testimony will provide a broad picture of the conditions underlying the need for enhanced methods and authorities to protect Federal tax dollars, not only for Medicare and our office, but for other offices of Inspectors General as well through such provisions as statutory law enforcement provisions.

With your endorsement and passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), our office acquired important and much needed authorities and financial resources which have permitted us to expand and intensify our fight against health care fraud. As a result of this funding, the Office of Investigations has been able to move steadily toward its goal of extending its investigative staff to be physically present in all States in the country particularly those areas that were underserved in lean budget years prior to HIPAA.

As we talk about Medicare fraud today, I must emphasis again that we continue to believe that most health care providers do their best to provide high quality care and are honest in their dealings with Medicare. When we talk about fraud, we are not talking

about providers who make innocent billing errors, but rather those who intentionally set out to defraud the Medicare program or abuse Medicare beneficiaries. The importance of our ongoing work is not only to protect the taxpayers and ensure quality healthcare for Medicare beneficiaries, but to also make the Medicare environment one in which honest providers can operate on a level-playing field and do not find themselves in unfair competition with criminals.

As a result of an unparalleled cooperative response to the problem of health care waste, fraud and abuse by the Congress, the Administration, the healthcare community, and senior advocacy groups, we have been able to identify, expose and respond to the problem more completely and accurately than before. It is bigger, more sophisticated, and more formidable than many may have imagined. Twenty years ago, Medicare expended $22 billion, and we were primarily investigating single-subject cases. Back then a million dollar case was considered rather large. Currently, program outlays exceed $200 billion, and multiple-subject cases are commonplace. We see millions of dollars stolen in a single scheme. With today's technology, fraudulent providers can bill the system electronically, make quick hits for large amounts of money, and move on before they are detected.

In addition to the change in the nature of health care fraud, we have also noticed a change in the individuals committing health care fraud. In the past, most of our investigations involved individuals with a legitimate reason for being in the health care system, but who misused their positions to fraudulently bill Medicare due to greed. In recent years, we have begun investigating an increasing number of criminals with no medical background, merely in the program to make large amounts of money illegally. Today's criminals know where the money is and how to get it. They also know where the radar is and how to fly under it, undetected.

Because we have better tools, and are better organized than in the past, we continue to have successes and are confident of favorable outcomes on several fronts. However, we must temper our optimism and remain vigilant. Due to the complexity of the Medicare program and the tremendous number of dollars flowing through the program, there will always be those who will continue to seek loopholes and look for ways to siphon those dollars earmarked for maintaining and improving the health of the elderly and disabled in this country.

BACKGROUND

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

To determine fraud, the OIG typically obtains information through a combination of investigative techniques tailored to each case. These tools include subpoenas of medical and billing records, use of search warrants, investigative interviews of provider employees, surveillance, and undercover operations. The OIG also receives allegations of wrongdoing from a number of sources, including beneficiaries, ex-employees of providers, competitors, contractors and Qui Tam (False Claims Act) complainants. Because Qui Tams typically are based on insider information, they have proved most useful in terms of identifying large-dollar vulnerabilities. In fact, since calendar year 1996, we have received 1,074 Qui Tam allegations, of which over 300 are under active investigation. The Medicare contractor fraud control units also refer cases to the OIG and other law enforcement authorities for consideration of civil or criminal prosecution and application of administrative sanctions. In FYs 1998 and 1999, 1,600 referrals were made by these fraud units. And finally, many of our leads on potential fraud are developed through our audits, inspections and evaluations of various aspects of the Medicare program.

The Government uses criminal and civil remedies to address health care violations of law. Criminal statutes are used to prosecute health care offenders who willfully intend to commit a crime. The standard of proof in these violations is beyond a reasonable doubt. In addition, the Government uses civil prosecutions against offenses that are committed with the actual knowledge of the falsity of the claim, with reckless disregard or with deliberate ignorance of the truth or the falsity of the claim. The other major civil remedy available to our agency is the Civil Monetary Penalties Law which has the same standard of proof as the civil False Claims Act. Neither the criminal nor civil statutes are used to cover mistakes, errors, misunderstanding of the rules, or simple negligence. Our office is very mindful of the differences between innocent errors ("erroneous" claims) and intentional or reckless conduct ("fraudulent claims") and strive to affect appropriate resolutions to these different types of inappropriate claims.

The Health Care Financing Administration (HCFA) is the largest single purchaser of health care in the world. With expenditures of approximately $316 billion, assets of $212 billion, and liabilities of $39 billion, HCFA is also the largest component of the Department. In 1999, Medicare and Medicaid outlays represent 33.7 cents of every dollar of health care spent in the United States. In view of Medicare's 39.5 million beneficiaries, 870 million claims processed and paid annually, complex reimbursement rules, and decentralized operations, the program is inherently at high risk for payment errors and fraudulent schemes.

NATURE OF MEDICARE FRAUD AND ABUSE

We in the Office of Inspector General are heartened by the support we have received from the Congress, the Administration, the healthcare community and Medicare beneficiaries in our fight against fraud, waste and abuse in the Medicare program. While our recent error estimates in the fee-for-service part of Medicare shows a general decline, it is still too high; all money improperly paid is wasteful. We recognize these audits do not always detect well known forms of fraud such as kickbacks or deliberate forgery of bills. Whatever the audits reveal or fail to reveal, we know from our investigations and from complaints that we receive that waste, fraud and abuse is still pervasive in the health care sector.

All of this is to say that we cannot let our guard down in our fight against fraud, waste, and abuse. We are still watching all areas of Medicare through our audits, inspections and investigations. And, we are continuing to encourage and receive support from industry and beneficiary groups in our efforts. At this time, however, I would like to single out some areas where we continue to have special concerns and give some examples of the results of several significant evaluations, audits and investigations which exemplify the types of fraudulent and abusive activities we continue to see.

Lack of Physical Address

- ***DME*** - After sampling 36 new durable medical equipment applicants in the Miami, Florida area, HCFA reported that 32 were not bona fide businesses. Among other problems, some bogus applicants did not have a physical address or an inventory of DME. According to HCFA, those companies should not have been issued a supplier number because they were not operational entities. To determine the prevalence of this problem, we sampled suppliers and applicants in 12 large metropolitan areas in New York, Florida, Texas, Illinois and California at HCFA's request. Our inspection found that 1 of every 14 suppliers and 1 of every 9 new applicants did not have a required physical address. When we checked

questionable addresses, we usually found that the business had closed or had a questionable presence at the address. Some addresses were merely mail drop locations or were nonexistent or could not be located. These types of problems with physical addresses often indicate potentially illegitimate business arrangements.

Services Not Rendered

- *DME* - A classic example is a case we uncovered in New York. The OIG was drawn into investigating this scheme after numerous Medicare beneficiaries complained to their carriers that claims had been submitted for services that were not actually rendered. These companies billed Medicare for millions in fraudulent claims. In one instance, three of the companies billing for ear implants received checks from Medicare totaling approximately $1 million in less than a month. The bank where the money was being deposited became suspicious and called the carrier which, in turn, stopped payment on the checks. Previously the carrier had placed a system alert on these companies when they had submitted fraudulent claims for MRI services. Because of this alert for improper MRI billings, the fictitious companies then began submitting claims for ear implants instead.

  As another example, the OIG investigated a matter involving members of a Russian organized crime syndicate who conspired to defraud the Medicare program by submitting false claims for durable medical equipment that was not prescribed, needed or delivered. One of the subjects of the investigation had a criminal record involving narcotics violations. A search at his home uncovered firearms, drugs and drug paraphernalia. In all, four individuals were found guilty of fraud. The loss to the Medicare program as a result of the scheme was $1.7 million.

Improper Acquisition and Use of Medicare Beneficiary Identification Numbers

- *DME*- In New York, two sales people from two DME companies were arrested and because of statements made, a search warrant was executed on one of the subject's residences. Agents found evidence of false Medicare billings. The scheme consisted of the two subjects visiting senior citizen high-rises and conducting health fairs where they coaxed beneficiaries into giving them their Medicare numbers. The subjects then furnished these numbers along with certificates of medical necessity to two DME companies. These companies then billed for equipment, much of which were never supplied, causing payments of more than $750,000 from the Medicare program. Both subjects arrested had recent, lengthy criminal records, including assaults on Federal agents and both

DME companies had previously been convicted as a result of OIG investigations. Each of the subjects was found guilty and sentenced to 2 years, 9 months incarceration and 2 years probation.

Excessive Billings for Individual Beneficiaries

- ***DME*** -We have uncovered another example of the improper use of Medicare beneficiary identification numbers in the Los Angeles area. We have found Los Angeles is permeated with fraudulent health care operations including laboratories, clinics, and DME. In 1997, in concert with the OIG and FBI's investigations of these entities, Transamerica Occidental Insurance, the Medicare contractor, reviewed the increased billings attributable to Medicare beneficiaries. We found some very disturbing patterns. Many beneficiaries showed an extremely high Medicare service rate. An example of one beneficiary's durable medical equipment history is demonstrated in Chart A.

CHART A

DURABLE MEDICAL EQUIPMENT

BENEFICIARY D (1/98-3/99):

Standard Wheelchair	(K0001)
Motorized Wheelchair	(K0011)
Semi-Electric Bed	(E0260)
Overlay for Mattress	(E0372)
Cane	(E0100)
Cane-3 prong	(E0105)
Walker	(E0143)
Foot, Arch Support	(L3040)
LSO	(L0500)
LSO-Custom	(L0565)
Knee Joints	(L1832)
Knee Orthosis	(L1800)
Knee Guantlet	(L1902)
KO-Swedish	(L1850)
KO-Custom	(L1845)
Cervical Collar	(L0180)
Wrist Control	(L3908)
Wrist Extension	(L3914)
HO-Hip joint	(L1686)
Heat Lamp	(E0200)
Heat Pad	(E0217)
Electric Heat Pad	(E0215)
Nebulizer	(E0570)
Entereal Formulae	(B4150)
Feeding Kit	(B4034)

Our review indicated that beneficiaries were being ping-ponged from one entity to another or their billing information was being traded or sold by many alleged medical providers. When we looked at over-utilized beneficiary numbers, we found they represented individuals who were enticed into the scheme by cash or gratuity, were mentally handicapped, and/or were homeless.

In February 1999, pre-pay edits were instituted on 40 beneficiary numbers, denying all Medicare payments. There were no complaints. CHART B illustrates the four month savings to the Medicare program on just 10 of these beneficiaries.

CHART B

OVER-UTILIZED BENEFICIARIES
3/99 - 7/99

	# of Services	Billed Amount	Payment Savings
Beneficiary A	757	$57,894.50	$20,899.00
Beneficiary B	611	$46,518.57	$19,964.00
Beneficiary C	670	$51,957.17	$24,197.00
Beneficiary D	647	$47,318.85	$21,297.00
Beneficiary E	747	$59,066.81	$22,868.00
Beneficiary F	562	$48,393.94	$21,299.00
Beneficiary G	425	$31,168.67	$14,298.00
Beneficiary H	710	$61,144.00	$25,967.00
Beneficiary I	790	$67,498.70	$25,842.00
Beneficiary J	631	$50,144.63	$21,667.00
	6,550	**$521,105.84**	**$219,025.00**

In August 1999, an additional 120 beneficiary numbers were placed on payment denial screens. There were still no complaints from beneficiaries. Since these screens were implemented the Medicare contractor has denied claims totaling over $7.3 million. We anticipate adding more Medicare beneficiary numbers to this project.

In addition to these investigations, we found several other problems in the area of durable medical equipment.

OIG Evaluations of Specific DME Services -

- We found that Medicare paid an estimated $20.6 million in 1997 for services that started after a beneficiary's date of death. Almost half of this was for durable medical equipment claims.

- We recently reported that 42 percent of claims for orthotic body jackets were for more expensive items than the one actually provided.

- We reported that nearly 25 percent of certificates of medical necessity for home oxygen were inaccurate or incomplete. In addition, 13 percent of beneficiaries reported never using their portable oxygen systems.

- We found that 57 percent of documentation for therapeutic shoe claims were missing or inaccurate.

- We found that Medicare allowed an estimated $79 million in 1997 in claims for blood glucose test strips, of which the appropriate documentation was flawed or missing. Of this, $16.5 million in claims were for beneficiaries who were not eligible to receive test strips because they did not receive insulin. In 18 percent of the claims, reviewers could not find documentation indicating that the product was delivered.

Partial Hospitalization and Community Mental Health Centers

In collaboration with HCFA, we examined the growth of Medicare expenditures to community mental health centers for partial hospitalization services (highly intensive psychiatric services). We found that Medicare was paying for services to beneficiaries who had no history of mental illness and for therapy sessions that consisted of only recreational and diversionary activities, such as watching television, dancing and playing games. Our review in five States, which accounted for 77 percent of partial

hospitalization payments to mental health centers nationally during 1996, disclosed that over 90 percent of the services, or $229 million in Medicare payments, were unallowable or highly questionable. From that review, we were able to identify potentially abusive centers for in-depth audits and, based on our results, referred all of these centers for investigation of potential fraud. Currently, investigations are underway at 18 centers identified from this work and other sources.

Hospital Outpatient Psychiatric Services

The OIG conducted a 10-State review of outpatient psychiatric services, which accounted for 77 percent of the value of the partial hospitalization program and other outpatient psychiatric claims at acute care hospitals nationally. We estimated that almost 60 percent of the $382 million in 1997 outpatient psychiatric claims made by hospitals did not meet Medicare reimbursement requirements. These unallowable services included: services not reasonable and necessary for the patient's condition; services not authorized and/or supervised by a physician; services not adequately documented or not documented at all; and services rendered by unlicenced personnel. Our reviews at individual hospitals found similar problems, as well as alteration of medical record after we selected the records for review. To determine whether fraud was a factor in these cases, additional work is being performed. Overall, we have 69 ongoing investigations.

Medicare Contractors

The Medicare program is administered by the Health Care Financing Administration (HCFA) with the help of 64 contractors that handle claims processing and administration. The contractors are responsible for paying health care providers for the services provided under Medicare fee-for-service, providing a full accounting of funds and conducting activities designed to safeguard the program and its funds. There are two types of contractors — fiscal intermediaries and carriers. Intermediaries process claims filed under Part A of the Medicare program from institutions, such as hospitals and skilled nursing facilities; carriers process claims under Part B of the program from other health care providers such as physicians and medical equipment suppliers.

Of all the problems we have observed, perhaps the most troubling has to do with contractors' own integrity -- misusing government funds and actively trying to conceal these actions and altering documents and falsifying statements that specific work was performed. In some cases, contractors prepared bogus documents to falsely demonstrate superior performance for which Medicare rewarded them with bonuses and additional contracts. In other examples, contractors adjusted their claims processing so that system edits designed to prevent inappropriate payments were turned off, resulting in misspent Medicare Trust Fund dollars. We have also encountered problems associated with

financial management and accounting procedures and longstanding weaknesses in internal controls, including deficiencies related to the receivable amounts reported in HCFA's financial statements and electronic data processing.

In addition, there have been numerous allegations that contractors have falsified statements that specific work was performed, and had altered, removed, concealed and destroyed documents to improve their ratings on Medicare performance evaluations. Wrongdoing has been identified and we have entered into civil settlements with 13 Medicare contractors since 1993, with total settlements exceeding $350 million. In addition, two contractors have entered into guilty pleas for obstruction of a federal audit.

Home Health

Looking behind the explosive growth in Medicare expenditures for home health care since 1990, OIG, using claims data from 1995 through part of 1996, found a high percentage of the payments were improper. We also determined that many home health agencies shared characteristics that could undermine the Department's ability to recover overpayments or levy sanctions. Our recommendations to strengthen the Medicare certification process and to otherwise protect the Trust Fund were adopted in the Balanced Budget Act of 1997. Conducted at the Department's request, our follow-up work, which examined 1998 claims data, noted that the payment error rate had fallen to 19 percent. Additional reviews at individual home health agencies have led to 420 investigations of potential fraud since October of 1997, and 130 of these investigations are ongoing.

- ***Improper Billing and Potential Abuse*** - A particularly egregious case of misappropriated Medicare funds and potential abuse of Medicare patients was noted at St. John's Home Health Agency, the highest paid home health agency in South Florida. We found that St. John's billed Medicare for nonrendered or upcoded home health services, that nurses and home health aides permitted subcontracting groups to use their names and/or create fraudulent documents to support nonrendered services, and that some nursing visits were provided by unlicensed persons. Further, subcontractors paid kickbacks to St. John's employees in order to do business with them. In December 1999, 26 people were indicted for racketeering, conspiring to racketeer, conspiring to launder money and conspiring to submit false claims against the Medicare program. Subsequent to plea or trial, there were 24 guilty verdicts (1 individual became a fugitive and 1 was acquitted); all 24 of those found guilty are in the process of being excluded from Federal health care programs.

- *Ghost Employees and Lack of Medical Credentials* - A married couple, neither of whom had medical certification, portrayed themselves as physical therapists and even contracted with several home health agencies to provide services to beneficiaries. One of the subjects began her own HHA using ghost employees and assuming the identities of six licensed therapists. Through this company and claims submitted by other HHA's for the couple's services, the Medicare program and private insurers were defrauded of over $400,000. Both husband and wife were found guilty of fraud and four home health agencies entered into civil settlements with the Government on their failure to check the credentials of contracted physical therapists.

Use of Deceased Physician's Billing Number
A subject in Florida was sentenced to 13 months incarceration for impersonating a physician and submitting false claims to Medicare, the Civilian Health and Medical Program of the Uniformed Services(CHAMPUS) and private insurance programs. A pharmacist reported that a doctor was prescribing large amounts of controlled substances. After some inquiries, it was found that the prescribing doctor had been dead since 1986. The subject, who was a friend and attorney of the deceased doctor, had intercepted a letter from Florida querying the doctor's application to practice medicine. The subject then received the deceased doctor's renewed license and practiced medicine at several clinics in Florida. He acted as medical director of the clinics and then opened another with his wife as office manager. The subject was ordered to pay $113,800 in restitution, $45,800 of that to Medicare.

Dialysis Company
A case that began with a Qui Tam complaint centered on misconduct perpetrated by National Medical Care, a nationwide dialysis company, and several of its subsidiaries before its 1996 merger with Fresenius Medical Care Holdings Inc. (FMCH), the Nation's largest provider of kidney dialysis products and services. The Government recently reached a record-breaking Medicare fraud settlement with Fresenius. As a result of a joint investigation by OIG and multiple law enforcement agencies and an OIG audit, FMCH agreed to a global resolution under which three subsidiaries pled guilty, and the company agreed to pay $486 million to resolve the criminal and civil aspects of the case. As part of the civil settlement agreement for credit balances, the company paid directly to HCFA $11 million for overpayments which were previously reported to the fiscal intermediaries but never recouped. The alleged criminal misconduct involved illegal kickback activity, submission of false claims for dialysis-related nutrition therapy services, improper billing for laboratory services and false reporting of credit balances.

As part of the settlement, the company also entered into the most comprehensive corporate integrity agreement ever imposed by the OIG.

RECENT ACCOMPLISHMENTS

Many specific, positive changes have been made to shore up the over $200 billion Medicare program and its payment methods. Thanks to increased resources provided through recent legislation, our Department, the Department of Justice (DoJ), and related agencies at the State and Federal levels now have increased authority and capacity to fight fraud and to reduce waste in all federally-funded health care programs. These new tools have facilitated our efforts to prevent fraud, waste and abuse from occurring in the first place.

HIPAA Accomplishments - Increased Recoveries, Exclusions, Convictions and Settlements

The Fraud and Abuse Control Program (the Program), a key part of the Health Insurance Portability and Accountability Act of 1996, enabled us to boost our efforts in identifying and preventing waste, fraud and abuse in Medicare. This legislation has provided much needed resources, stronger enforcement tools, and a management structure to coordinate the efforts of numerous fraud fighting units of Federal, State and local governments.

The Program is under the joint direction of the Attorney General and the Secretary of Health and Human Services, working through the Inspector General. HIPAA mandates a comprehensive program of investigations, audits and evaluations of health care delivery; authorizes new criminal, civil and administrative remedies; requires guidance to the health care industry about potentially fraudulent health care practices; and establishes a national data bank to receive and report final adverse actions imposed against health care providers. The Act also provides an innovative mechanism to fund these new anti-fraud efforts, thereby assuring that needed resources are always available for the effort.

We are grateful to the Congress in passing this landmark legislation and we are pleased to report that we are already reaping substantial benefits from the additional resources and authorities. In the past three years under HIPAA (FY 1997 through FY 1999), we have reported overall savings of $31.0 billion. This is comprised of $226 million in audit disallowances, $2.1 billion in investigative receivables, and $28.7 billion in savings from implemented legislative or regulatory recommendations and actions to put funds to better use. The savings that result from our recommendations that are implemented into law or regulation, and independently scored by the Congressional Budget Office or HCFA,

represent taxpayer or Medicare Trust Fund dollars that will not be spent for fraudulent gain.

During this same period, we excluded more than 8,697 abusive or fraudulent individuals and entities from doing business with Medicare, Medicaid and other Federal and State health care programs. Additional accomplishments include 1,085 convictions of individuals or entities that engaged in crimes against departmental programs, including Medicare. We increased convictions by nearly 20 percent in 1997, another 16 percent in 1998 and by almost 54 percent in 1999.

Medicare Fee-For-Service Payment Error Rate

The OIG issued its fourth report on the Medicare fee-for-service payment error rate and recently testimony before this Subcommittee on our findings. Based on a statistically valid sample, improper payments totaled an estimated $13.5 billion, or about 8.0 percent of the $169.5 billion in FY 1999 processed fee-for-service payments. Improper payments include those for: unsupported services, medically unnecessary services, errors due to incorrect coding and noncovered services. Over the four years we have conducted this audit, the improper payment rate declined by 42 percent, from a midpoint of $23.2 billion (14 percent) in 1996, to $13.5 billion (8.0 percent) in FY 1999--a drop of $9.7 billion.

Many Medicare watchers attribute at least part of this downward trend to the increased oversight and enforcement efforts of our office, HCFA, DoJ and the FBI that were made possible by the steady funding stream created by HIPAA. According to the Medicare Trustees and the Congressional Budget Office, these waste, fraud and abuse efforts contributed to Medicare's lowest inflation rate in history and to the extension of the viability of the Trust Fund until 2025 — a 26 year extension brought about over the last three years.

Waste, Fraud and Abuse Prevention

The OIG has continued to expand activities designed not just to uncover existing waste, fraud and abuse, but to prevent it. A cornerstone of our prevention efforts has been the development of compliance program guidance to encourage and enlist the private health care industry in the fight against waste, fraud and abuse. The guidance is developed in cooperation with the provider community and identifies steps that health care providers may voluntarily take to improve their compliance with Medicare and Medicaid rules. We have published eight compliance guidance documents covering hospitals, clinical laboratories, home health agencies, third-party billing companies, durable medical equipment, hospices, Medicare + Choice organizations and nursing facilities. We have

recently invited comments on our draft guidance related to individual physicians and small group practices.

The OIG has also increased its activities with respect to monitoring settlement agreements with integrity provisions and corporate integrity agreements that have been entered into by health care providers as part of a global settlement of OIG investigations and audits. The current caseload of approximately 440 is expected to increase to over 475 by the end of 2000. Our efforts to focus on preventing health care fraud also includes guidance to the industry on the propriety of health care transactions. The OIG has published two significant final regulations creating 10 new safe harbors to the Federal anti-kickback statute. Finally, the OIG continues to promote beneficiary involvement in identifying fraudulent activities. This includes operating our HHS hotline which currently receives approximately 48,000 calls per month.

UNDERCOVER OPERATIONS

We occasionally conduct undercover operations to identify potential fraud. Past undercover operations have investigated podiatrists, ophthalmologists, chiropractors, medical doctors, DME companies, billing companies and laboratories for various Medicare billing fraud schemes, such as billing for medically unnecessary services, billing for services not provided, soliciting and receiving kickbacks, upcoding services, unbundling services and misusing provider Medicare billing numbers. Many of these undercover operations are conducted jointly with other Federal agencies including the Federal Bureau of Investigations (FBI), the Internal Revenue Service (IRS), and the Drug Enforcement Administration (DEA), since violations often fall within their jurisdictions as well.

An ongoing multiagency undercover project investigated certain DME providers. The DME companies offered cash kickbacks to undercover operatives (Federal agents) in exchange for patient referrals. In addition, some companies billed Medicare and/or Medicaid for medically unnecessary services, services not provided, and/or upcoded services. The operation also identified physicians involved in the scheme. To date, this project has resulted in 20 convictions with nearly $1 million in restitutions, fines and savings. Additional cases are currently being adjudicated, and more convictions are expected.

STATUTORY PROVISIONS

We appreciate the hard work of this Subcommittee, and in particular Congresswoman Biggert (and Senator Collins), to craft legislation designed to help the law enforcement community. Such efforts will further strengthen the HHS Office of Inspector General to detect and investigate Medicare fraud and we recognize that many of the provisions that Congresswoman Biggert has included in H.R. 3461 will facilitate a more efficient and effective anti-fraud effort. We look forward to having a dialogue today about the provisions in this important legislation.

LAW ENFORCEMENT AUTHORITY

Statutory law enforcement authority is and has been a top priority for the HHS-Office of Inspector General, as well as the inspector general community, for a number of years. We appreciate the recognition that H.R. 3461 gives to this very important issue. Currently, we operate through temporary grants of law enforcement authority, granted by the United States Marshals Service. The HHS-OIG conducts lengthy and complex investigations that require the exercise of law enforcement powers (arrests, search warrants, undercover and consensual monitoring activities). In order to carry out these responsibilities, the HHS-OIG needs a permanent, not conditional, grant of law enforcement authority.

In support of IG law enforcement authority, earlier this year the Administration submitted to the Congress a legislative proposal that would amend the Inspector General Act to authorize criminal investigators in the offices of 23 presidentially-appointed Inspectors General to exercise law enforcement powers— namely authority to seek and execute search and arrest warrants, make an arrest without a warrant for offenses committed in their presence and to carry a firearm — in the course of their official duties.

Further details on this statutory law enforcement issue are attached to this statement.

CONCLUSION

As I stated at the beginning of my testimony, I believe a concentrated effort by a large number of people has resulted in tangible progress in combating fraud, waste and abuse in recent years. I particularly appreciate the strong partnerships that we have formed with the Congress, program managers and the law enforcement community. But as I have also discussed with you today, the problems that remain are serious, complicated and have profound consequences. I am particularly concerned about the deliberate fraud which we

cannot always precisely measure but that we know continues. We must never let down our guard, and we must continue to dedicate the resources and make the concerted effort to reduce these problems and continue to ensure the integrity of the Medicare program..

We in the Office of Inspector General continue to actively oversee the new resources and safeguards provided in the HIPAA and to ensure their effectiveness in preventing and combating criminal activities. For true criminals, the only effective safeguards are effective program measures to prevent fraud and a strong law enforcement presence with equally strong penalties applied to defrauders. In addition, we believe that granting statutory law enforcement authority would be a very positive and important step in providing continuity and permanence for our enforcement activities.

I greatly appreciate the opportunity you have given me today to focus attention on the types of fraud and abuse that still confront the Medicare program, the opportunity to share with you our progress as a result of some of our recent initiatives, and the ability to have a discussion on legislation vital to the inspector general community. I would be happy to answer any questions.

ATTACHMENT

Earlier this year, the Department of Justice submitted to the Congress a legislative proposal that would amend the Inspector General Act to authorize criminal investigators in the offices of 23 presidentially-appointed Inspectors General to exercise law enforcement powers in the course of their official duties — authority to seek and execute search and arrest warrants, make an arrest without a warrant for offenses committed in their presence, and to carry a firearm.

It is important to emphasize that this grant of statutory law enforcement authority would extend no new authorities, but would simply recognize in statute authorities that are already being exercised. Criminal investigators in the covered OIGs have exercised law enforcement powers for many years under designations as Special Deputy U.S. Marshals. Beginning in the mid-1980s the Department of Justice approved these deputations on a case-by-case basis. As the role of Inspectors General evolved, the need for such appointments was so consistent and the volume of requests so large that "blanket" deputations evolved. Since approximately 1995, virtually all criminal investigators in the offices of the 23 covered Inspectors General have exercised law enforcement authorities under office-wide deputations.

Although OIGs are already exercising law enforcement powers, both the Department of Justice and the OIGs believe that statutory recognition of these authorities is vital. Under the current arrangement, the U.S. Marshal's Service confers law enforcement authority upon over 2,500 OIG agents across the Federal government. However, day-to-day supervision and control over the exercise of those authorities rests with each Inspector General. The Marshals cannot and do not monitor the thousands of pending OIG investigations in which law enforcement authorities are being exercised. The proposed statutory grant of law enforcement authority would appropriately place all responsibility for law enforcement authorities to the Inspectors General, themselves, with important oversight by and accountability to the Attorney General.

Representatives of the IG community have been meeting with congressional staff to discuss statutory law enforcement authority for designated OIGs. During these discussions, some concern has been expressed that a statutory grant of authority -- instead of a renewable administrative deputation -- might result in *decreased* oversight of law enforcement. Exactly the opposite is true.

First, under this proposal, law enforcement powers must be exercised in accordance with guidelines promulgated by the Attorney General. These guidelines will govern issues

such as use of force, consensual interception of communications, coordination with other Federal investigators and prosecutors, adherence to personnel and training standards, and periodic reporting. Where an Inspector General fails to adhere to guidelines for exercise of law enforcement authorities, the Attorney General is authorized to suspend or rescind such authorities. Thus, the Justice Department retains oversight of the exercise of law enforcement powers.

In addition, for the first time, Inspectors General would be subject to "peer reviews" of their exercise of law enforcement powers, to be conducted by another Inspector General or committee of Inspectors General. The results of each review will be communicated directly to the Attorney General. With these DoJ guidelines and peer reviews, the Justice Department's bill would actually result in *enhanced* accountability by OIGs in their exercise of law enforcement authorities.

A statutory grant of authority would also provide certainty and permanence for OIG enforcement activities. The OIGs regularly conduct complex investigations that require the ongoing exercise of law enforcement authorities (arrests, search warrants, and undercover activities) during investigations that often last for years. As members of numerous national and local task forces, other Federal, State and local law enforcement officers depend on OIGs' uninterrupted participation in the enforcement activities of the task force. Administrative deputations, which must be periodically renewed, cannot offer such a guarantee of continuity.

In this regard, we have learned that the Justice Department is considering not renewing all OIG blanket deputation authorities as of January 31, 2001. If blanket deputations to the 23 OIGs covered in the bill are terminated, without passage of a statute granting law enforcement authority to IGs, it would jeopardize literally thousands of open investigations of fraud against agency programs across government. Investigations of fraud in health care, Federal procurement, telecommunications, Federal construction, bribery of public officials, crimes in subsidized housing, corruption in highway construction, child support enforcement and a host of other cases would simply cease. Moreover, if we were forced to return to a process in which we sought deputation for each individual case, the administrative burden for both the Department of Justice and the Inspectors General would, indeed, be enormous. We ask that the Congress foreclose this possibility with a grant of statutory law enforcement.

Statutory law enforcement authority would also be consistent with and promote the continued independence of the Inspectors General. Under the current arrangement, delay or non-renewal of a deputation could be perceived as an attempt to influence and

OIG, or even derail an investigation. We emphasize that we know of no instance in which such interference has occurred; however, a statutory grant would foreclose this perception.

The Department of Justice's legislative proposal would also ensure the consistency of law enforcement powers among OIGs. Some Inspectors General already exercise law enforcement powers under statutory authority unique to their offices (e.g., the OIGs at the Departments of Defense and Agriculture). Pending bills would confer law enforcement authority on other specific OIGs. The proposal sent by the Justice Department would ensure that *all* statutory Inspectors General operated under the same law enforcement authorities and with the same accountability and oversight.

Congressional staff have also asked whether the proposed legislation would broaden the authority of the Inspectors General or expand the categories of those authorized to exercise law enforcement powers. It would not. Law enforcement authority could only be exercised by trained, qualified law enforcement officers who report to the Assistant Inspector General for Investigations (auditors could not exercise these authorities), and only in connection with investigations that are already in the jurisdiction of the Inspector General to conduct. Thus, the proposal would have no impact on the jurisdiction of the various Inspectors General. Moreover, the proposal would carry with it no additional costs, since OIG agents are already exercising these authorities, are already fully trained in their exercise, and are already Federal law enforcement officers for purposes of the law enforcement retirement system, and otherwise.

The OIGs have achieved impressive successes in law enforcement. We regularly face situations which pose dangers to ourselves, our fellow law enforcement officers, and members of the public. For many years, we have exercised law enforcement authorities to further our statutory responsibilities to investigate fraud in our respective agency programs and operations. We have achieved these successes with an impressive record of professional and responsible conduct.

The Department of Justice has recognized this evolving role of Inspectors General by submitting to the Congress a legislative proposal that offers reliable, permanent law enforcement authorities to qualifying OIGs. On behalf of the entire OIG community, we urge you to endorse this proposal.

Mr. HORN. We thank you.

Our next witness is Penny Thompson, director, Program Integrity, Health Care Financing Administration.

Ms. THOMPSON. Chairman Horn, distinguished subcommittee members, thank you for inviting us to discuss our efforts to prevent fraud and keep unscrupulous providers out of the Medicare program. Safeguarding the Medicare program's financial interest is one of our highest priorities, and we greatly appreciate your interest and support.

We have made great strides in improving program integrity in the past several years, but we need to continue our forward movement and momentum. We have been aided in these efforts by the findings of the CFO audit and payment error estimation that legislation from this subcommittee requires the HHS Inspector General to conduct each year. Lessons learned are helping us to continually buildupon our success and bolster our zero tolerance policy for fraud, waste and abuse.

Among the lessons learned are the importance of systemic risk assessment to identify potential problems and program vulnerabilities, the usefulness of surveys and site visits to increase our assurance that billers are qualified and legitimate. Over the last 30 months we have conducted site visits to almost 40,000 durable medical equipment suppliers. And the importance of reaching out to our partners, beneficiaries, through our joint campaign with the AARP and the Administration on Aging to educate them about how to identify and report potential fraud.

These lessons are incorporated into our comprehensive plan for program integrity and are helping to reduce improper payments and keep questionable entities from billing the program. Although we are not law enforcement officials and do not conduct law enforcement investigations, we believe our program responsibilities extend to developing systems for preventing and detecting fraud as well as making referrals to law enforcement for investigation and supporting them and cooperating with them in the course of their investigations.

I would like to focus on our provider-supplier enrollment processes, which we believe to be an important means of preventing Medicare fraud. The primary purpose of provider enrollment is to ensure that only qualified and legitimate providers, suppliers and physicians obtain billing privileges. The best provider enrollment process is one in which all applicants are successfully processed into the program because unqualified or illegitimate individuals never bother to apply, knowing that they will be rejected. Thus the enrollment process must balance two competing needs: One, the need for sufficient scrutiny to effectively deter enrollment attempts from unqualified or illegitimate individuals and detect them if they attempt enrollment; and, two, the need to make the process as administratively simple as possible and reduce the burden on qualified, legitimate individuals and businesses seeking to build programs. This is a balancing act and we try very hard to get it right.

We plan to propose a new regulation on provider and supplier enrollment this summer and we are currently developing a national data base to include extensive information on providers as they enroll in our program. Under this program we would not issue a bill-

ing number in cases where not only a provider or supplier has been excluded from Medicare, but is also under payment suspension or has had unpaid Medicare debts previously or has been convicted of any felony inconsistent with the interests of the Medicare program, not just a health care conviction. And our proposed rule will offer the public a chance to comment or provide additional suggestions for improving the process. We believe that will help us in our efforts to allow only honest providers to do business with the Medicare program.

Preventing fraud and keeping unscrupulous providers out of the Medicare program is one of our top priorities. Over the past several years we have greatly intensified our efforts in this area and have enhanced our program integrity operations. But we agree that it is always a moving target and there are always people who are trying to find new ways and new vulnerabilities in order to get something for nothing.

We appreciate your interest in facilitating these efforts, particularly Representative Biggert's Medicare Fraud Prevention and Enforcement Act, and we look forward to working with you to strengthen our ability to pursue a zero tolerance policy for fraud, waste and abuse.

Thank you for the opportunity to testify at this hearing, and I welcome any questions.

[The prepared statement of Ms. Thompson follows:]

TESTIMONY OF
PENNY THOMPSON
PROGRAM INTEGRITY DIRECTOR
HEALTH CARE FINANCING ADMINISTRATION
on
PREVENTING MEDICARE FRAUD
before the
HOUSE GOVERNMENT REFORM SUBCOMMITTEE ON
GOVERNMENT MANAGEMENT, INFORMATION & TECHNOLOGY
July 25, 2000

Chairman Horn, Congressman Turner, Congresswoman Biggert, distinguished subcommittee members, thank you for inviting us to discuss our efforts to prevent fraud and keep unscrupulous providers out of the Medicare program and the Medicare Fraud Prevention and Enforcement Act, H.R. 3461. Safeguarding the Medicare program's interests is one of our highest priorities, and we greatly appreciate your interest and support.

We have made great strides in improving program integrity in the past several years. We have been aided immeasurably in these efforts by the findings of the CFO audit and payment error estimation that legislation from this Subcommittee requires the HHS Inspector General to conduct each year. Lessons learned are helping us to continually build upon our success and bolster our zero tolerance policy for fraud, waste, and abuse.

Among the lessons learned are

- the importance of systemic risk assessment to identify potential problems and program vulnerabilities;
- the ability of technology solutions to help us find and fight fraud;
- the usefulness of surveys and site visits to increase our assurance that billers are qualified and legitimate; and,
- the importance of reaching out to our partners—beneficiaries, providers and other Federal and State agencies—to gain their participation in our efforts to protect the integrity of the Medicare trust fund.

These lessons are incorporated into our Comprehensive Program Integrity Plan, and are helping us to reduce improper payments and keep questionable entities from billing the program.

Congresswoman Biggert, we appreciate your support, and the Medicare Fraud Prevention and Enforcement Act specifically. Your bill would authorize and strengthen the actions we have taken to implement the lessons we have learned. We look forward to working with you to prevent unscrupulous providers from entering the program, and to removing those who may already be defrauding the program at the taxpayers' expense.

BACKGROUND

In February 1999, we released our Comprehensive Plan for Program Integrity. Its development began two years ago when we sponsored an unprecedented national conference on fraud, waste, and abuse in Washington, D.C. Groups of experts from private insurers, consumer advocates, health care provider groups, state health officials and law enforcement agencies were invited to share successful techniques and explore new ideas. We synthesized and analyzed their discussions to determine the most effective strategies and practices already in place, and the new ideas that deserved further exploration. The result was a Comprehensive Program Integrity Plan with ten priorities. These priorities included:

- ***Increasing the Effectiveness of Medical Review and Benefit Integrity Activities.*** Medical review activities, where we review medical records to ensure that claims are correct, include all actions taken by contractors to determine whether a particular service was medically necessary, properly coded, and documented. Benefit integrity activities, such as data analysis and complaint investigation, allow us to identify and pursue billers suspected of outright fraud.
- ***Implementing the Medicare Integrity Program.*** This allows us to hire special contractors who focus solely on program integrity, as authorized under the Health Insurance Portability and Accountability Act. Until now, only insurance companies who process Medicare claims have been able to conduct audits, medical reviews, and other program integrity

activities. Under the new authority, we can and have started to contract with many more firms who can bring new energy and ideas to this essential task.

- ***Proactively Addressing the Balanced Budget Act.*** The BBA created several new programs, benefits, and payment systems. We continue to work to address potential program integrity problems these changes could raise before they occur.
- ***Promoting Provider Integrity.*** We have made clear that we do not simply pay bills, but enter into agreements to do business with providers. We have stepped up efforts to educate providers on how to comply with program rules; supported the development of compliance plans; increased the number of onsite visits we make; and are working to publish a proposed regulation to establish clear enrollment requirements, including conditions under which we will deny or revoke billing privileges.
- ***Focusing on specific parts of the program.*** These include inpatient hospital care, managed care, nursing homes, and community mental health centers. We have focused on these areas to reduce payment errors and ensure protection of beneficiaries.

We are committed to continuing our success and expanding it at every opportunity.

For the remainder of my testimony, I would like to focus on our efforts to promote provider integrity, and specifically talk about our provider/supplier enrollment processes. These are the subjects of a good part of the Medicare Fraud Prevention and Enforcement Act, and our activities and accomplishments to date may interest you.

Purpose of Provider Enrollment

The primary purpose of provider enrollment is to ensure that only qualified and legitimate providers, suppliers and physicians obtain billing privileges. Secondarily, we use our provider enrollment process to obtain needed information about payment and mailing instructions so that claims are processed and payments are made correctly. We collect a wide variety of information through the varying programs we administer. We continue to ensure the privacy and security of sensitive information. Additionally, the Department's privacy rule is scheduled to be finalized this year, which will further bolster the protection afforded to sensitive information.

The best provider enrollment process is one in which all applicants are successfully processed into the program, because unqualified or illegitimate individuals never bother to apply, knowing they will be rejected. Thus, the enrollment process must balance two competing needs: (1) the need for sufficient scrutiny to provide a effective deterrent to enrollment attempts from unqualified or illegitimate individuals (and detect them if they attempt enrollment) and (2) the need to make the process as administratively simple as possible and reduce burden on qualified, legitimate individuals and businesses seeking to bill the program.

To accomplish this, we use a three step approach, in which we:

- Collect key information that uniquely identifies the provider or supplier and requires them to identify where they will render services, whom their owners and managers are, and to submit proof of their qualifications to render health care along with pertinent data to establish claims payment. Since 1996, we collect this information on a standard, national enrollment form, and under penalty of law, providers and suppliers attest to the accuracy of the information they have provided.

- Conduct a data validation process, involving a variety of different data sources. Increasingly, the Internet has become a useful source of information to help validate information such as addresses. We also check licensing boards, sanction and debarment lists, and the new Healthcare Integrity and Protection Data Bank (HIPDB), a national health care fraud and abuse data collection program for reporting and disclosing certain final adverse actions taken against health care providers, suppliers, or practitioners.

- May also conduct site visits if a State survey (to ensure compliance with conditions of participation) has not been conducted, or if the entity or organization has not been subject to an accreditation by an approved accreditation authority (such as the Joint Commission on Accreditation of Healthcare Organizations). These are now conducted on all newly enrolling

durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) entrants, independent diagnostic testing facilities, and community mental health centers. Contractors also have the flexibility to conduct site visits in other areas if they suspect problems might exist, based on beneficiary complaints, tips from State agencies or authorities, or ongoing and completed investigations.

I would like to discuss some of these efforts in more detail, particularly focusing on areas where we found significant vulnerabilities.

Durable Medical Equipment

Durable medical equipment (DME) was one of the very first areas we targeted in our increased efforts to fight fraud, waste, and abuse. Medicare pays some $6 billion each year for wheelchairs, canes, and other durable medical supplies. But investigations by the HHS Inspector General found that a significant number of DME suppliers did not have physical business addresses, or were located in private homes, or had no actual supply of equipment to provide.

To respond to this problem, we took a number of steps. First, we increased the standards for DME suppliers. Since there was little to no State licensing of DME suppliers, we needed to step in and make sure that basic business requirements—such as honoring warranties, maintaining and repairing equipment, accepting returns, maintaining a physical facility on an appropriate site, maintaining liability insurance—were met by suppliers doing business with Medicare. Second, we established the National Supplier Clearinghouse, a national enrollment contractor for suppliers furnishing durable medical equipment, prothestics, and orthotics. Third, we authorized site visits for all newly enrolling and reenrolling suppliers.

These activities have increased our assurance that suppliers doing business with Medicare are legitimate and qualified. In fiscal years 1998 and 1999, the National Supplier Clearinghouse conducted tens of thousands of site visits. While we are happy to report that the vast majority of applicants past muster, about 500 did not. Since these 500 suppliers could not even pass the basic

screen of a site visit, they do not belong in the Medicare program, and should not receive Medicare funds.

The National Supplier Clearinghouse has been so effective that we have heard stories of fraud perpetrators "giving up" on getting to the program through the supplier enrollment process.

Community Mental Health Centers

As part of Operation Restore Trust, we began identifying patterns of fraud and abuse at community mental health centers (CMHC). We, along with the HHS Inspector General, found providers enrolled in Medicare who were not qualified to deliver psychiatric services, patients enrolled who were ineligible for the Medicare benefit, and services inappropriately billed to Medicare. In September 1998, we announced new actions to ensure that Medicare beneficiaries with acute mental illness receive quality treatment in CMHCs and that Medicare pays appropriately for those services. In 1999, we charged one of our Medicare Integrity Program contractors with conducting unannounced site visits for all new CMHC applicants to ensure that they provide all the services required for Medicare enrollment.

While these measures helped to reduce inappropriate reimbursements by removing unqualified providers, we also began intensified medical reviews of CMHC partial hospitalization services, with particular emphasis on States targeted in the Inspector General's October 1998 audit report. In those five States (Florida, Texas, Colorado, Pennsylvania, and Alabama), over 90 percent of CMHC partial hospitalization program claims in those states did not meet Medicare coverage requirements. So we directed our contractors for those areas to review 30 percent of every CMHC provider's claims, and then adjust review levels depending on results.

The President's FY 2001 budget includes several legislative proposals to strengthen and clarify the partial hospitalization benefit and reduce its misuse. Those proposals would create civil money penalties for false certification of a beneficiary's need for the benefit, prohibit partial hospitalization services from being furnished in a beneficiary's home or other residential setting,

and take other steps to prevent abuse of the Medicare program.

Another longstanding issue requiring legislation involves the statutory requirement that, to participate in Medicare, a CMHC must perform screening for admissions to State psychiatric facilities. Some State laws or regulations limit this function to designated facilities. As a result, many CMHCs in those States cannot meet the federal requirement. Up to this point, we have not pursued termination actions against CMHCs that are out of compliance with this requirement alone. While legislation has been introduced to modify this requirement, it has yet to become law.

Independent Diagnostic Testing Facilities

In another area, we found that entities that billed for and/or provided diagnostic tests often were not legitimate businesses or did not meet reasonable quality standards. To eliminate this problem, we took a page out of our successful durable medical equipment, prosthetics, orthotics, and supplies effort. We produced a regulation establishing new, higher standards for entry into the program, and told all existing entities that they had to re-enroll into the program, showing that they met the new requirements. We conducted site visits as part of this effort. In the end, only about half of the entities previously enrolled in the program successfully re-enrolled. Many did not bother to apply for re-enrolment.

Other Site Visits

Of course, our purpose here is not to prevent enrollment by qualified entities or individuals. The drops that we have seen in the number of DME suppliers, CMHCs, and IDTFs were all accompanied by surveillance strategies to ensure that beneficiary access was not impaired—to make sure that we had not raised the bar so high that we were keeping out good providers as well as bad ones. Again, it is a balancing act, and we try hard to get it right.

The last point I will make about site visits is the importance of some local flexibility, based on local knowledge, to conduct site visits where they are most needed. I heard one story from one of our contractors about their site visits to a very specific kind of applicant: physicians over 70 who

were enrolling to bill Medicare for the first time. The fraud unit knew of cases where physicians' identities were being used as fronts for illegal medical services, sometimes by relatives without the physician even knowing. As a result, this contractor flagged those enrollments, and conducted site visits to such physicians. They report that it was a worthwhile effort, uncovering some highly questionable circumstances leading to referrals for fraud investigation.

Future Efforts

We plan to propose a new regulation on provider and supplier enrollment this summer, and are currently developing a national database to include extensive information on providers as they enroll in our program. Under this program, we would not issue a billing number in cases where a provider or supplier has been excluded from Medicare, is currently under Medicare payment suspension, has unpaid Medicare debts, or has been convicted of a felony inconsistent with the interest of the Medicare program. Our proposed rule will provide the public a chance to offer additional comments or suggestions for the provider enrollment regulations.

Once the proposed rule is finalized, we will begin an enrollment clean up process. As part of this process, we will go back to providers and suppliers now billing the program and require them to confirm and update their information periodically, including data on their billing arrangements. Information collected will be entered into a new enrollment system, which is known as the Provider Enrollment, Chain, and Ownership System (PECOS).

PECOS will be a central source of provider/supplier enrollment information. In addition to chain ownership and related organization information, it will include information on providers' billing arrangements and any reassignment of benefits. The chain organization/related organization information will allow contractors to identify when a provider or supplier is part of a larger organization, and to view their entire line of business. PECOS also will permit a local contractor to view national data about an individual or entity, rather than simply the data that appears on a local provider file. And PECOS will identify providers and suppliers who have been denied privileges, or are subject to revocations or exclusions. By offering a more complete picture of

provider business operations, PECOS should help to ensure Medicare works only with reputable business partners. Our current schedule calls for PECOS to be up and running for Fiscal Intermediaries this September, with Carriers following in January 2002. I will now to turn to a few other issues that are taken up by the Medicare Fraud Prevention and Enforcement Act.

Third Party Billing Agents

Third party billing companies that operate ethically can provide a valuable service to providers and suppliers who seek out their help in submitting claims correctly and efficiently. These firms vary greatly, performing a wide variety of services from simply formatting claims for submission to Medicare and private insurance companies to managing the entire "business end" of provider practices.

Improper third party billing practices can pose a significant threat to Medicare. Billing companies that engage in behavior that gives rise to false claims can be held accountable under the False Claims Act. Under current regulations, we review these arrangements only when new Medicare providers or suppliers ask that their payments be made to an agent. These reviews have led to an increase in the number of third party billing contracts that are in compliance with existing laws and regulations. However, when billing companies assist in preparing bills or coding, but do not actually receive payment, they generally are not regulated. Billing arrangements for providers who entered the program before 1996 are not reviewed, and our overall ability to monitor third party billing practices is quite limited.

The new enrollment regulations and a new enrollment database for all providers, mentioned above, should solve some of these problems. The new system will specifically gather information on third-party billing companies. The new enrollment regulations will require providers to periodically update information, including their billing arrangements. And, in publishing the provider enrollment regulation proposal, we intend to invite public comments on how to address challenges in better oversight of third party billing companies.

Additionally, problems identified by us, the IG, and the General Accounting Office make clear that we may need to do even more. In follow up to a hearing by the House Commerce Committee, we organized a summit, bringing together billing agents, congressional staff, the GAO, and the IG to discuss how best to respond to the threats posed by unscrupulous third party billers. This summit allowed us to understand better the costs and benefits of collecting additional information, the challenges of defining "third party billing agent," and the difficulty of changing electronic claims submission standards to create audit trails. However, it also was clear that the billing agent community was willing and eager to work with us on the issue.

Limiting Bankruptcy Debt Discharge

We strongly support preventing fraudulent providers from using bankruptcy protection as a way to dodge responsibility for repaying overpayments, fines, or penalties. In the past, we have proposed HCFA authority to ensure that when providers declare bankruptcy in order to avoid an overpayment, penalty, or fine resulting from fraudulent behavior, the Medicare program can recoup those overpayments and fines. There are instances where providers owing the Medicare program millions of dollars in overpayments declare bankruptcy as soon as corrective actions are taken against them, and the public ends up swindled out of millions of dollars. Limiting debt discharge would help to increase the accountability of individuals and entities providing Medicare and Medicaid services, and we very strongly support enacting this into law.

Excluded Providers

Clearly, we must make sure payments do not go to excluded providers, and we are now developing a better system to make sure they do not. Our enrollment regulation will require this sort of information and will allow contractors to weed out the providers who do not belong in the program. However, we do not at this time support holding Medicare contractors financially liable for erroneous payments to individuals and entities that have been excluded from the program.

First, we do not believe this is a significant problem. A recent IG report sent to us estimated $30,000 in losses in 1997 due to improper payments to excluded providers. And we believe the

contractors are making a good faith effort to prevent such payments. Contractors have not always been given all the data they need to prevent them. The existing database of excluded providers can be unwieldy for the contractors to employ in their provider enrollment and claims processing operations, and critical data needed by the contractors are missing from many records. Working with the IG and our contractors, we have identified ways to improve our system for preventing such payments. We are now developing a new system that includes a significantly improved database on excluded providers. We will check that database against files of providers billing Medicare and against databases with employment information. That will help prevent excluded individuals and entities from re-entering the program, and will work much better than our current system.

We would like to note that one provision of Representative Biggert's bill, extending certain law enforcement authority to the HHS IG, is inconsistent with legislation that the Department of Justice has proposed, which would extend such authority to IGs on a government-wide scale. We look forward to working with you to ensure that this issue is addressed effectively.

CONCLUSION

Preventing fraud and keeping unscrupulous providers out of the Medicare program is one of our top priorities. Over the past several years, we have greatly intensified our efforts in this area, and have significantly enhanced our program integrity operations.

We appreciate your interest in facilitating our program integrity efforts, particularly Representative Biggert's Medicare Fraud Prevention and Enforcement Act, and hope our input is helpful. We look forward to working with you to strengthen our ability to pursue a zero tolerance policy for fraud, waste, and abuse. Thank you for the opportunity to discuss this important matter, and I am happy to answer your questions.

Mr. HORN. Thank you, and we now have John Krayniak, the deputy attorney general, director of the New Jersey Medicaid Fraud Control Unit Office of the Attorney General, State of New Jersey.

Mr. KRAYNIAK. Thank you. Good morning, Mr. Chairman and members of the committee. I appear today as a representative of the State Medicaid Fraud Control Units and the National Association of Medicaid Fraud Control Units. There are 47 State Medicaid Fraud Control Units in the association and the District of Columbia was recently certified.

Medicaid is a jointly funded State and Federal health insurance program for the indigent elderly and disabled.

Since the passage of the Medicare-Medicaid Antifraud and Abuse Amendment in 1977, which established the MMCUs, the States have had the primary role in investigating and prosecuting Medicaid fraud. Forty of the 48 units are located in the State attorney generals' offices and the other 7 are in law enforcement agencies in their respective States. Many units work very closely with the Federal authorities in their States and the local U.S. attorney's offices prosecutes many of the Medicaid fraud cases brought.

Recent legislation would expand the jurisdiction of the Medicaid Fraud Control Units to any Federal health care program if the investigation is primarily Medicaid related and the appropriate Inspector General of that agency which administers the program approves it. We anticipate that most of these investigations will be joint Medicaid and Medicare investigations.

We have seen how abuse in provider enrollment procedures have allowed those intent on committing fraud to become providers, which allows them to bill the Medicare and Medicaid programs. Since these providers, and I say that in quotes, are chasing government dollars and not interested in providing any medical service, they frequently victimize both Medicare and Medicaid, sometimes concurrently and sometimes one in succession after the other when they come under scrutiny in either program.

We have seen how individuals and groups trafficking in beneficiary and provider identification numbers have defrauded our government health care programs coast to coast. Some of these groups operate in specific geographic areas while others operate nationwide.

The schemes know no boundaries. We have seen time and time again the fraudulent billings by the durable medical equipment suppliers that Mr. Mederos described earlier through the use of mailbox businesses with suite numbers to hide their identity. We have also seen laboratory providers who have generated millions of dollars in medically unnecessary tests commit their fraud in New York, move to New Jersey, and then migrate to California and continue it.

We have seen undeniable linkage of individuals and companies showing that many of these schemes are interrelated. These are organized criminal conspiracies, and they are a distinct and serious threat to the integrity of our health care programs. These individuals, operating together, pose a far more serious threat than the same number of individuals acting independently. They employ sophisticated methods to commit their crimes, mask their involvement and launder the profits of their criminal activity.

The electronics claims submission brings with it obvious benefits of reduced time to process claims and a decrease in the administrative costs of processing these claims. Unfortunately, this system also assists those intent upon committing fraud. If you have a correct provider number, a correct beneficiary number, and match that with the common procedure terminology code that matches the diagnosis code listed, you essentially gain access to the government's coffers. Adding to this problem of rapid claims processing is the faster electronic transfer of funds. We have found that many providers do not bother to get a paper check. They have money directly wired into their accounts and that money is frequently wired out of those accounts sometimes within an hour of deposit from the government payers.

In one example in our written submission, a local police department in New Jersey uncovered a virtual assembly line of fraud. They discovered four individuals whose sole job it was to prepare fraudulent laboratory requisition forms, obtaining this information from 1,572 index cards that we seized at the scene. This operation was responsible for submission of almost 8,000 fraudulent claims in a 4-month period. In the three cases I cited in my written testimony, the laboratory cases in New York, New Jersey, and California we conservatively estimate accounting for an excess of $8 million in billings. Those investigations are ongoing today as we speak. The transportation case in Florida was responsible for at least $10 million.

Thank you very much for allowing us to participate in this very important hearing and inviting us to testify.

[The prepared statement of Mr. Krayniak follows:]

TESTIMONY
OF
JOHN KRAYNIAK
DEPUTY ATTORNEY GENERAL

DIRECTOR, NEW JERSEY
MEDICAID FRAUD CONTROL UNIT

BEFORE

THE HOUSE OF REPRESENTATIVES'
COMMITTEE ON GOVERNMENT REFORM
SUBCOMMITTEE ON GOVERNMENT, MANAGEMENT, INFORMATION AND TECHNOLOGY

JULY 25, 2000

2154 Rayburn House Office Building
Washington, D.C.

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you today to discuss the nature and magnitude of illegal activities occurring in government healthcare programs. My name is John Krayniak, I am a Deputy Attorney General in the New Jersey Attorney General's Office and the Director of the New Jersey Medicaid Fraud Control Unit. Attorney General John Farmer has made health care fraud a top priority and for the second year is co-Chair of the National Association of Attorney General's Health Care Fraud, Abuse and Advocacy Committee. I also appear today as a representative of the National Association of Medicaid Fraud Control Units (NAMFCU), which is made up of 48 State Medicaid Fraud Control Units.

By 2007 or perhaps even sooner, national health care expenditures are projected to exceed 2.1 trillion dollars for the first time.[1] This number may actually be a conservative estimate. Although this sum appears on its face to be an astoundingly high dollar amount and reflects unprecedented spending for national health care, numbers of this magnitude are accepted costs for health care in this country and may arguably demonstrate stable growth in the health care system. In fact, since 1996, national health care expenditures have consistently topped 1 trillion dollars.[2]

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[1] Source: Health Care Financing Administration (HCFA) Report, "Highlights of the National Health Expenditure Projections, 1997-2007," posted on www.hcfa.gov/stats.

[2] Source: Health Care Financing Administration (HCFA), Office of the Actuary: National Health Statistics Group.

Even though national health care expenditure statistics reflect public spending (state, local and federal government) as well as spending by the private sector, the governments' financial commitment to national health care is significant. Public spending is comprised largely of two government health care programs: Medicaid and Medicare. Government spending on these programs accounts for a significant percentage of the annual national health care expenditure. In 1998, government spending on Medicare and Medicaid accounted for 34% of all spending on health care in the United States. The Medicaid program alone spent $170.6 billion, which accounted for 15% of all health care spending in that year. The Medicare program spent $216.6 billion for health care related services, approximately 19% of all health care spending in 1998.[3] The enormous amount of money spent by the government for health care services has attracted a criminal element. Considering the sums that are spent each year, it is not surprising that our health care insurance programs have become targets for fraudulent activity.

The General Accounting Office (GAO) has estimated that fraud and abuse can account for up to 10% of health care costs. While it is impossible to establish a precise figure, we are certainly talking about tens of billions of dollars of fraud and abuse in the Medicare and Medicaid programs. There has certainly been progress in combating fraud and

[3] Source: Health Care Financing Administration (HCFA) Report, "Highlights National Health Expenditures, 1998," posted on www.hcfa.gov/stats.

abuse but this remains a critical concern. Every dollar lost to fraud is one dollar less to provide needed treatment, medicine and medical equipment to those in need.

The investigation and prosecution of health care fraud continues to be a top national law enforcement priority. The primary responsibility for combating Medicare fraud rests with federal law enforcement agencies, principally, the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) and the Federal Bureau of Investigation (FBI).

The responsibility for investigating and prosecuting Medicaid fraud rests with the State Medicaid Fraud Control Units (MFCUs). The Medicaid Fraud Control Units were established by the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, Public Law 95-142. The Units are charged with investigating and prosecuting provider fraud, fraud in the administration of the program, and patient abuse and neglect. The enabling legislation structured the Units into an integrated multi-disciplinary team of attorneys, auditors and investigators. The MFCUs are required to be separate and distinct from the state Medicaid programs to avoid conflicts of interest. Forty of the forty-eight Units are located in the state Attorney General's Office. Others are located in other state agencies with law enforcement responsibilities. NAMFCU's primary purpose is training, but since 1995 it has acted as a coordinating point between the Department of Justice and the states in working towards resolution of Qui Tam[4] cases against providers who operate on a national scale. Federal

[4] False claims cases filed by private parties on behalf of the government pursuant to 31 U.S.C. Sec. 3730 et. seq.

regulations require the MFCUs to be certified annually by the Secretary of the Department of Health and Human Services (HHS) and the Office of Inspector General of HHS has been delegated the administrative oversight responsibilities for the MFCUs. State and federal authorities work closely and each U. S. Attorney's Office has a joint federal/state Health Care Fraud Task Force and an Assistant U. S. Attorney is designated as the Health Care Fraud Coordinator in each office.

The Ticket to Work and Work Incentives Improvement Act of 1999 expanded the jurisdiction of the MFCUs to include investigation and prosecution of any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (.....), if the suspected fraud or violation of law in such case or investigation is primarily related to the state plan (Medicaid) under this title, conditioned upon the approval of the Inspector General of the relevant Federal agency.[5] It is anticipated that most of these investigations will be against providers who target both the Medicaid and Medicare programs.

The following comments address three specific problem areas.

[5] 42 U.S.C. 1396b(q)(3)(b).

PROVIDER ENROLLMENT

As a rule, the government places a greater burden on one seeking to drive a motor vehicle on the nation's highways, than one who seeks to be a provider to the Medicare or Medicaid programs. The provider number is the key that will unlock the government's coffers and should be more zealously guarded. A provider number should not be an entitlement to which anyone who wishes to apply can receive but should be viewed as a privilege of providing goods or services to government beneficiaries. Under existing regulations for provider application, provider applicants can conceal themselves behind a corporate shell whose address is frequently a post office box in a mailbox suite, so it appears it is a street address with a suite number. The service address, if any, is different. This allows the provider to submit false claims with little chance of apprehension if the false claims are detected. Law enforcement's attention will be directed to the address on the provider application. The only action law enforcement could take would be to notify the single-state agency to withhold payments based on the false claims detected. At best, the provider risks the loss of one or two weekly checks. The provider then simply submits another provider application using the same scheme and sometimes even the same address, continues providing service from the same location and repeats the cycle.

This has led to the phenomenon of hit and run billings where a provider "tests" the system by electronically submitting claims, with higher priced Common Procedure Terminology (CPT) codes. After it is determined that these claims will be paid the number of claims escalates dramatically until the provider comes under some scrutiny at which time

they "bust out" the scheme by closing shop. An on-site visit to the address given by the provider would have revealed the address was nothing more than a post office box. Provider enrollment is a critical stage of the process of maintaining program integrity and preventing providers intent on committing fraud from entering the system.

ORGANIZED CRIMINAL GROUPS IN HEALTH CARE

The face of health care fraud has changed dramatically. In the past, law enforcement was generally faced with a provider, who was a licensed professional, committing fraud by submitting claims for services not rendered or upcoding -- for claiming payment for a higher level of treatment than was actually provided. These providers were generally well-established in their communities and investigations often followed the typical path of a white collar crime investigation. After receiving information , usually from a patient or disgruntled former employee, subpoenas for records were served on the provider. There generally followed a period of time in which an audit of claims was performed and recipient interviews conducted and these cases were either settled through negotiation or less frequently litigated.

The nineties saw the advent of organized criminal rings whose sole purpose is to defraud government health care programs, generally Medicaid and Medicare. Most of these rings are made up of non-licensed individuals who target ancillary provider groups such as laboratories, durable medical equipment and transportation. They use licensed professionals such as doctors when necessary to carry out their schemes. The advent of electronic billing allows these groups to submit claims anonymously, in great volume and in rapid succession.

In order to effectively investigate organized criminal groups it is necessary to employ traditional law enforcement practices, such as the use of arrest and search warrants. These methods give law enforcement a better chance of obtaining evidence needed to successfully prosecute and to insure the defendant's presence at trial.

An example of the damage that can be done to a government insurance program is illustrated by the following case. At the center of this Medicaid fraud and kickback scheme was United Diagnostic Laboratory (UDL) in Manalapan, New Jersey. Mohammad Akthar Javid, twice convicted of Medicaid fraud in New York, operated United Clinical Laboratory (UCL) as the management arm of UDL . He masterminded a scheme where clinic owners submitted large numbers of blood specimens for analysis knowing the analysis would be billed and paid by the Medicaid program. The overwhelming majority of these blood tests were medically unnecessary because the blood specimens were often bought from drug addicted individuals. The names of Medicaid beneficiaries were randomly selected from files maintained by the clinic and listed on the laboratory requisition form. The Medicaid beneficiary numbers were obtained from beneficiaries utilizing the clinic for minimal medical service, as well as from the purchase, sale, and trading of Medicaid beneficiary numbers among conspirators. The information on the laboratory requisition form prepared at the clinic was utilized by the laboratory for billing. UDL's Medicaid billings increased to $5.9 million in 1995 from a little more than $500,000 in 1994. (Exhibit 1). The clinic owners were Rehan Zuberi and Arshad Khan and Tahir Sherani, all mentioned later in this report. An additional clinic owner was Zahid Ilyas.

This was a well-organized, highly efficient criminal enterprise that bilked the Medicaid program of a very substantial amount of money in a relatively short period of time. The defendants purchased blood from at least two blood brokers, one probably located in New York City and one located in Trenton, New Jersey. The latter admitted selling hundreds of vials of blood to Ilyas and Sherani. She also admitted selling hundreds of vials of human blood to another individual who had been involved in an earlier laboratory scheme with Javid and Ilyas.

The continuing vitality of this criminal enterprise is highlighted by the fact that Javid had been convicted several years earlier of almost identical conduct in New York. Some of these suspects who escaped prosecution simply moved to New Jersey and resumed their criminal activities after increased scrutiny by the New York Medicaid Fraud Control Unit. Cooperating witnesses provided information that members of this group routinely met and exchanged information and counseled each other on how to commit the laboratory fraud, launder the criminal profits and what steps to take to avoid detection. This enterprise was not confined to the New York/ New Jersey Metropolitan area. During the investigation of this and several other laboratory fraud cases, many of the defendants simply fled the jurisdiction. Several set up shop and resumed their criminal activities in Illinois where they were detected and prosecuted by federal and state authorities. Defendant Sherani fled to California during the investigation. After he was indicted he was arrested in West Covina, California, living in an apartment with two individuals who had been involved in laboratories in the New York/New Jersey Metropolitan area where substantial fraud had taken place.

Subsequent to Sherani's arrest, the New Jersey MFCU notified the California MFCU that they should increase their vigilance on independent laboratories operating in the Saint Gabriel Valley area, where West Covina is located.

Months later, it was discovered that California Medicaid checks payable to a laboratory in Irwindale, California were being converted into cash at a check-cashing facility in Jersey City, New Jersey. This information was provided to the California MFCU, which initiated a full-scale investigation. Their investigation resulted in the arrest of associates of Sherani, later determined to be from the New York City area. In the California cases, the defendants eliminated the more ghoulish aspect of the operation, that is obtaining blood. They simply took over a laboratory and used the computers and files to electronically submit false claims to California Medicaid. It is estimated that the defendants submitted claims for approximately $8 million before they were detected.

Defendant Sherani elected to go to trial in New Jersey rather than plead guilty. He was convicted of Conspiracy, Theft, Medicaid Fraud and Money Laundering after a three-week jury trial. Present in court with him almost everyday was an individual who gained notoriety by bilking the New York Medicaid program of millions of dollars approximately ten years earlier. He was convicted and sentenced to a prison sentence and had recently completed his period of parole.

ILLEGAL DISTRIBUTION OF MEDICARE OR MEDICAID BENEFICIARY OR PROVIDER NUMBER

Medicaid beneficiary numbers have become a valuable commodity in the livery transportation provider group. There was a substantial increase in expenditures for livery

transportation occurring over a relatively short time period. The number of livery providers increased contemporaneously. In an attempt to determine the cause for the dramatic increase in expenditures, audits of the claims submitted by many of the new providers were conducted. The claims submitted by the livery transportation providers were cross-checked to determine if there was a medical service rendered to the beneficiary on the same day. Once this was determined to be the case, the increase in expenditures took on an air of legitimacy. However, surveillance of select livery providers indicated the vans could not be providing the number of trips per day that claims were submitted for. Further investigation revealed these livery providers were canvassing neighborhood clinics. At the end of each day, they would purchase the names and Medicaid beneficiary numbers of all patients who were seen in the clinic that day. They generally paid $1.00 per name. The livery providers reasoned that if they submitted claims for transportation in conjunction with other medical services, they would escape further scrutiny. While it was impossible to accurately determine the number of names and Medicaid beneficiary numbers that were sold, it was clearly many hundreds. This information was passed around from livery provider to livery provider, each of whom billed numerous times for a beneficiary who walked to the doctor's office. Once this practice was discovered, action was taken against sixty livery transportation providers.

The case of State v. Tahir Sherani (Superior Court Docket No. 97-09-00044-S, Monmouth County, New Jersey) offers an illustration of misuse of a doctor's Medicaid provider number. The defendant owned a clinic in Newark, New Jersey, which between

September 26 and November 4, 1995, submitted at least 340 laboratory requisition forms, along with blood samples, for testing, to United Diagnostic Laboratories. United Diagnostic Laboratories conducted a panel of tests on each sample and billed and was paid by the Medicaid program $129,991.36. The defendant was paid $100 as a kickback for each of the laboratory requisition forms. All of the laboratory requisition forms bore the name of a New Jersey physician and his Medicaid provider number as referring physician. During the time these laboratory requisition forms were submitted, the doctor was doing volunteer work treating patients in Haiti. He never met the defendant nor did he ever work at the defendant's clinics. The doctor surmised that the defendant obtained his name and Medicaid provider number from one of several clinics in the area where the doctor worked part-time after his retirement and prior to doing volunteer work in Haiti. The defendant was convicted of Conspiracy, Medicaid Fraud, Theft by Deception and Financial Facilitation of Criminal Activity (Money Laundering).

The third example illustrates misuse of beneficiary numbers.

On December 20, 1995, Bell Atlantic's security department received a report of a possible theft of phone services originating out of an office located at 641 Broadway in Paterson, New Jersey. After conducting a preliminary investigation, a corporate investigator with Bell Atlantic Security drove to 641 Broadway in Paterson to investigate the complaint. Upon arrival, the investigator contacted the Paterson Police Department and requested that a patrol car be sent to the address. Two patrolmen responded to 641 Broadway, where they were met by the corporate investigator.

The investigator advised the officers that he had knowledge that long distance phone calls were being made from an office in the building located at 641 Broadway. He further advised the officers that the calls were made to Pakistan, lasted between 850 and 900 minutes, and amounted to approximately one thousand dollars in phone charges. He told the officers that the phones were installed in the name of a doctor, who had advised the investigator that he neither authorized the installation of the phone lines nor had knowledge of them. The investigator told the officers that he believed the calls were being made from the third floor office at 641 Broadway.

At approximately 10:00 a.m., the two officers accompanied the investigator into 641 Broadway. The officers went to the third floor office, where they were invited in by one of the four men who were working there. Those four individuals, who claimed to be employees of the office doing billing and other paperwork for various health clinics, denied knowledge of the calls to Pakistan. While the officers were speaking with the four employees, two additional Pakistani males entered the office. One was carrying a large red shopping bag. The other claimed to be manager of the office. When asked by the investigator about the calls to Pakistan, the manager acknowledged the calls and stated that he took care of the phone bills of the office.

While the officers were talking to the two men, the one carrying the shopping bag set it on the floor between him and the officers. At that moment, the officers saw a clear plastic bag sticking out of the shopping bag. The plastic bag contained a substantial number of test tubes that were filled with a red substance that was later determined to be human blood. The

officers also noticed that the office had no furniture aside from countertops, a few tables and a couple of chairs. The phones in question were plainly evident on the countertop in the small room. (See Exhibit 2 and Exhibit 3). It was evident that the "office" was hastily set up and was not equipped to treat or examine patients. (See Exhibit 4).

Located on the countertops near the phones were numerous 3" x 5" index cards with names and Medicaid numbers handwritten on them. (See Exhibit 5). Reams of computer forms consisting primarily of both blank and completed laboratory request forms for various clinical laboratories in New Jersey were stacked on the counters. Stacks of completed (i.e., name, address and Medicaid number filled in) laboratory request forms had been folded into quarters and banded together. On the counter next to the completed laboratory request forms were stacks of index cards, each of which contained a name and medicaid number of a medicaid recipient along with dates and an alphabetical designation of a laboratory.

Based upon the introduction of biohazardous material (unlabeled blood vials) transported in a shopping bag without refrigeration or protection against breakage into an office containing little more than stacks of blank and completed laboratory request forms and over 1,572 index cards containing the names and numbers of Medicaid recipients, the officers believed that the individuals were engaged in criminal activity.

Follow up investigation revealed that the four individuals had been employed to fill out forms by transferring information from index cards onto laboratory requisition forms. Specifically, they were hired to transcribe information contained on index cards to laboratory requisition forms, or claim forms. The information transferred was the name,

address and Medicaid number of each Medicaid recipient. The laboratory forms already contained the signature of a doctor. They were then instructed to mark the index cards with the date the claim form was filled out and the name of the clinic that was used to bill Medicaid.

Each laboratory requisition form requested a special panel of tests be conducted on the blood specimens. A panel is a packaged group of individual tests generally designed to test for specific illnesses. These panels were constructed to include all the most expensive tests the laboratory could bill for and not for any medical purpose. Each of these laboratory requisition forms were packaged with two vials of blood and sent to the laboratory for testing. The laboratory submitted a claim to Medicaid using the Medicaid recipient's number who appeared on the laboratory requisition form. Medicaid paid for each of these panels which cost between $300 and $720 each. The laboratory received payment from Medicaid and transferred approximately 90% of the Medicaid billing to a management company, United Clinical Laboratory. United Clinical Laboratory was owned and operated by Mohammad Akthar Javid. Mr. Javid was on parole from New York State after pleading guilty to two counts of Medicaid fraud and serving a prison sentence. Javid was "invisible" to the Medicaid agency since he was not a provider but a subcontractor to a provider, and did not apply for a provider number. He paid a $100 kickback to each of the clinic owners who referred blood specimens to United Diagnostic Laboratory. Investigation revealed that from September 6, 1995 through December 16, 1995, United Clinical Laboratory paid

$761,834.78 in kickbacks to "shell" corporations. As is often the case in law enforcement, an investigation of one crime leads to another. In this instance a complaint of theft of telephone services led to an assembly line of fraud. An audit of the entries on the 1,572 cards revealed 7,860 entries, each of which represented a claim.

An investigation conducted by the California Bureau of Medi-Cal Fraud illustrates the problems organized criminal groups as well as illegal distribution of beneficiary and provider number. In 1999, a laboratory was paid over $1.5 million when it submitted claims for laboratory tests that were purportedly run on Medi-Cal beneficiaries. The laboratory did not actually run any tests during the relevant time period. Instead of obtaining blood specimens and patient information referred from physicians, the laboratory bought only beneficiaries which were necessary for submitting these claims. After the lab received payment from Medi-Cal, persons acting in concert with the owners of the lab attempted to launder the Bureau of Medi-Cal checks through a California bank account as well as a check-cashing business in New Jersey. Law enforcement was able to seize $130,333.50 at the California bank and an additional $253,526.23 was seized in New Jersey by the New Jersey Attorney General's Office. The United States Postal Service assisted in recovering money by closing a post office box that was being used as a mail-drop. This allowed agents to seize an additional $83,996.49.

The Bureau of Medi-Cal Fraud discovered the owners of the above lab had at the same time taken over another lab in Huntington Beach, California. They did not re-license the laboratory in their names, yet they billed Medi-Cal and Medicare for services that were

not rendered. They stole physicians' identities and used those names as the referring physicians on laboratory requisition forms. This netted the defendants more than $392,000 from Medi-Cal and approximately $50,000 from Medicare. Confederates of these two defendants were able to cash $211,000 in Bureau of Medi-Cal checks at the check-cashing location in Jersey City, New Jersey.

These defendants, acting in concert with others, purchased yet another laboratory. Before the laboratory was operational, they submitted $638,610 in fraudulent claims to the Bureau of Medi-Cal. These claims were submitted by using stolen provider and beneficiary identification numbers. Several additional targets of these California investigations were previously identified as potential suspects in New Jersey laboratory investigations. The check-casher that was used to launder the Bureau of Medi-Cal checks also surfaced during New Jersey laboratory investigations.

The California Bureau of Medi-Cal Fraud investigations, described above, involved defendants and suspects not charged who had ties to New York and New Jersey laboratories or to defendants prosecuted in New York and New Jersey for laboratory fraud. In a second example, a different group of defendants obtained control over a laboratory in Los Angeles at the end of June 1998. These defendants had no known ties to New York or New Jersey. Medi-Cal billings increased dramatically in August. This laboratory closed in February 1999. Approximately the same time, these defendants obtained control over another laboratory in Los Angeles. The billings for this laboratory increased dramatically and the laboratory closed in July 1999. Both laboratories billed the Medi-Cal program for

approximately $2.5 million. The defendants were able to obtain this money by fraudulently creating claims for laboratory services with stolen beneficiary numbers. The Bureau of Medi-Cal Fraud identified approximately $500,000 in fraudulent billings. They contacted nine physicians who confirmed that their Medi-Cal provider identification number was used without their authorization as referring physicians on the laboratory requisitions. These fraudulent claims were paid through state warrants (checks). Some of these warrants were cashed at the same check-cashing location in New Jersey mentioned above.

The Florida Medicaid Fraud Control Unit investigated a case where the theft of beneficiary numbers was carried to a new level. A dispatcher for a transportation company in Palm Beach County had ready access to Medicaid beneficiary numbers from searching the files of her employer. Instead of merely selling the beneficiary numbers to other transportation providers, she forged trip-tickets using the beneficiary information from her files as well as known destinations, such as hospitals and doctor's offices. She sold them, often in bundles, to other transportation company owners. They submitted these at the end of the day along with their own and received payment from the Florida Medicaid program. This practice became so rampant that one of her best customer's billings increased to $3.9 million annually from $86,432 three years earlier. Overall, Medicaid transportation costs in Palm Beach County increased to $14.5 million a year from $4.4 million a year earlier.

CONCLUSION

It is clear that federal and state governments will spend hundreds of billions of dollars this year to fund the Medicare and Medicaid programs. It is equally evident that fraud committed against these programs deprives beneficiaries of tens of billions of dollars of services, medications and equipment that is necessary to treat illness and maintain a minimum quality of life. Organized criminal groups, whose sole purpose is to defraud the Medicare and Medicaid programs, operating throughout the country, pose a significant threat to the integrity of the Medicare and Medicaid programs and their ability to provide services sorely needed by the elderly, disabled and indigent in our society. Misuse of Medicare and Medicaid provider and beneficiary numbers contributes to the magnitude of this problem. Law enforcement has learned that those intent on defrauding the government health care programs will strike at targets of opportunity and frequently victimize both the Medicare or Medicaid program or shift their focus of fraud from one program to another when they come under scrutiny. This type of fraud presents a moving target and a challenge to both federal and state law enforcement authorities to protect the integrity of these vital programs.

Thank you very much for the opportunity to provide testimony.

Summary Chart

New Jersey Medical Assistance and Program Medicaid Payments to United Diagnostic Laboratories, Inc.

1995		Total for Month
January		$63,298.60
February		$72,555.78
March		$159,842.78
April		$164,500.42
May		$273,187.82
June		$561,630.69
July		$492,243.55
August		$586,116.19
September		$951,623.76
October		$1,662,205.41
November		$960,244.39
December		$0.00
	Total Paid:	**$5,947,449.39**

EXHIBIT 1

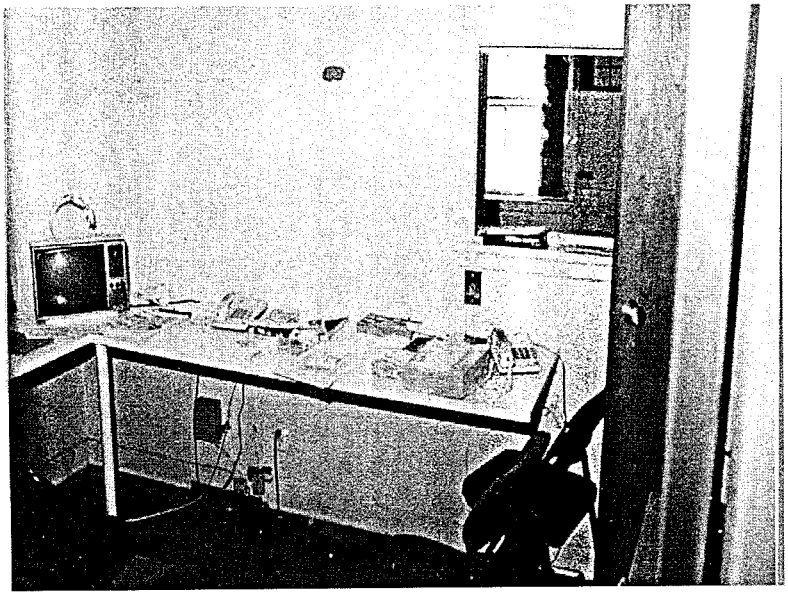


EXHIBIT 2

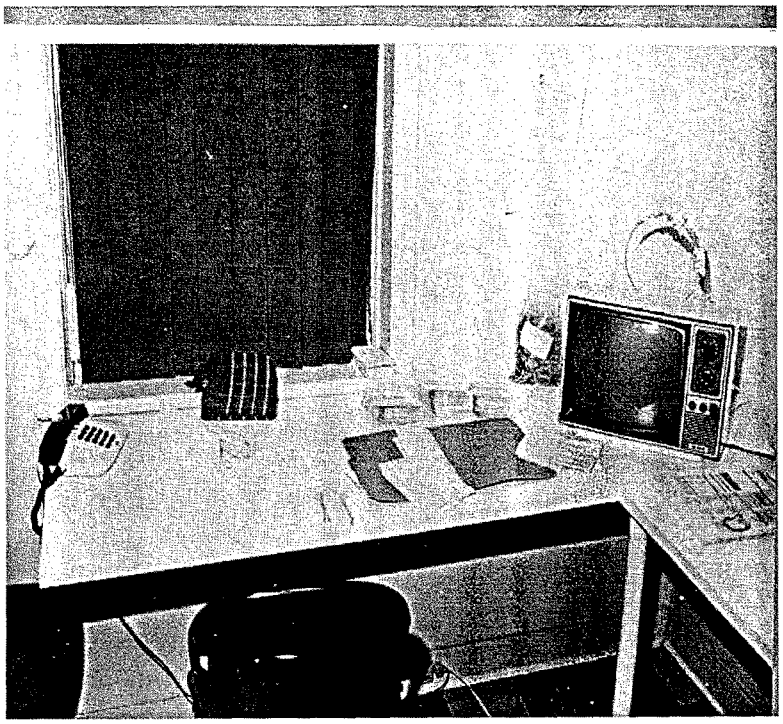
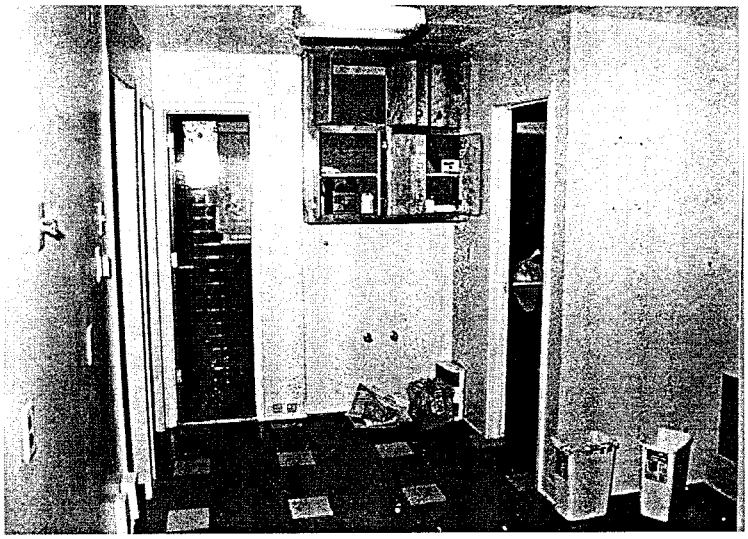


EXHIBIT 3



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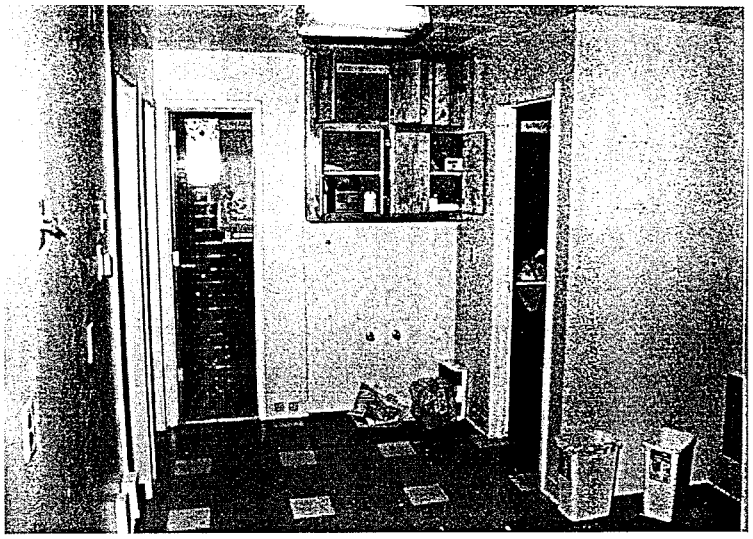

EXHIBIT 4

B J (F)

Med# 072090626801 DOB 03-14-61

10-19-95 UDL		
10-27-95- UDL		
11-07-95 (D) UDL.		
11-17-95 — B		
12.06.95 D UDL		
12-16-95 (A) UDL		

EXHIBIT 5

Mr. HORN. Well, thank you very much and the next witness, our last witness, will be introduced by the vice chairwoman, the gentlewoman from Illinois.

Mrs. BIGGERT. Thank you, Mr. Chairman. I am honored to introduce our next witness, Jonathan Lavin, who is coming to us from the great State of Illinois. Jon is currently the executive director of the Suburban Area Agency on Aging located in Oak Park, IL. I had asked Jon to testify before this subcommittee on the important role of Medicare beneficiaries in combating waste, fraud and abuse in the program, and I can think of no better individual to testify on this subject.

He has had extensive experience in this area. In 1998, his agency was awarded with one of the first Department of Health and Human Services grants to train seniors to identify fraudulent or abusive practices. As the subcommittee will hear, this project has been extremely successful.

I have worked with Jon on a number of important issues to Illinois' aging population; namely, long term care, and I know the many hours that he puts into his work. I am happy that he has taken time out from his busy schedule to be with us here today.

Thank you, Mr. Chairman.

Mr. HORN. Thank you, Mr. Lavin.

Mr. LAVIN. Thank you, Mr. Chairman; and thank you, Congresswoman Biggert. I am very honored and very pleased to be here this morning.

I think earlier we heard if the doctors and the durable medical equipment and the lab are all together, they can go ahead and perpetuate fraud and abuse situations. The missing element in that formula is the older person or the Medicare beneficiary.

Our role in the health care patrol programs, working across 43 States, is to make sure that older people understand their responsibilities and their rights and their investment in the Medicare and Medicaid systems. We hope to provide the information that is necessary for them to see if they are not receiving needed service, if they are having somebody ask them for a Medicare number where there is no necessity for that. We are looking to make sure that we bring back this program and the ownership of the program by the people it is meant to serve.

The Area Agency on Aging is 1 of 13 in Illinois and 1 of 655 in the Nation under the Older Americans Act, and one of the most important elements of the operation is to restore trust. One of the efforts to try to combat fraud and abuse in the Medicare programs is the fact that the Administration on Aging services and programs are part of the team in working on this issue.

We serve 130 communities in Cook County outside of the city of Chicago, and we have approximately 413,000 seniors in our region. Our project includes all of northeastern Illinois and serves not only our area but the city of Chicago and the collar counties. These include DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, and Will.

Our effort is to try to use older persons as peers to explain to other older people what jeopardy the Medicare programs face. We have recruited volunteers and trained them and have based our entire effort on the fact that this is an offensive and very upsetting

situation, to see a program meant and designed to provide essential medical care be misdirected for other types of activities.

I think one of the things that was said in the second panel was that often the billing payments and systems and the technical ways of trying to reduce costs cause desperation and possibly increase fraud and abuse, and I think it is an important piece to look at. We need to reimburse providers for the value of their services at the appropriate levels. When that doesn't occur, there can be people who take advantage. But there is also the fact, as we have clearly documented, a very small percentage of the providers have figured that there is money in "them thar hills", and Medicare is the name of it.

We present this message to seniors, and they very much understand the fact that they can't just sit here and let people move them around and give them services that may or may not be necessary or accept a milk shake in exchange for their Medicare number and that type of activity. They need to be very good consumers of care, and they need to look at their explanation of benefits to be sure that the services billed to Medicare are the ones received and the ones that are needed. They need to be careful not to accept a provision of a service by somebody when it is not from their own medical system, from their own doctor or hospital and from their own care providers under the Medicare system.

We have about 60 volunteers active in the program. We very much appreciate the fact that they are volunteering their time, and they are doing it because they share a sense of responsibility for the Medicare program and are very much wanting to see this program perpetuated and continued without this type of abuse and all of the necessary care being available.

Thank you, sir.

Mr. HORN. Thank you very much.

[The prepared statement of Mr. Lavin follows:]

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Testimony of

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Suburban Area Agency on Aging, Oak Park, Illinois

Before the

Subcommittee on Government Management, Information, and Technology

Committee on Government Reform

U.S. House of Representatives

The Role of Senior Citizens in the Effort to Protect the Medicaid and Medicare Programs

Prepared by Robert Noble and Jonathan Lavin

July 25, 2000

Room 2154 Rayburn House Office Building

Washington, D.C.

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The Role of Senior Citizens in the Effort to Protect the Medicare and Medicaid Programs from Fraud, Waste and Abuse

Good morning. My name is Jonathan Lavin, Executive Director of the Suburban Area Agency on Aging in Oak Park, IL. Thank you for the opportunity to discuss the contributions Older persons are making to the protection of Medicare an Medicaid from fraud, waste and abuse.

The Suburban Area Agency on Aging is a not-for-profit corporation which stands independent of the State Department of Aging, but which works in close coordination with that entity. It is one of 655 area agencies across the country sharing a mission mandated under the Older Americans Act. Under the designation of the Illinois Department on Aging, the Area Agency on Aging is intended to provide leadership on broad aging issues in the planning and service for suburban Cook County. We serve approximately 130 communities and nearly 415,000 older persons in this area.

We provide Older American Act and State Act on Aging funds to 39 community based senior service agencies which serve over 75,000 older persons (age 60 and over) and their care-givers. The services we support include congregate and home delivered meals, managed care choices, in-home care, information and assistance, legal assistance, nursing home ombudsman, senior community employment, housing assistance, disease prevention, health promotion, transportation, case management, senior center, elder abuse and neglect interventions, and other important direct services for older persons. All services are provided through community senior service agencies that are well known to older persons and have decades of success in reaching, understanding and helping them.

Our mission includes funding, planning, advocacy, coordination, information sharing, monitoring and evaluation, in order to develop or enhance a comprehensive and coordinated community based system of services in the planning and service area.

In 1998 we became one of the original twelve projects funded by the U. S. Department of Health

and Human Services' Administration on Aging to recruit and train retired individuals to reach out to older persons for help in identifying fraud, waste and abuse in the Medicare and Medicaid programs. In addition to federal funds, the donated time of our volunteers and the host sites for our presentations expand our program across the region. As part of the first grant from the Administration on Aging, we received funds from Blue Cross/Blue Shield for volunteer support and the preparation of a video on volunteer opportunities for retired professionals. The video is currently in production.

Our partners in this fraud and abuse program are the local senior services agencies throughout the metropolitan Chicago area. In addition working with the Illinois Department on Aging, we were able to tap the expertise of the Illinois Department of Insurance Senior Health Insurance Program,, the Office of Inspector General, the Illinois Attorney General's Office, the Office of Inspector General for the Department of Public Aid and the State Police. Both the Department on Aging Nursing Home Ombudsman Program and the sub-state Ombudsman that we support have worked with us on this issue.

Volunteers were recruited from all of Cook County and the Collar Counties (DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry and Will). The most effective outreach to volunteers was a response to a letter to the editor published by the Chicago Tribune. The author wrote that funds intended for care were being diverted to fraud schemes. We responded by saying that citizens can do more than be incensed about this issue, they can work with us to tell older persons what is happening in fraud and abuse by a very small number of abusive providers, and offer guidance to protect our Medicare and Medicaid systems.

The Area Agencies on Aging contracted with eleven host sites in the metropolitan Chicago area to organize presentations and supervise volunteers. Each host site is responsible for coordinating volunteer activity to provide at least two educational programs each week with various senior organizations, civic organizations and church groups. Volunteers also provide individual assistance to beneficiaries on specific issues and concerns identified after a

presentation that may be an inappropriate billing. The participating organizations are all current grantees to the Area Agencies on Aging under our Title III Older Americans Act programs. Older Americans Act funds are provided through appropriations to the Administration on Aging here in Washington, D.C. Those funds are allocated to the states and then to planning and service areas for distribution to the community senior service agencies. Along with other major providers of senior services, this is called the National Aging Network under the Older Americans Act. This network in northeastern Illinois was able to implement volunteer recruitment and presentations in a rapid and effective fashion because of the solid relationships with the communities they serve.

This Hearing will highlight how government health care programs have begun to attract a new, more sophisticated criminal and what actions may be taken through law to protect our elderly. I will describe how Older persons are making a real contribution to stopping schemes initiated by this new breed of criminal. Let me give you some examples of how they have contributed to the fight against health care fraud.

Diabetic Project

Diabetic testing supplies are becoming a major issue in the Mid-west, and across the country. It is very common to see firms offering to supply these items at little or no cost to Medicare and Medicaid enrollees. We began to suspect that this could lead to abuse of these programs, and even to fraud. In coordination with the States of Iowa and Wisconsin, we began to use a multi-tiered approach to addressing these concerns. First, we referred a number of situations to the Health Care Financing Administration's (HCFA) Durable Medical Equipment Regional Carriers (DMERC). These situations included practices such as sending more of a product to the customers than they requested or needed and obtaining prescriptions for items from a physician other than the customer's attending physician. There were complaints concerning fourteen separate companies. The DMERCs followed through with education of providers who were not billing appropriately and recovery of overpayments where called for.

We also began to educate seniors by making presentations at various training sites, through our newsletters and at health fairs. We linked up with the Diabetic Association and with various support groups for diabetics to assist us in our education work.

The health care investigators at the U. S. Attorney Offices were kept advised of any information that came to our volunteers, in order to ensure that they were up-to-date on situations that might cause a criminal investigation to be initiated. These investigators look for patterns of behavior which might mark fraudulent actions and the information we provided them was valuable in identifying these pattens.

Last, we began to work with HCFA, through the U. S. Administration on Aging, Department of Health and Human Services, to try to modify the manner in which this particular benefit is billed, in an effort to narrow the opportunities for national firms to commit fraud or abuse. This last effort is still going on, and may yield positive results in the future. We believe that there may be some investigations currently on-going by law enforcement, as well. Much of the education work as well as the identification of possibly fraudulent or abusive actions came through the efforts of seniors who got involved in this project.

Podiatric services

In suburban Chicago, a senior was seen by a podiatrist in a Senior Housing Center. She went to have her toe-nails trimmed. The podiatrist submitted a bill to Medicare for performing an incision and drainage procedure instead of the nail trim. The difference is that routine foot care such as trimming nails is not covered by Medicare. The incision and drainage is covered by the program.

It appeared that the podiatrist hoped the patient would not notice that there was a discrepancy in the services claimed versus the service rendered. However, the patient did notice and confronted the podiatrist about it. When she did not get a satisfactory answer from the physician, she called one of our Operation Restore Trust coordinators, and the information was

passed on to the Medicare contractor for review. It is still being looked into.

A New Diaper Scam

In another Senior Housing Center, a durable medical equipment (DME) supplier gave out adult diapers to residents. He collected Medicaid numbers and names in return, and then billed Medicaid for them, using a different description to be sure to get paid. The seniors were told they could use these so that when they took long driving trips they would not have to stop to use the toilet. This matter is under investigation at this time.

These three examples are only a small sample of the variety of schemes found in health care fraud. The GAO and the Department of Justice have estimated that as much as $1 out of every $10 spent on health care in this country actually is stolen through a fraud scheme. While it is not possible to determine how many health care providers have become involved in fraud, it is generally accepted that the number is quite small, when compared to the total number of people in the health care industry. The estimate is that 4% of the providers are responsible for the vast majority of the fraud. Most health care providers are honest, caring and supportive of their patients and assist in efforts to resolve problems in the system. No one wants to destroy the trust seniors have in the health care profession. What everyone wants is to root out the small number of "bad actors" and see that they are no longer able to steal from these programs.

Health care is a $1 trillion industry in this country. The largest part of it is funded by the Medicare and Medicaid programs, almost $460 billion in all. The amounts lost to thieves are simply mind boggling - as much as $100 million per year from all sources, if the estimated losses are close to accurate. It was with these numbers in mind that the Secretary of Health and Human Services decided to take some innovative action. When we began with our program, Medicare fraud and abuse was estimated at over $24 billion per year. We saw this estimate reduced to approximately $12 billion, but last year it edged up once again to $13 billion. This translates to almost $600 million in Illinois.

Operation Restore Trust and Harkin Grants

In 1995 the President appearing at the White House Conference on Aging directed the Secretary of the Department of Health and Human Services to launch an ambitious demonstration project called Operation Restore Trust. This project had a variety of goals, all focused on the central issue of protecting the Medicare and Medicaid programs from fraud and abuse. One of the most significant goals was to prove that more could be done to protect the Medicare and Medicaid programs from the incursions of criminals by the cooperative efforts of a broad spectrum of entities in federal, State and local government and in the private sector. The auditors, computer systems, law enforcement, accountants, FBI, inspector generals, HCFA, and other major payers and enforcers were organized to recover funds, prevent further losses and prosecute. One of the federal agencies included in this project was the Administration on Aging (AOA) whose role did not fit readily into this framework, but was one of the most important additions. AoA is responsible for reaching older persons to provide support and comfort through supportive and nutrition services. The addition of AoA represented the incorporation of older persons in the campaign to protect their Medicare and Medicaid programs.

Operation Restore Trust focused on fraud schemes targeted against the most vulnerable of the Medicare and Medicaid population; those who lived in nursing facilities; those who were suffering from a physically debilitating illness or injury; those who were home-bound due to illness or injury; or those who were terminally ill. Thus the project looked at nursing facility care, home health care, durable medical equipment sales and rental and hospice programs. The project examined these issues in five states; New York, Florida, Texas, California and Illinois, where more than one-third of all the program dollars spent in these benefit categories are paid out.

It was never the object of this project to make law enforcement agents of the older persons or their care-givers. They were trained on how to identify possible fraud and report it. More importantly, we delivered the message that seniors have a responsibility to preserve the

Medicare and Medicaid programs, which are so important to them. They were taught that without their vigilance, their names and their Medicare or Medicaid identification numbers could be used in a fraud scheme without their knowledge. Our mission was to help seniors become the eyes and ears of these programs in our neighborhoods. They were told they could have a positive impact by bringing the matter to the attention of the Office of Inspector General, the FBI, a Medicaid Fraud Control Unit or some other law enforcement agency for appropriate investigation.

According to the Secretary of the Department of Health and Human Services, approximately twenty-three dollars were returned to the federal government for each dollar spent during the two year duration of the demonstration project. Nationally more than $187 million was recovered in fines, penalties and restitution.

Beyond the dollars and cents, two other premises were proven to be sound: First, it was clear that broad collaboration and improved communication between government agencies, at all levels of government, made sense and paid dividends. Second, it showed that the inclusion of those people most directly affected by these fraud schemes; older persons who rely on Medicare and Medicaid for their health insurance coverage, are an effective bulwark against the efforts of thieves to steal from these important government programs. When the original Operation Restore Trust demonstration project ended in 1997, the Secretary of Health and Human Services decided to expand the concept beyond the original five states which were involved in the original project. Fourteen states were added, with the intent to gradually expand the concept across all states.

Operation Restore Trust led to the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) and the extension of the Fraud and Abuse programs across the country. These grants are awarded to establish "train the trainer" programs to prepare retired professional volunteers to go to venues where they can most effectively reach large numbers of older persons and educate them on the threat of fraud and abuse against government health

programs; how to identify and report possible fraud schemes; and, some steps they can take to protect themselves from those schemes.

We are one of 43 current programs funded by Harkin Grants, nationwide. Each of these grants works through a network of Seniors who are trained on how the Medicare program is being plundered, what the damages are, how to identify the signs of potential fraud, how to report their observations and how to train other seniors on these topics. In our program, one retired professional, Robert Noble volunteered. He had recently retired from the Office of Inspector General. We recruited him as the program officer for this grant The volunteers are able to "reach" older persons with a very understandable and compelling message on the necessity of protecting their Medicare and Medicaid programs.

There are two major impacts of our program: First, the reports of potential fraud referred to law enforcement are of a higher quality. The reporting individual provides direct information about the fraud they observed. The reporter has a better idea of what might really be fraud, and can frame the complaint in a more informative manner. This means there are fewer false alarms over billing errors or other innocuous issues. Second, the seniors who attend presentations given by our volunteers also learn simple common-sense ideas on how to protect themselves from being duped by someone trying to commit fraud. Seniors are empowered by this knowledge, and become better consumers.

Volunteers go to as many venues as possible to deliver their message. Senior housing sites, congregate meal sites, senior clubs, and Senior Centers are just a few of the places that presentations are made. The following chart identifies how many volunteers, presentations, and older persons we reached in the past year.

Performance Indicators

The results of this program of education and empowerment have been very significant. Again,

using figures provided by the Office of Inspector General, more than 6800 complaints have been submitted for follow-up. So far, more than $27 million in Medicare and Medicaid savings have been documented.

	Metropolitan Chicago
Senior Volunteers trained :	122
Seniors trained by trainers:	27,732
Media Events :	41
Presentations	536
Complaints Submitted	264
Complaints Determined for Follow-up	56

We know that we have submitted some good issues to law enforcement. Conversely, we understand that many false leads were resolved before they were sent on to law enforcement, saving time and effort on reports that would not bear fruit.

The Department of Health and Human Services maintains a Hotline - the HHS-TIPS line, which is used by seniors to make fraud referrals. This hotline was established in 1995. From its initiation until February 1999, more than 450,000 calls had been received. The hotline was overwhelmed by the volume of calls. To help relieve the pressure and to help increase the access of our seniors, we developed a "back-door" to the hot-line staff. We also started a dialogue with the Hot-line staff that allows us to be sure our seniors information gets timely and appropriate attention.

In our service area we have been very successful in reaching out to our senior population to deliver this important message. However, what we have done is not enough. We must continue to reach our senior population, but we must also begin expanding our audience to other people who interact with seniors on a regular basis.

Our 2000-2002 grant was recently approved. We will be targeting managers of senior housing units; care givers such as younger family members; employers of seniors who have chosen to continue to work instead of retiring; and employers of the care givers . We will continue to pursue partnerships with other agencies charged with protecting the rights and interests of seniors, and will encourage them to join us in disseminating this information. We will ask our volunteers to talk to Boards and Advisory Committees of Area Agencies throughout Illinois on our message and their role in helping to protect Medicare and Medicaid into the future. We will continue to reach the large, ethnically diverse community of Metropolitan Chicago.

One question remains. Can this simple message really work? Does reading Medicare summary notices help stop fraud? Let me give you one last example. I want to qualify this example, as it relates events that occurred before Operation Restore Trust was initiated, and before the out reach programs we now feel are so effective were put in place.

In a small southern community a chiropractor began approaching his patients with an unusual offer. He asked them to ignore any insurance statements they might get after visiting his office for treatment. In return, he offered to pay them one-third of all the money he got from their insurance companies. These companies included Medicare, Medicaid, and private insurers.

This soon became a cottage industry in this community. Dozens of people took advantage of the chiropractor's offer. It went on for more than two years. It was initially discovered by an alert Office of the Inspector General investigator.

Ultimately, more than 100 people were convicted or pled guilty to criminal charges. They included the chiropractor, his wife and three staff members. The rest were local citizens. More than $4 million was recovered in restitution, with additional fines totaling in the hundreds of thousands of dollars. Many of the people involved went to jail for one year or longer. In the case of the doctor it was much longer.

Stop and think how much that says about the effectiveness of having people read and pay attention to their Medicare statement. This was the single most important part of this scheme. If one person had heard our message, and had come forward, think how much money could have been saved, how many hours of investigative resources could have been conserved. Certainly we can't stifle all temptation, but if the members of this community had believed there was someone looking after these programs, it seems very likely that one or more of them would have responded to the doctor's overtures by reporting them to the appropriate authorities.

The whole key to this scheme's success was that the patients did not read their insurance payment notices. If that is true, then urging people to read those notices could become the single most potent tool that we have, outside of law enforcement, in preventing health care fraud.

Comments on H. R. 3461,

the "Medicare Fraud Prevention and Enforcement Act of 1999"

We are very pleased to support H. R. 3461. This Act contains provisions which give the government greater control and an earlier ability to prevent over access to the Medicare program by would-be providers of services. These controls make it much harder for unscrupulous entrepreneurs to obtain Medicare provider numbers. The proposed tools including background checks are appropriate to achieve these goals. We support the requirement that each new durable medical equipment (DME) provider receive a site visit from a HCFA employee upon application, if adequately funded.

The bill limits the ability of a person under investigation to hide behind the bankruptcy laws and prevent the government from obtaining restitution if successful in their efforts to prosecute criminal behavior.

There are a number of other provisions which will help to increase the protection of these very important programs including the regulation of billing agents..

One significant provision of the bill we support gives full law enforcement authority to the Inspector General for HHS. This recognizes the contributions of the Office of Inspector General and the potential for increased effectiveness by offering them the law enforcement tools and authority of other federal investigation agencies working on criminal matters.

Appreciation

The Suburban Area Agency on Aging has been pleased to participate in the AOA "Anti-Fraud, Waste and Abuse Community Volunteers Demonstration Project." We appreciate the assistance provided by Stasys Zukas, our program officer in the Regional office of the Combined Regions 5 and 7 of the AOA, and his able colleague, Fran Wersells; and, Jeanette Takamura, Assistant Secretary, Brian Lutz and Valerie Saroka from AOA headquarters in Washington, D. C. Our project also works closely with the Northeastern Illinois Area Agency on Aging, Charles Johnson, Executive Director; and the Chicago Department on Aging, Anna Willis, Commissioner and Mary Ann Cicero, Division Director. We are also grateful for the advice and expertise of the Illinois Department on Aging and Margo Schreiber, Director, Cheryl Sugent, Division Manager, and Jennifer Merck, Project Director, who have been our leaders in Operation Restore Trust since its inception in May, 1995.

I also want to thank Robert Noble, Project Director; Vicki Mikels, Director of Elder Rights; and Diane Slezak, Deputy Director for their work on this program and in developing this testimony.

Finally, let me again thank this Committee for the opportunity to appear to describe the important role seniors have in the fight against fraud, waste and abuse in the Medicare and Medicaid programs, to describe our efforts to make these projects work and to offer my opinion on this piece of legislation.

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Mr. HORN. We are now going to go to questions, and that will be 5 minutes for each of us, alternating between the majority and the minority. I would like to start with Mr. Hast and Mr. Hartwig.

Mr. Hartwig, in your chart B, what I would like to ask you—let's take that first case, 757 services in a 4-month period. Did the computer system indicate that fact or did you have to dig out each one of these cases one by one, Mr. Hartwig?

Mr. HARTWIG. These are beneficiary numbers that we identified were being sold or used for illegal purposes. And working with the HCFA contractor and HCFA, we stopped payment on all of the claims. This would have been—that was a computer edit. So if a claim came in under that beneficiary's number, that claim was not paid. So, those would have been the number of services that were billed under that beneficiary's number as recorded by the Medicare contractor.

Mr. HORN. Did the 757 come up by computer?

Mr. HARTWIG. Yes.

Mr. HORN. Have you got a computer sweep, which I know a lot of insurance companies do, where a person has had a particular type of operation, it is logical to have other things in relation to that, do you have such a situation?

Mr. HARTWIG. We, being the OIG, our auditors have some screens that they have used. The Health Care Financing Administration requires contractors to employ similar edits. The detail of those edits I am not that familiar with.

Mr. HORN. In the testimony on prepaid edits, they were begun on 40 patients?

Mr. HARTWIG. Yes.

Mr. HORN. Aren't there prepaid edits on every claim?

Mr. HARTWIG. When we were drawing the distinction, these prepaid edits denied every claim submitted under this beneficiary number.

Mr. HORN. How did you select the 40 patients?

Mr. HARTWIG. In an investigation we had determined that it appeared these beneficiaries, their numbers were being traded through interviews, through investigative technique, and just looking at the utilization of the providers that we were focusing our criminal investigation on, and we looked at the utilization rates of beneficiaries. Actually, there was a computer application that we had developed so we could trace the utilization of beneficiary numbers; and that is how we identified the first 40. That is how we identified the next 120 that some edit was put on, and I think it is going to be how we will identify future beneficiaries to be added.

I might add that one of the issues with using beneficiary numbers is that it removes a very important control from the health care system and that control—and it was mentioned by Mr. Lavin—is the beneficiary's role by either co-payment or by looking at what is being billed. They can obtain beneficiary numbers and just use them either by the beneficiary being mentally incompetent or by paying the beneficiary. It removes a very important cornerstone of the Medicare payment edit system.

Mr. HORN. On page 9 of your testimony you say a contractor turned off the automatic edits. Shouldn't there be a safeguard to prevent this?

Mr. HARTWIG. That was our investigation of contractors, and we did find that it was disturbing that contractors would turn off edits. And we have made recommendations that contractors should not be able to turn off and on edits. Again, that just removes one of the foundations of the integrity of the Medicare system.

Mr. HORN. Has that been changed so that they cannot turn off edits?

Mr. HARTWIG. I believe contractors can still turn off edits if they so desire.

Mr. HORN. Isn't that a real problem?

Mr. HARTWIG. We in the IG think it is.

Mr. HORN. How about it?

Ms. THOMPSON. We don't agree that it is a big problem. Clearly, we don't want Medicare contractors to turn off edits and to decide to just flush claims through the system. We do give contractors a great deal of flexibility, as private insurers on whom we are relying, to safeguard the claims, to introduce a number of different edits into the system. Those edits may change over time depending on the availability of resources.

There may be issues associated with particular situations, for example, where we have transitions from one contractor to another contractor serving providers, suppliers, or physicians in a particular community; and so there may need to be a turning off of edits and an implementing of a new set of edits.

Mr. HORN. Why would you have to turn off the edits? Isn't that just leaving it open to fraud?

Ms. THOMPSON. The question is whether or not you want to turn off one set of edits in favor of another or decide that one set of edits are not giving you as good a return. So the question is not whether you have edits but whether or not we give the contractor some flexibility to introduce new and, we hope, better edits.

Mr. HORN. So around the country in terms of the intermediaries, it is your office that decides whether the edits are continued or not?

Ms. THOMPSON. We ask the contractors to conduct an edit effectiveness assessment. Under that assessment, they look at the computer edits that they have working and decide whether or not those are—continue to be effective edits. As we have discussed here, lots of times problems move from one part of the program to another part of the program and you see different kinds of abuses. We want the private insurance companies that we are contracting with to process these claims to be able to adjust to that incoming information.

Mr. HORN. Mr. Hartwig, has the Office of Inspector General ever looked at that process where the Office of Program Integrity has the control over the edits and edits are changed? Presumably on a transition is what I have heard. What does the Deputy Inspector General think about that?

Mr. HARTWIG. We have looked at them, actually, in some of the criminal investigations, but our auditors are very active in looking at program edits and how they identify patterns of abuse.

Mr. HORN. Well, if there are state-of-art computer systems to track the beneficiary records and provider records immediately and when the claim was filed, wouldn't most of these schemes be

caught if we had a decent program here for intermediaries and everybody else?

Mr. HARTWIG. My experience with the criminal element is that they understand exactly what those radars are and what the edits are, and they are going to find ways to circumvent them. I don't know that there is a single computer edit that could be implemented that would totally take care of the problem of the Willie Suttons targeting the health care program. Our investigations many times reveal that the criminals are aware of what the edits are by having the claims rejected and then making every effort to ensure that claims resubmitted pass whatever edits the contractors have in place.

Mr. HORN. The gentleman from Texas, Mr. Turner, 7 minutes.

Mr. TURNER. Mr. Hartwig, I want to ask you about this grant of authority under section 10 of the bill which you referred to earlier in your testimony. Do I take it that this would be the first time that the Office of Inspector General has been granted the power to execute a search warrant or to make an arrest? Would this be the first time in law this has occurred?

Mr. HARTWIG. This is not the first time in statute. The Department of Defense has statutory law enforcement, and the Department of Agriculture has statutory law enforcement. Currently, all of the Offices of Inspectors General mentioned in the bill submitted to Congress, and currently the HHS Office of Inspector General, has the authority to make arrests and execute search warrants and has the authority to operate using law enforcement powers. That authority, however, emanates from the U.S. Marshals Service. So all of the agents—I am a Special Deputy U.S. Marshals with the ability to execute a search warrant and make an arrest—and I have had that authority now a little over a decade.

The question that we have is that is the most appropriate way for Inspectors General to execute those authorities a temporary administrative grant by the Marshals Service? We believe that it is more appropriate for the Congress of the United States to legislate that authority to give it more permanence—as you look at our investigations and the length of time—not just HHS, but all of the Inspectors General.

Mr. TURNER. So the Inspectors General at the Department of Defense and the Department of Agriculture already have this authority?

Mr. HARTWIG. They have statutory law enforcement authority, yes.

Mr. TURNER. What would be the reason that you have not received such authority in the past?

Mr. HARTWIG. I think that there are a number of reasons.

First of all, the Department of Justice is a very important player in this process, and they are not generally willing to give out law enforcement authority. And as it looks at the Offices of Inspectors General, our first deputation occurred in 1985 and over that time period IGs have made more and more extensive use of law enforcement authority. Over the years, those authorities have been expanded to where we now have blanket deputations for all 23 Inspectors General. And I think, having watched the Inspectors General in operation, the Department of Justice has agreed that it is

necessary—and the Office of Management and Budget has agreed that it is good government—and that is why the bill was submitted earlier this year, and that is why we support Congresswoman Biggert's efforts in this area.

Mr. TURNER. There is no expressed opposition to this provision?

Mr. HARTWIG. I cannot imagine anyone being opposed.

Mr. TURNER. Is there any other provision in the bill which has been objected to by any of your agencies or perhaps by the provider community in looking at this bill? Have there been concerns voiced regarding any sections of the bill?

Mr. HAST. Not that I am aware of.

Mr. HARTWIG. Not that I am aware of.

Ms. THOMPSON. We have provided some technical comments that I think really go to more drafting language.

The one thing that I would point out is that we believe that we have the authority to conduct site visits for any provider, supplier or physician at any time. As I mentioned in our testimony, we believe that the flexibility about where to deploy those resources, particularly based on new and emerging intelligence, is an important authority to retain.

One of the comments that we made to the staff in talking through some of the provisions of the bill was ensuring that it did not undermine our authority to go out and conduct a site visit if we believe that there is particular vulnerability in a particular area.

The other provision that I would mention which we do disagree with is the provision which would require or hold Medicare contractors liable for improper payments made to excluded providers. We don't consider that to be a major problem. In fact, we recently—and this is new information that is just coming from the Office of Inspector General—had an audit done of claims in 1997 and found a very minimal amount of such payments. We don't think that it is a serious issue. We believe that is more of a performance matter for us to take up with our contractors when such mistakes are made, as in any other kind of mistake where an improper payment is made for reasons that we believe should have been obvious and detectable to that contractor.

Mr. TURNER. Thank you, Ms. Thompson. I want to commend Mrs. Biggert on her work. This is a significant piece of legislation, and I commend her for bringing it forward to the committee.

Mr. HORN. I thank the gentleman for his comments. I agree with you.

We now yield to the gentlewoman from Illinois 7 minutes.

Mrs. BIGGERT. Thank you, Mr. Chairman and Mr. Turner.

That was the question of Ms. Thompson that I wanted to ask, because we certainly want to have everything out in the open and if there is any disagreement on what we should be doing.

I think probably that, with the site visits, that we certainly would welcome continued and any site visit, but I think in the bill is to make sure that any provider going into the business has the background check and a site visit. And I think we can—from what we have heard from the previous testimony when there was no check of any address, no check of the provider or the name but

really just companies rolling over with the same person, that certainly is fraught to having the fraud and abuse that takes place.

In my opening remarks, I alluded to the fact that GAO made a study to determine the extent to which criminals are accessing the Medicare program with the sole intent of defrauding it. And in this report you study cases in my home State of Illinois and North Carolina and Florida and found that there was substantial evidence of corruption which had corrupted a number of medical entities with the purpose of stealing from Medicare and Medicaid, and I think it is safe to say that this is not limited to those three States. Can you give us any estimate of how widespread this problem is?

Mr. HAST. I think the problem is nationwide. The larger the State, the more money that is being put into the programs, I think the more fraud that you are seeing. In addition to the States that we studied, New York, New Jersey, California have had very large problems with Medicare fraud. But I would say that it is in every State and in every region.

Mrs. BIGGERT. So it is something that is universal to our country?

Mr. HAST. Absolutely.

Mrs. BIGGERT. This is probably directed to Mr. Hast, Mr. Hartwig and Ms. Thompson. Can you provide this subcommittee with an estimate of how much of all suspected Medicare fraud and abuse is prosecuted and also an estimate of the sentences both in the length of jail time and financial penalties assessed?

Mr. HARTWIG. I don't know that I would dare give a percentage. I think Congress has granted us new authorities and new funding for health care fraud; and I think with that we have been able to identify and prosecute—not just the HHS, OIG and Health Care Financing Administration but the Department of Justice and the FBI, we have been able to identify and prosecute many more people today than we were in the past. I think we are seeing greater jail time, and I think some of that has to do with better education and better law enforcement. I think some of it has to do with the schemes are much larger today than they might have been 10 years ago.

So, I think with the new resources and with the new funding we are better able to identify health care defrauders and investigate them and better able to prosecute them. What percentage we reach, I would not—and there is some deterrence even if you don't reach them all.

Mrs. BIGGERT. Thank you.

Mr. Lavin, once your agency suspects and seniors might have reported to you that they suspect fraud or their bills are not matching up with what the services that they were provided are, where do you refer that case? Can you detail for us how many of your cases have been prosecuted or adjudicated?

Mr. LAVIN. When we receive a report from an older person, one of the first things that we do is make sure that it is not a normal process which might not be to the liking of the person but would be legal and correct under Medicare. So one of the outcomes of our program is to try to make sure that we don't send inappropriate situations to the Medicare agency.

But most of our referrals go through a process of looking at the carrier and seeing if the provider had made a mistake, going to the actual Medicare carrier as far as the payment process to see if there is a process that they have looked at and if this is under the appropriate rules and guidelines there. If those two steps don't resolve the problem, then we are able to use the HHS Medicare number and make referrals there.

One of the things that we did over the years in this project is be able to find direct contacts with HCFA and the people who operate that line to make sure that we can get those cases heard and understood earlier. We have had about 56 complaints that we have determined require followup.

All of these systems and processes, none of these things come easy. Once we have done our job, we get these over to the appropriate organizations; and they do the followup and the investigation. So we don't have any actual returns in terms of saying this case drew down this much money.

We see our purpose not in terms of recovery, it is in terms of making sure that people are cognizant of their responsibilities to keep an eye on Medicare and make sure what they are getting is appropriate and people are meeting their needs and nothing more.

Mrs. BIGGERT. By appropriate agencies, how do you determine what is the appropriate agency?

Mr. LAVIN. Most of the time we really do go through that process of, first of all, checking with the providers to see if it is a mistake and then going to the carrier, the ones responsible for payment; and they have investigations and processes to see if there is an inappropriate billing going to them.

Mrs. BIGGERT. Thank you.

Mr. Hast and Mr. Hartwig and Ms. Thompson, one of the provisions of the bill requires agencies that bill Medicare on behalf of the physicians or provider groups to register with the Health Care Financing Administration, and it also requires backup ground checks before a number is allocated. Do you think, No. 1, that this is a cumbersome process? Do you agree with it? Will it take too long for getting the numbers? I know even in criminal background checks the fingerprint is going to be done and searching the background takes times. To me, it is a very important component.

Ms. THOMPSON. I believe that there are ways that we can operationalize these requirements to make them work and work in a reasonable and businesslike way.

One of the things that I keep trying to emphasize—again, the vast majority of the legitimate and honest providers and suppliers and physicians who sometimes, and understandably so, balk at basically having to pay the price for the misdeeds of others. And it is true that they do in the sense that, to the extent that we have to go through more elaborate mechanisms because we cannot trust everything that everyone sends to us, the honest and legitimate and qualified providers and physicians and suppliers are paying a price for that protection.

But I agree completely with you that protection serves us all better; and to the extent that the program is strengthened for all of us and for, ultimately, the purposes for which it was created, I think that that also serves the interest. And I think they agree as

well, the vast majority of physicians and providers and suppliers. I think we can make things automated and focus on key information, that we can make the process work in a less cumbersome manner than people might be somewhat concerned about. So I feel confident that we can work out those details in a reasonable way.

Mrs. BIGGERT. Thank you.

Mr. HARTWIG. I agree. I think the cost and whatever inconvenience is outweighed by keeping providers who should not be in the program out of it. Once they are allowed in, catching and convicting them, that is the biggest inconvenience. Once you allow these people into the program and they are diverting money from the legitimate providers who have, I think, a right to have a program free from a lot of falsification and fraud. So, whatever delay might occur, I think it is well worth the benefit that—those provisions would give. Especially with billing agencies where we have found now toward the end of some criminal investigations, you find out there was a billing agency involved and that would be better known up front for a number of reasons.

Mr. HAST. I think the benefit far outweighs the inconvenience.

Mrs. BIGGERT. Thank you. Thank you, Mr. Chairman.

Mr. HORN. The gentleman from California, Mr. Ose, 7 minutes for questions.

Mr. OSE. I want to talk focus on section 5.

Ms. Thompson, are you responsible for the integrity of the program in terms of paying the claims that come in or identifying who is eligible for receipt of payment?

Ms. THOMPSON. I am responsible for coordinating our integrity initiatives. There are a great number of people who are involved in doing that.

Mr. OSE. Did I understand your testimony, that you had some questions or doubts about the provision that puts the burden on the contracting entity for any payments made to disqualified recipients?

Ms. THOMPSON. Yes.

Mr. OSE. Is there a list of entities whose past behavior has qualified them for being listed on the excluded list?

Ms. THOMPSON. Yes.

Mr. OSE. I am confused why it would be if we have a list of excluded entities that are—are contractors aware of the list? So they have a copy of the list of excluded entities?

Ms. THOMPSON. Yes.

Mr. OSE. I am unclear—if one of our contractors makes a payment to an excluded entity, I am unclear as to why HCFA wouldn't put the burden of covering that cost onto that contractor.

Ms. THOMPSON. Let me make a few points about it.

First, the list that they receive is not a data base. It is a WordPerfect file, and it doesn't contain all of the relevant information necessary to do that process correctly. That is a problem that we have been working on with the Office of Inspector General who sends us that list. We are developing that data base so it is much more easily matched against electronic files in order to prevent those kinds of payments.

I don't know that we have done all that we should be doing in order to give them all of the information that they need in order

to protect against those payments, and we are working on that problem.

Second, we had an Office of Inspector General report that involved an audit of 1997 claims and found only 12 excluded physicians to whom payments had been made and $30,000 in improper payments. So we don't think that it is a significant issue.

Third, our contractors are paid on a cost basis. We have a concern about their ability to deal with liability issues. I think that there would be some concern and I think it would be reasonably put on their part about whether or not they are going to begin to have liability for a whole range of payment errors. And there are payment errors. There are 1 billion claims and 1 million providers. Human error is going to work its way into the system, and there are going to be mistakes made. We consider that to be a performance issue. We renew the contracts on an annual basis, and we would prefer to deal with that as a performance issue.

Mr. OSE. So $30,000 in payments made to unqualified entities, you believe this legislation goes too far in putting the burden of such payments on our contractors?

Ms. THOMPSON. Yes.

Mr. OSE. Mr. Krayniak, you prosecuted some cases in New Jersey having to do with—it appears, and I tried to follow this through, but it appears to be California patients and checks being cashed in New Jersey and the transfer of information back and forth. What I am curious about is the individuals that you prosecuted, for instance, Sherani in one case and—I will find the others here in a moment—what were the sentences that were imposed on those folks?

Mr. KRAYNIAK. Mr. Javid was sentenced to 10 years in State prison and recently completed his sentence, and I believe on July 5 of this year he was deported. Mr. Sherani was sentenced to 1 year in county jail and 5 years probation, and he is still under probationary supervision.

Mr. OSE. He is a naturalized citizen?

Mr. KRAYNIAK. That is correct.

Mr. OSE. There were two other individuals.

Mr. HORN. Was that in a California prison or New Jersey prison?

Mr. KRAYNIAK. New Jersey prison.

Mr. OSE. Let me—something jumped off your testimony, and I can't tell you the page. You talked in your testimony about conduct that had occurred in New York that was, I guess, by Javid, and then the pressure—scrutiny became great enough from the Medicaid Fraud Control Unit in New York that the organization moved to New Jersey and continued to conduct its affairs there?

Mr. KRAYNIAK. That is correct.

Mr. OSE. Was there any interaction between the New York and New Jersey Medicaid Fraud Control Units?

Mr. KRAYNIAK. Yes. Once we saw that our laboratory billings were escalating very rapidly, we conducted a number of investigative steps. We discovered that some of the laboratories had very recently opened in New Jersey, and doing background checks led us to New York, and the first step would be the New York Medicaid Fraud Control Unit. Once we became aware of their investigation, which spanned several years and sent a number of people to pris-

on, we focused more on the people that they identified both as suspects and ancillary targets. That is how we came up with, for instance, Mr. Javid. He had been convicted twice of Medicaid fraud in New York, and he was on parole when he committed the offenses in New Jersey.

Mr. OSE. Let me go on. I am curious. You are a State Attorney General?

Mr. KRAYNIAK. That is correct.

Mr. OSE. Before I forget, I want to recommend that you call the U.S. attorney in Sacramento, a fellow named Paul Saeve, and offer to share with him your experiences. Because he has a number of cases going on in Los Angeles of this nature, and I just want to make sure that he has got every resource possible.

In terms of the cases you cite in your testimony, for instance with Sherani, the defendant was convicted of conspiracy, Medicaid fraud, theft by deception and financial facilitation of criminal activity, which most of us would identify as money laundering. He was convicted and he was sentenced to what?

Mr. KRAYNIAK. One year in the county jail in New Jersey.

Mr. OSE. If I recall correctly, the fraud that he perpetrated was about $130,000?

Mr. KRAYNIAK. He was convicted of $74,500 of fraud. In New Jersey, under the statute that we prosecuted at that time, the cutoff for a presumptive prison sentence was $75,000. The witness that was necessary to add that additional money fled to Pakistan days before he was scheduled to testify, even though we had obtained a material witness order for him from a New York court.

Mr. OSE. How much activity does the U.S. attorney take in these cases?

Mr. KRAYNIAK. It depends. We prosecute the Medicaid fraud. We work with the local U.S. attorney's office in New Jersey and keep them apprised of what we are doing. What we have found is if we can identify a fraud pattern very early, we would institute administrative action as well as criminal action. We have seen when we shut down the Medicaid paying operation some of these laboratories simply start billing Medicare, and that is why we notify the U.S. attorney's office, so they can bring the Federal authorities in and commence, really, a concurrent investigation.

Mr. OSE. Ms. Thompson, you indicated that you are not law enforcement and not investigative but when you find something interesting, you make referrals. Those go to the U.S. attorney?

Ms. THOMPSON. Those referrals go to the Office of Inspector General.

Mr. OSE. And you all figure out whether they are criminal or not?

Mr. HARTWIG. Yes. We would make the referral to the U.S. attorney's office.

Mr. OSE. How many cases do you refer?

Ms. THOMPSON. Last year, a little over 1,000.

Mr. OSE. How many do you refer?

Mr. HARTWIG. Probably around the same amount. We have approximately 2,000 open health care investigations.

Mr. OSE. Mr. Chairman, Mrs. Biggert has astutely included a number of thresholds for qualifying providers within her bill, site

visits, criminal checks and the like. I am curious—I always like to introduce money into the equation. People pay attention to money. But there is nothing in here about bonding the provider—in other words, having a third-party who actually puts their financial wherewithal on the line to validate the performance of somebody. Can you comment on that?

Ms. THOMPSON. There are provisions included in the Balanced Budget Amendment that provided authority for requiring bonds for certain kinds of suppliers—durable medical equipment, home health, community mental health centers and companies of outpatient rehab facilities, I believe.

Mr. OSE. Have you seen any related reduction in problems within those areas?

Ms. THOMPSON. We issued a final—interim final regulation. There was a great deal of concern about that, particularly with regard to home health agencies and the impact on access particularly in some rural areas for home health agencies that were not able to obtain bonds.

We also had included a provision because the law states that we shall impose a minimum of $50,000 bond. We had actually used that, what we thought was flexibility, to require that the bond be at least $50,000 or 15 percent of annual billings so that it would trail more with the financial exposure of the Medicare program.

Again, that raised lots of concerns, and there were a couple of different hearings on that issue. There was a GAO report commissioned to discuss how we had implemented those provisions of the bond requirements; and, ultimately, the General Accounting Office, while supporting the idea of a bond, thought that the $50,000 level would provide sufficient protection.

Mr. OSE. The question that comes to mind is that, on your testimony on page 5 directly related to durable medical equipment, the suggestion is that the more thresholds that were imposed for sites visits or licensing or what have you there is a direct correlation to a reduction in the fraud.

The issue that I have—frankly, Mr. Horn, I am not suggesting this, but I want to draw an example. If I am a bonding agency and you are a provider and Ms. Thompson wants—you want to qualify for Ms. Thompson's programs and you want to satisfy Ms. Thompson that there are certain financial obligations that we are going to cover our backside on and you come to me and ask me for a bond, I am going to charge you 1 or 2 or 3 percent, but I am going to make sure that you have the collateral to pay me back in civil court if there is ever a claim on the bonds.

I understand the issue on home health service agencies and the like, where margins might be very thin and the like, but having that third-party involvement as we do in, say, contracting for the construction of a building, having that third-party involvement, I can tell you that having their oversight is a very, very influential element to this. If I were to make one suggestion, it would be that perhaps we need to examine that very closely.

I yield back the balance of my time.

Mr. HORN. I am going to have the gentlewoman from Illinois round it out as soon as I ask a few questions here.

Let me ask Mr. Hast, do you support granting full law enforcement authority to the Health and Human Service Inspector General in terms of criminal investigators? What is the reaction of the General Accounting Office on that?

Mr. HAST. I would like to say that the General Accounting Office has not done work in that area, but after 20 years in law enforcement and being retired from the Secret Service, I certainly would endorse full law enforcement authority to the IG.

Mr. HORN. Do you support statutory law enforcement powers to the other Presidential appointees to the Office of Inspector General?

Mr. HAST. Speaking for myself and from my 20 years experience in law enforcement, yes, I would.

Mr. HORN. I am sorry?

Mr. HAST. Yes, I absolutely would.

Mr. HORN. OK.

Ms. Thompson, do you also handle the Medicaid program as well as Medicare in terms of program integrity?

Ms. THOMPSON. We have a slightly different approach to that. I do have overall coordination responsibility, but we have also designated our southern consortium as a region dealing with the States as the lead for our fraud and abuse initiative in Medicaid.

Mr. HORN. Thirty years ago, when I was involved with civil rights across the board in the executive branch, it seems to me in a lot of these areas if we have a check system we ought to send that software throughout the group that you are responsible for. Now, does Medicare do that, provide the software, or does everybody have to figure out their own system? It seems to me that it ought to be one national system.

Ms. THOMPSON. For the Medicare contractor community, we do have some standardized editing processes. Some exist in our systems, and some exist where we have gone out and purchased off-the-shelf software that was privately available and required our contractors to use that. As I mentioned before, then we also ask our contractors to invest their own resources in devising editing systems and software and approaches that might be useful in their particular area with problems that they are seeing.

We recently, I think you will be interested in knowing, held a technology conference on technology solutions to detecting fraud and addressing fraud. A number of people here today were present at that conference, and it was cosponsored with the Department of Justice and included both Medicare and Medicaid. And I think one of the things that we are trying to do is the sharing of experiences between those programs. I think Medicare has some lessons to offer Medicaid, and I think Medicaid and different States are trying different kinds of things and innovating and they are offering other things. So that exchange of information is something that we are very much trying to support and facilitate.

Mr. HORN. From your overview of the United States with these programs, do you think we have less fraud in Medicaid than we do in Medicare?

Ms. THOMPSON. It is a hard question to answer. I do think that there are different issues.

Mr. HORN. You have the States involved with Medicaid. They are not that involved with Medicare; is that correct?

Ms. THOMPSON. That is correct. I do think, because of the benefit package and because of the differences in population, sometimes the problems are slightly different. What we do find, though, and this is something as well that we have facilitated and coordinated when we share information at the State level and get the Medicare contractor and the Office of Inspector General and the Medicaid Fraud Control Unit and the Medicaid agency together, what people often find are problems with the same kinds of providers and maybe even, in many cases, the same exact providers.

So I think it is true if someone is out to defraud a program they are going to try as many settings as they possibly can, and they frequently might try to do something in Medicare as well as Medicaid.

Mr. HORN. In terms of resources in this area, did the General Accounting Office take a look at that with, say, the Inspectors General? Are we hiring more people to relate to this situation and try to get at the fraud? Are you stabilized or losing slots, if you will?

Mr. HARTWIG. In 1996, Congress passed some legislation that granted a stable funding source for the Office of Inspector General, the Department of Justice, FBI and HCFA's integrity issues and expanded some of our authorities. I am happy to report that the Office of Inspector General, at least on the investigative side, has almost doubled since 1996. We are looking to continue to expand. The legislation does come up for some review I think within the next year or two. I think that the OIG has expanded its efforts, not just on the audit and evaluation side, but certainly on the investigation side. We have increased offices. We have more agents on the street. We work very cooperatively with other law enforcement offices, and I think we are doing more today based largely on Congress passing that piece of legislation.

Mr. HORN. I asked the two witnesses on panel two if they had any thoughts when they heard from panel three in the Q and A. Do the gentlemen have any thoughts you would like to add? If so, join us at the table.

I just say, when you are expanding your Inspector General group, you might want to think about the members on panel two. I would think with that experience they would be able to stop a lot of fraud. I found that was true when I ran a university. You sometimes need to get people who know the inside.

My last question is to Mr. Lavin. What are the common-sense techniques that senior citizens can use to identify health care fraud?

Mr. LAVIN. One of the major things is to never accept a free service from somebody you don't know. Be sure that you don't let out your Medicare card number to anybody. It is kind of like a charge card. Giving out that number is not a smart idea.

Be sure that you check your explanation of Medicare benefits and do a good job of seeing if the services billed are the ones that you actually received.

I think, in general, just be a good consumer of services. Make sure that you are getting only what you need and make sure that

it is the services that will help you; and if you have a problem with that, try to pursue it through the normal processes.

Mr. HORN. I thank you for that. I think that is very helpful. I know many hospitals have put in decent billing that is actually translatable into English in particular so one can read what has happened there, and we have learned a lot from that situation.

I now ask my colleague and the vice chair if she would like to close it out with some questions.

Mrs. BIGGERT. Thank you, Mr. Chairman.

Just to go back to section 5, I know that—and ask a question of Mr. Hartwig. Ms. Thompson testified that there was some fear that carriers would potentially drive—be driven out of the program with that liability. I think that the reason for putting this in was the fact that, by making these Medicare contractors liable for erroneous payments, they would be encouraged to assert greater due diligence in making sure that they were reviewing the provider applications and paying the claims. My question is, do you agree that this section is not necessary or that it does help?

Mr. HARTWIG. I think the Office of Inspector General has been very supportive of that provision, and we have had a number of investigations involving contractor integrity. I think it is important that we would hold, or I think the bill would hold, contractors liable for only those exclusions that they are aware of.

We believe that keeping bad providers out of the program is important, and excluding providers once you find out that they are bad is just as important. We think making carriers liable—and they are only liable if they pay; there is no penalty if they don't pay any of the claims—would help in keeping this important program integrity system in place.

Mrs. BIGGERT. Thank you.

One other question that came up about the bonding. I know for bonding with a notary public you have to have the bonding. Do you think that this would be a component that would help this bill to do away with the fraud, waste and abuse or is it a necessary component? Or not? Any reaction?

Ms. THOMPSON. I believe there is already statutory authority for bonding for the particular areas that you might be most interested in. We can have more discussions about that with your staff and our experiences of implementing those provisions and see if there is additional legislation which is necessary.

Mr. HARTWIG. We have been a strong supporter of provider bonding of Medicare providers as well.

Mrs. BIGGERT. Thank you. I would like to thank the panel and all of the witnesses today. We appreciate what you have had to say, and I am glad that most of you support the bill. Thank you, Mr. Chairman.

Mr. HORN. We thank you for helping on the witnesses.

This has been one of our most enlightening and, I might add, disheartening hearings. This year, obviously, we have had a lot of fraud committed in Medicare and some in Medicaid. And although fighting fraud is progress, and progress has been made over the last few years, there remains a lot of opportunities to drain the Medicare system.

Hopefully, Mrs. Biggert's bill and Senator Collins' bill in the Senate will plug some of those gaps that are allowing billions of dollars to flow from the system into the hands of those who illegally profit at the expense of Medicare beneficiaries and, more important and equally important, the average American taxpayer.

The staff that helped on this particular hearing was chaired by J. Russell George, the director and chief counsel for the subcommittee. Randy Kaplan is to your right, my left, the counsel for this hearing. And Jim Brown, legislative assistant to Congresswoman Biggert, has been very helpful. Also, Bonnie Heald, director of communications for the subcommittee; Bryan Sisk, clerk; Elizabeth Seong, staff assistant; Will Ackerly, intern; and Davidson Hulfish, intern.

The minority staff is Trey Henderson, counsel, and Jean Gosa, minority clerk.

And a help to all of us and deep appreciation goes to Doreen Dotzler, the official reporter of debates for this hearing.

We thank all of you as witnesses. If you have some ideas headed back to where you have got your business or other things, that you would write us a note; and we will keep the record open for a couple of weeks. And anybody in the audience that wants to give us a suggestion, we would welcome those, too. Just write us within the next few weeks.

With that, we are adjourning.

[Whereupon, at 12:33 p.m., the subcommittee was adjourned.]

[Additional information submitted the hearing record follows:]

SUBURBAN AREA AGENCY ON Aging

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July 28, 2000

Honorable Steve Horn
Chairman, Subcommittee on Government
Management, Information and Technology
B-373 Rayburn Office Building
Washington, D.C.

Dear Congressman Horn,

Thank you for the great honor to testify before your Subcommittee on Government Management, Information and Technology on Tuesday, July 25. I would like to provide additional information to my testimony before the record of the hearing is closed.

In response to Congresswoman Biggert's question on the success of our program in reporting fraud and abuse, I verbally emphasized the public information aspects of our service, but I do want to clarify that we understand that three cases reported through our program provided a return of $146,370 to the Medicare system.

In response to your question at the end of the hearing on how older persons may protect their Medicare Program, I am submitting our brochure that elaborates on preventative steps older persons may take to detect and avoid fraud and abuse in their Medicare services and billings.

Again, thank you for inviting me to this important hearing. We are very proud of Congresswoman Biggert and are pleased that she is providing leadership on this issue. We look forward to the enactment of H.R. .

Sincerely,

Jonathan Lavin
Executive Director

cc: Honorable Judy Biggert, Honorable Doug Ose, Honorable Jim Turner, Randy Kaplan

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You Pay!

Protect Your Benefits

Report Health Care Fraud, Waste and Abuse. Every Report Counts!

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Kankakee, Illinois 60901
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City of Chicago Department on Aging

510 Peshtigo Court
Chicago, Illinois 60611
312/744-4016

How Do I Report Suspicious Activities?

For Suburban Chicago and the Collar Counties, contact:

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OR

Office of Inspector General's Fraud Tips Hotline

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To request a volunteer Medicare/ Medicaid anti-fraud presentation, contact your local Volunteer Host Site at:

OR
Suburban Area Agency on Aging
1-800-699-9043

This project is supported by a grant from the Administration on Aging, Department of Health and Human Services. The Illinois Department on Aging supports the Area Agencies on Aging on this project.

Health Care Medicare and Medicaid Fraud

Who Pays?

How Much Money is Lost to Health Care Fraud?

$1 out of every $10 spent on Medicare and Medicaid, according to experts, is lost to fraud and abuse! That is a loss of $56,000 every minute! In Illinois alone, 1.3 billion dollars are lost or stolen every year! Recent studies have shown that health care fraud is becoming more lucrative than drug dealing.

Why Should I Care?

Medicare and Medicaid fraud costs you money. Your tax dollars are paying the health care cheats. As a Medicare beneficiary, you may experience higher cost in the form of increased premiums, co-payments and deductibles. Loss due to fraud also prevents Medicare from offering more covered services.

Where Are These Crimes Most Common?

- Home Health Care
- Durable Medical Equipment
- Pharmacies
- Nursing Homes

What Can I Do?

Never give your Medicare/Medicaid number over the telephone or to people you do not know. Treat your Medicare/Medicaid card as you would your credit card.

Never allow anyone to convince you to contact your physician requesting a service which you do not need.

Never accept Medicare/Medicaid services that are represented to you as being free. If the services are truly "free," they do not need your Medicare number.

Never accept medical supplies or equipment from a door-to-door sales person.

Never allow anyone to review your medical records or your prescription medications without your physician's approval.

Never accept an offer for free medical equipment. Remember, only your physician can order medical equipment for you.

Beware of providers who present themselves as being part of Medicare, the Health Care Financing Administration, the Department of Health and Human Services, or any branch of the Federal Government. Neither the Federal Government nor Medicare endorses the products or services of any individual provider.

Beware of a provider who uses pressure or scare tactics to sell you a high priced medical service without giving you the opportunity for a second opinion.

Always review your Explanation of Medicare/Medicaid Benefits (EOMB) or Medicare Summary Notices (MSN) to ensure they properly reflect services that you received.

Always keep a record of your health care appointments and the services you received so you can compare them to your statements.

Always report suspicious activities.

PRESIDENT'S COUNCIL on INTEGRITY & EFFICIENCY

August 3, 2000

The Honorable Stephen Horn, Chairman
Subcommittee on Government Management,
Information and Technology
Committee on Government Reform
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

On behalf of the President's Council on Integrity and Efficiency (PCIE), I would like to thank you for your Subcommittee's consideration of statutory law enforcement legislation as part of your Medicare fraud hearing, held on July 25 2000. At the close of the hearing, you graciously offered to accept additional comments regarding the testimony and issues presented. As the PCIE Vice Chair, I am writing in support of proposed legislation granting statutory law enforcement authority to designated Offices of Inspector General (OIGs).

In order to carry out our responsibilities with efficiency, continuity, and independence, the OIGs need a permanent, not conditional, grant of law enforcement authority. The Administration's legislative proposal to Congress would amend the Inspector General Act to authorize duly trained and qualified criminal investigators in the offices of 23 presidentially-appointed Inspectors General currently operating under blanket deputation authority to exercise law enforcement powers. These powers include the authority to seek and execute search and arrest warrants, make an arrest without a warrant for offenses committed in their presence and to carry a firearm in the course of their official duties. This proposal would replace the current system of blanket deputation with a statutory grant of authority. The Department of Justice has recently expressed serious reservations about whether the current deputation process is an appropriate vehicle to confer law enforcement authority upon a wide array of OIG criminal investigators across government. A grant of permanent statutory law enforcement authority would avoid any possible interruption in our pending investigative work.

Granting statutory law enforcement authority would represent a crucial step toward ensuring the continued impact and effectiveness of the OIGs. For many years, the Inspector General community has successfully and responsibly exercised law enforcement authorities in carrying out our statutory responsibilities to investigate fraud, waste and abuse in agency programs and operations. In so doing, the OIGs have achieved an impressive record of professional conduct. As the role of the Inspectors General continues to evolve, and the nature of our investigations becomes increasingly complex, the OIGs need a reliable enforcement mechanism. The proposed legislation would offer such a mechanism to qualifying OIGs.

As you and your colleagues consider this vital piece of legislation, we would like to highlight three significant points. First, the OIGs would not receive any additional or new authorities as a result of this legislation. The long-standing authority under blanket deputation would merely be codified. Second, only those 23 OIGs who currently have met the Department of Justice requirements and operate under a blanket deputation authority would be granted the permanent authority. Finally, by appropriately conferring all responsibility for law enforcement authorities in the Inspectors General, this legislation promises more accountability as the OIGs would be subject to peer review and enhanced oversight by the Attorney General.

Again, thank you for your consideration and the opportunity to express our support for this legislation. Granting statutory law enforcement authority would further strengthen the ability of the OIGs to protect and preserve the integrity of Federal programs. If you have any questions or would like to arrange for a briefing to discuss these comments in further detail, please contact me at (202) 416-2026.

Sincerely,

Gaston L. Gianni, Jr.
Vice Chair

cc: Subcommittee Members

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