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MEDICARE FRAUD PREVENTION AND ENFORCEMENT EFFORTS

HEARING

BEFORE THE

PERMANENT
SUBCOMMITTEE ON INVESTIGATIONS
OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

DECEMBER 9, 1998
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WEDNESDAY, DECEMBER 9, 1998

U.S. SENATE,
PERMANENT SUBCOMMITTEE ON INVESTIGATION,
OF THE COMMITTEE ON GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., at the Federal Courthouse, 219 South Dearborn Street, Room 2525, Chicago, Illinois, Hon. Susan Collins, Chairman of the Subcommittee, presiding.

Present: Senator Collins and Durbin.

OPENING STATEMENT OF SENATOR COLLINS

Senator COLLINS. Good morning. The Subcommittee will please come to order. Let me begin today by taking the opportunity to thank my colleague, Senator Dick Durbin, for inviting me to the beautiful, albeit, supposed to be windy City of Chicago, as the Permanent Subcommittee on Investigations continues its inquiry into fraud in the Medicare Program.

Senator Durbin and I have worked together on several initiatives to protect consumers from fraud. He traveled to my home State of Maine last February to attend a hearing this Subcommittee held regarding telephone billing fraud known as slamming. On the day of the hearing we did not have a crystal clear day like today. This is a typical Maine day, the weather you are having today.

However, that cold February day the weather changed from snow to rain to ice to sleet and back to snow throughout the day. And Senator Durbin's heroic efforts to participate in that hearing reminded me of the faithful postal carrier in that neither rain nor wind nor snow nor all three at once could deter him from attending that hearing. I appreciate his commitment to protecting consumers throughout the United States as well as his long time interest and concern about the subject of this hearing, Medicare fraud.

This is the third hearing that the Subcommittee has held examining waste, fraud and abuse in the Medicare Program. At our first hearing on June 26, 1997, we heard from a variety of witnesses including representatives from the General Accounting Office, the Inspectors General's Office, the FBI and the Health Care Financing Administration.

That hearing provided an overview of the problem and evaluated the extent to which waste, fraud and abuse affects the Medicare Program. We learned that the Medicare Trust Fund loses more than $20 billion per year. I want to repeat that—$20 billion a year

in improper payments, an astounding and completely unacceptable financial drain on the system.

As we in Congress struggle with how to restore the solvency of the Medicare Program and look at painful issues such as whether we should needs test part of Medicare, it is terrible that we're losing this kind of money each year to waste, fraud and abuse. Surely we should make sure that we stem that drain before we pursue other issues to restore solvency.

This loss undermines the fiscal integrity of Medicare and our ability to provide needed health care services to the 38 million Americans who rely on this vital program.

During our second hearing on January 29, 1998, we explored a dangerous trend in Medicare fraud. That is the increasing number of bogus providers who enter the system with the sole and explicit purpose of robbing it. One of our witnesses told us that he went into Medicare fraud because it was way easier than dealing drugs. He could make way more money at far less risk.

In another example, the Subcommittee investigators uncovered two physicians who submitted more than $690,000 in fraudulent Medicare claims after listing nothing more than a Brooklyn, New York laundromat as their office location. If anyone had done the least bit of checking, it would have been evident that this was completely bogus.

In another case revealed by the Subcommittee, over $6 million in Medicare funds were sent to durable medical equipment companies that provided no goods or services whatsoever. One of these companies even listed an absurd fictitious address—physical address—that had it existed would have been in the middle of the runway of the Miami International Airport.

Today's hearing is a continuation of the Subcommittee's efforts to fight waste, fraud and abuse in the Medicare Program. The most effective way to stop this attack on Medicare is to prevent the fraud in the first place instead of chasing after the money from the crooks long after the money is gone.

This hearing will focus on the successful fraud prevention and enforcement efforts in Illinois and the surrounding areas that have been undertaken by an impressive coalition of Federal and State agencies and private organizations during the past 3 years.

In highlighting these efforts, we hope to draw some lessons that may be useful in preventing Medicare fraud nationwide. As Congress and the administration work to maintain the solvency of the Medicare Program, we must be far more aggressive in curtailing the billions of dollars lost each year to waste, fraud, abuse and improper payments. Unfortunately, this task is not as easy as it sounds. There isn't a line item in the Federal budget entitled Medicare waste, fraud and abuse that we can simply strike and be done with it.

Fraud not only compromises the solvency of the Medicare Program, but also in some cases directly affects the quality of care delivered to older and disabled Americans. We have a solemn obligation to those Americans and to all of our Nation's taxpayers to protect Medicare. We must ensure the solvency of the Medicare Trust Fund so that it can continue to serve older and disabled Americans into the 21st Century.

We must guard against unscrupulous providers who give our seniors inferior or substandard health care. And we must protect the Nation's taxpayers from career criminals whose illegal schemes cost us millions of dollars each year.

Let me make this clear. The vast majority of health care professionals are dedicated and caring individuals whose top priority is the well being of their patients. They too are appalled by the unscrupulous providers and others who take advantage of weaknesses in the program to steal millions of dollars from the Medicare Trust Fund. Our goal is to bring about effective Medicare reform that will prevent such fraud in the future, allowing millions of Americans to continue to rely on this vital program's many capable, caring and conscientious health care providers.

Today we will hear about two successful demonstration projects designed to prevent fraud and abuse. The first program, Operation Restore Trust, was a demonstration project initiated by the Department of Health and Human Services in 1995. The goal of the ORT Program was not only to detect and punish fraud and abuse using traditional law enforcement techniques, but also to identify areas of vulnerability in order to stop fraud before it happens. This hearing will assist those of us in Congress in evaluating the effectiveness of this program.

The second project we will discuss today involves tapping the skills and the expertise of retired professionals who are beneficiaries themselves and ask them to help us in identifying and reporting waste, fraud and abuse in the program. In May 1997, the Administration on Aging at the direction of Congress awarded funds to 12 organizations around the country to recruit and train retired doctors, nurses, teachers, lawyers, accountants and other professionals to identify Medicare fraud and to conduct community education activities.

One of the entities that received support was the Suburban Area Agency on Aging in Oak Park, Illinois, an organization represented by one of our witnesses today. I look forward to hearing about the accomplishments of this innovative volunteer program operating here in Illinois.

Indeed, I look forward to hearing from all of our witnesses this morning as they describe their efforts to fight and prevent the kind of abuse that our previous hearings have uncovered. I realize that I opened the hearing without identifying myself. I'm used to being in either Maine or Washington. So perhaps I should do that more formally at this point.

I am Senator Susan Collins. I'm from the State of Maine, the great State of Maine, as we say. And I am the Chairman of the Permanent Subcommittee on Investigations. It is now my pleasure to yield to my friend and distinguished colleague, Senator Dick Durbin.

OPENING STATEMENT OF SENATOR DURBIN

Senator DURBIN. Thank you, Senator Collins. And I'm happy to welcome you to Chicago, having endured the horizontal rain storm in Maine when I visited for the hearing there. I can tell you that if you stick around here for a few more weeks, you may find the same thing in Chicago. Fortunately, today we have a wonderful,

beautiful day in a beautiful city known as the windy city, and it's always a debate topic as to whether that relates to the weather or the politicians, but whatever the origin of that phrase, we certainly love this town and the State that it's in. Thank you for joining us.

This Permanent Subcommittee on Investigations is a Subcommittee of great history, and one that has made a valuable contribution to the Nation over the years. Senator Collins, as the most recent Chair of this Subcommittee, has carried on that fine tradition. I can honestly tell you it is one of my best and most rewarding assignments as a U.S. Senator from Illinois, because Senator Collins has a special feeling about issues involving consumers and the need to make certain that we are fair and do everything in our power to give consumers a break. And whether it's Medicare and the seniors and their families who will lose from the cheats and the waste and the fraud, telephone slamming and cramming, an issue that came to my attention here in Chicago, and we have worked on together in Washington, or doing something to make sure that the food safety inspection system across America is the very best that it can be. This Subcommittee leads the way, and I am honored to be a Member of it. And I thank you for this important hearing today.

For the 38½ million Americans who rely on Medicare for their health protection, this is more than just another governmental program. This is literally a matter of life and death. It is a question of quality health care versus some of the budget constraints which we're all very aware of. If our debate in Washington goes as planned, for the next few months we will talk a great deal about the future of Social Security, and we should.

The fact is that Social Security untouched will be solvent and will pay out every year with a cost of living adjustment for at least three more decades. That doesn't mean that we should shirk our responsibility. We certainly ought to address even longer term solvency.

Medicare, on the other hand, is in a much more precarious position. Medicare untouched, by some estimates, may go bankrupt as soon as 2008. We continue to put money from our General Treasury into the Medicare system to try to keep costs under control. Congress is under pressure, and should be, to respond to this as quickly as possible.

None of us want to raise premiums. None of us want to cut back on services. But we have to face the reality. This hearing addresses what I consider to be the first and easiest place for us to visit to help Medicare. To go after some $23 billion in waste every single year, waste that affects every senior citizen. Waste that denies to seniors the basic and good quality medical care which they've come to expect. The kind of waste which defrauds taxpayers and is virtually intolerable.

The hearings that we've had in Washington have been a revelation. You can read about it in the newspaper, but when Senator Collins brings in a man who has been convicted of Medicare fraud who will not appear except behind a curtain and he testifies to us what he was able to get by with, it is just disgusting. To think that some rip-off artist would get into the Medicare system and literally abuse it by taking advantage of senior citizens and taxpayers. This

man is serving time in prison. I'm convinced that a lot of others should, too.

But make no mistake. As the Senator has said, the vast majority of providers are honest people. They're doing their very best. They worry about the bureaucracy of the forms and all of the things that government tosses in their path. But they understand, I hope, that we have got to keep this system as good and effective as possible.

Some of the examples Senator Collins noted I'll never forget. To have a medical care provider provide an address to the Federal Government which even the most cursory examination of the telephone book or even a driver in Miami in this case would have told you was a total fictitious address, an address in the middle of the runway at Miami International Airport. To have addresses given that turn out to be laundromats, turn out to be drop boxes, and these are people who are literally billing the Medicare system thousands and millions of dollars a year for fictitious services and equipment.

We had a case where one so-called durable medical equipment company was providing diapers for incontinent nursing home patients. Each diaper cost 30 cents. They billed the Federal Government $8 for each one of them, referring to them as urinary collection devices. This is common and, unfortunately, it takes the money out of the system that needs to be put back in to help so many people.

Luckily, we've taken an initiative at the Federal level, Operation Restore Trust, which we are going to explore today, and just see how effective it's been. There's entirely too much fraud still in the system, but maybe we're moving in the right direction. And those who will testify and tell us about it will give us an indication of our success and what more we can do.

I happen to believe the first line of defense on Medicare fraud are seniors and their families. I understand that many elderly people under Medicare are not in a position because of a physical ailment or other problems to police the system for us, to read carefully every line item in their billing, but honestly, if they can and if their families can join them in this effort, it is the first line of defense. To look and find something preposterous that is being billed to the Federal Government and to say this just isn't right and it isn't fair and I'm going to tell somebody about it.

There's nothing, I think, more effective than to have seniors activated and mobilized to do just this. And we're going to hear testimony today about efforts to make that happen. I think that will go a long way.

Second, the Federal Government has to do a better job. To think that, as Senator Collins and I have seen, so many people are ripping off the system in such obvious ways without the kind of surveillance that's necessary really calls for new legislation. And Senator Collins and I are working on a bill which will bring basic accountability and auditing procedures here to make certain that we catch up with those that are trying to cheat the system.

The basic message which I hope goes out today from this hearing in Chicago is that when it comes to cutting corners and cheating seniors and ripping off the Treasury, that is absolutely unacceptable. Whether it's Medicare or any other program, we are not going

to tolerate it. We hope that we can mobilize a bipartisan effort in the U.S. Senate, in Congress and across the Nation.

The President's announcement this week of further initiatives by the administration give us encouragement, but we have to make sure that we do our job by getting the facts straight, and that's what this hearing is all about.

I thank Senator Collins and all those in the audience for joining us today. I'm looking forward to it.

Senator COLLINS. Thank you, Senator. We will now hear from our panel of witnesses who will discuss their efforts to fight and prevent waste, fraud and abuse in the Medicare Program.

I'd ask that our witnesses come forward at this point. Our first witness is Dorothy Collins. She is Regional Administrator for the Health Care Financing Administration here in Chicago. Ms. Collins is responsible for monitoring the Medicare Program in Illinois and five surrounding States.

I would also note that I have an aunt with the same exact name, but we are not related in this case, but good name.

Our second witness is James Kopf. He is the Director of the Criminal Investigations Division of the Department of Health and Human Services, Office of Inspector General. Mr. Kopf has more than 20 years of Federal law enforcement experience. He served as the National Coordinator of Operation Restore Trust Demonstration Project during its first year.

Finally, we will hear from Barbara Coyle, who has very kindly agreed to step in this morning at the last moment to testify in place of John Grayson, who had been slated to testify before the Subcommittee today. Unfortunately, Mr. Grayson is ill and is unable to be with us this morning. We very much appreciate Ms. Coyle stepping into the breech and taking up the cause.

Ms. Coyle is from Evergreen Park, Illinois. She is a retired public health nurse. She volunteers with Catholic Charities, the South Suburban Senior Services, and with the Southwest Council in Aging for the Suburban Area Agency on Aging. She is accompanied by Jonathan Lavin, who is the Executive Director of the Suburban Area Agency on Aging, the Triple A, I think I'll call it from now on.

Again, we are very pleased to have you all with us. We have a rule at the Permanent Subcommittee on Investigations that requires us to swear in all of the witnesses. I want to tell you it's not that we doubt that any of you will do anything but tell us the truth, but it is part of our rule. So I'm going to ask that you all stand and raise your right hand so that I can swear you in.

(Witnesses sworn.)

Thank you. You may be seated. We will make your entire written testimony part of the hearing record. We're going to ask that you limit your oral testimony to no more than 15 minutes a person this morning. And we will start with Ms. Collins.

TESTIMONY OF DOROTHY COLLINS,[1] REGIONAL ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, CHICAGO, ILLINOIS

Ms. COLLINS. Good morning. Chairwoman Collins, Senator Durbin, thank you very much for inviting me here today to discuss Operation Restore Trust and our ongoing fight against fraud, waste and abuse.

Operation Restore Trust was launched by President Clinton in 1995 as a five-State demonstration project. It has rapidly become the way we do day-to-day business nationwide because of its overwhelming success.

Operation Restore Trust, along with the stable funding for program integrity work that was established in 1996, marks a turning point in our fight against fraud, waste and abuse. It has led to record levels of convictions, fines, restitutions and exclusions of unscrupulous providers.

It has shown us how to move faster and smarter. We are using what we learn broadly and aggressively. We are conducting more audits, more reviews and site visits than ever before.

Operation Restore Trust also helped generate broad support to close loopholes, raise standards, promote efficiencies and prevent problems in the first place.

Most importantly, Operation Restore Trust taught us how critically important it is to coordinate with all of our partners, from the FBI to the individual beneficiary. And it inspired us to work with our partners to develop a comprehensive program integrity plan. Together we are making fraud and abuse harder to accomplish, easier to see and less appealing to the unscrupulous.

Illinois was among the first Operation Restore Trust demonstration States. We brought together teams from the Health Care Financing Administration, the Office of the Inspector General and the Administration on Aging to target areas where we knew we had problems, home health agencies, nursing homes, hospices and durable medical equipment suppliers. We tackled these problems through several key elements of Operation Restore Trust.

We used statistical methods to identify potential problems. We cooperated through inter-disciplinary teams to review questionable providers. We coordinated investigations with law enforcement to assure coordination at all relevant levels of investigation. We empowered aging organizations, ombudsmen and individual beneficiaries and health care workers, by training them to detect and report potential problems. And we looked for efficiency. For example, by using State survey officials who already monitor care for quality, to also look for questionable billing practices.

In Illinois, one of our first projects focused on 20 home health agencies. We used statistical analysis to draw up a list of agencies that had aberrant billing patterns. We coordinated our plans with our law enforcement partners who had separate investigations underway. We trained State registered nurse surveyors who conduct home health agency quality reviews to spot program integrity problems and had them conduct surveys of the agencies on that list.

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[1] The prepared statement of Ms. Collins appears in the Appendix on page 31.

The State surveyors also, and importantly, visited individual beneficiaries at home to ask about their care. They found that far too often services were overused, not medically necessary or not covered by Medicare. In some cases, the beneficiary was not even homebound. We then had our claims processing contractor review the State surveyors' findings. They determined that these 20 home health agencies had been improperly paid more than $777,000, which is now being recouped.

They also prevented further improper payment of another $570,000 to these agencies. All for an investment, in this particular project, of about $52,000.

Other Operation Restore Trust initiative in Illinois uncovered hospice billing for patients who were not terminally ill and there were other questionable practices. Several hospice cases have been referred to law enforcement for further action.

We also found durable medical equipment vendors billing for unnecessary and expensive supplies that were simply being stockpiled in nursing home storage rooms. One provider has been referred to the FBI and substantial overpayments are being recovered from other providers.

Overall, Operation Restore Trust has saved more than $200 million nationwide in its first 2 years through restitutions, fines, settlements and identified overpayments. Its expansion began as soon as its success became apparent.

In 1997, we began to incorporate Operation Restore Trust into our day-to-day business approach. We added community mental health centers' abuse of Medicare's partial hospitalization benefit to the Operation Restore Trust project list and found centers with no trained professionals providing no treatment of any kind or billing for therapies such as bingo. We now have a national initiative underway to stop these abuses. As the result of initiation of the community health center review in Illinois, a provider with 13 sites was found not to meet even the basic requirements and is now no longer a Medicare provider.

We also initiated special reviews of rehabilitation agencies, home health agencies and other types of providers in other States.

Also in 1997, we made significant improvements to Operation Restore Trust's special anti-fraud hotline, 1–800–HHS–TIPS, so that beneficiaries and health care workers with potential problems to report can get information quickly to the right people who will follow up.

Since this hotline started in June 1995, its operators have spoken to some 145,000 individuals regarding potential fraud, waste and abuse problems. In this region, we have received about 4,000 complaints through the hotline so far, which have led to almost $2 million in recoveries in about 350 cases and an additional 75 referrals to law enforcement for further criminal investigation.

In order to build on the lessons of Operation Restore Trust, the Health Care Financing Administration has developed a comprehensive program integrity plan which is nearing completion. We began last March by sponsoring an unprecedented National Conference on Fraud, Waste and Abuse. Groups of experts from private insurers, consumer advocates, health care provider groups, State health offi-

cials and law enforcement agencies shared successful techniques and explored new ideas.

Those discussions were synthesized and analyzed to determine the most effective approaches and most promising new ideas. The result is a comprehensive program integrity plan with several clear objectives, which all can be traced to lessons learned in Operation Restore Trust. These objectives are to increase the effectiveness of our medical review, to implement the Medicare Integrity Program, proactively address the new programs initiated in the Balanced Budget Act, promote provider integrity, prepare for the year 2000 computer issue and target known problem areas such as congregate care scams and the community mental health centers.

This plan also notes the legislative initiatives recently announced by the President to address fraud, waste and abuse in the Medicare Program.

In conclusion, Operation Restore Trust has led to unprecedented success and it has become the standard for our business operating procedures and practices. We greatly appreciate your interest and support for these efforts and we look forward to working with you as we continue to move forward, and I am happy to answer any questions you might have.

Senator COLLINS. Thank you, Ms. Collins. Mr. Kopf, would you please proceed.

TESTIMONY OF JAMES A. KOPF,[1] DIRECTOR, CRIMINAL INVESTIGATIONS DIVISION, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. KOPF. Thank you. Good morning, Madam Chairman, Senator Durbin. Thank you for inviting me to participate in this vital hearing.

I'm James A. Kopf, the Director of the Criminal Investigations Division in the Office of Inspector General at the U.S. Department of Health and Human Services. I'm here to tell you about some innovative practices we have developed in fighting fraud and abuse in Medicare and Medicaid. We've had noble successes, but we cannot let our guard down and be satisfied with today's successes in this area.

Let me share some insights about our experiences with the constantly escalating assaults on our programs. With annual expenditures of well over $300 billion, the Medicare and Medicaid Programs present a sizeable target to those who seek to unjustly enrich themselves at the taxpayers' expense.

In late fall of 1994, with resources shrinking, Health and Human Service Secretary Donna Shalala, asked the Inspector General, June Gibbs Brown, to develop a new approach that would enlist the resources of the various health and human services components to attack fraud and abuse in Medicare and Medicaid. It was decided to implement a coordinated effort involving the OIG, the Health Care Financing Administration and the Administration on Aging.

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[1] The prepared statement of Mr. Kopf appears in the Appendix on page 35.

Those three components of HHS served as a cornerstone to the department's new initiative and brought the department's many years of experience and expertise together in a concentrated effort.

In addition, we invited the Department of Justice, including the Federal Bureau of Investigation, the U.S. Attorneys Office, State and local agencies involved in fighting health care fraud and abuse to participate in this combined effort which became known as Operation Restore Trust. It was started in March 1995 and became a presidential initiative in May of that year.

The purpose of the initiative was three-fold. To coordinate all available resources in an effort to make a significant impact on health care fraud and abuse. To reach out and educate the public on the growing problem of the health care fraud schemes. And to demonstrate the combined effort would be the most cost efficient method of attacking this problem with results yielding a significant return on the dollars invested.

We focused our efforts on five key States and three high growth areas. The States were New York, Florida, Illinois, Texas and California. These States represented over one-third of all the beneficiaries and expenditures in the Medicare and Medicaid Program. The high growth areas were both health, nursing facilities and durable medical equipment.

Our audits, evaluations and investigations indicated that the home health industry had become the target for unscrupulous providers. Criminals had increased their profit margin five-fold in the 2 years preceding Operation Restore Trust. Nursing facilities also came under scrutiny not only for fraud and abuse, but also for the potential of quality of care and patient abuse issues. Durable medical equipment is traditionally a hotbed for those who want to steal from the government.

At the time, Medicare provider numbers, that are the authorized numbers used to bill the Medicare Program, were easily obtainable and no prior health care experience was required to go into the DME business. As was mentioned before, so profitable was this area that criminal elements in south Florida decided to leave a lucrative drug business and open up DME companies because, as you mentioned, it was more profitable and less risky.

After the first year of the project, hospice care was added as a high growth focus area based on our audits of the industry and indicated a potential for fraud and abuse. Project coordinators in each of the five States established work groups comprised of the agencies I mentioned earlier. The work groups determined project goals and objectives unique to each State and implemented innovative plans that made the best of all the available resources.

The States coordinated their efforts with the OIG, HCFA and AOA headquarters, which in turn shared the results in the States' efforts with the entire demonstration team. The result was a cohesive, concentrated attack on health care fraud. Members of the partnerships we formed are here today to tell you about the results of this initiative. Each will provide a unique perspective as to what they hope to see accomplished.

I am here to share information regarding some of the successful cases that flowed out of this project. First, during Operation Restore Trust, a scheme was uncovered involving incontinence sup-

plies provided to nursing home patients. Adult diapers are not items that a nursing facility can bill separately to Medicare. The cost of providing adult diapers is the responsibility of the nursing facility as part of its routine costs of providing care to patients.

Investigations revealed that unscrupulous providers convinced nursing home operators that they had found a legitimate way to bill Medicare for the diapers. In return for the names and the Medicare numbers of incontinent patients, these suppliers provided the nursing homes with an endless supply of adult diapers at no cost. The suppliers then billed Medicare as if the diapers were an item known as a female urinary collection device that Senator Durbin referred to earlier.

This device could be billed for $7 to $8 per item while the cost of purchasing the diaper was only 30 cents. The supplier billed Medicare as if the more expensive collection devices were being provided three times a day, 7 days a week. The cost to Medicare mounted at an incredible rate. The suppliers quickly recouped their overhead and began making money.

If I may, I'd like to show you. This is the adult diaper that sells for 30 cents. This is the actual device that was billed at $7 to $8, the female urinary collection device. As you can see, there's a vast difference between the two of them.

This particular scheme was found to be so widespread that involved patients and suppliers throughout the country. These cases have been successfully investigated and a number of the investigations are still ongoing, including here in the State of Illinois. We were able to detect this scheme and investigate all the matters concerned because of the combined efforts and the resources of all of the partners of ORT.

In all, savings to Medicare as a result of this type of investigation has amounted to an estimated $104 million in 1996, with projected estimated savings to be $534 million over the next 5 years.

The next case had some distinct characteristics not found in some of our investigations. This supplier provided incontinent care kits to nursing homes. These relatively inexpensive kits included a pair of latex gloves, a small cup of sterile water, a disinfectant, an absorbent pan, a pair of plastic tweezers and a small plastic pair of scissors. The supplier misrepresented the patients as having chronic incontinence in order to bill Medicare, then inflated the number of kits actually provided. An average of 90 kits per month per patient was billed, but only about a third of that number was actually provided.

What sets this investigation apart from the others was the fact that the perpetrators closed and then reincorporated their business under different names 31 times during the course of the investigation. Shortly after they started doing business with Medicare, the Quisenberrys, a father and daughter team, became aware that the Medicare contractor who processes the claims was scrutinizing the claims due to the concerns about possible fraud and abuse in this area.

Before the company du jour could run up enough claims to gain the attention of the contractor, the Quisenberrys would simply close the business and incorporate a different name and a different location. They were able to accomplish this by enlisting the aid of

friends and family who fronted the operation for them. When this investigation was concluded, the Quisenberrys and five of their associates were named in a Racketeering, Influenced, Corrupt Organization indictment. The RICO indictment was the first of its kind in the health care fraud arena.

More significantly, it was the largest RICO indictment in the history of the judicial district in which it was filed, alleging damages of approximately $30 million to the Medicare Program. All parties pled guilty to their part in the scheme. This is not the largest Medicare fraud case we have investigated, but the Quisenberry case clearly was one of the more unique investigations setting the trend in how to cheat the government. A number of jurisdictions are now considering similar charges in other investigations that are related to this type of scheme.

Although this supplier was actually based in Michigan, it did over $1 million in business with nursing homes in Illinois, and for that reason it was included as part of Operation Restore Trust. Again, if it was not for the resources and the expertise brought under the ORT umbrella by all of the partners, this investigation would not have come to a successful conclusion.

Based on periodic cost reports, Medicare reimburses home health agencies, nursing facilities and other providers who render care in a facility-like setting. The cost report is used to itemize the total cost of operation of the provider and identifies the proportion of the provider's total cost to costs that was related to the care of Medicare beneficiaries and forms on the basis of Medicare reimbursement.

It is possible, however, to bury within this document expenditures which are totally unrelated to providing Medicare beneficiaries with treatment. Through ORT we initiated a number of cost report cases in Illinois as they apply to nursing facilities or home confined patients. In one case, a nursing home administrator embezzled money from the owners of his nursing home by including non-medical expenses in the cost report disguising them as reimbursable items.

In some instances, the money was actually used for improvements on his private residence and an accumulation of over 200 pornographic videotapes. In addition, he created a ghost employee and paid himself a sizeable salary under that name. He also embezzled money from residents in the nursing home by gaining control of their personal finances.

In all, this man stole $1.6 million, all but $200,000 was obtained through false claims on the false cost reports. He pled guilty as a result of this investigation and was sentenced to a total of 46 months' imprisonment and ordered to pay $1.6 million in restitutions, including $67,000 to a Medicare beneficiary from whom he swindled money.

In another type of case which was identified during Operation Restore Trust, a number of businesses who identified themselves as community health care centers were found to be defrauding Medicare and Medicaid. These providers supplied adult day care under the guise of mental health therapy. Patients at other nursing facilities were delivered by the provider and held for the day in an empty warehouse of an abandoned building. They were allowed to

watch T.V. or play cards, but were otherwise provided no structured care.

The providers claimed the expense of providing transportation, meals and services of mental health professionals when they did not in fact provide any of these services. These investigations are far from complete and are very serious questions about the quality of care received by nursing home patients.

Last, I'll describe the case of Home Pharmacy Services, a firm that operated in Illinois that provided pharmaceuticals for residents of 96 nursing facilities in that part of the State. These supplies were paid predominantly through Medicaid, although the example clearly demonstrates the application of the ORT protocol.

Under the rules of Medicaid, drugs that are unused at the time of the patient's death or discharge are to be destroyed. This company, however, was recovering the unused drugs, repackaging them and reselling them often to other Medicaid patients. In addition, the unused drugs were not stored in appropriate places, usually creating a substantial health risk. The drugs could have lost the potency necessary to produce the medical goals of subsequent patients to which they were given. And more seriously, the drugs could have become toxic and threatened the user's health.

An ORT coordinated task force executed a search warrant on the premises of the business in May 1996. Agents filled two 14-foot postal trucks with records and evidence including a large amount of the recovered drugs which had not been repackaged. The drugs had been stored in store rooms that were neither sanitized nor climate controlled.

The parent corporation of Home Pharmacy Services subsequently entered into a settlement negotiation with the Office of the U.S. Attorney and our office. As a result, the corporation paid $5.3 million in penalties and restitutions, entered into a corporate integrity plan and agreed to cooperate in the criminal prosecution of the manager and former owner of Home Pharmacy Services.

The former owner, who had sold his business to the current owners, and who had actually started the scheme, entered into a plea agreement with the U.S. Attorney's Office. He was sentenced to 2 years in a Federal penitentiary and ordered to pay $750,000 in fines and restitutions to the government.

This case came to fruition because of a cooperative effort put forth under Operation Restore Trust. The investigation was the earliest joint effort under the ORT and was an investigation comprised of a health care task force in the Southern District of Illinois. The task force was comprised of a team of agents from several State and Federal agencies including HHS, OIG, the FBI, Postal Inspection Service, the Illinois Medicaid Fraud Control Unit, the IRS and the Illinois Pharmacy Board.

Funding made available through ORT helped make it possible to open an OIG field office in Fairview Heights, Illinois, the city in which the Office of the U.S Attorney for the Southern District is located, making prosecution easier. As you can see, the Operation Restore Trust experience provided all of us with a new template for the way we do business. New lines of communications were opened and cooperation among agencies involved in fighting health care fraud reached new heights.

The proof is in the remarkable return on investment realized under the 2 year demonstration project. In the five States, we identified $187.5 million in fines, restitutions and settlements. This constitutes approximately $23 to $1 investment in the project.

Operation Restore Trust also paved the way for the passage of the Health Insurance Portability and Accountability Act in 1996. That statute included a solid funding base which allows our agency to continue an aggressive fight against fraud and abuse in the Medicare and Medicaid Programs. It also enabled us to become a full partner with other law enforcement agencies in pursuing these goals.

We're very proud of our accomplishments, but we cannot be naive or rest on our laurels. Every day criminal elements are developing new and novel approaches to exploiting Medicare and Medicaid and other health care programs. We need to stay ahead of them. We are therefore eager to work with this Subcommittee to further redefine our tools and the program safeguards needed to protect taxpayer dollars and Medicare resources.

Thank you for holding this hearing, and I welcome your questions.

Senator COLLINS. Thank you very much. Ms. Coyle.

TESTIMONY OF BARBARA COYLE,[1] VOLUNTEER, CATHOLIC CHARITIES, SUBURBAN AREA AGENCY ON AGING; ACCOMPANIED BY JONATHAN LAVIN,[2] EXECUTIVE DIRECTOR, SUBURBAN AREA AGENCY ON AGING

Ms. COYLE. This morning I am going to be John Grayson, if you don't mind. My name actually is Barbara Coyle, and I am a retired public health nurse. I am also a volunteer in the Suburban Area Agency on Aging Health Care Anti-Fraud, Waste and Abuse Community Volunteer Demonstration Project.

While I am talking as John Grayson, I would also like to tell you that essentially what I am saying represents all of the volunteers and the presenters in this program.

Mr. Grayson's testimony reads: I first heard about the project from a public service announcement that was on the radio. I contacted Ms. Mary Clare Toomey, project director, and subsequently enrolled in her training program. In my training class, there were 38 volunteers. And the training program extended over a period of 3 days, during which the speakers included staff from the Office of Inspector General, the Illinois Department of Public Aid, Ombudsman Program and the Medicare Fraud Units.

In my area, Catholic Charities Northwest, based in Arlington Heights, Illinois, is the host site with Mary Nommenson, the local coordinator of the program. Mary makes calls to various senior organizations and sets up the appointments for me to make my presentations. I am generally assisted by another volunteer named Jim Grimm, who is present at this hearing, from Elk Grove Village. He does a little bit of the speaking and helps me by passing out literature and conducting surveys and doing personal interviews after my presentation.

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[1] The prepared statement of Mr. Grayson submitted by Ms. Coyle appears in the Appendix on page 39.

[2] The prepared statement of Mr. Lavin and Ms. Toomey appears in the Appendix on page 40.

At the presentations I first introduce myself and then attempt to build some interest and some enthusiasm for what we're doing by pointing out to the senior citizens that Medicare spends $200 billion a year of which it is estimated that $20 billion is lost through fraud, waste and abuse. I point out that it is predicted that Medicare will go bankrupt in 10 years and that undoubtedly, as it starts to go bankrupt, benefits will be reduced or co-payments will be increased. So it is in all of our interest to help save Medicare by doing what we can to spot any indications of fraud and abuse.

I want to point out that we are saving this vital program not just for ourselves, but for our children and potentially our grandchildren. I explain how easy it is for crooks to swindle the system by merely having a doctor's prescription for unnecessary procedures or equipment as well as having your Medicare number. I explained that the Medicare number is just like your credit card number and that you should never give it out to anyone who isn't known to you to be a genuine provider of services.

I relate some of the instances or types of fraud that have been perpetrated on people and the system. These examples of fraud are the ones that already have been conceived by the crooks who have been caught, but the possibilities for new theft and fraud schemes are infinite and changing constantly.

We are seeking the help of our audiences in spotting fraud, because they are on the front lines and have the best opportunity to see suspicious activity first. I emphasize that it is very important for them to examine their medical summary notice or explanation of medical benefits following a medical procedure. They need to be sure that they received everything that was billed to Medicare.

When they do spot something that doesn't look right, the first call should be to their medical provider to obtain an explanation. If they aren't satisfied with this, I suggest they call their SHIP counselor—Senior Health Insurance Program counselor—to assist them in getting an explanation. If they still aren't satisfied, then I suggest that they call the numbers on the pamphlet I give them, which would either be the Federal 1–800–HHS–TIPS line, a local number at the Suburban Area Agency on Aging (1–800–699–9043), or call Mary Nommenson at Catholic Charities (847–253–5500).

I try to give them an incentive by telling them that there is now a bounty being paid to whistle blowers who help us uncover fraud. They could be paid 10 percent of whatever is recovered, up to $1,000.

I conclude by reiterating the three main points I wanted to make. First, don't give your Medicare number to anyone that you don't know. Second, check your explanation of medical benefits carefully to make sure you received everything that Medicare is being billed for. And third, save our literature so that if you do come across anything that doesn't look right, you'll have our number and where you can call us.

I close by thanking them for their attention and by urging them to help us save Medicare. I then explain that Jim Grimm and myself will be available after the presentation to talk to anybody who wants to ask us questions. We also want to hear them tell us about their own experiences. Generally we do have a few people who want to talk to us on a one-to-one basis. We ask them to fill out

the survey form so that we can report these back to our host for documentation and statistics.

I personally have provided presentations to a variety of community organizations and am constantly amazed at the level of interest by participants in attendance. There are usually three or four individuals in the audience who share their personal stories of suspected fraud and abuse after the presentation.

I have found participation in the Suburban Area Agency on Aging's Fraud and Abuse Program to be challenging and rewarding and am very pleased to be able to relate my experience with you today.

Senator COLLINS. Thank you very much, Ms. Coyle.

Mr. Lavin, please proceed.

Mr. LAVIN. I'm not scheduled to give oral testimony.

Senator COLLINS. OK. At this point I'm going to turn to Senator Durbin to lead off the questions of the witnesses.

Senator DURBIN. Thank you, Madam Chairman. Thank you for your testimony. I appreciate it very much. Ms. Collins, can you start off by making clear a part of this record a statement about some of the process that is followed. For example, it's my understanding that in each State there is an intermediary or some company that has been hired by Medicare which basically does the work of receiving the bills from the providers and sends those bills on to the Federal Government. Is that correct?

Ms. COLLINS. Yes, that's true.

Senator DURBIN. In our State of Illinois, what company is that?

Ms. COLLINS. Currently now the intermediary for Part A operations is Administar Federal and for Part B claims it is Wisconsin Physician Services.

Senator DURBIN. Does that change from time to time? Is there a bidding process or some sort of a reevaluation?

Ms. COLLINS. These contracts are fairly new in the State. They were only established this last year, because the long-time contractor, Health Care Service Corporation, withdrew from the program this year. Many contractors have been in the programs for a long, long time, but there has been some turnover recently.

Senator DURBIN. And so let's say that I wanted to open up a business which was going to sell durable medical equipment to senior citizens. In this State I would contact the intermediary, is that correct, to establish myself?

Ms. COLLINS. Yes, that's right.

Senator DURBIN. And the intermediary would then issue me a number to provide services or equipment, whatever it happens to be?

Ms. COLLINS. Yes. And we have changed the process somewhat related to enrollment of new providers, particularly suppliers, due to the problems that have been identified in the Operation Restore Trust effort. It is no longer just call up and get a number. There is a screening process that is carried out.

Senator DURBIN. Is every prospective provider screened?

Ms. COLLINS. Right now the suppliers, all suppliers, prospective providers, are screened and there is a site visit conducted. Other prospective providers, say a new hospital or other kind of organiza-

tion, there's a different process that is undertaken, not necessarily called a provider enrollment screening process.

Senator DURBIN. What does screening consist of?

Ms. COLLINS. Information is collected for verification of location and address.

Senator DURBIN. Physical verification?

Ms. COLLINS. There are on-site reviews that are taking place for new suppliers and for previous suppliers, there is a 3-year cycle of on-site reviews that we're undertaking now to check those suppliers who already have a provider number.

Senator DURBIN. Is there a criminal background check as part of this?

Ms. COLLINS. I would be glad to provide that for the record.

[The information provided follows:]

INFORMATION REQUESTED FOR THE RECORD

Criminal background checks.—We do not currently perform criminal background checks on potential providers or suppliers. We are interested in studying whether criminal background checks could help reduce fraud among some or all provider and supplier groups. Our contractors do use third party validation sources to verify information on provider and supplier application forms, and some of these sources contain criminal background information. We ask all providers and suppliers on our enrollment applications whether any individual with 5 percent or more ownership (including individual health care practitioners who seek to be enumerated as a provider in the Medicare program) has been convicted of a health care related crime or a felony. Any who say yes are referred to contractor fraud units for further investigation. If owners have been excluded from Medicare by the HHS Inspector General, the application is denied. We also are currently developing a regulation that will implement a Balanced Budget Act provision giving the HHS Secretary authority to deny or revoke enrollment to any convicted felon.

Senator DURBIN. Now, one of the things that we have tried to stress is the important role the seniors can play in detecting fraud in the Medicare system. Ms. Collins, you would agree with that, I'm sure.

Ms. COLLINS. Oh, yes. Definitely.

Senator DURBIN. And so what troubles me is I learn that HCFA is considering a change in the billing procedure under Medicare, whereas in the past there used to be a statement of benefits and an explanation of benefits sent to senior citizens, which will give them a better understanding of what they're being billed for.

If I'm not mistaken, HCFA is at least considering reducing or suppressing, as they say, some of this information. That would seem to be counter-productive to me. It wouldn't really help the seniors if they didn't have enough information to detect the fraud, would it?

Ms. COLLINS. Right. I share your concern with that. There has been some suppression of those notices that have gone to beneficiaries. But we are changing that. By April of this year we will be requiring all of our intermediaries to issue notices regarding claims on virtually all claims.

Senator DURBIN. I want to make sure I understand this.

Ms. COLLINS. Sure.

Senator DURBIN. Because I thought this was a HCFA procedure that was underway to reduce the explanation of benefits that were being mailed out. Are you saying that's been changed?

Ms. COLLINS. We will be telling contractors in April to mail out notices, either the explanation of medical benefits or the Medicare summary notice, on virtually all claims. You are correct that there has been some suppression of those notices currently. But we are taking steps to rectify that situation.

Senator DURBIN. That's good. And do you believe that you are sending out—I'm going to ask Ms. Coyle the same question, Mr. Lavin as well. Do you believe you're sending out clear information as to senior citizens on Medicare about the TIPS hotline and what they should do to police their own bills to find out if there's potential fraud?

Ms. COLLINS. There is always room for improvement with that information. The HHS–TIPS number and supporting information are provided with the explanation of medical benefits and the Medicare summary notice.

Senator DURBIN. I would say, Ms. Collins, if a survey that I read is accurate, that we are not doing a good enough job. And I say we, because Congress has a responsibility here, too, to provide you the resources to get that done.

What I refer to is a survey done by the AARP and one done by the Office of Inspector General, I might add, as well, concerning the public level of awareness of Medicare fraud and our government efforts to combat it. The findings, are you aware of them, Ms. Collins, are rather troubling.

They confirmed that 85 percent of seniors were not aware of any government agency working to reduce fraud in Medicare, 83 percent were not aware of the Office of Inspector General hotline, and 85 percent believed it was their responsibility personally to report fraud, that's good, 74 percent reported always reviewing the explanation of Medicare benefits. I say that because it clearly says to me, if this is accurate, and I believe that these two surveys are, we need to do a lot more so that seniors can learn of their responsibilities and their opportunities.

Ms. Coyle, has that been your experience, too, that many seniors don't know what's available?

Ms. COYLE. Right. True.

Senator DURBIN. So that stops them from using the system we're putting in place from Operation Restore Trust. Mr. Kopf, one of these surveys was by your office, is that your finding as well?

Mr. KOPF. The survey did indicate that many of the seniors did not know the efforts we've made. What we're doing now is increasing our efforts to get the word out to the senior citizens, not only of our office but of the various schemes and fraudulent use of people that are involved in this type of thing so they can refer it accurately to us.

Senator DURBIN. It seems like this is a big undertaking. I mean, the numbers of people, Ms. Coyle, that you referred to and Mr. Lavin, the agency that's been involved in it, in the thousands. And if I'm not mistaken, the number of Medicare beneficiaries in our State could approximately reach what, 2 million, or is it somewhere in that neighborhood? I think it might be.

Ms. COYLE. Oh, I'm not aware of that. I'm sorry.

Senator DURBIN. I'm not aware of——

Mr. LAVIN. I think 2 million is a high figure.

Senator DURBIN. One-point-six million.

Mr. LAVIN. That's it.

Senator DURBIN. So we have a long way to go here in terms of reaching that level of public information. I think we have to do a lot more. Mr. Kopf, that question of suppressing the explanation of benefits under Medicare, do you have any feelings about that?

Mr. KOPF. We would encourage that the explanation of medical benefits continue to go out to the beneficiaries because it works hand in glove with the efforts that all of us are trying to do to inform the public. And once we inform the public, they would actually have a piece of paper in front of them to remind them of what they should be looking for.

For example, if they receive the care or not.

Senator DURBIN. Now, let's assume that we've got a suspicious situation here. And you've been involved in some of these investigations. I'd really like to ask you what kind of cooperation you receive from the U.S. Attorney's Office and other prosecutors when you've detected a potential fraud?

Mr. KOPF. We've received a high degree of cooperation. Over the last couple of years especially, since the initiation of Operation Restore Trust, a lot of U.S. Attorneys have hired prosecutors to come into their offices.

There has been a ramp up of education. These cases are a little more complex than the prosecutors are used to. But the cooperation is there. Their task force, because of ORT, and now through HCFA, are task forced in literally all of the districts throughout the country in health care form. So I think there's a good foundation for cooperative effort, not only with our offices and the U.S. Attorneys, but also with HCFA and AOA, in a combined effort to bring the information together.

Senator DURBIN. I have some other questions, but I'm going to defer to the Chairman to ask hers and then I'll return. But if I might ask one last question. The TIPS procedure which offers an incentive to beneficiaries alone. I believe it's an incentive only to beneficiaries, but am I mistaken on that? The 10 percent, is that available only to beneficiaries?

Ms. COLLINS. Yes.

[The information provided follows:]

INFORMATION REQUESTED FOR THE RECORD

Incentive payments for reporting fraud and abuse.—Incentive payments of up to $1,000 for those who report fraud and abuse in Medicare can be made to both beneficiaries and non-beneficiaries. These payments can be made starting in January 1999 and should bolster our critical efforts to enlist the support of Medicare beneficiaries, health care workers, and our many other partners in the fight against fraud, waste and abuse.

Senator DURBIN. It raises a question in my mind as to why that incentive is not available to anyone who would produce information that would lead to a successful prosecution and recovery of money that should not have been spent under Medicare.

There are Qui Tam actions and others under the Federal Law which create rewards, incentives for whistle blowers and investigators and the like to come forward. Do you think that might be of some benefit in perhaps engaging others to keep an eye out for this kind of Medicare fraud?

Mr. KOPF. I think any type of system that encourages turning in individuals that are defrauding the government is good. Of course, with a reward type of system, it's a little bit difficult. These cases take a long time to develop and the financial rewards are usually 2 and 3 years down the road.

But as you mentioned, not only this type of system that HCFA is putting into effect, but the simple effect that the Qui Tam issue has grown so large that a lot of people are using that as a vehicle to inform us of wrongdoing.

Senator DURBIN. It's been a major source of litigation in southern Illinois against one particular agency in our State. And it created the type of incentive where, frankly, the people who were blowing the whistle were discouraged many, many times but stuck with it, because they believed they had legitimate claims. Ultimately they did and they will be rewarded for that.

I think when we look at the magnitude of this problem, in the area of $20 billion plus, we need similar mechanisms available so that whistle blowers and those who perceive wrongdoing won't be easily discouraged from trying to ferret it out. I yield to the Chairman.

Senator COLLINS. Thank you, Senator. I want to follow up on a couple of the excellent points that you raised.

Ms. Collins, you talked about the screening and on-site reviews that your region is doing. And I want to commend you for those. From the previous hearings this Subcommittee has held, Senator Durbin and I know how effective a simple on-site visit can be or even a minimal screening can be to exclude the completely bogus provider of services, or actually that don't provide any services in a lot of cases.

I want to clarify, however. Is this screening and on-site review that is being done only being done in the States that are part of Operation Restore Trust?

Ms. COLLINS. No. It's in all States.

Senator COLLINS. It is now in all States?

Ms. COLLINS. Yes.

Senator COLLINS. When was that adopted, do you know?

Ms. COLLINS. That has recently been expanded.

[The information provided follows:]

INFORMATION REQUESTED FOR THE RECORD

Site visits to medical equipment suppliers.—We announced plans for a nationwide policy of mandatory site visits for all durable medical equipment suppliers on January 24, 1998. We began requiring site visits of all newly enrolling suppliers and virtually all re-enrolling suppliers in June.

Senator COLLINS. That is something that we are looking at putting into legislation. I am pleased to hear that it's recently been expanded. I think it will really help screen out some people right up front before damage is done.

Mr. Lavin, we were talking earlier. Senator Durbin raised the issue of the need to get more information to seniors about what to do when they spot fraud. And Ms. Coyle was telling about the efforts the volunteers are making in making the presentations. I notice that you've also put out what I think is a really terrific brochure. It starts off saying, "Who pays? You do."

It tells seniors what to do. It also gives some tips. Could you talk to us a bit about the brochure and give us some idea on how you're distributing it?

Mr. LAVIN. Yes. Thank you very much. Barbara is really nice to have come in to give John Grayson's testimony. He lives in the northwest suburbs and she lives in the southern. It's probably about 60 miles distance between the two. So she did an excellent job of filling his shoes at the very last minute.

Today in the audience—please bear with me—(I'm mentioning this to answer your question) we have our volunteers and some of the people who are staffed at local agencies in Skokie, Lake County, Oak Park, Kankakee, Elk Grove Village, Harvey, Northfield, Kane, and McHenry counties, and possibly others came in since we started this.

We really put our emphasis on making sure that the community is part of this information campaign. We work with 11 different organizations that are community based. Jointly we seek to get the word out about the Operation Restore Trust message to report things that don't look right. We try to act as a buffer if there's something that may be correct, but does not look right. Our goal is to help cut the congestion at the 1–800–HHS–TIPS line so that the really important calls are not lost.

Our approach in the Operation Restore Trust brochure was to use the aging network of our volunteers as well as their host sites. We said to them that we want to present something that would really help get the message across. They helped design this particular brochure. We sent out drafts of it. They sent back comments. And they use the brochure combined with their own agency materials. In Barbara's case, Catholic Charities South Suburban Senior Services, created a brochure saying, "If you have a question or concerns about your Medicare or Medicaid charges, call MAMA"—which means what, Barbara?

Ms. COYLE. It's the Medicare And Medicaid Advocacy program.

Mr. LAVIN. So the MAMA is, picked up right away in terms of knowing you are going to get help, you're going to get a good explanation, and you're going to get the homework done on your behalf—right in your community. So we're very proud of this presentation.

We've also in the early days, when we had a small contract from the Administration on Aging, we were able to get out over 15,000 brochures to older persons, some translated into Russian, Spanish, and Polish for this area. We are doing a good job of getting information together, getting it into the hands of people like Barbara, John Grayson, and the folks here with us today to give these brochures to the people, and hopefully the information will be there when they have a question, they will call us, and make contact with the local agency. They can then begin a relationship with their volunteers and with their community organization for a number of programs and benefits.

All of this is possible—(see they should have let me testify!)—because we were able to take this program and put it right into our older Americans Act at Senior Service Network throughout the metropolitan area existing programs and community agencies that help older people. By allowing us to work on this problem and

using our ability to get the message out to all the people, this program went very quickly. We had volunteers in the community within 3 months of the notification of our grant.

Senator COLLINS. It's an excellent effort, and I really commend you for it. I was in Iowa in October and visited the Area Agency on Aging. And they have a similar effort underway and it's something that I'd very much like to see New England start doing as well.

Mr. Kopf, don't you think if we could somehow get this information in the hand of every Medicare beneficiary, maybe you'd be overwhelmed, I don't know, but given the findings that Senator Durbin gave us from the AARP survey and the survey from your office, it seems to me that most seniors don't know where to go if they have a problem. Do you think we should be doing more to try to get information such as this in the hands of more beneficiaries?

Mr. KOPF. Definitely. We may be overwhelmed, but I welcome that problem rather than letting other people go about stealing from the government.

The more outreach we can do, the more we can put out to the general public, not only the beneficiaries, but also the children of beneficiaries, that help them, the better we're going to be at doing our job. Not only can they become our eyes and ears, which is most important, because our resources are such that it's limited to certain areas, but they can become our eyes and ears and they can also make significant recommendations as to how they're seeing on such issues as quality of care and the services being given.

So it's really a win-win situation when something like this happens.

Senator COLLINS. Ms. Coyle, I like the reference in the testimony that you delivered to treating your Medicare number as you would treat a credit card number. I think that's a very good analogy that all of us can relate to, and yet we know from our previous hearings that oftentimes seniors have been very trusting in giving out that number.

As you've been giving the presentations yourself, are people surprised that they need to be that careful, or what is their reaction?

Ms. COYLE. I'll tell you the response we receive. They indicate to us that they really have never thought about it before. So actually, we repeat that message, treat your Medicare card like a credit card, we may say it four or five times during the presentation. It's really one of the most important things we do.

One of our volunteers gave a presentation at a low income senior citizen housing unit, and after the presentation, one of the residents went to the coordinator for the building and reported that there was something funny going on in their building. There was a group that was going around to the residents and offering them fun days, free trips to Navy Pier, in exchange for their Medicare number.

Senator COLLINS. Interesting.

Ms. COYLE. And now that's under investigation. But here's the tale of a resident, once informed, who could act on something like that.

Senator COLLINS. See, that shows exactly the value of the outreach you're doing. Because you alert people that there's a problem

and all of a sudden it triggers a thought in their minds that may well expose a major fraud. So I think this program sounds very worthwhile.

Before I yield back to Senator Durbin, I want to just raise one issue with you, Mr. Kopf. And that's on the Quisenberry, I think is the name of the case.

Mr. KOPF. Yes.

Senator COLLINS. Thank you. This case is incredible to me, because as I understand it, this family reincorporated the business more than 30 times, is that correct?

Mr. KOPF. That's correct.

Senator COLLINS. And that didn't raise any red flags? Is that because in each case it was under a different provider number?

Mr. KOPF. It was under a different provider number under each case. And at the time the Quisenberrys entered into their fraudulent schemes, the contractors, while they had state-of-the-art computers tracking it, the state-of-the-art at the time was really archaic to what it is now. So that by the time the contractors were aware that a scheme was going on, it was usually 6 to 9 months after it had already been started. The Quisenberrys were smart enough to know that they could stay below the radar screen of the contractors if after that time period they simply reincorporated.

Now, as you know, incorporating a business is a State function and not controlled by the Federal Government. So they could have as many incorporations as they can getting different provider numbers. Today, however, that time period has shrunk dramatically, because of the knowledge that HCFA has gained through correcting provider numbers being issued, and also the computer system. So there's no longer this long gap that was there before HCFA now has a customer information database that can more rapidly pinpoint the scope and extent of any of the billers in relation to the beneficiaries and utilization of that particular project.

Senator COLLINS. Does the HCFA form which is used to grant a provider number by the intermediary ask whether or not the company has ever done business in the past with Medicare under a different provider number?

Mr. KOPF. I'm not sure. I don't believe that it does.

Senator COLLINS. Ms. Collins, do you know?

Ms. COLLINS. I honestly don't know the answer to that question.

Senator COLLINS. It seems that would be a simple fix is to automatically have a question about have you ever done business with Medicare under a different provider number. And that you could tell whether they've been suspended or terminated from the program. It seems like that would give you a tracking so that you just can't swiftly close down 1 day, open up the next day, apply for a new number and go on ripping off the program.

Ms. COLLINS. I don't know if that is specifically asked, but we're certainly asking for a great deal more information than we ever have before. And the checking that we do is more thorough than ever before. But I just can't answer that question specifically.

Senator COLLINS. If you would, for the record, get back to us on that.

Ms. COLLINS. Well, I'll be happy to.

[The information provided follows:]

INFORMATION REQUESTED FOR THE RECORD

Application forms.—Medicare provider application forms do specifically ask whether the provider or supplier has ever billed Medicare or Medicaid before. Applicants who have previously billed Medicare or Medicaid must submit information regarding that prior billing entity.

Senator COLLINS. That would be great, because that's an issue that we may want to pursue. Senator Durbin.

Senator DURBIN. Mr. Kopf, why do these cases take 3 years to investigate and prosecute?

Mr. KOPF. Most health care cases are very complex white collar crime investigations that involve a lot of documentation to be observed and gone through. When we issue a subpoena, for example, to look at records, the records are in massive amounts.

The tracking of an individual case from the initiation of the complaint that comes in is such that it not only deals with one particular issue, but it will spread to other areas. For example, in one particular company they were taking the money used in a home health agency and depositing that money, sending it off shore to the Cayman Islands, reinvesting it under related businesses such as a travel agency, such as employing health care benefits for their own employees. And really it becomes a very complex case. It's hard to understand.

Second of all, as we go about presenting the cases, it really has to have the type of jury appeal to show that there was clear intent involved. Usually one of the chief defenses that is used is the provider will say, well, we did give a service. And so we were providing the community with something. But taking that all into consideration, by the time you go through the documentation to compare it to the utilization, it's really a complex white collar crime case.

Senator DURBIN. I seemed to detect at some of our earlier hearings that, for better or for worse, Florida seems to be a leader in fraud, probably because of the number of seniors there and the language situation that presents itself from time to time. If I'm not wrong, one of the earlier witnesses testified about these community mental health centers and really it was Florida where it appears they first figured out how to get into the system and to bill Medicare for services which should not have been billed.

Is that a correct observation, or am I being too tough on that?

Mr. KOPF. Florida is certainly a prime target area because of the number of seniors that reside in that State. California and New York are second and third right behind it. And also, not only because there are a lot of beneficiaries that live in this State, but as you pointed out, there is a language difference. There are a lot of aliens that come in, and rather than trust the local physician, they'll go back to their own community. And it's a difficult situation.

Senator DURBIN. What are you detecting in Florida and those other States that we can expect to become the next national trend in terms of Medicare fraud?

Mr. KOPF. I think one of the areas that we mentioned earlier was the community mental health centers. I think that is an area that we have found through our studies, our audits already completed, is a rapidly growing industry. I think it increased in payments well over 500 percent over the last couple of years.

We looked at that to be one of the new areas. That's on the bad side. The good side is we have detected it early. And working with HCFA and working with the seniors in the State, I think we'll be able to possibly put this under control more rapidly than some of the other schemes in the past.

Clearly though, the durable medical equipment will always be a prime target, especially where there are a lot of seniors and there's a lot of advertising and telemarketing going on.

Senator DURBIN. How many of these cases lead to debarment each year where a provider is debarred from doing business, any further business with the Federal Government?

Mr. KOPF. Last year our office excluded from the program over 3,000 providers.

Senator DURBIN. Out of how many? What's the universe?

Mr. KOPF. I really don't know. It's a vast universe, but it's increasing. I think we're having closer cooperation with State facilities, particularly the Medicaid Fraud Control Units.

Also other agencies such as the FBI that are bringing their private cases to us that are convicted, so that we can get these people out of the system.

Senator DURBIN. Ms. Collins, there's a problem, is there not, once a provider has been excluded or debarred as to whether or not they continue to receive payments from the intermediaries at HCFA?

Ms. COLLINS. Clearly that has to be addressed to assure that these excluded providers do not get any future payments from Medicare.

Senator DURBIN. Well, one of the provisions in the bill that Senator Collins and I will be working on is requiring Medicare or Medicaid contractors to reimburse the Federal Government if they continue to pay a provider which has been found guilty and debarred from doing business with the government.

That seems so obvious. I'm sure a lot of people listening are thinking, wait a minute, you have said that these people cheated the taxpayers and now you said they can't do business with the Federal Government. And yet the intermediary continues to do business with them and pay it out of the Treasury.

That seems to be something that we ought to address and shouldn't have much controversy associated with it.

Ms. COLLINS. Well, I would respond that I think there are other ways to address that rather than holding the intermediary liable for that payment. We have a responsibility to make sure that the intermediary has the good information in order to assure that those payments are not made. And I believe Mr. Kopf has talked about our efforts in that regard to assure that those payments are not made with improved databases and cross-checks.

[The information provided follows:]

INFORMATION REQUESTED FOR THE RECORD

Payment to excluded providers.—Clearly, we must make sure payments do not go to excluded providers, and we are now developing a more sophisticated system to make sure that they do not. We expect contractors to make a good faith effort to prevent payment to excluded providers. However, contractors have not always been given all the data needed to prevent payment to excluded providers. Working with the HHS Inspector General and our contractors, we have identified ways to improve our system for preventing such improper payments. The system we are now developing includes a

substantially improved database on excluded providers. That will help make sure our contractors have the information they need to prevent improper payments to these providers. We will instruct contractors to check that database against files of providers billing Medicare. We also will instruct contractors to check the excluded provider database against databases with employment information. That will help prevent excluded individuals and entities from getting back into the program, and should be much more effective than our old system.

In addition, we are considering a regulation to require providers to periodically re-enroll in Medicare, thereby allowing us to reevaluate whether each provider continues to meet Medicare's standards. This would help assure that only legitimate providers are enrolled and able to receive Medicare payments.

Senator DURBIN. I might return to the point made by Senator Collins about Medicare numbers. I don't know how they are provided to seniors. Once you qualify for Medicare, do you receive notice in the mail from the Federal Government of your Medicare number?

Ms. COLLINS. Yes. You receive a card and a number.

Senator DURBIN. And is there any kind of warning or advice on there about how important it is to keep that number confidential?

Ms. COLLINS. Yes. And in our literature we do provide information about that.

Senator DURBIN. Well, I hope we're doing everything we can as people do with new credit cards to impress upon seniors the need to keep that number confidential.

One other element that we checked out was, Mr. Kopf, perhaps you can address it. It appears that some of these providers, once they've been discovered as having defrauded the government, have been able to escape fines by declaring bankruptcy. Are you familiar with that?

Mr. KOPF. Very much, yes.

Senator DURBIN. Could you explain that?

Mr. KOPF. What happens is once an individual knows they are under investigation, is they will declare bankruptcy. They'll dissipate all of the illegal gotten funds as quickly as they can. And what this does to us, it hinders our ability to collect those ill gotten gains and bring them back to the Treasury, bring them back to the Trust Funds.

It's been on the increase and it seems to be a way of doing business once they're aware that we are looking at them. We can almost count on within a few months that all of a sudden they've claimed bankruptcy and have an inability to pay back the government.

Senator DURBIN. One of the provisions of the bill we're working on would not allow them to discharge this debt to the Federal Government, so that we could continue to pursue them and collect it. And I hope that we can provide that as well.

Mr. KOPF. That would be excellent.

Senator DURBIN. I don't think the bankruptcy court should be a shelter for those who have defrauded the government from paying back what they have taken from us.

I'd like to thank this panel for your testimony and yield back to the Chairman at this point.

Senator COLLINS. Mr. Kopf, one of the cases that you cited in your testimony involved a pharmaceutical company that, if I under-

stood you right, was improperly recycling drugs, I guess would be one way to put it, from nursing home facilities in cases where the patient had either died or been discharged, and not used the full amount of the drug. The drug is then being repackaged and resold. Is that correct?

Mr. KOPF. That's correct.

Senator COLLINS. And that's an important case because in many instances when we talk about Medicare fraud, we talk about the monetary loss. But in this case, what was being done posed a health threat as well. Because the people were getting drugs that weren't properly stored, that may have been expired. Is that accurate?

Mr. KOPF. That's correct. That's accurate.

Senator COLLINS. Why hasn't a problem like this been identified earlier? Is this a case where the controls on pharmaceuticals that aren't used are inadequate? Talk to us a bit about how this occurred and how it could be prevented.

Mr. KOPF. It occurred because when this particular pharmaceutical company came to a nursing home, the nursing home assumed that they were doing a service for that nursing home. There's a lot of trust that goes between each individual. And the nursing home would trust the pharmaceutical company to provide that service and then the nursing home would not have to provide that service.

As you know, criminals lie. And they were able to——

Senator COLLINS. I am beginning to realize that.

Mr. KOPF. So they're able to convince the nursing homes that they are going about the normal destruction of these different drugs when in fact they weren't. Probably two things that could occur at this time is that, again, an awareness to the nursing homes about this type of fraud scheme once it's gone through the courts and it's public. Let them know to be aware of the proper disposal of the drugs would go a long way.

Senator COLLINS. Ms. Collins, I wanted to go back to the issue that Senator Durbin raised about when people get their Medicare card. You referred that there is literature that comes with that. Could you explain to us, I mean, is there some sort of brochure that gives the 1–800–HHS–TIPS number and some of the kinds of guidelines that this brochure has?

Ms. COLLINS. A new Medicare beneficiary, when they receive their card, they will receive a Medicare handbook. And in that handbook there is information regarding the hotline number and other helpful phone numbers to contact if there are questions or concerns.

Senator COLLINS. Is the 1–800 number put on the explanation of benefits form?

Ms. COLLINS. Yes, it is.

Senator COLLINS. Good. I think that the more we can get that out and the more we can have dedicated volunteers like Ms. Coyle out there doing demonstrations and talking to people, the more we can involve senior citizens in this problem. I think the seniors are very eager to help. They are very protective of this program. And they realize how vital it is to their well being. And I think enlisting them is a wonderful idea.

For that reason, I really enjoyed learning about Operation Restore Trust both from the HCFA perspective, the IG's perspective and the Area Agency's perspective, and that of a dedicated volunteer.

This hearing will be very helpful to Senator Durbin and me as we complete our process of drafting a Medicare Anti-Fraud bill which we hope to introduce shortly after we reconvene in January.

I don't have any further questions, but I want to see if Senator Durbin may.

Senator DURBIN. I might have one last question. And that is whether or not, there is an area of medical care which I consider to be very important and very good, but also open to a lot of abuse and that's home health care. Because unlike a nursing home situation or an institutional situation where there is usually a paper trail and a lot of witnesses, many of the services and pieces of equipment provided through home delivery and home health care usually consists of a provider and a senior with no one else on the scene and very little paper to evidence the transaction.

Ms. Collins, how can we preserve home health care and the important contribution it makes toward the health of America and still have appropriate accounting and auditing so that the rip-off artists don't gravitate toward it?

Ms. COLLINS. Well, I think the challenge has to be addressed in several ways. There are certain reimbursement incentives that we want to make sure are driven in the right direction. One of the loopholes that was closed in the Balanced Budget Act was to require that services are billed for from where they are given and not from some billing location which may be conveniently in a very high cost area so the reimbursement is inflated.

Also our involvement of the surveyors in their routine survey work where they become the eyes of the agency and the ears of the agency. They are highly professional, trained participants in not only assuring quality of care provided to home health beneficiaries receiving the home health care. They also have a working knowledge of Medicare coverage and billing requirements, and are trained in program integrity issues, to help us spot them. And more importantly, they have the knowledge and a relationship with us, and with the Inspector General, to report on those issues so that there can be prompt follow-up.

Senator DURBIN. Well, I thank you. And I thank each of you for your testimony today. I think I've come away from this hearing with some specific things in mind. When it comes to HCFA, I think that your testimony, Ms. Collins, today was good news to Senator Collins and myself about additional activities by your agency to verify the locations and backgrounds of the providers.

I think that that is a very positive improvement. I'm also happy to hear that what appeared to be a decision to suppress some explanation of benefits has been reversed so that seniors receive enough information to make important reviews of their own medical billing.

Mr. Kopf, continue your work, of course, and I hope that we can provide you the resources and change the law in a way to make your effort even more successful in the future. I hope that we can find ways of creating more incentives for whistle blowers and peo-

ple to come forward, because I think this is a valuable part of the process and what we are trying to achieve. And I thank you for all that you've contributed today in your testimony.

Ms. Coyle and Mr. Lavin, thank you, too. I think seniors many times can provide the kind of expertise and knowledge to really make this work and work well. And what you've been able to do through Operation Restore Trust and with your own suburban agency has demonstrated that time and time again.

I hope that many of the seniors who hear about this get a little upset to think that somebody is trying to rip them off. I can recall my mom calling me once in a while and saying, I'm not sure they're treating me right. And I hope that this will be additional incentive to spread this program across the country. And some basic things like telling people how important it is to keep their numbers to themselves and confidential so that they aren't used by other people.

Thank you for your testimony. You've really given us, I think, first-hand information about efforts that are being made and Senator Collins, thank you for being here.

Senator COLLINS. My pleasure. It is my hope, Senator Durbin, that perhaps it was the combined experience of Operation Restore Trust and the hearings that we held in Washington that exposed what happens when you don't have site visits that perhaps prompted HCFA to expand this nationwide.

But whatever its cause, it's certainly good news and we look forward to working with all of you. I want to again thank Senator Durbin for inviting me to his home State. I can see why he's so proud to represent Chicago and indeed the entire State of Illinois. And I want to come back again.

Thank you all very much for attending the hearing and for your contributions. I also want to thank our staff who worked very hard. Senator Durbin's staff was very helpful in the logistics for this hearing and Marianne Upton from his Washington staff, who has been working with us on several issues, is also here today, as well as several members of my staff, Steve Abbott, my Chief of Staff, Tim Shea, Don Mullinax, Eric Eskew, and Lindsey Ledwin from the Subcommittee, all worked very hard and I want to thank them for their efforts as well.

This hearing is now adjourned.

(Whereupon, 11:42 a.m., the Subcommittee was adjourned.)

APPENDIX

PREPARED STATEMENT OF DOROTHY COLLINS

Chairwoman Collins, Senator Durbin, distinguished Subcommittee members, thank you for inviting me here today to discuss Operation Restore Trust and our ongoing fight against fraud, waste and abuse. We greatly appreciate your interest and Support for this essential effort.

Operation Restore Trust was launched by President Clinton in May 1995 as a five-State demonstration project targeting just three areas. It has rapidly become the way that we do day-to-day business throughout our agency because of its overwhelming success.

Operation Restore Trust, along with the stable funding for program integrity work that was established by the Health Insurance Portability and Accountability Act in 1996, marks a turning point in our fight against fraud, waste and abuse. It has lead to record levels of criminal convictions, civil monetary fines, financial restitutions, and permanent exclusions of unscrupulous providers from our programs. It has shown us how to move faster and smarter. We are using what we have learned broadly and aggressively, and conducting more audits, medical reviews, and site visits than ever before. It has generated broad bipartisan support for changes in the law to close loopholes, raise standards, promote efficiency, and prevent problems from occurring in the first place. And it has inspired us to work with our partners to develop a Comprehensive Program Integrity Plan to make fraud and abuse harder to accomplish, easier to see, and less appealing to those who are unscrupulous.

Most importantly, Operation Restore Trust has taught us how critically important it is for us to coordinate with all our partners, from the Federal Bureau of Investigation on down to individual beneficiaries.

Since the inception of Operation Restore Trust, we have been greatly assisted by provisions of the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997, which included increased and dedicated funding to fight fraud, waste and abuse, and several other important provisions which help protect program integrity. We are committed to continuing our success and expanding it at every opportunity.

BACKGROUND

Illinois was among the first five Operation Restore Trust demonstration States, the others being California, Florida, New York, and Texas. Together these States include nearly 40 percent of all Medicare and Medicaid beneficiaries. Operation Restore Trust brought together teams from the Health Care Financing Administration, the HHS Inspector General, and the Administration on Aging in these States to target three fast-growing areas where we knew we had problems—home health, nursing homes and hospices, and durable medical equipment.

Operation Restore Trust includes several key elements:

- *Sophistication*—Advanced statistical methods are used to identify areas and individual providers for investigation and audit;
- *Cooperation*—Interdisciplinary teams review questionable providers, both for problems specific to that provider and to indications of more systemic problems in our programs;
- *Coordination*—Investigations are planned and conducted together with law enforcement agencies at all relevant levels;
- *Empowerment*—State and local aging organizations, ombudsmen and individual beneficiaries and health care workers are engaged and trained to detect and report potential problems, with reporting facilitated through a toll-free anti-fraud hotline; and

- *Efficiency*—State survey officials who already monitor care for quality are used as eyes and ears to also look for questionable billing. Increased cooperation and coordination also eliminate duplication of efforts that occurred in the past.

In Illinois, one of our first Operation Restore Trust projects focused on 20 home health agencies that we identified through a process that has now become standard practice.

- We used statistical analysis to rank all agencies for total dollars paid, dollars paid per beneficiary, number of service units per beneficiary, and volume of claims.
- We drew up a list of those that had aberrant billing patterns based on our analysis, and had our law enforcement partners review this list so we would not target any that were already under separate investigations.
- We worked with the State to specially train its registered nurse surveyors, who already routinely conducted home health agency quality reviews for us, to spot program integrity problems, as well. These nurse surveyors conducted thorough surveys of the questionable agencies we had identified, including their medical documentation records.
- The State surveyors also, importantly, visited individual beneficiaries in their homes to ask about the care the home health agencies were providing. They found that far too often services for which the taxpayers were being billed were either overused, not medically necessary, or not covered by Medicare. In some cases, the beneficiary was not even homebound, which is an essential criterion to qualify for home health care.
- We had our claims processing contractor review the State surveyor's findings and conduct further studies. They determined that these 20 home health agencies had been improperly paid more than $777,000, which is now being recouped. In addition, they prevented further improper payment of another $569,555 to these agencies, all for an investment in this particular project of just $52,889. Similar Operation Restore Trust successes were achieved in all the five pilot States.

Other Operation Restore Trust initiatives in Illinois uncovered hospices billing for patients who were not terminally ill, and durable medical equipment vendors billing for unnecessary and expensive supplies that were simply being stockpiled in nursing homes storage rooms.

EXPANSION

Overall, Operation Restore Trust saved more than $200 million in its first two years through restitutions, fines, settlements, and identified overpayments. Its expansion began as soon as its success became apparent.

In 1997, we began working to incorporate Operation Restore Trust into our day-to-day business approach throughout the country. Operation Restore Trust strategies were expanded to a total of 19 States—Arizona, California, Connecticut, Florida, Illinois, Indiana, Louisiana, Massachusetts, Minnesota, Missouri, New Jersey, Ohio, Oklahoma, South Dakota, Tennessee, Texas, Utah, Virginia, and Wyoming.

Community mental health center abuse of Medicare's partial hospitalization benefit was added to the Operation Restore Trust project list, as our analyses showed costs soaring far beyond any reasonable projection. The partial hospitalization benefit provides outpatient psychiatric services to mentally ill patients who otherwise would have to be hospitalized. Operation Restore Trust investigations found centers with no trained professionals, providing no treatment of any kind, or billing us for "therapies" such as bingo. We now have a national initiative underway to terminate the most egregious community mental health centers, and to closely monitor others to ensure appropriate care and compliance with coverage requirements.

We made significant improvements to Operation Restore Trust's special anti-fraud hotline, 1–800–HHS–TIPS, so beneficiaries and health care workers with potential problems to report could get more user-friendly service and quicker access to live operators. As Secretary Shalala has said, beneficiaries and honest providers are among our most important allies in fighting fraud, and we must make sure they know how to reach us and how they can help. This hotline is a critical link, and since its inception in June 1995 HHS operators have spoken to approximately 145,000 individuals regarding potential issues of fraud, waste and abuse.

We have received 3,956 complaints through the hotline in Region Five since its beginning in 1995 that so far have lead to $1.9 million in recoveries on 352 cases, with another 75 cases referred to law enforcement for further criminal investigation.

Here in Region Five, we expanded Operation Restore Trust investigations into Indiana, Minnesota, and Ohio. This year we have expanded them into Wisconsin. And next year we are planning to use Operation Restore Trust strategies to target suspected problems in clinical laboratories, hospices, and skilled nursing facilities.

Because of Operation Restore Trust, we are getting more information from beneficiaries about potential problems, and seeing much broader public awareness in general of how to fight health care fraud. We are seeing routine program integrity referrals from State surveyors. We are seeing provider groups do more to educate their members on program integrity issues, like the need for proper documentation. We have secured several important changes in legislation and regulation that help fight fraud, waste, and abuse, including:

- home health reforms that close loopholes, eliminate incentives to bill for unnecessary or uncovered care, and tighten eligibility standards;
- the ability to bar convicted health care felons from ever again getting paid by Medicare, and to exclude family members of sanctioned providers as well, so that they can't continue operating just by transferring the business in name to a relative; and
- the right to require providers to give us their social security and employer identification numbers so that we can check to see if they've ever committed health fraud in the past.

In fact, the success of Operation Restore Trust and our overall crackdown on fraud, waste and abuse may have generated undue concern among some providers. Let me be clear—we have no intention of prosecuting anyone for honest mistakes. If providers do make billing errors, we do want to find those errors, preferably before we make payment. If we find errors after we make payment, make no mistake about it, we do want the money back.

But we are not looking to put anyone in jail for honest mistakes, and we are not going to refer physicians to law enforcement agencies for occasional errors. We know that most providers are honest and conscientious, and we have to believe that the provider knows he or she was violating billing rules before we make any referrals. Let me also be clear, however, that we have zero tolerance for fraud, waste, and abuse.

COMPREHENSIVE PLAN

In order to further institutionalize and build on the lessons of Operation Restore Trust, we have developed a Comprehensive Program Integrity Plan, which is nearing completion. Its development began last March when we sponsored an unprecedented national conference on fraud, waste, and abuse in Washington, D.C., with broad representation from our many partners in this effort. The bulk of the conference consisted of discussion sessions. 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. Their discussions were synthesized and analyzed to determine the most effective strategies and practices already in place, and which among the new ideas that were raised deserve further exploration. The result is a Comprehensive Program Integrity Plan with several clear objectives.

Increase the Effectiveness of Medical Review. This includes:

- increasing the overall level of review, and targeting it on problem areas such as durable medical equipment, physician evaluation and management services, and home health claims;
- hiring additional physicians as claims processing contractor Medical Directors to improve the effectiveness of medical review and foster better understanding of program integrity issues among physicians;
- making more efficient use of prepayment review with claims processing computer "edits" that automatically deny improper claims;
- training for approximately 500 Medicare and Medicaid contractor employees by the HHS Inspector General's office on how to develop cases for prosecution when warranted;
- evaluating local review policies to determine where national policy may be needed; and
- measuring how well individual contractors perform medical review activities.

Implement the Medicare Integrity Program. This allows us to hire special contractors who will focus solely on Program integrity, as authorized under the Health Insurance Portability and Accountability Act. We are now reviewing public comments

on a proposed regulation for how these contracts will work, and expect to issue a final regulation early next year. 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 contract with many more firms who can bring new energy and ideas to this essential task. We expect to have four new types of contractors:

- payment Safeguard Contractors will focus on medical review, fraud case development, cost report audits and related program safeguard functions as needed;
- a Coordination of Benefits Contractor will consolidate all activities associated with making sure Medicare does not pay for claims when private insurers or other government programs are liable;
- a Statistical Analysis Contractor will provide a comprehensive on-going analysis of trends, utilization data and other information which helps detect fraud, waste, and abuse; and,
- Managed Care Integrity Contractor(s) will target the program integrity issues that are unique to health plans.

We have already issued one Program Safeguard Contract solicitation to establish a multiple awards contract for these MIP activities. Once established, the multiple awards contract will allow us to issue Task Orders for any or all program integrity activities. This way we can have a pool of contractors available to undertake the work before we solicit proposals for specific contractors' workloads. This lets us experiment with various configurations of program integrity activities, and provides flexibility that will help mitigate risk related to the Year 2000 issue and other challenges. We also will be able to turn to these contractors when various situations arise, such as the appearance of new scams or the departure of another contractor.

Proactively Address the Balanced Budget Act. This law created several new programs, benefits, and payment systems which all create new vulnerabilities. We are acting to address program integrity problems before they occur for:

- the Children's Health Insurance Program;
- diabetes self-management, mammography screening, prostate cancer screening, and osteoporosis screening benefits;
- reimbursement changes for physicians assistants and nurse practitioners; and,
- the prospective payment system for skilled nursing facilities.

Promote Provider Integrity. We intend to make clear that we do not simply pay bills, but enter into agreements to do business with providers. To do so, we will:

- step up efforts to educate providers on how to comply with program rules;
- publish a proposed regulation to establish clear enrollment and periodic reenrollment requirements, including conditions under which we will deny or revoke billing privileges and an appeal process for providers whose billing privileges are denied or revoked; and
- pursue bond requirements for certain types of providers, pending receipt of a General Accounting Office report on how to best use bonds to protect program integrity.

Prepare for the Year 2000 Computer Issue. We have special work groups exploring how the millennium problem could impact program integrity efforts. They are evaluating the function, value, and Year 2000 risks for each of our program integrity efforts, and developing a plan to mitigate or circumvent any problems if they do arise.

Target Known Problem Areas. These include inpatient hospital care, managed care, congregate care (delivered settings such as assisted living facilities), nursing homes, and community mental health centers.

- *Inpatient Hospital Care.* We will have Medicare's Peer Review Organizations (PROs) investigate, correct, and prevent problems documented in audits of Medicare, such as providing unnecessary or uncovered services, failing to properly document care, and coding claims incorrectly. PROs currently perform activities such as validating diagnostic codes and reviewing medical records. Our new contracts with them will include strong financial incentives to reduce improper payment rates for inpatient care.
- *Managed Care.* As mentioned above, we will hire a special program integrity contractor to focus on managed care, where fraud, waste, and abuse are more

likely to involve inadequate care, avoiding enrollment of high-cost patients, and misrepresenting data on which payment rates are based. We expect such contractors to verify data, review beneficiary appeals to ensure that access to care is not denied inappropriately, and monitor plan compliance with Medicare rules.

- *Congregate Care.* Beneficiaries in nursing homes, assisted living centers or adult day care facilities are easy targets because there is easy access to large numbers of beneficiary billing numbers. Unscrupulous providers conduct "gang visits" in which all beneficiaries receive a service or supply whether they need it or not, or they submit bills for every beneficiary without furnishing anything at all. They also submit duplicate bills to both Medicare and other payers for services that only one payer should cover. We will mount Operation Restore Trust style projects to fight these types of scams. We also will work to anticipate shifting incentives for congregate care fraud, waste, and abuse as we move to more prospective payment systems.
- *Nursing Homes.* As one of our original Operation Restore Trust focus areas, much is already underway to fight fraud, waste, and abuse and improve the quality of care. We will continue our initiative, announced by the President this summer, in which we are: working with States to improve their nursing home inspection systems; cracking down on nursing homes that repeatedly violate safety rules; seeking to require criminal background checks on all new nursing home employees; working to reduce the incidence of bed sores, dehydration, and malnutrition; and publishing nursing home quality ratings on the Internet. We also are likely to work with law enforcement partners to address egregious cases. And we will continue to develop Operation Restore Trust style projects targeted on specific nursing home fraud, waste, and abuse problems.
- *Community Mental Health Centers.* As another of our earlier Operation Restore Trust focus areas, much is already being done to stop abuses in this area, as well. We have a 10-point action plan underway which first and foremost ensures that beneficiaries who need intensive psychiatric services get them from qualified providers. We are doing so through coordination with other agencies, providers, and advocacy groups. This beneficiary protection is essential as we terminate the worst offenders and work aggressively to bring others into compliance with all rules and regulations. We are increasing claims review and developing a prospective payment system that will eliminate incentives for inappropriate, unnecessary or inefficient care. We also are increasing scrutiny of new applicants and requiring site visits nationwide to ensure that they meet all of Medicare's core requirements. Already this year we have denied Medicare participation to more than 100 applicants because they failed to provide all the required services. And last year President Clinton sought legislation to strengthen CMHC enforcement activities by: authorizing fines for falsely certifying a beneficiary's eligibility for partial hospitalization services; prohibiting partial hospitalization services from being provided in a beneficiary's home or other residential setting; and authorizing the Secretary to set additional requirements for CMHCs to participate in the Medicare program.

CONCLUSION

Operation Restore Trust has lead to unprecedented success in fighting fraud, waste and abuse. It has become the way we do business on a day-to-day basis throughout our Regional Office here in Chicago and the Nation. It lead us to conduct an unprecedented national conference on how to fight health care fraud, and from there to develop a Comprehensive Program Integrity Plan that builds on our successes and lessons learned. We greatly appreciate your interest and support for these efforts. Senator Collins, I know this area is of particular concern to you, and that you have conducted previous hearings and drafted legislation to help us in these efforts. We are honored to have you here with us today in Chicago. We look forward to working with you and Senator Durbin on further efforts to protect Medicare from fraud, waste and abuse, and I am happy to answer any questions you may have.

PREPARED STATEMENT OF JAMES A. KOPF

Good morning Madam Chairman. I am James A. Kopf, Director of the Criminal Investigations Division in the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services (HHS). I am here to tell you about some inno-

vative practices we have developed to fight fraud and abuse in the Medicare and Medicaid programs. We have had notable successes; and we know we cannot let our guard down or be satisfied with today's tools.

Let me share some insights about our experiences with the constantly escalating assaults on our programs.

Developing New Enforcement Approaches

With annual expenditures of well over $300 billion, the Medicare and Medicaid programs present a sizeable target to those who seek to unjustly enrich themselves at the taxpayers' expense.

In late fall of 1994, with resources shrinking, the HHS Secretary asked the Inspector General to develop a new approach that would enlist the resources of the various HHS components to attack fraud and abuse in Medicare and Medicaid. It was decided to implement a coordinated effort involving the OIG, the Health Care Financing Administration (HCFA) and the Administration on Aging (AoA). Those three components of HHS served as the cornerstone for the Department's new initiative and brought the Department's many years of experience and expertise together in a concerted effort.

In addition, we invited the Department of Justice, including the Federal Bureau of Investigation, the Offices of the United States Attorneys, and State and local agencies involved in fighting health care fraud and abuse issues to participate in this combined effort, which became known as Operation Restore Trust (ORT). It was started in March 1995, then became a Presidential initiative in May of that year.

The purpose of this initiative was threefold: (1) to coordinate all available resources in an effort to make a significant impact on health care fraud and abuse; (2) to reach out and educate the public on the growing health care fraud schemes and issues; and (3) to demonstrate that a combined effort would be the most cost efficient method of attacking this problem, with results yielding a significant return on the dollars invested.

We focused our efforts on five key States and three high-growth program areas. The States were New York, Florida, Illinois, Texas, and California. These States represented over one third of all beneficiaries and expenditures for Medicare and Medicaid nationally. The high-growth program areas were home health care, nursing facilities, and durable medical equipment.

Our audits, evaluations, and investigations indicated that the home health industry had become a target for unscrupulous providers. Nursing facilities also came under scrutiny, not only for fraud and abuse, but also for potential of quality of care and patient abuse issues. Durable medical equipment (DME) is traditionally a hot bed for those who choose to steal from the government. At that time, Medicare provider numbers (i.e., authorized numbers used to bill the Medicare program) were easily obtainable, and no prior health care experience was required to go into the DME business. So profitable was this area that criminal elements in South Florida were leaving the illegal drug business to open DME companies. This was as profitable as dealing in drugs and was less risky.

After the first year of the project, hospice care was added as a high-growth focus area, based on audits of the industry that indicated a high potential for fraud and abuse.

Project Coordinators in each of the five States established work groups comprised of the agencies I mentioned earlier. The work groups determined project goals and objectives unique to each State and implemented innovative plans that made the best use of available resources. The States coordinated their efforts with the OIG, HCFA, and AoA headquarters, which in turn shared the results of each State's efforts with the entire demonstration team. The result was a cohesive, concentrated attack on health care fraud.

Members of the partnerships we found are here today to tell you about the results of this initiative. Each will provide a unique perspective as to what they hoped to see accomplished. I am here to share information regarding some of the successful cases that flowed out of this project locally.

Examples of Schemes Investigated in Illinois

Incontinence Supplies

First, during Operation Restore Trust, a scheme was uncovered involving incontinence supplies provided to nursing home patients. Adult diapers are not items that a nursing facility can bill separately to Medicare. The cost of providing adult diapers is the responsibility of the nursing facility as a part of its routine cost of providing care to patients.

Investigations revealed that unscrupulous suppliers convinced nursing home operators that they had found a legitimate way to bill Medicare for the diapers. In return for the names and Medicare numbers of incontinent patients, these suppliers provided the nursing homes with an endless supply of adult diapers at no cost. The suppliers then billed Medicare as if the diapers were an item known as a "Female Urinary Collection Device." This device could be billed for $7.00 to $8.00 per item while the cost for purchasing the diapers was only 30 cents per diaper. The supplier billed Medicare as if the more expensive collection devices were provided three times a day, 7 days a week. The cost to Medicare mounted at an incredible rate. The suppliers quickly recouped their overhead and began making money.

This particular scheme was found to be so wide-spread that it involved patients and suppliers throughout the country. These cases have been successfully investigated, and a number of these investigations are still ongoing, including some in Illinois.

We were able to detect this scheme and investigate these matters in Illinois because of efforts and resources provided through ORT. In all States, savings to Medicare are as a result of these types of investigations resulted in savings estimated at $104 million in 1996, projected to about $534 million over 5 years.

Changing Identities

The next case had some distinct characteristics not found in the preceding examples. This supplier provided incontinence care kits to nursing homes. These relatively inexpensive kits included a pair of latex gloves, a small cup of sterile water, a disinfectant, an absorbent pad, a pair of plastic tweezers and a small plastic pair of scissors. The supplier misrepresented the patients as having chronic incontinence in order to bill Medicare, then inflated the number of kits actually provided. An average of 90 kits per month per patient was billed, but only about a third of that number was provided.

What sets this investigation apart from the others was the fact that the perpetrators closed and then reincorporated their business under different names 31 times to avoid detection. Shortly after they started doing business with Medicare, the Quisenberrys, a father/daughter team, became aware that the Medicare contractor who processed their claims was scrutinizing the claims due to concerns about possible fraud or abuse. Before their company du jour would run up enough claims to gain the attention of the contractor, the Quisenberrys would simply close the business and incorporate under a different name and location. They were able to accomplish this by enlisting the aid of friends and family who "fronted" for them.

When this investigation was concluded, the Quisenberrys and five of their associates were named in a Racketeering Influenced, Corrupt Organization (RICO) indictment. The RICO indictment was the first of its kind in the health care fraud arena. More significantly, it was the largest RICO indictment in the history of the judicial district in which it was filed, alleging damages of approximately $30 million to the Medicare program. All the parties charged pled guilty to their part in this scheme. While not being the largest Medicare fraud case which we have investigated, the Quisenberry case clearly was one of the more unique investigations, setting a trend on how to cheat the Government. A number of jurisdictions are now considering similar charges in other investigations.

Although this supplier was actually based in Michigan, it did over $1 million in business with nursing homes in Illinois, and for that reason, it was included as an Operation Restore Trust investigation. Again, if not for the resources and expertise that were brought in under ORT, this investigation would not have been brought to a successful conclusion.

Phony Cost Reports

Based on periodic cost reports, Medicare reimburses Home health agencies, nursing facilities, and some other providers who render care in a facility-like setting. The cost report is used to itemize the total cost of operation of the provider. It identifies the proportion of the provider's total cost that is related to the care of Medicare beneficiaries and forms the basis for Medicare reimbursement. It is possible, however, to "bury" within this document expenditures which are totally unrelated to providing Medicare beneficiaries with treatment.

Through ORT, we initiated a number of cost report cases in Illinois as they apply to nursing facilities or home-confined patients.

In one case, a nursing home administrator embezzled money from the owners of his nursing home by including non-medical expenses in the cost report, disguising them as reimbursable items. In some instances, the money was actually used for improvements to his private residence and an accumulation of over 200 pornographic video tapes. In addition, he created a ghost employee and paid himself a

sizeable salary under that name. He also embezzled money from residents in the nursing home by gaining control of their personal finances.

In all, this man stole approximately $1.6 million. All but $200,000 was obtained through false cost reports. He pled guilty as a result of this investigation and was sentenced to a total of 46 months imprisonment and ordered to pay $1.6 million in restitution, including over $67,000 to a Medicare beneficiary from whom he swindled money.

Exploiting the Frail Elderly to Bill Medicare

In another type of case that was identified during Operation Restore Trust, a number of businesses identifying themselves as Community Mental Health Centers were found to be defrauding the Medicare and Medicaid programs. These providers supplied adult day care under the guise of mental health therapy.

Patients at area nursing facilities were delivered by the provider and held for the day in empty warehouses or other abandoned buildings. They were allowed to watch TV or play cards, but were otherwise provided no structure or care. The providers claimed the expense of providing transportation, meals and the services of mental health professionals when they did not, in fact, provide any of these services. These investigations are far from complete and have raised serious questions about the quality of care received by nursing facility patients.

Home Pharmacy Services

Last, I will describe the case of Home Pharmacy Services, a firm that operated in Southern Illinois that provided pharmaceuticals for residents of 96 nursing facilities in that part of the State. These supplies were paid for predominantly through Medicaid, although the example clearly demonstrates the application of the ORT protocol.

Under the rules of Medicaid, drugs that are unused at the time of a patient's death or discharge are to be destroyed. This company, however, was recovering the unused drugs, repackaging them and re-selling them, often to other Medicaid recipients. In addition, the unused drugs were not stored appropriately after they were recovered by the company, creating a substantial health risk. The drugs could have lost the potency necessary to produce the medical goals of the subsequent patient; and, more seriously, the drugs could become toxic and threaten the user's health.

An ORT-coordinated task force executed a search warrant on the premises of this business in May, 1996. Agents filled two 14-foot Postal trucks with records and evidence, including a large amount of recovered drugs which had not yet been repackaged. The drugs were being stored in store rooms which were neither sanitized nor climate controlled.

The parent corporation of Home Pharmacy Services subsequently entered into settlement negotiations with the Office of the United States Attorney and with our office. As a result, the corporation agreed to pay $5.3 million in penalties and restitution, enter into a corporate integrity plan, and cooperate in the criminal prosecution of the manager and former owner of Home Pharmacy Services. The former owner, who had sold his business to the current owners devised this scheme, entered into a plea agreement with the United States Attorney. He was sentenced to two years in a Federal penitentiary and ordered to pay $750,000 in fines and restitution to the Federal government.

This case came to fruition because of the cooperative effort put forth under the auspices of Operation Restore Trust. The investigation was one of the earliest joint efforts under ORT and was the first investigation of the Health Care Fraud Task Force in the Southern District of Illinois which was itself a product of Operation Restore Trust. The Task Force was comprised of a team of agents from several State and Federal agencies, including the HHS OIG, the FBI, Postal Inspection Service, the Illinois Medicaid Fraud Control Unit, the IRS, and the Illinois Pharmacy Board. Funding made available through ORT helped make it possible to open an OIG field office in Fairview Heights, Illinois, the city in which the Office of the United States Attorney for the Southern District of Illinois is located and where this case was prosecuted.

Conclusion

As you can see, the Operation Restore Trust experience provided all of us with a new template for the way we do business. New lines of communication were opened, and cooperation among agencies involved in fighting health care fraud reached new heights. The proof is in the remarkable return on investment realized at the end of the 2-year project. In the five States, the initiative identified $187.5 million in restitutions, fines, settlements, and other overpayments. This constitutes a return of more than $23 for every $1 invested in the project.

Operation Restore Trust paved the way for the passage of the Health Insurance Portability and Accountability Act of 1996. That statute included a solid funding base that allows our agency to continue to aggressively fight fraud and abuse in the Medicare and Medicaid programs and to be a full partner with the other agencies and law enforcement entities in this effort.

We are proud of our accomplishments, and we cannot afford to be naive or to rest on our laurels. Even as we speak, criminal elements are developing novel new approaches to exploit Medicare, Medicaid, and other health care programs. We need to stay ahead of them. We are therefore, eager to work with this committee to further refine our tools and the program safeguards needed to protect taxpayer dollars and medical care resources.

Thank you for holding this hearing. I welcome your questions.

PREPARED STATEMENT OF JOHN GRAYSON SUBMITTED BY BARBARA COYLE

My name is John Grayson and I am a volunteer at the Suburban Area Agency on Aging for the Health Care Anti-Fraud, Waste and Abuse Community Volunteer Demonstration Project. I am a retired owner of a manufacturing company in the north west suburbs, and have been with the project since October 1997. Next to me is Jonathan Lavin, Executive Director of the Suburban Area Agency on Aging in Oak Park, Illinois and Mimi Toomey also with the Suburban Area Agency on Aging in Oak Park, Illinois.

I first heard about the project from a public service announcement that was on the radio. I contacted Miss Toomey and subsequently enrolled in her training program. In my training class there were 38 volunteers and the training program extended over the period of 3 days, during which the speakers included staff from the Office of Inspector General, Illinois Department of Public Aid, Ombudsman Program and the Medicare Fraud Units. In my area the Catholic Charities Northwest is the host and Mary Nommenson is the coordinator. Mary makes calls to various senior organizations and sets up the appointments for me to make my presentations. I am generally assisted by another volunteer named Jim Grimm, from Elk Grove Village, who does a little bit of the speaking and helps by passing out literature and conducting surveys and doing personal interviews after my presentation.

At the presentations, I first introduce myself and attempt to build some interest and some enthusiasm for what we're doing by pointing out to the senior citizens that Medicare spends 200 billion dollars a year of which it is estimated that 20 billion dollars is lost through fraud, waste and abuse. I point out that it is predicted that Medicare will go bankrupt in 10 years, and that, undoubtedly, as it starts to go bankrupt, benefits will be reduced or co-payments will be increased so it is in all of our interests to help save Medicare by doing what we can to spot any indications of fraud and abuse. I want to point out that we are saving this not just for ourselves but for our children and potentially our grandchildren. I explain how easy it is for crooks to swindle the system by merely having a doctor's prescription for unnecessary procedures or equipment as well as having your Medicare number. I explain that the Medicare number is just like your credit card number and that you should never give it out to anyone who isn't known to you to be a genuine provider of services. I relate some of the instances or types of fraud that have been perpetrated on people and the system. These are the examples of fraud that has already been detected, by crooks who have been caught, but the possibilities for theft and fraud are infinite, and changing constantly. We are seeking the help of our audiences in spotting fraud, because they are on the front line and have the best opportunity to see it first. I emphasize that it is very important for them to examine their medical summary notice, or explanation of medical benefits, following a medical procedure. They need to be sure that they received everything that was billed to Medicare. When they do spot something that doesn't look right, the first call should be to their medical provider to obtain explanation. If they aren't satisfied with that, I suggest they call their SHIP counselor, Senior Health Insurance Program counselor, to assist them in getting an explanation. If they still aren't satisfied, then I suggest that they call the numbers on the pamphlet I give them, which would either be the Federal HHS-TIPS line or our local number at the Suburban Area Agency on Aging, or call Mary Nommenson at Catholic Charities. I try to give them an incentive by telling them that there is now a bounty being paid to whistle blowers who help us to uncover fraud and that they could be paid 10 percent of whatever is recovered up to $1,000.

I conclude by reiterating the three main points I wanted to make. First, don't give your Medicare number to anyone that you don't know. Second, check your expla-

nation of medical benefits carefully to make sure you received everything that Medicare is being billed for. And save our literature so that if you do come across anything that doesn't look right, you'll have our number where you can call us. I close by thanking them for their attention and by urging them to help us to save Medicare. I then explain that Jim Grimm and myself will be available after the presentation to talk to anybody that wants to ask us questions. We also want to hear them tell us about their own experiences. Generally we do have a few people who do want to talk to us on a one-on-one basis. We ask them to fill out the survey form so that we can report these back to our host for documentation and statistics.

I personally have provided presentations to a variety of community organizations and am constantly amazed at the level of interest by participants in attendance. There are usually three or four individuals in the audience who share their personal stories of suspected fraud or abuse after the presentation.

I have found participation in the Suburban Area Agency on Aging's fraud and abuse program to be challenging and rewarding and am very pleased to be able to relate my experience with you today.

PREPARED STATEMENT OF JONATHAN LAVIN AND MARY CLARE TOOMEY

The Suburban Area Agency on Aging, and the Northeastern Illinois Area Agency on Aging are pleased to be participants in the U.S. Administration on Aging "Health Care Anti-Fraud, Waste, and Abuse Community Volunteer Demonstration Project." We greatly appreciate the assistance provided to us from Stasys Zukas our program officer in the Chicago office of the combined Regions 5 and 7 offices for the Administration on Aging, and in Washington D.C., Brian Lutz and Valarie Soroka. Our project also works in conjunction with the City of Chicago Department on Aging which has assisted us to spread the word on what Medicare beneficiaries and senior service agencies may do to identify and report fraud and abuse in the Medicare and Medicaid programs. We also want to mention how much we appreciate the advice and experience offered to us by the Illinois Department on Aging which has always been one of the leaders in Operation Restore Trust since it began in May of 1995.

We are one of twelve projects funded by the U.S. Department of Health and Human Services' Administration on Aging to recruit and train retired individuals to identify waste, fraud, and abuse in the Medicare and Medicaid program. In addition to the federal funds we receive, Blue Cross/Blue Shield of Illinois has provided us resources for volunteer recruitment and training in each of the first two years of the project. We also identify the time of our volunteers as in-kind match to our grant award. Once trained, these volunteers alert other seniors and help them recognize and report excessive charges for services or supplies, unnecessary service charges, and questionable billing practices.

This Project is centered in local senior service agencies throughout the metropolitan Chicago area. In addition we were able to tap the expertise of the Illinois Department of Insurance Senior Health Insurance Program, the Illinois Nursing Home Ombudsman Program, the Office of Inspector General, the Illinois Attorney General's Office, Office of Inspector General, Department of Public Aid, and the State Police. Volunteers are recruited from all of suburban Cook County and the Collar Counties (DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, and Will).

The Area Agencies on Aging have subcontracted with eleven host sites in the metropolitan Chicago area to organize presentations and supervise volunteers. Each host site is responsible for coordinating volunteers to provide at least two educational programs per week with various senior organizations, civic organizations and church groups. Volunteers also provide individual assistance to beneficiaries on a as-needed basis for specific issues and concerns. The participating organizations are all current grantees to the Area Agencies on Aging under Title III of the Older Americans Act and through the direction from Washington D.C. by the Administration on Aging and from Springfield, Illinois from the Illinois Department on Aging, to the regional level and then to the community as part of the Illinois senior service network. This network was able to develop proposals and implement volunteer recruitment and presentations in a rapid and effective fashion under this program.

We emphasize that the vast majority of health care providers are honest and are trying to provide the best care that they can. We have worked with a number of doctors, nursing home administrators, hospital staff and other health care professionals to develop strategies which better ensure the integrity of the Medicare and Medicaid programs. It is in fact only a small percentage of unscrupulous people who are creating a serious problem.

The U.S. General Accounting Office estimates that as much as $20 billion are lost each year to fraud, waste and abuse. What is more, consumer surveys by the Amer-

ican Association of Retired Persons and the U.S. Department of Health and Human Services reveal that these practices are causing a great mistrust in the public's perception of our health care system. Like a neighborhood watch system, our mission is to be the eyes and ears of the Medicare program in our communities—to help restore trust and help ensure that people are receiving the care that we pay for.

The level of interest in this project demonstrated by the retired professionals has been quite impressive. Retired attorneys, paralegals, registered nurses and insurance professionals have made up the majority of those trained.

The cooperation of federal, state, and local agencies to unite our efforts in combating fraud and abuse in Medicare and Medicaid was an achievement in itself. These groups have integrated efforts to not only raise beneficiary awareness, but have developed a system to share information which has been invaluable to our project. Agencies such as the Office of Inspector General, Illinois Department of Public Aid and the Illinois state police have provided speakers to participate in training the retired beneficiaries. The groups involved have benefited from the partnerships formed as a result of the combined efforts to combat Medicare and Medicaid fraud and abuse.

Based on information provided by the Office of Inspector General we share "horror" stories with beneficiaries at presentations. We site specific examples of what to be aware of in detecting fraud and abuse. According to the latest figures, over $3 million has been recouped as a result of the volunteer activities across the country, but most important is the message we are sending to fellow seniors that they have the responsibility to help preserve their own Medicare and Medicaid programs.

Of course, not every allegation becomes a case for investigation. A good deal of our assistance comes from helping people to navigate the health care system including who they should call, how to get information, and how to be better health care consumers. We try to educate people not only about what may be fraud, but also, what isn't fraud. A simple call to their provider or to their Medicare insurance carrier may clear up the discrepancy. But in those instances where something still may not seem right, the case is referred to the Office of Inspector General for investigation.

To date, the Health Care Waste, Fraud and Abuse Community Volunteer Projects across the country have trained over 2,000 retired volunteers, held over 1,200 training sessions, informed more than 250,000 persons through community education sessions, reached more than 7 million persons through public service announcements and media messages, and referred several hundred cases to the Office of Inspector General which are currently under investigation.

In the fiscal year 1999, the Administration on Aging has received $7 million to expand these volunteer projects nationwide, affirming the success of our combined efforts to combat fraud, waste and abuse in the health care system.

The following figures highlight major achievements made during the period October 1997-October, 1998 in the Chicago Metropolitan Area:

- Number of individuals trained: 105
- Number of retired professionals trained: 85
- Number of others trained: 20
- Number of people reached through anti-fraud presentations: 10,075
- Number of individual beneficiary contacts: 90
- Number of suspected fraud reports made OR to be made by a volunteer: 21
- Number of reports NOT found to be fraudulent and handled locally: 69

We are very pleased to have the opportunity to continue our project. We ask you to examine a few issues that may impact the program in the future:

1. The Health Care Financing Administration is suggesting that they may save funds by suspending the mailing of Summary of Benefits (previously the Explanation of Medicare Benefits Notice). If these notices are not sent to Medicare beneficiaries, a key tool for the combating of Medicare fraud and abuse will be lost. We ask that these notices continue to be mailed and that you join us in promoting the close examination of those notices by beneficiaries.
2. We ask that the Administration on Aging program be briefed of major findings by others who are combating fraud in the federal government so that our volunteers may offer current and accurate information in their presentations. The more knowledgeable we are of the fraud and abuse stories in the major headlines, the more convincing our message is to our audiences.

Thank you for asking us to participate in this hearing.

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