

**MEDICAID PROVIDER ENROLLMENT: ASSESSING  
STATE EFFORTS TO PREVENT FRAUD**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE ON  
OVERSIGHT AND INVESTIGATIONS  
OF THE  
COMMITTEE ON COMMERCE  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED SIXTH CONGRESS  
SECOND SESSION

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JULY 18, 2000  
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## **MEDICAID PROVIDER ENROLLMENT: ASSESS- ING STATE EFFORTS TO PREVENT FRAUD**

**TUESDAY, JULY 18, 2000**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON COMMERCE,  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 10:05 a.m., in room 2322, Rayburn House Office Building, Hon. Fred Upton (chairman) presiding.

Members present: Representatives Upton, Cox, Burr, Bilbray, Bryant, Stupak, and DeGette.

Staff present: Chuck Clapton, majority counsel; Jason Scism, legislative clerk; and Chris Knauer, minority investigator.

Mr. UPTON. Good morning, everybody. Thanks for coming on time.

For my colleagues, I'll make unanimous consent that I guess no one can object to that their opening remarks will be made part of the record. And if they get here before I finish, which will not be too long, obviously they will be able to deliver that. For those of you in the audience, we do have a number of subcommittee meetings this morning; and the House is in session, though we're not expecting votes for a couple of hours; but we'll see.

Let me begin by thanking all of the witnesses who are testifying today. Many of them are currently serving on the front lines of our national efforts to combat health care fraud. They have unique insights into what we can do to win the battle to eliminate fraud from important programs like Medicare and Medicaid, and I appreciate their agreeing to appear today to share that information with us.

Today we'll hear very disturbing testimony about how the California Medicaid program may have lost \$1 billion—"b" as in big—dollars due to medical equipment fraud. One of the witnesses will tell us how he saw firsthand how easy it was to become a California Medicaid provider and make tens and sometimes hundreds of thousands of dollars a month by submitting false claims. He'll also tell us how honest equipment companies were unable to compete with these criminals and were forced out of business or persuaded to join in the criminal activities.

What is even more disturbing is the fact that much of this fraud could have been prevented with simple, inexpensive techniques to evaluate the applicants before they're able to enroll as Medicaid providers.

It seems to me that a State has already won half of the battle if they can keep criminals out of the Medicaid program before they can submit any false claims. This is especially true when you consider that the cost of these techniques can be sometimes between \$100 and \$200 per provider, while denying just one criminal access to a Medicaid program can prevent them from submitting hundreds of thousands of dollars worth of false claims.

Both California and Florida have shown how common-sense techniques like criminal background checks and site visits to a provider's place of business can be very successful methods of preventing Medicaid fraud before it gets started. The rigorous controls that Florida has put into place have contributed to the dramatic decrease in fraud that has recently allowed them to save \$100 million over 2 years. California is now also putting into place similar provider enrollment controls that should dramatically decrease the size and scope of their fraud problem.

I hope that the representatives from both of these States as well as other witnesses share with us their recommendations on how such provider enrollment controls can best be used to prevent Medicaid fraud across the country. The most important question that I hope can be answered today is what more should be done to encourage all State Medicaid programs to adopt similar provider enrollment techniques.

One lesson that I've seen from the committee's prior work on health care fraud issues is that criminals are always going to try to find ways to make money by ripping off government-run health programs. They know which programs have tough safeguards in place and which ones are vulnerable to fraud. Sometimes, like roaches scurrying from the bright light of public attention, these criminals will inevitably seek out the dark cracks and crevices provided by States that lack adequate anti-fraud safeguards.

What I hope we can learn today is how we can stop these criminals in their tracks and to ensure that we will never again have to hear about another State losing a billion dollars to a similar Medicaid fraud scheme.

I welcome all of our witnesses, and I ask the vice chairman of the subcommittee if he'd like to make an opening statement. Mr. Burr.

Mr. BURR. I thank the chairman and apologize for my tardiness this morning.

Let me just say, very briefly, that every time this committee takes up medical fraud, I think it's really easy for us to see the human face behind it. It's a billion dollars in California that doesn't end up serving the population that it was intended for.

Mr. Chairman, we have talked many times about the fact that one of the most important things we can do federally is to do no damage. In this particular case, I think that this is a California problem. It may be a problem in other States, but I think it's important for every Member of Congress to realize, as we go through and set up the Federal guidelines and in some cases expand what we cover, that it's sometimes this institution that creates the incentive for new criminals in the Medicaid system and for fraud to, in fact, flourish. We've got to make sure that every dollar that's de-

voted to health care goes to the beneficiaries and not to those that are in the system only to gain from it.

I'm hopeful that California and others will use this committee to tighten, strengthen and secure their systems. And if there is anything that we can do—I know that I speak for all the members on this side and many of which can't be with us today—our hope is that the Medicaid systems truly are there to fill the needs of those who most need it; and if there's a way for us to set guidelines that tightens it, to help the States, then this member and I think this side is certainly willing to do that.

With that, I yield back.

Mr. UPTON. Mr. Bryant.

Mr. BRYANT. Thank you, Mr. Chairman. I apologize for arriving late. I was downtown doing my duty and whatever that might be—

Mr. UPTON. Giving blood?

Mr. BRYANT. Giving blood.

Mr. UPTON. Good.

Mr. BRYANT. [continuing] and I appreciate you having this hearing. I have confidence in how you stand on this issue as well as my colleague from North Carolina, and I would associate myself with your remarks without even hearing either one of them. I have great confidence in both of you, and I will yield back my time.

Mr. UPTON. Thank you.

[Additional statement submitted for the record follows:]

PREPARED STATEMENT OF HON. TOM BLILEY, CHAIRMAN, COMMITTEE ON COMMERCE

Let me begin by thanking Chairman Upton for holding this hearing this morning, and welcoming all of our witnesses. I believe that hearings like this one, and oversight generally, are among the most important functions that the Committee performs. This is especially true of activities relating to Federal health care programs, which prevent scarce Medicare and Medicaid dollars from being lost to fraud and abuse. Whether it was the hearings that exposed Medicare contractor fraud or the investigations that uncovered billing companies submitting false claims, the Committee on Commerce has taken the lead in protecting both the American taxpayers and the beneficiaries who depend on Medicare and Medicaid to pay for their health care services.

Unfortunately, today's testimony clearly indicates how much more needs to be done to eliminate fraud and abuse from these important health care programs. The amount of money lost to the fraud schemes that we will hear about today is staggering—California's Medicaid program over the past few years may have lost almost ONE BILLION dollars to fraud involving durable medical equipment. These losses are all the more disturbing because many could have been prevented by simple and inexpensive techniques for reviewing providers before they are allowed to participate in Medicaid programs.

One might think that common sense would prompt all States to use techniques like criminal background checks and site visits to a provider's place of business before allowing an individual to begin submitting Medicaid claims. For as little as fifty dollars per provider, such techniques can be used to identify and screen out individuals who otherwise are able to commit hundreds of thousands of dollars of fraud in a single month.

Governor Jeb Bush, the State of Florida and Mr. King-Shaw's office should all be commended for the excellent programs they have put in place to review providers before they are allowed to enroll in Florida's Medicaid program. These efforts have contributed to the one hundred million dollars in savings that they have recently been able to achieve through fraud reduction and prevention. In response to their recent problems, California also has begun to adopt some of these very rigorous new provider enrollment controls.

Unfortunately, the General Accounting Office will tell us that not all States are in step with Florida and California's efforts to root out fraud. The criminals who commit health care fraud are clever. As Florida and California tighten up their con-

trols, we can expect to see these fraud schemes migrate to States with less rigorous controls.

To insure that the types of fraud described by today's witnesses will not be repeated in other States, all States should adopt basic, common-sense safeguards. This hearing will hopefully identify means to encourage such activities. I also believe that Congressional oversight should be used to hold States that are not using these techniques accountable for their lapses.

I will also assure all of you that today's hearing will not be end of the Committee's inquiries into these matters. This Committee will continue to do its part to eliminate Medicare and Medicaid fraud. I believe that America's taxpayers and Medicaid's beneficiaries should expect no less from us.

Thank you again Chairman Upton, and I will now look forward to hearing from our witnesses.

Mr. UPTON. We have two panels today. The first panel is Mr. Ruben Assatourian. Mr. Assastourian, if you will come to the table. Mr. Assatourian, we have long-standing committee rules that in this subcommittee we take testimony under oath. Do you have any objection to that?

Mr. ASSATOURIAN. No.

Mr. UPTON. And, second, under committee rules, you're allowed to have counsel also represent you. Do you wish to do that?

Mr. ASSATOURIAN. Yes.

Mr. UPTON. And if he could state his name for the record.

Mr. TURNER. Mr. Chairman, my name is Stephen Turner, counsel for Mr. Assatourian.

Mr. UPTON. If you would both raise your right hand.

[Witnesses sworn.]

Mr. UPTON. You're now under oath.

Mr. Assatourian, please have a seat. Your statement, which I was able to read in its entirety, will be made part of the record in its entirety. If you could limit your opening statement to about 5 minutes, that would be terrific.

We'll start—and you might need to push the mike a little bit closer to you so that people in the back can hear.

Mr. ASSATOURIAN. I will limit the statement. I will make it as short as possible.

Mr. UPTON. Okay.

**TESTIMONY OF RUBEN ASSATOURIAN, PRESIDENT, APICAL CORPORATION; ACCOMPANIED BY STEPHEN H. TURNER, ATTORNEY, CARLSON, MESSER & TURNER L.L.P.**

Mr. ASSATOURIAN. My name is Ruben Assatourian. I would like to thank you for giving me the opportunity to testify before this committee.

Currently, I am the President of Apical Corporation, a medical import and distribution company which I started several years ago. The company does not have any Federal or State contracts and is not involved in Medicare, Medi-Cal or any type of government medical billing. We import high-quality medical products from some of the most reputable European manufacturers in Germany, Spain, France and Italy, in most cases as the exclusive national distributor. The products range from orthopedic bracing, sports medicine products and compression stockings. In addition, we do purchase and distribute the products from several reputable American manufacturers.

In 1997, while my business was growing, I was also a territory manager for a few American medical manufacturers. At their request, I was asked to start selling their products to retail medical supply stores, also known as DMEs, and providers. While, for the most part, the great majority of providers are honest and legitimate individuals and businesses, American-owned and also from different ethnic backgrounds, serving their communities, I realized that the Medi-Cal program in California, with its loopholes and defunct oversight system, has offered criminals a business opportunity more lucrative than the software and the dot-com industry.

The California Medi-Cal system is a broken down ATM machine, which is spitting out cash uncontrollably without the need for even an ATM card. Armani suits have been charged to Medi-Cal, round-trip tickets overseas and silverware for patients have been charged to the Medi-Cal system.

An enormous amount of fraud in the Medi-Cal system has been committed involving adult diapers. In fact, more adult diapers are shipped to Southern California than the entire country combined; and, contrary to popular belief, Southern California does not have a big bladder control problem.

From the bidding process, where manufacturers bid to put their products on the Medi-Cal formulary, to the State employees who were caught selling Medi-Cal provider numbers and the criminal providers who make hundreds of thousands of dollars a year in pure profit, the whole system has become a magnet for criminals. The State Treasury has been looted to the tune of hundreds of millions of dollars.

The fraud is perpetrated in four ways. The first one is getting a provider number. Until 1997, the standard procedure for a provider was a waiting period of 3 to 6 months to obtain a Medi-Cal provider card. As a result of the publicity that Medi-Cal was easy money, many immigrants from the former Soviet republics, with the dream of making easy money, rushed to this business. In many cases, the applicants did not have the basic education of reading and writing English.

From early 1998, the problem got out of control when corrupt State employees within the Health Department started selling Medi-Cal provider numbers from anywhere between \$10,000 to \$20,000, thus luring people, mostly immigrants, into the business. One client informed me he was able to obtain a provider number within 48 hours for \$15,000 before he had even signed a lease for a store.

No. 2, billing Medi-Cal. Once the provider number is obtained, to give the appearance of a legitimate business the provider would make a one-time purchase of approximately \$5,000 in inventory. Prior to getting the provider number, a State employee would have to visit the store to verify the legitimacy of the business by looking at the store operation and purchase invoices for the merchandise the provider had purchased. In some cases, the signature would be obtained without any official visits to the store; and in cases where a visit would be made it would serve no purpose, the reason being that, while I am convinced that the State employees who were making such visits did have the right intention to detect fraud, the problem is that they were unqualified to detect fraud in this area.

For example, auditors from the State Controller's Office who had the primary responsibility of detecting fraud are trained accountants, and I am sure they are qualified to detect fraud in accounting matters. Unfortunately, they have been given the responsibility of detecting fraud in medical products, and fraud does not always happen in the accounting figures. For example, it can happen in the combination of products billed.

In some instances, I have been contacted by State Controller's auditors asking me if it is normal for a small medical supply company to bill Medi-Cal for a hundred pairs of high-compression pantyhose a month. The answer is, no, it is not normal unless the provider has multiple contracts with hospitals and vein specialists.

Mr. UPTON. You can finish up. We'll give you a minute or 2.

Mr. ASSATOURIAN. Passing an audit. A fraudulent provider can pass an audit or could pass an audit by purchasing phony invoices for the supplies the provider billed Medi-Cal from a phony distributor. A fraudulent distributor has very low overhead because they are not in the business of selling products but rather invoices. Consequently, they do not have the expenses of a legitimate business, such as inventory, insurance, payroll, delivery vehicles and warehousing expenses. On those occasions where products were actually sold to a fraudulent provider, the provider would dump the products on the market.

I am aware of situations in which my clients could purchase products for which my company was the sole national distributor for 20 percent of the cost my company was required to pay the manufacturer. Obviously, a legitimate distributor cannot compete in this environment.

The way it works is this: A provider would purchase an invoice for a hundred thousand dollars worth of nonexistent merchandise and pay the phony distributor the full value of the invoice, and the distributor would keep 20 percent for himself and reimburse the provider with \$75,000 in cash. Under these choking circumstances it has become absolutely impossible to conduct normal business, and any provider who would get caught with unacceptable practices would get a penalty and be allowed to continue doing business. Had it not been for the FBI coming into the picture with a sledgehammer and an industrial grade vacuum cleaner, every legitimate distributor and provider would end up bankrupt, leaving the medical business to criminal organizations.

I will stop. The rest of the statement is already on the record, and if you have any questions—

Mr. UPTON. We do. And how we're going to proceed here is that each of us will take about 5 minutes and ask you some questions and see how long it goes.

[The prepared statement of Ruben Assatourian follows:]

PREPARED STATEMENT OF RUBEN ASSATOURIAN, APICAL CORPORATION

Chairman Upton, distinguished members, my name is Ruben Assatourian, and I would like to thank you for giving me the opportunity to testify before this committee.

I am an American citizen. I was born in Iran, where my father had a successful business during the Shah, because of our Armenian heritage, and our being Christian, and the political instability in Iran, my father had sent the whole family to Switzerland, where we lived, and went to school, with my father spending 2 weeks

of every month, with us in Switzerland, and the other 2 weeks attending to his business in Iran. After the revolution in Iran, we moved to the United States.

In 1980, we started a family business, and on the advice of my father, I started learning about medical products and the business. With no experience whatsoever, I went through the process of educating myself about the medical products, and started selling medical products to countries such as Kuwait and Qatar, where American made products are considered to be the best. The learning process was extremely difficult and costly. In many cases, the result was a financial disaster for me. However, never in my entire life have I received any welfare, financial assistance, medical aid or even unemployment from any branch of the federal or the state government.

Currently, I am the president of Apical Corporation, a medical import and distribution company, which I started several years ago. The company does not have any Federal or State contracts, and is not involved in Medicare, Medi-Cal or any other type of government medical billing. We import high quality medical products from some of the most reputable European manufacturers in Germany, Spain, France and Italy, in most cases, as the exclusive national distributor. The products range from orthopedic bracing, to sports medicine products and compression stocking. In addition, we do purchase and distribute products from several reputable American manufacturers.

Sales have been the primary part of my responsibility, where I demonstrate medical products to potential customers. I was not introduced to "Medi-Cal", which is the medical assistance program for the poor in California, until 1997. Prior to that, my sales activity was mostly in the hospital and the doctor's market, where I would go to hospitals such as the Children's Hospital in Los Angeles, the V.A., Kaiser Permanente, among others, for demonstration and in-service of orthopedic casting products.

The story I am telling you, is not a plot out of the popular TV show the "Sopranos", this story is called Medi-Cal, and the hellish environment under which businesses have to survive. It involves fraud, corruption, criminals, scams and a splash of ethnic discrimination.

In 1997, while my business was growing, I was also territory manager for a few American medical manufacturers, and at their request, I was asked to start selling their products to the retail medical supply stores, also known as "DME's" and "Providers". While for the most part, a great majority of the providers are honest and legitimate individuals and businesses, American owned, and also, from different ethnic backgrounds serving their communities, I realized that the "Medi-Cal" program in California, with its loopholes and defunct oversight system, has offered criminals, a business opportunity, more lucrative than the software and the dot.com industry. The California "Medi-Cal" system, is a broken down "ATM" machine, which is spitting out cash uncontrollably without the need for even an "ATM" card. Armani suits have been charged to Medi-Cal cards, round-trip tickets overseas, and silverware for patients have been charged to Medi-Cal.

Currently the joke is that a car salesman asked a potential customer, why don't you get a brand new Lexus with your Medi-Cal card, and the man asks, what about the monthly payments? And the car salesman says, monthly payments are no problem, we accept food stamps. Medi-cal should have a new marketing logo: DON'T LEAVE HOME WITHOUT IT!

Unfortunately, there is no humor in this situation. This mess and corruption has made life a living miserable hell for distributors such as me, and providers, who are trying to conduct legitimate business and grow. Instead, we are now paying the price and the penalty for the actions of others. An enormous amount of fraud in the Medi-Cal system has been committed involving adult diapers, in fact, more Adult diapers are shipped to Southern California, than the entire country combined. And contrary to popular belief, Southern California does not have a big bladder control problem! From the bidding process, where manufacturers bid to put their products on the Medi-Cal formulary, to the state employees who were caught selling Medi-Cal provider numbers, and the criminal providers who make Hundreds of Thousands of Dollars a year in pure profit. The whole system has become a magnet for criminals. The State treasury has been looted to the tune of Hundreds of Millions of Dollars.

A medical supply store opens up, and starts billing Medi-Cal for medical products never purchased. The products are billed to patient's Medi-Cal cards, which in many cases are stolen. In one extreme case which I have heard, the provider was actually dating a nurse in a doctor's office and promising her marriage, in exchange for patient Medi-Cal card numbers. In cases where the patient knows his or her number is being used illegally, the patient receives compensation, either in the form of cash, or presents. In either case, depending on the appetite or sophistication of the pro-

vider, they can net anywhere from \$5,000 to \$100,000 per month in pure profit, for single store operators, and several hundred thousand Dollars a month in profit, for providers who are fronts for groups who own and control several stores. As a result, the taxpayers, finance the lavish life style, expensive cars, houses, and the commercial properties that these criminals purchase.

The fraud is perpetrated in 4 ways:

**1) Getting a provider number:**

Until 1997, the standard procedure for a provider was a waiting period of 3 to 6 months to obtain a Medi-Cal provider number. As a result of the publicity that Medi-Cal was easy money, many immigrants from the former Soviet Republics, with the dream of making easy money, rushed to this business. In many cases, the applicants did not have the basic education of reading and writing English. From early 1998, the problem got out of control, when corrupt State employees within the Health Department started selling Medi-Cal provider numbers from anywhere between \$10,000 to \$20,000 thus luring people, mostly immigrants into the business. One client informed me, he was able to obtain a provider number within 48 hours, for \$15,000 before he had even signed a lease for a store.

**2) Billing Medi-Cal**

Once the provider number is obtained, to give the appearance of a legitimate business, the provider would make a one-time purchase of approximately \$5,000 in inventory. Prior to getting the provider number, a State employee would have to visit the store to verify the legitimacy of the business, by looking at the store operation, and purchase invoices for the merchandise the provider had purchased. In some cases, the signature would be obtained without any official visits to the store, and in cases where a visit would be made, it would serve no purpose. The reason being that while I am convinced that the state employees who were making such visits did have the right intention to detect fraud, the problem is that they were unqualified to detect fraud in this area. For example, auditors from the State Controller's office, who had the primary responsibility of detecting fraud, are trained accountants in accounting, and I am sure they are qualified to detect fraud in accounting matters, unfortunately, they have been given the responsibility of detecting fraud in medical products, and fraud does not always happen in the accounting figures. For example, it can happen in the combination of products billed. In some instances, I have been contacted by State Controller's auditors, asking me if it is normal for a small medical supply company, to bill Medi-Cal for 100 pairs of high compression pantyhose a month. The answer is no, it is not normal, unless the provider has multiple contracts with hospitals and vein specialists.

**3) Passing an audit**

A fraudulent provider could pass an audit by purchasing phony invoices for the supplies the provider billed Medi-Cal, from a phony distributor. A fraudulent distributor, has very low overhead, because they are not in the business of selling products, but rather invoices. Consequently, they do not have the expenses of a legitimate business, such as inventory, insurance, payroll, delivery vehicles, and warehousing expenses. On those occasions where products were actually sold to a fraudulent provider, the provider would dump the product on the market. I am aware of situations, in which, my clients could purchase products for which my company was the sole national distributor, for 20% of the cost my company was required to pay the manufacturer. Obviously, a legitimate distributor cannot compete in this environment.

In 1998, in addition to it's main distribution center, and it's office, my company had 8 storage facilities, filled with merchandise we could not sell, because providers were interested in purchasing fake invoices from phony distributors, at a cost of approximately 25% The way this works is that a provider would purchase an invoice for \$100,000 worth of non-existent merchandise, and pay the distributor the full value of the invoice, and the distributor would keep 25% for himself and reimburse the provider with \$75,000 in cash. Under these choking circumstances, it had become absolutely impossible to conduct normal business. And any provider who would get caught with unacceptable practices, would get a penalty, and be allowed to continue doing business. Had it not been for the F.B.I. coming into the picture with a sledgehammer and an industrial grade vacuum cleaner, every legitimate distributor and provider would end up bankrupt, leaving the medical business to criminal organizations.

**4) Products on the Medi-Cal formulary**

Unlike Medicare, which reimburses providers, based on product specifications, and not product brand names, therefore, increasing competition, and lowering

prices, Medi-Cal reimbursements are based on product brand names, which contrary to the Medicare system, stifles competition, and raises prices and cost to the State of California. For example, Medicare reimburses providers approximately \$200 for a double hinged range of motion knee brace. The provider may purchase this product at the lowest possible price, and bill Medicare, as long as the product meets the specification. In this situation the provider has a choice of shopping around all over the country, and buying at the lowest possible price. This practice is fair and generates healthy competition. Unlike the Medicare system, Medi-Cal has a bidding process, which is so rigged and flawed, that Fortune 100 companies such as Kimberly-Clark and Proctor & Gamble, which happen to be among the largest diaper manufacturers in the world have no chance of selling in the Medi-Cal system, whereas Donald Duck the entertainer, who has never manufactured a diaper in his entire career could be awarded a lucrative 5 year contract. The entire Medi-Cal incontinence system is a joke, full of lawsuits, threats, cozy relationships and non-existent product categories, unheard of, in the industry. And this is the way it works. Medi-Cal puts out a bid for incontinence products, which is usually awarded to somewhere between 5 and 10 suppliers for a period of 5 years. This means that any provider who bills incontinence products to Medi-Cal should purchase the products of one of these 10 suppliers, either direct or through the distributors. Every step of this bid is a comedy, the new formulary for incontinence which is supposed to go into effect in about three months, has already been cancelled and put to a new bid 3 times already, and this has dragged on since 1998. The original contract award was issued in 1998, and because of legal threats by suppliers who were not awarded major portions of the contract, the bid was cancelled, rightly so. For example, portions of the contract, which could mean Millions of Dollars in revenue, had gone to a sales representative working out of his home, who somehow, had qualified himself as an incontinence supplier to the State, under one brand. The other portion of the contract had gone to the manufacturer who employed the sales representative, under a different brand. Another portion of the contract, had gone to the same manufacturer's distributor, who had introduced the same products under a different brand. Funny enough, another portion of the contract had gone to a distributor which private labels products, and the leftover and crumbs of the contract was left to the actual manufacturers. By the way, in this entire process, the bidders had managed to convince the bidding committee to allow them to bid on ridiculous products which did not make any sense, with high reimbursements. This cozy and unhealthy relationship costs the State of California, and the taxpayers Millions of Dollars. Medi-Cal should follow Medicare's lead, and start reimbursing based on product specifications, and not brand names. To give you an example, a trimfit diaper, which is a terminology in the industry for low cost diapers, costs me \$20, the very same diaper from a manufacturer which is on the Medi-Cal formulary would cost me \$24, a 20% price difference. If distributors and providers are given the opportunity to purchase from the lowest possible source, as long as the product meets the specifications, the millions of dollars saved by the State of California, could be put into a much better use, like fighting crime in the State, or improving the public school system.

In conclusion, if I may, as a distributor, who got sucked into this mess, and has seen first hand what has happened in the Medi-Cal system, I would like to offer the following brief points.

Everyone involved shares a part of the blame, and there is plenty to go around. When I was offered the opportunity to testify before this committee, before my attorney finished his sentence, I immediately accepted the invitation, I was grateful for being given the opportunity to testify behind a screen, to hide my identity, which I refused. I am not, and never have been an F.B.I. informant, but rather, a witness. It is my understanding, that as a result of my testimony, 20 or 30 convictions have been made. Obviously, the F.B.I. would have the accurate figure. In personal terms, the last 2 years have had a devastating effect on my personal and business life. As a married man, and father of a 5 year old son, and a nine month old son, I have received death threats, at one point, I was forced to hire armed bodyguards. For the first time in my life, I have purchased a hand gun, that I keep at one of my offices. No one can blame the law enforcement for cleaning up this mess. However, because of a few criminals with Armenian backgrounds, the entire Armenian community has received a black eye. Individuals with access to the media have publicized this fact. As an American, I am outraged at the fact that this much money has disappeared because of fraud, and as an Armenian, I am wounded that the Armenian names are immediately released and distributed to the media and the industry, while, the names of the corrupt officials within the health department who were luring and selling provider numbers to providers, who are equally guilty, have been swept under the rug. The very same corrupts, employees have been transferred to other

jobs with pay, pending investigation, while, any provider caught with irregularities is immediately looked at, as a criminal. Because of the bad publicity that the Armenians have received, my competitors now openly tell my customers not to do business with me, and as a salesman, I have to spend half my time with my customers defending my ethnic background. American providers can easily purchase products on credit, and Armenians have to purchase on a C.O.D. basis, because of their last name. Several loose, and out of control employees within the State, assure providers that purchasing from non Armenian distributors would be a safer strategy. Today, in Los Angeles, if you are an Armenian, and you are in the Medical business, life looks very grim.

Obviously, fraud cannot be eliminated completely, it is widely suspected that criminals are migrating from the healthcare field, into the Adult Daycare business. Additional regulation only chases the criminals into a new field of fraud, while it paralyzes honest business people trying to make a living in the healthcare field, and in some case forcing small mom and pop operations, out of business. New regulations, leaves the rest of us holding the bag, while it does nothing to stop the criminals. Basic, simple, common sense steps could immediately reduce the level of corruption:

- 1) Providers should purchase from authorized distributors, therefore, eliminating phony distributors out of the business.
- 2) The brand name reimbursement process should end. Any product that meets the specification of a specific category, should be billable. This will open up the playing field, increase healthy competition, and save the State of California Millions of Dollars.
- 3) Obtaining a driver's license in California, is not a right, it is a privilege. The same rule should apply to anyone who wishes to become a provider and bill Medi-Cal. Anyone wishing to become a provider should pass a basic test, ensuring, at least the provider has basic knowledge of the industry.
- 4) Providers should be bonded.

This concludes my opening statement, I wish to thank you for your patience, and I will gladly answer any questions you may have.

Mr. UPTON. Now, as I understand it, you came forward about—what—2 years ago; is that right?

Mr. ASSATOURIAN. I was subpoenaed by the FBI to testify before the grand jury as a witness; and it is my understanding; as a result of my testimony, I think 20 or 30 providers have been convicted.

Mr. UPTON. Right. And when did they actually subpoena you to—when were you aware that an investigation was ongoing, about?

Mr. ASSATOURIAN. Two years ago.

Mr. UPTON. Two years ago. As you deal with your peers, now you're still involved in this, right? Are you still a provider?

Mr. ASSATOURIAN. I am not a provider. I'm a distributor.

Mr. UPTON. I am sorry. But you're still a distributor, a wholesaler; is that right?

Mr. ASSATOURIAN. Yes, sir.

Mr. UPTON. Since you appeared before the grand jury and your story has become fairly public, have you seen changes by the State of California, positive changes in terms of trying to weed this out?

Mr. ASSATOURIAN. Yes, I have. Unfortunately, I think these changes will be temporary, because the whole system has to be fixed because it's like killing cockroaches. You kill the cockroaches for a couple of weeks, it's all clean. Eventually, they came back through another crack.

Mr. UPTON. The State of California and a number of other States have been talking about performing onsite visits. Have you seen that in a major way in the State of California?

Mr. ASSATOURIAN. Yes, yes. Except, again, if I may, even though the people making the onsite visits have the right intention, they do want to stop fraud. The problem is that, in many cases, some of the people making the visits are just not qualified to detect the

fraud. Fraud could be going on right in front of their eyes and they might not know it because the people who are making these onsite visits should be familiar with the business, first of all.

Mr. UPTON. As I've read some of the statements that we are going to hear from a second panel later on, in some of the other States as they have conducted their investigations, there's some examples such as an inspector going to a wholesaler or provider, that the address is on the 10th floor of a building, and the building only has nine stories. They have got empty lots, P.O. boxes, no equipment that is there. As they visit some of the businesses and actually look at some of the equipment on the shelf, it's dusty. It seems to be, in at least a number of cases, a fairly easy, routine job to figure out whether or not they're in the real business or whether they're not.

Mr. ASSATOURIAN. As far as fraud is concerned in the area that you are talking about, it has stopped—like people getting Medi-Cal checks at a Laundromat, at a P.O. Box, that has stopped. However, pretty much what has happened, it has cleaned out the scam artists who are more primitive. Now there are more sophisticated people in the business. And it just—if I may, just like the drug problem, the DEA goes in with this high-tech equipment and the drug dealers always have the money to buy better equipment. The basic problem has been solved, yes.

Mr. UPTON. But you would urge that the States continue to do onsite visits. What is California visiting now? Is it once a year? Is it more than that? Do you know?

Mr. ASSATOURIAN. I think there are providers who have been visited several times, and there are providers who haven't been visited in—with the exception of last year, there were providers who had never been visited in a matter of 2 or 3 years.

Mr. UPTON. Tell us exactly how it is that you actually get an enrollment number, code. What is the process for someone new in the business trying to get an enrollment number?

Mr. ASSATOURIAN. I am not a provider. We are just distributors. However, my understanding is there is a moratorium right now, but until—prior to the FBI stepping in, the process was, if somebody wanted to open up a store, it was just a matter of 1, 2, 3, that's it, let's do it. And there were people out of Sacramento who were selling provider numbers from anywhere between \$10,000 to \$20,000 and within 24 hours a provider could be set up to rape the system. Whereas it used to be 3 to 6 months, but in 1997 and 1998 it was out of control and out of date.

Mr. UPTON. Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

You, in the conclusion of your opening statement, raised four points that you said were basic, simple, common-sense steps that could eliminate or immediately reduce the level of corruption. Let me go through some of those if I could.

Providers should purchase from authorized distributors, therefore eliminating phony distributors out of the business. Is there some type of certification that distributors and medical equipment go through?

Mr. ASSATOURIAN. No. What I'm referring to is that the provider should purchase from an authorized distributor—authorized dis-

tributor meaning that the distributor purchases directly from the manufacturer, instead of going through like gray market distributors.

Mr. BURR. Is there any type of certification that the State does for authorized distributors versus unauthorized distributors?

Mr. ASSATOURIAN. Hmm.

Mr. BURR. Then whose responsibility do you see it to determine whether the distributor is an authorized distributor? A provider doesn't know where you might purchase your product from or whether you purchase product at all.

Mr. ASSATOURIAN. Well, the provider should call the manufacturer, and/or the State should verify that the distributors are authorized distributors for a specific number of manufacturers—

Mr. BURR. So your suggestion is somebody has to verify the legitimacy of the distributor?

Mr. ASSATOURIAN. Yes. The provider can either call the manufacturer and verify if, for example, Ruben Assatourian is authorized distributor.

Mr. BURR. How many providers that you sell to would pick up the phone and call a manufacturer to determine whether you were an authorized distributor?

Mr. ASSATOURIAN. Maybe 1 or 2.

Mr. BURR. Not too many?

Mr. ASSATOURIAN. Not too many. Until the FBI stepped in, these people didn't even know what an 800 number was.

Mr. BURR. Let me get into the brand name reimbursement versus the product category reimbursement. How much of a problem do you perceive that to be?

Mr. ASSATOURIAN. That is one of the biggest problems right now with the whole reimbursement system. Because, as I've said—as I've put in the opening statements, Medicare reimbursement is based on product specification.

Mr. BURR. Medicare is also considering going to some areas where they're getting away from product categories and going into specifically named brand name products, and what would your suggestion be to Medicare?

Mr. ASSATOURIAN. It would automatically start skyrocketing the prices both for Medicare and the provider. Because for as long as there's an enforcement or as long as there's a brand name requirement, that drives up the cost. Because then the manufacturers, the four or five or 10 manufacturers, know that their product can only be billed to Medi-Cal or Medicare or whatever. It becomes like a little cozy exclusive club, and they can charge whatever they want.

Whereas, right now, under the Medicare guidelines, there's very strong, healthy competition for manufacturers to sell their products, unlike Medi-Cal where the whole reimbursement system has become a joke because the reimbursements are made based on specific brand names. The manufacturers who make those brand names control the pricing and, ultimately, the reimbursement by the State of California which, if stopped, could save the State millions of dollars a year.

Mr. BURR. Are there currently new providers opening up in California that are not reputable providers who are obtaining whatever

license or, I am not sure what Medi-Cal uses, a provider number? Is that process still going on?

Mr. ASSATOURIAN. The fraud?

Mr. BURR. Yes.

Mr. ASSATOURIAN. Not to the extent that it was going on in 1997 and 1998, but, yes, it is.

Mr. BURR. There are new providers who have opened up who have no intentions of doing anything other than the shell game that's been happening?

Mr. ASSATOURIAN. Absolutely.

Mr. BURR. What has changed in the process in California that you've seen as it relates to what a provider must go through to get whatever numbers they need to from Medi-Cal?

Mr. ASSATOURIAN. The only change I've seen is that they have to wait for a long time, which these people don't mind. And my understanding is that the State now does a criminal background check or a broader background check. But while they're going through the waiting period now they have migrated to a new, more lucrative area of fraud, which is the adult day care center business in California. Now, that's going to be the next jackpot for the criminals. There's a huge potential for profit in that area, and that's where the big problem is going to be.

Mr. BURR. The last point you hit on is that providers should be bonded. How important do you feel about that and are there any requirements currently?

Mr. ASSATOURIAN. I think currently—I am not sure if it's being enforced or maybe it's being considered, but I think it is extremely important. Because as long as the providers know they have to deal with the legal systems, somehow it will eliminate or minimize the fraud.

Mr. BURR. We certainly have some other witnesses that will help to clarify some of it. I appreciate your testimony.

I yield back, Mr. Chairman.

Mr. UPTON. Mr. Bryant.

Mr. BRYANT. Thank you. I thank the witness for being here. I have just a few questions.

Regarding your cooperation with the authorities, I assume they were Federal. You mentioned the FBI. The case—the grand jury you testified before, was it a Federal grand jury?

Mr. ASSATOURIAN. Yes.

Mr. BRYANT. So this investigation that you cooperated in primarily was done by the Federal authorities; and it is, to your knowledge—realizing you're not a lawyer, but you have a lawyer with you—it was handled—the people have been charged and I assume some convicted, that's been in Federal court?

Mr. ASSATOURIAN. Yes, sir.

Mr. BRYANT. Are there Federal task forces out there—again, you might want to talk to your lawyer—in California that the U.S. attorneys have in place that go specifically after health care fraud and abuse?

Mr. TURNER. I'll answer that question.

I am aware of such a task force, yes.

Mr. BRYANT. Are there similar or counterparts in the State system in terms of State prosecutors? Do they have such task—medical health care task forces for fraud?

Mr. TURNER. Certainly it's my understanding that witnesses testifying later today can testify more knowledgeable. I believe they're participants in such a task force, but I've been told that the representatives of the State do participate in the task force of which I am aware.

Mr. BRYANT. I wanted to—Mr. Assatourian, I want to ask you about a couple of your other points that you make, and Mr. Burr touched on this. But you make a comment of item four about products at a Medi-Cal formulary. You mentioned that, unlike Medicare, Medi-Cal has a bidding process which is so rigged and flawed that Fortune 100 companies such as Kimberly Clark and Proctor & Gamble, which happen to be among the largest diaper manufacturers in the world, have no chance of selling in the Medi-Cal system. You mentioned, whereas Donald Duck, the entertainer, who has never manufactured a diaper in his entire career, could be awarded a contract.

Now you touched on that. How do you—why do you characterize that system as so flawed and corrupt? What is it about the bidding process?

Mr. ASSATOURIAN. Well, the whole process is done in a way to shut out new manufacturers; and it pretty much ensures companies that were on the formulary—it will offer them continuity. And there's pretty much—there's two ways of getting on the formulary, the right way and cheating the system. If you do it the right way, the way some of the manufacturers do, it's hell for them. Sometimes they put a lot of products on the formulary, sometimes they get unlucky and 1 or 2 products—whereas the bidding process offers people who are absolutely unqualified to get on the formulary, and the formulary in general is a 5-year contract. So anybody who gets on the formulary is guaranteed of making millions of dollars in the 5 years, and as a result you have a lot of unqualified companies who just get on the formulary just for the ride.

Mr. BRYANT. Now where is the corruption—where is the—how does that take place? How do they get on that formulary when they're not qualified, so to speak?

Mr. ASSATOURIAN. Well, the manufacturers have too much say in the process, and they also have too much say in the categories of products.

Just to give you an example, in the last bid that was canceled it had one ridiculous product on the bid which even the manufacturers couldn't figure out, but a couple of the bidders had convinced the State to put that on the bid. A liner—I don't remember the exact details, but, for example, a bladder control liner with 2000 cc capacity, which is ridiculous. How much could an incontinent patient—I mean, 2000 cc is not needed for an incontinent patient.

Mr. BRYANT. I understand that, but in terms of—where is the corruption? Who is responsible for that type of fraud existing in that environment? Is it the people in the California government who draw the specifications for these products or is it—

Mr. ASSATOURIAN. The Department of Health and Human Services in California, which pretty much consults with the manufac-

turers and the bidders. There is just too much of a cozy relationship. It shuts out other qualified manufacturers and distributors out of the process.

Mr. BRYANT. The cases you worked for the Federal authorities involved, I assume, people in competition with you, other wholesalers who were corrupt, as well as people within the government, the State government, who were selling numbers and doing things. On both ends you have people again from within as well as providers I guess—so you have got people in the government, providers and others, wholesalers, that are a part of this corrupt process?

Mr. ASSATOURIAN. Yes.

Mr. BRYANT. Okay. And I think the bottom line for you and probably the message we take out today, one is that we just simply need better enforcement of the existing laws.

Mr. ASSATOURIAN. Better enforcement and some new laws. Because reasonable laws—because new laws—I mean, you can't just drive legitimate people out of the business. Because, the bottom line, the damage is done to the recipients, people who are supposed to receive these medical products; and they are the ones who get damaged because they get bounced back and forth. New laws and better enforcement, yes.

Mr. BRYANT. Mr. Chairman, I would yield back my time.

Mr. UPTON. Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman. I apologize for being late. I was at another matter.

Mr. Assatourian, you make the statement in your testimony that the California Medi-Cal system is a broken-down ATM machine which is spitting out cash uncontrollably without the need for even an ATM card. Armani suits have been charged to Medi-Cal cards, round-trip tickets overseas and silverware for patients have been charged to Medi-Cal. Do you still stand by this statement or are you suggesting that the California Medicaid system is still totally out of control today?

Mr. ASSATOURIAN. No. I was making reference to what the situation was like in 1997 and 1998. It's been—I think 75 or 80 percent of the problem has been fixed.

Mr. STUPAK. Okay. What steps did they take to fix those problems? You said 75 to 80 percent of the problems have been fixed. What steps did California take to fix the problem?

Mr. ASSATOURIAN. Pretty much the FBI came in with a sledgehammer and put all of them out of business, case closed.

Mr. STUPAK. Okay. Do you believe they're doing a good job now in addressing fraud in California in the Medi-Cal system?

Mr. ASSATOURIAN. Yes, yes, they are. Except, usually, in cases like this, there are always victims, innocent victims. Even though they're doing a good job, there's also a lot of innocent victims who are being stepped on.

Mr. STUPAK. How about from a policy point of view? Do you think that policies have been changed so that we do not go back to this uncontrollable ATM machine spitting out cash?

Mr. ASSATOURIAN. I think policies have been changed, but, unfortunately, I truly do believe corruption will not end, the fraud will not end. The best they can hope for or the best this country can hope for is to bring the level of fraud to an acceptable level. Be-

cause, right now, it's gone back to normal; and my guess is within another 12 months the whole circus will start all over again except not in that level, in a more—in a lower level.

Mr. STUPAK. But if the policies have been changed, you still believe it's going to continue in the next 12 months, it will go back to like it was?

Mr. ASSATOURIAN. I think so. Because it's the U.S. health care system. It's the most—

Mr. STUPAK. So even if you change the policy, it's still going to continue?

Mr. ASSATOURIAN. What I'm saying is it will continue but not as bad as it the way it was in 1997 and 1998. Again, as I'm saying, nobody will be ever—nobody will be able to stop fraud 100 percent. The fraud will always be there, regardless. It just will be at an acceptable level.

Mr. STUPAK. What is an acceptable level, in your mind?

Mr. ASSATOURIAN. This is just a guesstimate.

Mr. STUPAK. Sure.

Mr. ASSATOURIAN. I would say—I don't know. I would say maybe 2 or 3 or even 5 percent, even though I think that's high.

Mr. BURR. Would the gentleman from Michigan yield for a second?

Mr. STUPAK. Sure.

Mr. BURR. I just want you to finish the sentence that you started. You said it's the U.S. health system.

Mr. ASSATOURIAN. The most lucrative business in the world. The U.S. health care system is more lucrative than the computer industry, the software industry or any industry. It's pretty much recession proof. It has nothing to do with retail sales. It has nothing to do with—it is not directly linked to the economy. It just—it's a recession-proof, lucrative business.

Mr. BILBRAY. Guaranteed market.

Mr. ASSATOURIAN. Guaranteed market.

Mr. STUPAK. Reclaiming my time, what steps do you think should be taken then to prevent this? What steps would you do if you were head of Medi-Cal in California?

Mr. ASSATOURIAN. As I have put in my opening statement, I mean, there's just—this is not brain surgery. Just four or five very simple steps would cut the fraud dramatically.

Mr. STUPAK. What are those four or five different steps?

Mr. ASSATOURIAN. The first step in my mind is that the provider should purchase from authorized distributors to control the quality of the product and to control the cost.

And then the brand name reimbursement system which is currently in place in California should end. I mean, California is bleeding the money because of the way they are making these reimbursements. It should be copied—it should use the same format Medicare does. The reimbursement should be based—should be made based on the product specification, not the brand name. Every time there's a brand name requirement it drives up the cost, it kills competition, and it costs taxpayers and the State of California millions of dollars a year.

Mr. STUPAK. Okay. You have your five points there. Is there anything else that you believe they should be doing that they are not doing?

Mr. ASSATOURIAN. Better people who are supposed to be enforcing these laws should be better trained in the medical field. Again, I respect their intentions. Their intentions are very well—in many cases, they're not trained for that area.

Mr. STUPAK. You mentioned bonding. Explain that a little bit more. Would you elaborate on this? What amount should be provided by the bond—by those who have to be bonded?

Mr. ASSATOURIAN. I don't know. I would say it should be reasonable so legitimate businesses don't go bankrupt. I mean, a bond maybe in the amount of 50,000 or 100,000, in a level that will not destroy and drive people out of the business. After all, people who are in the business, they are serving a purpose.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. UPTON. Mr. Bilbray.

Mr. BILBRAY. Thank you, Mr. Chairman.

Let me ask you—and if you don't understand it, I understand—but I would like to know, in your professional opinion, why would the State of California be using the brand naming approach?

Mr. ASSATOURIAN. I don't know. I would like to find out myself.

Mr. BILBRAY. Do you think it's a concept of quality or something?

Mr. ASSATOURIAN. No, it has nothing to do with quality. I do not know the reason, but I do know it is costing a tremendous amount of money.

Mr. BILBRAY. In all your imagination you can't figure out why they would do that?

Mr. ASSATOURIAN. No. I think it's an old system that's been there, and nobody's really paid attention to it.

Mr. BILBRAY. Is it possible this was part of the good old boy system that was developed because of political influence in the past?

Mr. ASSATOURIAN. Could be.

Mr. BILBRAY. Okay. Why would the FBI need to go into a State like California? Why couldn't the State of California have handled this themselves? Let's face it, California is not exactly what you call a Podunk little political subdivision—

Mr. ASSATOURIAN. No.

Mr. BILBRAY. [continuing] small, little, intimate group of 32 million people. Why would the FBI need to intervene on that and why couldn't the State of California handle that themselves?

Mr. ASSATOURIAN. I wouldn't know. I think some of the next witnesses would have a better answer to that.

Mr. BILBRAY. Okay. I was just hoping you would use your imagination. I'll try to get the—ask the State and see if they can go over—I just thought you might have an opinion about that.

Mr. ASSATOURIAN. I do have an opinion, but I don't think it's appropriate for me to—

Mr. BILBRAY. Well, let me be more blunt then. Do you think the State of California basically didn't focus on this, looked the other way, or they were negligent in oversight?

Mr. ASSATOURIAN. Yes.

Mr. BILBRAY. Okay. I'm only asking your opinion.

Mr. ASSATOURIAN. That's part of the problem. When provider numbers were being sold within the State—I mean, within the Health Department, that pretty much explains the level of indifference. I mean, when a government employee is selling a Medi-Cal provider number for anywhere from between \$10,000 to \$20,000, that pretty much speaks for itself. And the way I see it you are right. I could be wrong, but I think the State of California is one of the wealthiest States in the union, and it's being robbed blindly, and the State of California has a lot to answer for.

Mr. BILBRAY. But you used a word that would indicate you do not believe it was a conscious effort or action but it was negligence. You used the word indifference.

Mr. ASSATOURIAN. Yes.

Mr. BILBRAY. Which is a fancy word for they didn't give a damn.

Mr. ASSATOURIAN. The way I would put it is that I don't think they intentionally ignored it. I think they were maybe preoccupied with something else.

Mr. BILBRAY. I appreciate that; and that was a very fair testimony, Mr. Chairman. I will yield back my time.

Mr. UPTON. Thank you.

I just want to say, closing comment from me, we do appreciate your testimony today. That's for sure. We have had a number of hearings along this line, trying to provide not only the States but the Federal Government better tools to go after fraud and abuse in the Medicaid program, so your testimony is particularly enlightening.

I don't know if other members have further questions. Mr. Stupak, do you have further question or comment?

Mr. STUPAK. Mr. Chairman, just if I could, I am still a little unclear here. I know I got in here late and didn't get a chance to hear all this. But the system obviously broke down in California. So from where we sit how do you rectify that from happening again? Where were California individuals then to let this thing get so out of control? You said somewhere between 1997, 1998 about 75, 80 percent of the fraud was going on; and you said there's probably always going to be some, some small acceptable level, 2, 3, maybe 5 percent. How did a system like this get so out of control and where were the California officials?

Mr. ASSATOURIAN. I think the State officials got caught by surprise. Again, I am not saying they intentionally ignored it. I think they just—they were caught by surprise. I mean, when you have more providers in the city, when you have more of them than 7-Elevens and gas stations put together, it should say something. They just got caught by surprise. When they realized what the problem is, I don't think they knew how to deal with it.

Mr. STUPAK. I ran for Congress in 1992. I mean, fraud and Medicare and Medicaid was a big issue, even back in 1992. It has every year since then. It's one of the reasons I am on this Subcommittee on Oversight and Investigations. I guess I find it hard to believe they get caught by surprise, sleeping at the switch or something, obviously.

All right. Thank you, Mr. Chairman.

Mr. BRYANT. Mr. Chairman.

Mr. UPTON. Yes.

Mr. BRYANT. Could I have a follow-up question?

Mr. UPTON. Yes.

Mr. BRYANT. Given the reputation California has for being on the cutting edge of everything, you've mentioned, and I meant to ask you in my first round, a new idea or concept that's going to be the crime wave of the future, and did you say adult day care?

Mr. ASSATOURIAN. Centers, yes.

Mr. BRYANT. Explain to us who are uninformed, outside of California, what that involves and where that's going. Maybe we can be alert for that.

Mr. ASSATOURIAN. I think in general it's a program that the State reimburses providers. The business is called adult day care centers.

The way it works, if I am not mistaken, is that the elderly people, instead of their children sending them to retirement homes, what they do is they take them to this very nice equipped day care center where their parents or the elderly are entertained. There's physical therapy, food, entertainment, everything. And they check them in around—let's say in the morning, and then they pick them up at night. And if the adult day care center also has pick up and delivery accommodations, I think the State pays a couple of extra dollars.

So in general, if I'm not mistaken, I think for each guest the State pays somewhere from \$60 to \$70 per day, if I'm not mistaken; and that translates—with a hundred guests, that translates to about, if I'm not mistaken, \$30,000 to \$40,000 net profit per month for the day care center after taking out the overhead. And that's where the gold rush is now. Fraud, that's where the next wave of fraud is going to be. It has already started, but it's getting there.

Mr. BILBRAY. Would the gentleman yield?

Mr. BRYANT. I'm happy to yield.

Mr. BILBRAY. Let me say, as a parent and also a son of a senior citizen, the number 60 to 70 does seem high. When is the last time anybody in this room sent their kids to camp for—\$60 or \$70 a day is basically what healthy young people are charged to be able to go to a summer camp. You get into that. I just want to say it to be fair about this.

And the other issue that I would ask, California has been on the cutting edge about a lot of things, and we've had some great successes, and we've tried to warn the rest of the country of some of our failures. I would just like to remind my colleagues that, as I made the statement about it not being a small State, one of the things we may run into here is that the unit is so large, the big bureaucracies, big systems have the potential for making big mistakes; and the administrative size of the State may be part of the situation we want to look at, too, as we look at implementing national programs.

And I'd yield back to the gentleman.

Mr. BURR. Mr. Chairman, let me get into the adult day care just a little bit more if we can. Are you suggesting that California has an open policy for all seniors or is there an income level cutoff?

Mr. ASSATOURIAN. I am not familiar with the details. What I just said was pretty much vague information I have heard in the business, I guess.

Mr. BURR. What you're telling us is those criminal elements are now eyeing this area?

Mr. ASSATOURIAN. They're already in there.

Mr. BURR. They're already in there. The \$60 or \$70, regardless of what it is, that's \$60 or \$70 for them just being there. That's not for service provided other than the facility that they go to?

Mr. ASSATOURIAN. That is my understanding. Except one of the next witnesses, Mr. Cates, he will be in a better position to answer the question. Because really what I've heard is that is very general information. What I know is based on what I hear. The fraud is already there. They're at it.

Mr. BURR. But the fact that individuals might claim for \$60 for somebody that's in the facility is not fraud.

Mr. ASSATOURIAN. No, that's not fraud. The problem is—

Mr. BURR. Tell us where the fraud is going to be.

Mr. ASSATOURIAN. The fraud is, after 1 or 2 visits—they're supposed to be there every day. The fraud—after the first visit, those people don't want to go there every day. They have their own homes. They want to stay home and watch TV on their couch. So after the first visit they just starting getting—the facilities start getting reimbursement for nonvisiting guests. That's where the fraud comes in.

Mr. BURR. I appreciate you clarifying that. Thank you.

Yield back.

Mr. UPTON. Mr. Stupak.

Mr. STUPAK. Just if the committee jointly could ask the GAO—I know they have done a general survey of the States as to what went on in the States' enforcement, but maybe they could do a more in-depth, detailed postmortem, if you will, on California so we can understand what happened, what lessons learned and where were the policy breakdowns. Because, as the witness indicated, the next area is adult day care center fraud. And I know, like I said, they have done a general survey, but I would like to see in detail, if GAO could put that together for us, where it really happened in California. Maybe we can learn a few things from it and make sure it doesn't happen again.

Mr. UPTON. No one has further questions, so, Mr. Assatourian, thank you very much for being with us this morning.

Our second panel includes the following: Ms. Kathleen Connell, Controller of the Office of the California State Controller; Mr. Alan Cates, Chief of the California Medicaid Fraud Bureau; Mr. Thomas Kubic, Deputy Assistant Director of the Criminal Investigations Division, Federal Bureau of Investigation; Mr. Ruben King-Shaw, Secretary of the Florida Agency for Health Care Administration; Mr. Doug Wagoner, Vice President of the Public Sector, ChoicePoint; and Leslie Aronovitz from the General Accounting Office.

Witnesses, if you would come and find the right spot—let's see, sit down; and then we'll get the name tags in front of you.

You heard the first panel when we swore them in. Do any of you object to having your testimony being taken under oath? The committee rules are in front of you.

You should also know you're able to have legal counsel with you. Do any of you wish legal counsel?

If you would stand and raise your right hand.

[Witnesses sworn.]

Mr. UPTON. You are now under oath.

Ms. Aronovitz, we'll start with you. If you would use that mike a little closer as well. Again, thank you for your testimony in advance. It is made part of the record in its entirety, and if you could keep it to 5 minutes, that'd be terrific.

**TESTIMONY OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH, GENERAL ACCOUNTING OFFICE; THOMAS T. KUBIC, DEPUTY ASSISTANT DIRECTOR, CRIMINAL INVESTIGATIONS DIVISION, FEDERAL BUREAU OF INVESTIGATIONS; KATHLEEN CONNELL, CONTROLLER, OFFICE OF THE CALIFORNIA STATE CONTROLLER; J. ALAN CATES, CHIEF, CALIFORNIA MEDICAID FRAUD BUREAU; RUBEN J. KING-SHAW, SECRETARY, FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION; AND DOUG WAGONER, VICE PRESIDENT, PUBLIC SECTOR, CHOICEPOINT**

Ms. ARONOVITZ. We sure will. Mr. Chairman and members of the subcommittee, we are pleased to be here as you discuss efforts to better assure the integrity of providers who bill the Medicaid program. With hundreds of millions of claims being processed each year, Federal health programs need to rely on the integrity of their health care providers, since it would be impossible to perform detailed checks on every claim. But as you will hear, and as you have heard from the first panel, there is much work to be done to ensure the legitimacy of all providers.

Since States have wide latitude in how they structure their Medicaid provider enrollment processes, some States are much more aggressive than others. While we found through a survey that few States have taken comprehensive measures to prevent problem providers from participating in their Medicaid programs, the more aggressive States are employing variations of several key provider enrollment activities. For example, some States are beefing up their provider enrollment application and more stringently reviewing the submitted information. Some are now requiring Medicaid provider applicants to disclose information on their criminal background, financial status and health care program exclusions and sanctions as well as information about their business's owners. In Florida, applicants are required to submit fingerprints, which are checked with both State law enforcement authorities and the FBI.

Some States are also strengthening their provider agreements. Several now have a clause allowing either party to terminate the agreement without cause after giving advance notice. Some State Medicaid officials say this allows them to get problem providers out of the program more expeditiously than they could otherwise. Some States, which tighten standards for newly enrolling providers, have also required existing Medicaid providers to reenroll in the pro-

gram under the new standards, such as the enhanced disclosure requirements.

Taking a lesson from Medicare, several States have found that visiting the sites of provider applicants is useful in verifying if applicants have bona fide businesses. Last year, when one State began conducting site visits of all newly enrolling noninstitutional providers, it found numerous applicants with nonexistent addresses or mailbox-only operations. Now, officials report that such a finding is a rare occurrence. I should note that not all States believe that site visits are cost effective, and we believe that a risk-based approach may prove the most useful.

One last key activity is better controlling billing numbers. As you have heard, because some individuals or groups intent on defrauding the program use the billing numbers of deceased or retired providers, many States are now canceling the numbers of inactive providers to prevent those numbers from being used fraudulently to bill the program.

Up until now, we have been discussing Medicaid, but Medicare shares many of the same providers, and it also has been the victim of improper billing and outright fraud. As the result of the experiences with fraudulent providers, strengthening Medicare provider enrollment procedures became part of the Health Care Financing Administration's comprehensive plan for program integrity.

Last year, HCFA began to develop a standardized and strengthened Medicare provider enrollment process, but its plan does not include similar actions for Medicaid. Dealing with such issues in Medicaid is complicated by the fact that Medicaid enrollment policies are shaped by individual State actions. Despite its singular approach, we believe that the current revamping of Medicare's provider enrollment process provides an added opportunity for HCFA to help States strengthen their Medicaid process as well. By combining their efforts to validate enrollment application information, perform site visits on select providers, and to share the results of potential providers in HCFA's new provider data base, both Medicare and Medicaid might realize efficiencies that could benefit both programs.

Although HCFA officials agree in concept, many logistics would still need to be worked out.

Mr. Chairman, this concludes my remarks and I'll be happy to answer any questions you and the other subcommittee members have.

[The prepared statement of Leslie G. Aronovitz follows:]

PREPARED STATEMENT OF LESLIE G. ARONOVITZ, ASSOCIATE DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GAO

Mr. Chairman and Members of the Subcommittee: We are pleased to be here as you discuss efforts to better ensure the integrity of providers who bill the Medicaid program. In the past, we have reported to the Congress that scrutinizing providers more rigorously before they begin billing the federal government's two major health care programs, Medicare and Medicaid, is an extremely important means of protecting program funds and beneficiaries.<sup>1</sup> In fiscal year 2001, federal funding of Medicare and Medicaid is projected to reach about \$342 billion.

<sup>1</sup> *Fraud and Abuse: Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers* (GAO/T-HEHS-96-7, Nov. 2, 1995); *Fraud and Abuse: Providers Excluded from Medicaid*

My remarks today will focus on (1) why it is important to take steps to ensure that only honest providers bill federal health care programs, (2) what Medicare is doing to strengthen its provider enrollment process, (3) what states are doing to ensure provider integrity in the Medicaid program, and (4) what additional opportunities exist to improve these efforts. My comments are based on our past work and work we are now conducting for the Commerce Committee on state fraud and abuse control efforts in the Medicaid program.

In brief, with hundreds of millions of claims to process each year, Medicare and Medicaid must rely in part on provider honesty in billing. As a result, it is critical to protect program funds by making efforts to ensure that only legitimate providers bill these programs. Recent incidents of Medicaid fraud perpetrated by dishonest medical equipment suppliers in California and other cases of Medicare and Medicaid fraud underscore these programs' vulnerability. Although the Health Care Financing Administration (HCFA) has made revamping its provider enrollment process a priority for Medicare, it has not sought similar efforts in state Medicaid programs. Medicaid state agencies report differing practices to ensure provider integrity, with only nine states reporting that they perform comprehensive provider enrollment activities. Because HCFA is redesigning its Medicare provider enrollment process, the HCFA Administrator has suggested that developing a joint Medicare/Medicaid provider enrollment process might be beneficial for both programs. Thus, HCFA and the states have an additional opportunity to work together to develop new procedures for Medicaid that could better ensure provider integrity for both programs while minimizing the administrative burden and cost.

#### BACKGROUND

Medicare is a federal health insurance program for certain disabled persons and those 65 years and older. It is administered by HCFA, within the Department of Health and Human Services (HHS), through about 50 claims administration contractors. Medicaid is a jointly funded federal-state health insurance program for eligible low-income and medically needy people. HCFA oversees the Medicaid program at the federal level, but at the state level, the program actually consists of 56 separate state-operated programs (including the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Marianas—hereafter referred to collectively as "states"). The federal government matches state Medicaid spending according to a formula that is based on each state's per capita income. Within broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets its payment rates; and administers its program—including the enrollment of its providers.

Although Medicare and Medicaid have different structures and governance, and serve different populations, many providers bill both programs and must separately enroll in each. Enrollment refers to all of the application and verification activities that occur before a provider is issued a provider number and approved to bill a federal health care program.

My comments today are based on our past and on-going work for the Commerce Committee on controlling fraud and abuse in the Medicaid program. This statement focuses on enrollment processes for noninstitutional providers, because there are some specific requirements for institutions such as hospitals and nursing homes. Noninstitutional providers include durable medical equipment suppliers, physicians or physician groups, home health agencies, transportation companies, and laboratories—in effect, any providers who do not provide care in an institutional setting such as a hospital or nursing home. To gain more information on state efforts, we surveyed the 56 state Medicaid programs.<sup>2</sup> Several survey questions focused on states' provider enrollment activities. For this statement, we supplemented the states' self-reported survey data with on-site or telephone interviews of Medicaid officials from several states, including Connecticut, Florida, Georgia, New Jersey, and Texas, that reported taking actions to tighten their provider enrollment processes.

#### PROBLEMS WITH FRAUDULENT PROVIDERS UNDERSCORE THE VALUE OF ENSURING PROVIDER INTEGRITY

With hundreds of millions of claims being processed each year, federal health care programs need to rely to an extent on the integrity of their providers. Medicare and Medicaid receive claims for services, equipment, and supplies, and use automated

*Continue to Participate in Federal Health Programs* (GAO/T-HEHS-96-205, Sept. 5, 1996); *Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies* (GAO/HEHS-98-29, Dec. 16, 1997.)

<sup>2</sup>Fifty-three of the 56 state Medicaid programs responded to the survey.

computer edits as a check before payment to help ensure the claims are legitimate and billed by an enrolled provider. While some of the claims are also reviewed after payment is made, with such a massive number of claims, it is impossible to perform detailed checks on a significant share of them.

Most providers bill appropriately, reducing the risks from not being able to scrutinize claims more comprehensively. However, both programs have been victims of improper billing and outright fraud. For example, we recently reported on seven criminal health care fraud investigations, four of which involved both the Medicare and Medicaid programs.<sup>3</sup> In one of these cases, providers filed more than \$120 million in fraudulent Medicare claims and \$1.5 million in fraudulent Medicaid claims before being caught.

Recent fraud cases in California underscore Medicaid's vulnerability to providers who are eager to defraud the program. As you have heard from other witnesses today in more detail, since July 1999, a state-federal task force targeting questionable pharmaceutical and durable medical equipment providers has found large-scale fraud in California's Medicaid program—Medi-Cal. More than 100 Medicaid providers, wholesalers, and suppliers have been charged with more than \$50 million in fraud since July 1999. At least 61 of these individuals have already been convicted and paid about \$15 million in restitution. An additional 250 providers, wholesalers, and suppliers are being investigated for possible fraud that could exceed \$250 million. In some cases, investigators found that providers set up shop for 4 or 5 months to bill Medi-Cal and collect payments for services not rendered and then closed down before the fraud was detected. These so-called “bump and run providers” often made off with hundreds of thousands of dollars before they disappeared.

These cases follow a pattern that has been seen in federal health care programs since at least the early 1990s. Investigations, some conducted as part of Operation Restore Trust,<sup>4</sup> pinpointed weaknesses in provider enrollment procedures that have allowed questionable providers easy entry into the Medicare and Medicaid programs. Examples follow:

- A man convicted of health care fraud in 1989 and excluded from participating in Medicaid and Medicare was arrested in 2000 on new charges that he secretly ran several companies that received \$40 million in Medicare reimbursements for fraudulent ambulance transportation claims. His involvement in the companies was hidden when these companies enrolled as Medicare providers. Employees of the companies routinely falsified paperwork for ambulance transports for patients who did not need this service. For example, patients, typically people being taken for radiation and dialysis treatment, would be described as “bed-confined,” even though covert videotaping by federal investigators showed them walking to the ambulances.
- A provider opened two “storefront clinics” in New Jersey and began billing the Medicaid and Medicare programs for such invasive procedures as colonoscopies and upper gastrointestinal endoscopies. An investigation revealed that the clinic owner was not licensed to practice medicine in New Jersey and, in fact, did not have any medical license. Before the scheme was detected, the clinic owner had billed the Medicaid program for over \$6 million and had defrauded the Medicare program of over \$166,000.
- The owner of a medical supply company in New York pleaded guilty to billing Medicaid for more than \$1.2 million for supplies that were never provided. The company, operated out of the owner's home, filed claims for medical items for several patients authorized by a physician who had been dead for more than 10 years.

Checking the credentials and qualifications of such providers more thoroughly might have raised questions about their integrity. Periodically requiring providers to re-enroll would allow regular scrutiny and updating of their information. As a result, federal health programs could keep tighter control over the current validity of billing numbers. Failure to do so leaves federal health programs vulnerable to questionable providers who either may not be providing services to beneficiaries as billed or be providing poor quality services. For example, in 1996, HCFA reported that of 36 new applicants to provide durable medical equipment to Medicare beneficiaries in Miami, 32 were not bona fide businesses. Some of these entities did not have a physical address or an inventory of durable medical equipment. To determine

<sup>3</sup>*Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers* (GAO/OSI-00-1R, Oct. 5, 1999).

<sup>4</sup>Operation Restore Trust was a 2-year demonstration to target Medicare and Medicaid fraud in five states conducted by HHS and federal law enforcement agencies.

whether this was only a problem in Florida, the HHS Office of Inspector General (OIG) conducted on-site inspections of 420 suppliers with Medicare billing numbers issued between January and June 1996 and 35 applicants who had applied but had not yet been enrolled.<sup>5</sup> The OIG found that 31 of the 420 enrolled suppliers and 4 of the 35 new applicants did not have the required physical business address, or their addresses were suspect. Some had closed suddenly, leaving no forwarding address. Some operated out of homes, while others lacked inventory, making their suppliers' status suspect. Other enrolled suppliers did not provide the level of service expected, because they did not make repairs on items supplied to beneficiaries that were still under warranty or allow beneficiaries to return unsuitable items.<sup>6</sup>

As one convicted Medicaid fraud felon whose previous experience was owning a nightclub in Miami, Florida, remarked,

"I had no experience or training in health care services . . . Without this experience and with no knowledge of the Medicare program, I purchased a business and started billing Medicare. It was very easy for me to get approval from Medicare to become a provider . . . They gave me a provider number over the phone. No one from the government or anywhere else ever came to me or my place of business to check any information on the application. No one ever checked my credentials or asked if I was qualified to operate a medical supply business."

By the time this man was arrested in 1994, he owned seven medical supply companies, using the different billing numbers to hide the number of claims he was submitting. All of his businesses were at the same location, and he used the same staff and computers to bill under different numbers. He estimated that he billed about \$32 million to Medicare in total, most for services not rendered.<sup>7</sup>

Some states and the federal government have realized that their programs do not have all the tools needed to address the problem of providers entering their programs intent on committing fraud. One state audit pointed out that the state's Medicaid program could not terminate a problem provider quickly and that providers could potentially sell their businesses, including their billing numbers, to others. In this state, once a provider was accepted into the program, there was no mechanism to ensure that Medicaid had up-to-date information about the provider, thus allowing billing numbers to be potentially misused by others. Furthermore, no efforts were made to verify information on the enrollment form. Because the state program accepted copies of out-of-state licenses rather than verifying them, a provider could produce a fraudulent out-of-state license and thereby be enrolled to treat Medicaid patients.

#### EFFORTS TO STRENGTHEN MEDICARE PROVIDER ENROLLMENT UNDER WAY

As a result of repeated experiences with fraudulent and abusive providers, strengthening Medicare provider enrollment procedures became part of HCFA's Comprehensive Plan for Program Integrity issued in 1999.<sup>8</sup> Medicare had delegated provider enrollment to its claims administration contractors, which resulted in somewhat different processes at every contractor, with no clearly enunciated national enrollment requirements. HCFA is developing a standardized and strengthened provider enrollment process, which would hold providers to financial and performance standards before they could enroll in the Medicare program. HCFA has taken, or is planning, a number of other steps, including

- publishing a notice of proposed rulemaking to set standards for provider enrollment, specifying that HCFA can deny and revoke billing privileges and periodically require providers to reenroll;
- implementing a new centralized data system on enrolled providers—the Provider Enrollment, Chain and Ownership System (PECOS), which can be used to track ownership and relationships between providers;
- developing a new standard enrollment form that will ask for detailed information in many categories, such as ownership; and
- requiring provider Social Security numbers on the enrollment form, which then will be verified through the Social Security Administration.

<sup>5</sup>These suppliers were located in 12 large metropolitan areas in New York, Florida, Texas, Illinois, and California.

<sup>6</sup>HHS OIG, *Medical Equipment Suppliers: Assuring Legitimacy*, OEI-04-96-00240 (Washington, D.C.: HHS, Dec. 1997).

<sup>7</sup>*Medicare Fraud Prevention: The Medicare Enrollment Process*, (Appendix—Statement of Convicted Medicare Fraud Felon, hearings before the Permanent Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate, 105th Congress, 2nd Sess. (Jan. 29, 1998).

<sup>8</sup>The Comprehensive Plan, published in Feb. 1999, outlined HCFA's key program integrity initiatives for the next 6 to 18 months. It addresses five management areas, including provider integrity.

In addition to our ongoing Medicaid work on this issue, we are now reviewing the Medicare provider enrollment process and will be reporting about it later this year. In that study, we are primarily focusing on the activities Medicare contractors perform to enroll new providers and HCFA's plans to require providers to periodically reenroll.

While HCFA has a number of actions planned or in process to help strengthen Medicare provider enrollment, its plan for program integrity does not include any actions to strengthen provider enrollment in Medicaid. Dealing with such issues at the federal level is more complex in Medicaid because of the differing program requirements and state approaches to ensuring program integrity. Because the Medicaid program is administered by the states under federal oversight, both federal requirements and state actions form a state's Medicaid provider enrollment program.

#### FEDERAL REQUIREMENTS ARE MINIMAL, BUT A FEW STATES HAVE AGGRESSIVE PROVIDER ENROLLMENT PROGRAMS

Because states design their own Medicaid provider enrollment processes, some are much more comprehensive than others. However, despite the importance of activities to ensure the integrity of Medicaid providers, HCFA does relatively little to oversee states' efforts. Responses to our survey revealed a handful of states that have developed aggressive actions through their enrollment processes to help ensure provider integrity. These efforts range from requiring and verifying comprehensive information on the enrollment form to performing site visits at potential providers' offices. We describe these practices later because we believe they can help other states that want to strengthen their provider enrollment processes.

#### *Minimal Federal Requirements Exist to Ensure Medicaid Provider Integrity*

There are few federal requirements for states to follow in enrolling Medicaid providers. All states must have an agreement between the state Medicaid agency and each provider or organization furnishing services to beneficiaries under the plan. However, there is no federal requirement that the provider certify the accuracy of information provided. Providers must also agree to minimum treatment record-keeping standards; give state and federal authorities access to treatment records; and disclose or supply upon request information concerning health care entity ownership and the identities of certain employees with criminal histories. In addition, the Balanced Budget Act of 1997 (BBA) established additional enrollment safeguards regarding home health agencies and durable medical equipment suppliers.

HCFA's guidance to states, incorporated in the State Medicaid Manual, indicates that states may only enroll providers that are qualified to provide the specified service and that have not been excluded from federal health care programs.<sup>9</sup> A qualified provider is one that is licensed to practice in the state, if licensure is required, and that provides services within the scope of practice as defined by state law. States can impose additional qualifications on providers that they enroll in their Medicaid programs. Recently, the OIG found evidence that some state Medicaid programs have paid excluded providers for providing services to beneficiaries, and the OIG is thus concerned that some states may not be checking on whether a provider has been excluded.<sup>10</sup>

Finally, the federal government provides states matching funds for automated claims processing and information retrieval systems, called Medicaid Management Information Systems (MMIS), provided that the states' systems meet certain specifications. States that receive federal funding for their MMIS must collect and enter into their systems certain types of provider information to help ensure that their providers are eligible. This information includes a unique Medicaid provider identification number, the provider's Social Security number, and, if applicable, the provider's Medicare number. In addition, state information systems need to be able to support certain functions, such as enrolling providers only after they agree to abide by the state Medicaid program's rules and helping to screen applicants by verifying their state license or certification, if applicable.

<sup>9</sup>The HHS OIG excludes individuals and entities from participating in federal health care programs under various provisions of the Social Security Act including sections 1128, 1128A, 1156, and 1892. When an exclusion is imposed, Medicare, Medicaid, and other federal health care program payments are prohibited for any items or services furnished, ordered, or prescribed by an excluded provider other than for emergency items or services not provided in a hospital emergency room. Reasons for the exclusion may bear on a provider's professional competence, professional performance, or financial integrity. Payment is also prohibited to any managed care organization that contracts with an excluded provider.

<sup>10</sup>We reviewed these processes, including the OIG's process to exclude providers, in 1996. See *Fraud and Abuse: Providers Excluded From Medicaid Continue to Participate in Federal Health Programs* (GAO/T-HEHS-96-205, Sept. 5, 1996).

*Limited Federal Oversight of State Enrollment Processes*

Although little attention has been given to state Medicaid provider enrollment processes,<sup>11</sup> HCFA is facilitating state Medicaid fraud and abuse control activities through the HCFA Medicaid Fraud and Abuse National Initiative. Of the 53 state Medicaid agencies that replied to our survey on efforts to control fraud and abuse, only 16 reported that HCFA staff visited their agency to review their fraud and abuse control activities during their most recent fiscal year. In interviews with HCFA and state Medicaid agency officials during our five state site visits, officials generally reported that HCFA was not overseeing their provider enrollment activities.

However, HCFA is working with state Medicaid programs on strengthening their fraud and abuse control activities through its Medicaid Fraud and Abuse National Initiative. The goal of this initiative is to facilitate, not oversee or direct, state efforts. The initiative is led from HCFA's Atlanta regional office and has coordinators in each of its 10 regional offices. Although the initiative's plan does not list provider enrollment as one of its strategic goals, its national work group has a goal to work with states to help them avoid providers who have been excluded, suspended, debarred, or sanctioned from other federal health care programs. Recently, HCFA teams consisting of regional office Medicaid fraud and abuse coordinators reviewed eight states' Medicaid program integrity procedures. In those states, they checked two processes relevant to provider enrollment—providers' disclosure of ownership, significant business transactions, and employee criminal history information; and states' processes to ensure that excluded providers do not participate or receive payment for services. HCFA has not yet reported its findings on this eight-state review.

*Wide Variation in State Efforts to Check Provider Integrity*

States have considerable latitude in how they structure their provider enrollment processes. While some states have begun to strengthen these processes, few have taken comprehensive measures to prevent problem providers from entering Medicaid. In our survey, while almost all states reported checking licensure and whether providers had been excluded from federal programs, less than half reported checking whether providers had criminal records or had a site to conduct business. About two-thirds of the states reported canceling inactive billing numbers, even though billing numbers are used to receive payment. Canceling billing numbers that have been inactive can help prevent unauthorized individuals from adopting and using those numbers. States were least likely to conduct checks of whether the provider is actually located at the address reported—21 states reported doing so. This may overstate the amount of checking that states are doing, because of the states that reported doing these checks, at least one had begun doing this within the last year, and one had done so on a trial basis in some parts of the state. Only nine states reported conducting all four of these checks—licensure, excluded provider, criminal record, and business location.

HCFA has found site visits to be useful in verifying whether applicants for enrollment in Medicare have bona fide businesses. In our survey, 19 states reported that they conducted site visits when a provider initially applies to become enrolled. Most states that conducted site visits reported visiting only certain providers that they feel have a greater likelihood of abusing the program—for example, the Kansas Medicaid program reported visiting only durable medical equipment suppliers. Because these site visits cost money, such targeting is seen by those states as the best approach. Only New Hampshire, which reported enrolling about 5,000 providers in the last 3 years, said that it checked the sites of all providers before enrollment.

Once enrolled, many states allow providers to stay indefinitely in the program without having to update information about their status. As a result, while some providers may be reporting changes to the Medicaid program, such as selling a business and its associated billing number, others may not. Twenty-six states reported allowing providers to continue to bill indefinitely once enrolled. Others had an enrollment time limit, which often varied by provider type. Eighteen states reported conducting visits to help determine whether providers should remain in the program. These states generally reported visiting only certain providers, with 11 reporting that they visited such providers at least once a year.

Because billing numbers allow claims to be processed, they are valuable and need to be guarded. Existing businesses may be sold to owners that intend to defraud

<sup>11</sup> Before the Systems Performance Review (SPR), a triennial standards-based review to re-approve/approve a state's MMIS as well as any reduction in federal financial participation levels, was repealed by the BBA, HCFA performed indirect oversight of provider enrollment via the SPR. Part of the review included an evaluation of the provider enrollment subsystem within the state MMIS.

Medicaid, and dead or retired providers' numbers can be used by unscrupulous individuals. Canceling inactive billing numbers can prevent questionable providers from deliberately obtaining multiple numbers to keep "in reserve" in the event that their practices result in suspension of claims under the primary number. Once again, a number of states reported doing nothing to control billing numbers. Only thirty-three states reported canceling inactive billing numbers. Of those, 16 reported canceling providers' numbers when they did not submit a bill for 2 years. Five states reported that they canceled a provider number if no bill had been submitted in more than 3 years.

*States' Key Activities to Ensure the Integrity of Potential Providers*

Some states, including Connecticut, Florida, Georgia, New Jersey, and Texas, are engaged in a number of activities that make it more difficult for questionable providers to enter and remain in their Medicaid programs. These include more stringent review of information on the provider enrollment application; developing provider agreements that give the state more flexibility to terminate without delays; reenrolling existing providers under new, stricter standards; increasing scrutiny of applications from certain provider types and continued scrutiny after enrollment; conducting preenrollment site visits; and establishing better control over provider billing numbers. Examples follow.

**More Stringent Review of Provider Enrollment Applications.** In late 1998, Connecticut began using information from its fraud and abuse cases to help it determine what to require of new providers. Earlier audits had revealed that durable medical equipment providers operating in networks—many of which were family-based—were defrauding the program. As a result, representatives from Connecticut's Office of the Attorney General and Office of the Chief State's Attorney worked with Medicaid quality assurance and provider relations staff to revise the Medicaid enrollment process, starting with the provider enrollment application.

Connecticut's new application requires providers to disclose business or personal relationships with other Medicaid providers. In addition, applicants must now state whether they have any administrative sanctions, civil judgments, criminal convictions, or bankruptcies, and whether they are enrolled in federal or other states' health care programs. Further, the Connecticut Medicaid application requires submission of the names and Social Security numbers of all owners, officers, and directors of the provider's business. A critical step in the state's enrollment process is verification of the enrollment application information. Connecticut has a contractor that uses various on-line databases to check applicants' personal, financial and criminal backgrounds. Similar to Connecticut, beginning July 1, 2000, Georgia started using a revised provider enrollment application that requires the applicant to disclose criminal background, exclusions and sanctions, and ownership information on the application form.

As a result of problems with provider fraud in South Florida, in December 1995, Florida began to implement several changes in provider enrollment procedures. Florida now requires noninstitutional providers to undergo fingerprinting and criminal history background screenings. For group providers, all officers, directors, managers, and owners of 5 percent or more of the business must be screened. Applicants are required to submit fingerprints and to pay for the background checks. Fingerprints are checked with both state law enforcement authorities and the Federal Bureau of Investigation.

**Strengthened Provider Agreements.** Several states now include provisions in their provider agreements that allow either the provider or the Medicaid program to terminate the agreement without cause after giving the other party advance notice. While the details vary, such a clause is now part of the Medicaid provider agreements required by Connecticut, Florida, Georgia, and Texas. New Jersey's provider agreement currently allows providers to terminate their agreement without cause after giving the program 30 days written notice. However, New Jersey Medicaid officials told us that a provision giving Medicaid the same termination rights is being developed. A Texas Medicaid official told us that the termination-without-cause provision was an important new tool to help protect the Texas Medicaid program by allowing officials to remove problem providers more expeditiously.

**Reenrollment Under Stricter Standards.** Several states that tightened standards for newly enrolling providers also required existing Medicaid providers to reenroll under the new standards. For example, after strengthening the Texas Medicaid program's provider enrollment process for new applicants, the Texas legislature directed Medicaid officials, beginning September 1, 1997, to initiate a 2-year period during which all current providers would be required to reenroll in the Medicaid program. Texas Medicaid providers—both new applicants and existing providers—must now sign a provider agreement that includes stricter terms of partici-

pation and new anti-fraud-and-abuse language. When Texas providers were slow to reenroll, the legislature extended the deadline by a year to September 1, 2000, and reduced some requirements, such as filling out a provider information form, but not the requirement that providers sign the new agreement. Texas Medicaid officials reported that as of May 31, 2000, 68 percent of the providers had reenrolled. Similarly, starting in 1996, Florida required all noninstitutional Medicaid providers to reenroll on a staggered basis under stricter standards. When Florida began the reenrollment, there were approximately 80,000 Medicaid providers; when it ended, there were about 20,000 less. State program officials report that access to health care was not affected by the reduction in Medicaid providers.

**Special Scrutiny of Certain Provider Types.** As several other states have done, New Jersey's Division of Medical Assistance and Health Services has instituted special Medicaid enrollment procedures for certain types of providers. The New Jersey Medicaid program's fiscal agent handles all aspects of the Medicaid provider enrollment process for most provider types. However, enrollment applications from pharmacies, independent laboratories, transportation companies, and durable medical equipment providers receive extra attention. Both the Medicaid Program Integrity staff and Medicaid Fraud Control Unit (MFCU)<sup>12</sup> staff review pharmacy and independent laboratory enrollment applications. The review includes a criminal background check. Other New Jersey Medicaid program personnel review applications from durable medical equipment and transportation providers.<sup>13</sup> Program consultants conduct preenrollment site visits to pharmacy and durable medical equipment applicants. In addition, physician group practices are visited on-site after they are enrolled. This type of approach can root out those individuals who set up a physical location only long enough to enroll in the program. For example, in an Illinois Medicaid fraud case involving a laboratory, an individual paid 1 month's rent on office space and state-of-the-art medical testing equipment to obtain the certification needed to bill Medicaid for complex laboratory tests. But after receiving certification, no patients were actually tested, although Medicaid was billed for laboratory services.

Florida requires certain types of Medicaid providers, including home health agencies, durable medical equipment suppliers, nonemergency transportation providers, physician groups with more than 50 percent nonphysician ownership, and independent laboratories to obtain surety bonds. On May 25, 2000, legislation was enacted that increases the maximum surety bond the Medicaid agency can require a prospective or participating provider to obtain. Under the new law, Medicaid can require the current \$50,000 flat rate or, if greater, the total amount billed by the provider during the current or most recent calendar year. Florida officials indicated that a primary reason for the surety bond requirement is that in underwriting a bond, surety companies check the capacity and financial ability of the providers to operate as a valid business. Florida officials consider such a review an effective screening tool to help keep less qualified providers out of the program. However, obtaining a surety bond does not reflect how well an applicant will perform as a health care provider, just that they are a business. In a previous report, we pointed out that these requirements may negatively affect the ability of small providers to serve beneficiaries. In addition, individuals with no history of criminal action but an intent to defraud the program could still obtain bonds.<sup>14</sup>

**Preenrollment Site Visits.** In 1999, after receiving new budget authority from the state, the recently reestablished Georgia Medicaid program's Provider Enrollment Unit began conducting site audits on all new noninstitutional provider applicants. Georgia's site audit requirements include verification of the provider's business location, a check of the provider's compliance with the Americans With Disabilities Act, and a check of the provider's business license. The audit also checks compliance with any additional criteria that are required for that category of provider as stipulated in the state's Medicaid provider manual. Georgia Medicaid officials reported that when they began the site audits they detected numerous applicants with nonexistent addresses or mailbox-only operations; now such a finding is rare.

<sup>12</sup> Under the Social Security Act, Sec. 1902 (a)(61), states are required to have a MFCU or a waiver of this requirement from the Secretary of Health and Human Services. These units are to be separate from a state's Medicaid agency and are responsible for investigating and prosecuting Medicaid provider fraud, patient abuse, and program administration fraud. Forty-eight states have MFCUs.

<sup>13</sup> Since November 1998, a moratorium has been in effect on the enrollment of "invalid coach" providers by New Jersey's Medicaid program. Invalid coaches provide transportation services to beneficiaries who require assistance.

<sup>14</sup> *Medicare Home Health Agencies: Role of Surety Bonds in Increasing Scrutiny and Reducing Overpayments* (GAO/HEHS-99-23, Jan. 29, 1999.)

According to Texas Medicaid officials, that state had a less successful experiment with preenrollment site visits. In 1997, in part because of the experience of the Florida Medicaid program, the Texas legislature directed its Medicaid program to establish a pilot project aimed at reducing fraud by conducting random on-site reviews of prospective Medicaid providers in targeted counties. For the pilot, program officials selected the three urban counties that had the largest concentration of providers in the specialties designated by the legislation—durable medical equipment providers, home health care providers, therapists, and laboratories. At a minimum, Texas Medicaid investigators were required to inspect the providers' sites; review appropriate licenses or other authorities; interview the providers' representatives, staff, and patients; and review medical and business records. Only nine provider applications were received during this time period. The nine applicants reviewed during the 5-month pilot were found to be capable of delivering the specific services proposed in their applications and to have fully operational businesses. Program officials calculated that the reviews cost an average of \$4,200 per provider—too high to be cost-effective—and they recommended against extending the pilot or implementing the preenrollment reviews statewide.

Site visits are done before enrollment in the Florida Medicaid program for certain types of provider applicants, including pharmacies, durable medical equipment suppliers, physicians' group practices that are at least 50 percent owned by nonphysicians, independent laboratories, home health agencies, and some transportation companies. Florida officials plan to begin conducting checks on 100 percent of the pharmacies in two counties that historically have had a problem with fraud. In addition, the state or its contractor may conduct site visits on any existing providers if they are considered to be high risk, have exhibited aberrant billing practices, or are the subject of a complaint made to the Medicaid state agency.

**Better Control of Medicaid Billing Numbers.** Because control of Medicaid billing numbers has been lax in some states, Medicaid has been billed by individuals using information from deceased or retired providers—either directly or as referring physicians. In an effort to better control Medicaid billing numbers, Texas Medicaid officials developed the Texas Provider Identification System, which they planned to institute in conjunction with their provider enrollment changes. At present, Texas providers can legitimately have and use several Medicaid provider numbers simultaneously. Under the new system, each provider would have one seven-digit base number to which locator code numbers could be added to indicate where a service was performed. Texas has had to delay implementing the new identification system because the start-up of the state's new MMIS is behind schedule. The Georgia Medicaid program uses a billing number system similar to the one envisioned by Texas Medicaid officials. Medicaid providers in Georgia have a base number to which letters are added that indicate the location where the service was provided.

As previously mentioned, many states now cancel the billing numbers of providers who have not submitted a bill to the Medicaid program during a certain period of time. Of the states whose Medicaid officials we interviewed, Florida, Georgia, and Texas currently cancel the billing numbers of inactive providers, while Connecticut and New Jersey do not.

The state Medicaid officials reported that the strengthened provider enrollment measures they have adopted have given them important new tools to help ensure the integrity of their Medicaid programs. Despite the obstacles encountered in recent efforts to better ensure the integrity of their Medicaid providers, Texas Medicaid officials reported that they have sent a strong message to providers about the program's intolerance for fraudulent and abusive practices. Connecticut Medicaid officials said that while it is difficult to quantify the deterrent effect of their provider enrollment measures, preventing fraudulent providers from entering the Medicaid program is inherently more cost-effective than trying to recover inappropriately expended funds.

#### IMPROVING MEDICARE PROVIDER ENROLLMENT CREATES ADDITIONAL OPPORTUNITIES TO STRENGTHEN MEDICAID

The current revamping of Medicare's provider enrollment process may provide an opportunity for HCFA to help states strengthen the provider enrollment process in their Medicaid programs. Because many of the same providers bill both programs, we were interested in finding out whether the programs' working together could more efficiently screen out problematic providers. Sharing a standard enrollment form with Medicare and checking providers using the new database, PECOS might help Medicaid programs more effectively operate their provider enrollment processes.

The HCFA Administrator has suggested that developing a joint Medicare/Medicaid provider enrollment process might be beneficial for both programs. A HCFA official with responsibility for program integrity activities advised us that HCFA plans to solicit state Medicaid officials' comments in the next month concerning the use of HCFA's provider enrollment form for enrollment of both Medicare and Medicaid providers.

Combining Medicare and state Medicaid efforts would not necessarily mean that states with particularly aggressive or more comprehensive provider enrollment programs would not continue them. HCFA and the states would need to agree on the minimum requirements of a provider enrollment process in Medicaid and to what extent enrollment through the Medicare process satisfied those requirements. For example, it might be reasonable to have states verify provider business addresses and readiness to provide services through state-controlled site visits. Either Medicare or Medicaid could be responsible for verifying provider credentials and qualifications. The Medicare program could be responsible for verifying Social Security numbers and other information available in national databases, as well as for entering provider information into the PECOS system. This would allow the states to put more effort into activities that are best done at the local and state levels.

One other recent development will affect both programs' enrollment processes. As contemplated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), HHS is developing the National Provider Identifier, a single, unique identifier for each provider to be used in transactions with all health payers. This number could help eliminate the multiple identification numbers for the same provider present in today's environment that unscrupulous providers can use to obscure their billing practices. This system would more easily track all the activities of a provider by his or her unique identifier. Currently, the draft of the final regulation is awaiting approval by HCFA, HHS, and the Office of Management and Budget.

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

#### GAO CONTACT AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please call Sheila K. Avruch, Assistant Director, on (202) 512-7277. Key contributors to this testimony include Barrett W. Bader and Bonnie L. Brown.

#### RELATED GAO PRODUCTS

*Medicaid: Federal and State Leadership Needed to Control Fraud and Abuse* (GAO/T-HEHS-00-30, Nov. 9, 1999).

*Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers* (GAO/OSI-00-1R, Oct. 5, 1999).

*Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

*Medicare Home Health Agencies: Role of Surety Bonds in Increasing Scrutiny and Reducing Overpayments* (GAO/HEHS-99-23, Jan. 29, 1999).

*Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies* (GAO/HEHS-98-29, Dec. 16, 1997).

*Fraud and Abuse: Providers Excluded From Medicaid Continue to Participate in Federal Health Programs* (GAO/T-HEHS-96-205, Sept. 5, 1996).

*Fraud and Abuse: Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers* (GAO/T-HEHS-96-7, Nov. 2, 1995).

Mr. UPTON. Thank you. Bonus for finishing early.

Mr. Kubic.

#### TESTIMONY OF THOMAS T. KUBIC

Mr. KUBIC. Good morning, Mr. Chairman. My name is Tom Kubic. I'm the deputy assistant director of the FBI with responsibilities for the White Collar Crime Program. I want to thank the chairman and the subcommittee for allowing me to appear today, and I have prepared a formal statement. With your approval, I will submit it for the record.

To begin with, I'd like to mention that one of the key reasons we have been able to make such progress in the area of health care fraud law enforcement is the fact that the Congress has been providing the Bureau with increased funding for both support employ-

ees as well as new agents to come on board and work these types of cases. In addition, the passing of the new legislation has also helped significantly by providing us with laws that are precise, that are direct and that are on point with the nature of the fraud that we are seeing.

By way of background, in 1992, FBI had about 112 special agents nationally working within the health care fraud program. Today, there is almost 500 agents working health care fraud matters nationally. There is also a corresponding growth in the number of cases that we were investigating. Today, we investigate over 3,000 allegations of health care fraud nationally. We have also seen increases in the number of individuals, companies and providers who have been indicted and convicted within the area of health care fraud. For example, the most recent information shows that in 1999, there were 615 individuals convicted nationally.

The question you might ask is why is—why is there such a major difference in Medicaid fraud, and I would offer for the committee's consideration—the subcommittee's consideration, the fact that the various regulations and rules that have grown up and the differences in State-by-State application of these rules make this area a particularly ripe area for fraudsters. Also, with specific reference to the State of California, the tremendous amounts of money, over \$18 billion, and the tremendous number of people in the program make it a particularly ripe area for unscrupulous providers.

Based, in fact, on an increasing number of referrals from the California controller's office and a number of audit reports that were indicative of fraud, the FBI joined with California authorities in a task force. Earlier there was a comment about why is it necessary for the FBI to participate or to initiate these types of investigations? And I remind the subcommittee that upwards of half of the money within the Medicaid program is, in fact, Federal funds, and it is in that fashion that we get our jurisdiction.

The task force was particularly successful because of a very aggressive United States attorney's office in the eastern District of California, which has the reputation of tolerating, kind of a zero tolerance for fraud. Working with them, agents working from audit reports were able to successfully aggressively address this type of fraud.

I will also try to finish a little earlier and leave some time. You clearly noticed I did not bring a sledgehammer nor an industrial grade vacuum cleaner.

Mr. UPTON. Just handcuffs.

Mr. KUBIC. Just handcuffs. I will assure you that we are continuing to investigate approximately 300 additional providers in the State of California in a joint effort. I can assure the committee that we will continue to conduct those investigations and take them to their logical conclusion, which we think will be indictments, arrests and forfeiture of assets to be returned to the people. Thank you.

[The prepared statement of Thomas T. Kubic follows:]

PREPARED STATEMENT OF THOMAS T. KUBIC, DEPUTY ASSISTANT DIRECTOR,  
CRIMINAL INVESTIGATIVE DIVISION, FEDERAL BUREAU OF INVESTIGATION

Good morning. I am Thomas T. Kubic of the FBI. I want to thank the chairman and the entire sub-committee for allowing me to appear this morning. I'd like to dis-

discuss the serious nature of health care fraud and to brief you on innovative techniques that the FBI is currently utilizing to address the crime problem. Specifically, I am going to brief you on our efforts in California and the significant legislative changes that have occurred due, in part, to the efforts of the Sacramento task force.

As the sub-committee is well aware, in 1996, Congress enacted comprehensive legislation to combat the health care fraud problem which continues to rob our health insurance programs of billions of dollars annually. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), gave the FBI increased funding and new legal tools to address this very crime problem. We at the FBI interpreted this as a message that Congress wanted the FBI to step up our efforts. We responded. I and other senior management officials have used this increased funding to hire, equip, and train more agents and professional support employees to be assigned to health care fraud matters. In 1992 the FBI had 112 special agents investigating 591 cases. Today, thanks to the funding received through the HIPAA legislation, we now have 493 agents investigating over 3,000 allegations of health care crimes. Criminal health care fraud indictments have also dramatically increased by 50% from 409 to 615 in 1999. Despite the large number of criminal investigations and convictions of the most egregious instances of health care fraud, the FBI does not measure its successes solely on the number of convictions obtained. Rather, the effectiveness of the entire federal government's response to health care fraud can also be measured in the *prevention* of health care fraud and abuse.

The FBI, as the principal investigative agency of the Department of Justice, plays a significant role in health care fraud prevention efforts. No segment of the health care system is immune from fraud, certainly not the Medicaid program. In 1998, approximately \$170 billion was expended nationally by Medicaid programs. Because the rules and regulations vary from state to state, and since each state administers its own Medicaid program, I believe that the Medicaid program is just as susceptible, if not more so, to fraud than its sister program, Medicare. The Medi-Cal program, California's version of Medicaid, saw expenditures over \$18 billion in 1998, the second highest in the United States. In 1998, Medi-Cal provided health care for over 4.8 million recipients. In California, the Medi-Cal program is administered by The California Department of Health Services. Given the magnitude of the Medi-Cal program, the Sacramento division of the FBI, in conjunction with the California State Comptroller's Office, identified a potential crime problem involving health care fraud.

The California State Comptroller's Office began auditing and referring all suspect pharmacies and other provider types throughout California to our Sacramento division for investigation. Through these referrals, FBI Sacramento began to identify and develop evidence of Medicaid fraud at suspect pharmacies. Sacramento's Health Care Fraud Task Force was formed to address this particular crime problem.

Using the newly created health care fraud task force, which commenced in 1998 and includes members from the Sacramento division of the FBI, the California State Comptroller's Office, the California Attorney General's Office, the California Department of Health Services, and the United States Attorney's Office, the Sacramento division of the FBI initiated its "phony pharm" and, then later, "unwholesum" initiatives to investigate and prosecute individuals suspected of orchestrating the most egregious fraud against the Medi-Cal program.

The "phony pharm" initiative prosecutes pharmacies and durable medical equipment suppliers that submit fraudulent claims to Medi-Cal. To date, investigators have focused primarily upon pharmacies that engage in fraudulent billing practices and illegitimate suppliers of durable medical equipment, such as leg braces, back supports, and other durable medical goods. Under this initiative, the Sacramento task force targets those fraudulent providers with insufficient inventories or purchase records to substantiate the volume of business indicated by their Medi-Cal claims. Investigation has revealed that many illegitimate pharmacies and suppliers often set up shell companies or make use of a "store front" to set up their "business," quickly obtain provider numbers, bill Medi-Cal for high amounts in a short period of time, and then shut down. Many times these business operators will reopen in a few months under a new business name.

Approximately six months after the onset of the "phony pharm" initiative, the Sacramento task force realized that some of the targeted pharmacies and DME suppliers have been aided by unscrupulous wholesalers willing to create and sell phony invoices for pharmaceuticals or DME supplies. Pharmacies and DME suppliers involved in fraud schemes then use these phony invoices to substantiate their Medi-Cal claims to auditors and law enforcement officers. Under the "unwholesum" initiative, the Sacramento task force targets wholesale companies suspected of supplying phony invoices.

As a result of this state-federal partnership, 115 defendant Medi-Cal providers have been charged by federal prosecutors with health care fraud offenses. Collectively, these providers and suppliers have been charged with defrauding the Medi-Cal program of more than \$58 million. To date, based on the strength of the investigative efforts, 69 of the defendants have pleaded guilty. These individuals are serving a minimum of 1 year incarceration, and have been ordered to pay, collectively, more than \$20 million in court ordered restitution.

Currently, investigations by the Sacramento task force have targeted more than 300 medical providers, including wholesalers and suppliers. The targeted providers are suspected of defrauding more than \$250 million in Medi-Cal funds.

A major component in the success of the Sacramento task force is the prosecutive support that investigators receive. The eastern district of California has a long standing reputation for pursuing health care fraud vigorously and effectively. The investigative members of the task force combined with the prosecutive support which they receive has equated to a very effective and efficient approach to this identified crime problem.

One of the most flagrant examples of the type of fraud perpetrated against the Medi-Cal program is the Heravi case. The Heravis, suppliers of leg braces, back supports, and other DME, were charged with defrauding Medi-Cal out of more than \$9 million. The Heravis submitted thousands of fraudulent claims for DME supplies that were never delivered to patients. In October 1999, the Heravis entered guilty pleas in the federal health care fraud case brought against them by the United States attorney's office in Sacramento. Additionally, the Heravis agreed to a civil forfeiture recovery totaling \$4.74 million, the largest in the history of the eastern district of California.

In addition to the Heravi case, other significant accomplishments attributed to the Sacramento task force include: in June, 1999, Zaruti Ovesepyan and business associates were charged with health care fraud violations in a scheme totaling \$5.94 million, and in July, 1999, Razmik Ovasapian was charged with health care fraud violations involving in excess of \$1.18 million. These high dollar amounts of fraud were due, in part, to the ease with which suppliers could obtain provider numbers and certification to allow them to bill Medi-Cal.

A recent bill enacted in California recognized the need to attack fraud more effectively. On July 29, 1999, Governor Gray Davis signed legislation which provided \$3.5 million for the creation of a new fraud prevention bureau, aimed at providers of durable medical equipment, transportation, laboratory, and pharmacy companies. This fraud prevention bureau is the first of its kind in the nation. It is the result of a joint effort between the Sacramento health care fraud task force and the state Medi-Cal program. The fraud prevention bureau is a new program of the California Department of Health services. It includes a more comprehensive process for provider applications and certification process, provider agreements, and an enrollment term of only four years for the specified category of providers.

The department now conducts regular field audits to determine whether the volume of Medi-Cal claims submitted to the state are consistent with the amount of business that providers have. The department is also conducting on-site visits to almost all Medi-Cal providers and has a moratorium on the issuance of new Medi-Cal provider numbers. These efforts have prevented fraudulent providers from shutting down and opening again in several weeks or months using a new provider number.

I would specifically like to emphasize the provider application and certification process. We have seen in California, as well as other jurisdictions, unscrupulous individuals enter the health care industry with one goal in mind, to steal from health insurers. The best defense we have against these individuals is to strengthen the provider enrollment and certification process and to keep these individuals out of our health care programs in the first place. The recognition of this HCF crime problem by the task force has, in part, led to these legislative changes.

Based on our experience in California, it certainly would facilitate law enforcement's efforts if other states would tighten their respective provider enrollment process and certification process. We have included presentations on the Sacramento operation at all of our recent health care fraud training programs, as well as past and future manager's conferences, and we look forward to the franchising of this investigative approach in other states.

That concludes my prepared remarks and at this time I would be pleased to answer any questions that you may have.

Mr. UPTON. Thank you.  
Ms. Connell.

**TESTIMONY OF KATHLEEN CONNELL**

Ms. CONNELL. Yes. I'm Kathleen Connell. I am California State Controller. It is an elected position. I was elected by the voters of California in November 1994. I am serving in my second term. I am delighted that the Congressional Committee is holding this hearing today. Medi-Cal fraud and the effort to reform Medi-Cal programs in California has been a high priority in my administration.

When I came into office in 1995, I initiated an audit of the Department of Health Services, which is the Department that runs the Medi-Cal programs in California, because I felt it was a very important part of our budget. In California, to give you some sense of the scope of this program, \$22.5 billion is spent in this budget year in Medi-Cal activities; \$13.2 billion of that is Federal; \$9 billion of that is general-funded.

The role of the State Controller is to audit State programs, and in that capacity, I determined it was necessary to do the first-ever audit of the Department of Health Services. We completed that audit in roughly a year. We submitted that audit information to the legislature and to the Governor. At that point, it was Governor Pete Wilson who was responsible for the operation of the Department of Health Services. That audit report, which indicated \$467 million of audit problems in the Department of Health Services, did not receive a response. We issued an update report to the Governor and to the legislature 6 months later, and then subsequently a year later.

Over a course of a period of roughly of 3 years, we began to see some administrative changes in the Department of Health Services, but it was very slow and taxing work.

Independently of the effort to audit the Department of Health Services, we went forward and audited Medi-Cal providers in four categories: Medical labs, Department of durable medical equipment providers, pharmacists and physicians. To date, we have issued 339 reports. We have referred 70 percent of those reports for criminal investigation and prosecution by the U.S. Attorney General's office, by the State Attorney General's office and by the FBI, and we have identified savings to date of \$547 million. All of that information is included in the charts which I provided in my testimony.

I'd like to direct my comments now to what has evolved over the course of the last few years and how the FBI got engaged in this effort. When we began referring cases to the State Attorney General's office there was no interest in prosecuting those cases. At that point, cases were referred to the FBI. A task force was made up of the FBI, the State Controller's office, and the U.S. Attorney General's office. In the election cycle of 1998, Governor Gray Davis was elected. He had been a prior controller and was committed to the efforts that were underway on Medi-Cal reform. He has significantly expanded the Medi-Cal efforts in the Department of Health Services, and Mr. Cates is here today to discuss their activities.

We've also expanded the task force now to include the Attorney General's office and the Department of Health Services. That task force is now being led by the Governor's office, and they are making a concerted effort to assist us in wrestling Medi-Cal fraud and dealing with the after efforts of it.

Unfortunately, in the midst of this effort to crack down on Medi-Cal fraud because we had been so aggressive, some of the people that we had investigated and had brought for criminal prosecution have filed a lawsuit against the State Controller's office. Those lawsuits were heard in Federal court, and two Federal actions have significantly handicapped the ability of the State controller to play an active role in investigating Medi-Cal fraud. The Federal courts have recently ruled that under a Federal definition of single State agency, that only one agency can be empowered to be engaged in the effort to operate a Medi-Cal program.

In California, that designated agency was the Department of Health Services. They had contracted with the State Controller's office for a period of years well before I got elected to office in 1994 to conduct the audits, because we are the constitutional officer responsible for conducting State audits.

Under the Federal court appeals ruling, the State Controller's office can no longer conduct the audits in the way that we had. When we had conducted audits prior to the ruling in 1999, we conducted audits—when we found that there was indication of fraud, we would basically pull the trigger. We would freeze the funding for that Medi-Cal provider until we could indeed investigate the level of fraud, which had occurred in their program activity.

Under the current law the State controller can only do the audit, send the audit report, not a finding to the Department of Health Services. The Department of Health Services then needs to review the audit review report, make its own finding that Medi-Cal fraud has indeed occurred, and at that point can seek to stop the funding.

This lag factor has significantly slowed down the ability to carry forth on the audits. It has substantially reduced the effectiveness of our efforts as a task force to move forward with the enlightened effort of the Governor's office and the continued support of the FBI.

So I have asked, in my testimony today, if Congress could get clarification of the single State agency. If it requires legislation, we would certainly hope you would do that. I have been in conversation with State controllers around the country. They are, indeed, concerned that similar kinds of judgments will be made by their courts. This is obviously an easy way to take your audit capacity out of the game of controlling Medi-Cal fraud. We've proven we have been effective, and as a result of that, I think there's continuing concern on the part of providers that they rule us handicapped in this process.

I would like to spend a moment responding to Mr. Assatourian's questions about how he feels we should improve the system and his four common sense steps, and I think the committee should be aware that those steps have actually been addressed. He indicated that getting a provider number is extraordinarily simple. I carry the bill called the Romero bill, which was AB 874. It passed, was signed by the Governor last year, which has now tightened up the ability in California to get a provider number.

We carried another bill, which has put in place a bond program for anyone who does Medi-Cal provider work in California. That bond is now set at \$25,000 a year. That bill was also signed by Governor Davis. We have been carrying these bills for a number of years, but we're finally delighted they made it through the system.

The third concern that he had is that obtaining a Medi-Cal card should be more difficult. We agreed. That language has been in the bill, it was passed and it's in effect.

And finally, his concern was that we should purchase from authorized distributors. We agree with that, but that is not our role as a State controller; that's really Department of Health Services. We are doing, however, in the State Controller's office, what we call third party validation. It is a normal part of the audit process. We do not accept the fact that people have invoices. We go beyond the invoices because many of these invoices are phony, and we go back to the provider's supplier, and that is part of a normal audit process. The FBI can verify that as well.

In relationship to products on the Medi-Cal formulary, I am carrying a bill this year which will deal with that and will modify the Medi-Cal formulary role. That has reached it's policy committees in the Senate now. It has gotten a lot of opposition from providers in California, and it may not pass this year because of the opposition it has received.

And finally, in relationship to his concern about the training of auditors, I can't comment on the Department of Health Services. All of our auditors are trained specifically in Medi-Cal audits. They are very informed in this field, and that, indeed, is how we've gotten to the savings of \$547 million.

[The prepared statement of Kathleen Connell follows:]

PREPARED STATEMENT OF KATHLEEN CONNELL, CONTROLLER FOR THE STATE OF CALIFORNIA,

Good Morning Mr. Chairman and Members. My name is Kathleen Connell. I am the State Controller of California, a State Constitutional Office elected by the voters. I serve as the chief financial officer for California.

In my testimony this morning, I will outline efforts that my office has initiated in combating Medicaid fraud in California and identify the challenges which are continuing. I have produced a report specifically for this Committee setting forth my full remarks which I would submit for the record. The report provides a complete history of the efforts of my office as well as detailed statistics on our efforts.

At the beginning of my administration in 1995, I set the elimination of waste and fraud in state programs as my highest priority. The Medi-Cal program, California's version of the Medicaid program, was then, and continues to be, one of the most significant parts of California's annual budget. In the current fiscal year, over \$22.5 billion is appropriated for Medi-Cal, of which \$13.2 billion is federal funds. General fund expenditures of over \$9 billion for Medi-Cal will account for nearly 12% of all General Funds in the state budget.

Early in my administration, I directed auditors to expand the review of billing practices of Medi-Cal providers. In June 1996, I issued a report on 11 pharmacy providers in Long Beach, California, which identified over \$2 million in unallowable costs. Significantly, two of the eleven closed their businesses immediately after the auditors arrived. This raised my concern that there were additional areas of apparent fraud that had not been previously identified.

The Controller's office then expanded its efforts into other provider categories and found similar results in audits of durable medical equipment providers, physicians, and laboratories. To date, the Controller's office has issued 367 reports, demanded repayment of \$141 million, saved the taxpayers an additional \$385 million in cost avoidance, and withheld \$23.5 million in payments to providers identified by law enforcement as engaging in fraudulent activities. The total savings from the efforts of our office are over \$547 million, more than one-half of which is *federal funding*. In addition, the Controller's office referred 238 cases to the Medi-Cal Fraud Control Unit located in the California Department of Justice for criminal investigation and prosecution.

In 1998, seeking to pursue criminal prosecution of our Medi-Cal findings, the Controller's office initiated a partnership with the Federal Bureau of Investigation, the

U.S. Attorney General's Office, and the California Department of Justice to pursue criminal investigations and subsequent prosecution.

To assist the California Department of Health Services in carrying out its administrative responsibilities, the Controller's office sponsored legislation which gave that Department more authority to tighten up the provider enrollment process, increase penalties for fraud, and expand the use of bond requirements. This legislation was signed into law last year, and represents significant change to the way we operate Medi-Cal in California. Please refer to chart 4 in my report, which outlines the specifics of these legislative changes.

The Controller's office has also participated in the newly created California Governor's Task Force on Medi-Cal Fraud, which is intended to coordinate the efforts of all state and federal agencies involved in anti-fraud efforts in Medi-Cal.

The increased anti-fraud activities from all of these agencies, which resulted from our initiatives, are having a significant effect. The California Legislative Analyst noted that 31% of the providers of durable medical products—one of the first provider types to be targeted by my auditors—had been removed from the provider roles and that claims for this group have declined by nearly 10%. In addition the Legislative Analyst anticipates similar results in the future in other provider types that our office's audits have targeted.

While this is good news, it is also clear that fraudulent providers have noticed these efforts and are taking steps to circumvent the current prevention and detection efforts. New schemes involve:

- Using false identification to masquerade as licensed providers who are retired, no longer practicing in California, or dead;
- Using marketers to pay beneficiaries to use their Medi-Cal card to bill for services that are unnecessary or not provided;
- Stealing beneficiary Medi-Cal information from hospital records and using it to bill for services not provided;
- Buying an established health care business and billing under that name; and
- Developing some documentation to avoid detection by performing unnecessary invasive procedures (for example, drawing blood) and then billing for tests never performed. In addition to the health risks to the person having this type of procedure, this practice can increase the possibility of the spread of disease in the general population.

It is clear that the fight against fraud in the Medi-Cal program is still far from over. There are two concerns regarding the future of Medi-Cal anti-fraud efforts that I would like to discuss:

First, recent federal court rulings have minimized the Controller's office's role in combating Medi-Cal fraud and abuse. Without our efforts to identify the problem and take action, Medi-Cal provider fraud could have gone unnoticed and/or untreated for long periods of time. While much has been accomplished, it is clear that this is a problem that will require long-term dedication by state and federal officials.

Second, recent federal court rulings have undermined the Controller's office's ability to carry out a critical oversight role, limiting our ability to conduct audits. In addition, the Controller's office is currently prohibited from initiating withholds on payments to suspected fraudulent providers or referring them to the Department of Justice for criminal investigation and prosecution. Cracking down on fraud cannot occur without the ability to stop the flow of funds. Under the current court rulings, even when fraud is detected, the Controller's office cannot withhold payment nor even inform the Department of Health Services that fraud is suspected. Only a report can be submitted with the intention that the Department of Health Services would recognize the fraudulent activity. As a result, our payments may be continued for some time. Even when prosecution is successful, those additional payments are often not recovered.

Essentially, the federal courts have interpreted federal law and regulations to require that the Controller's office not engage in *any* activities in which it might exercise *any* discretion.

Even though the Controller's office has an independent duty under California law to determine the legality and propriety of payments made from the State Treasury, the federal courts have determined that the State of California modified this duty when it accepted federal money and agreed to be bound by federal Medicaid law.

Let me briefly explain what has occurred. The Medicaid law and rules require the designation of a single state agency to administer this program and prohibit any other agency from exercising administrative discretion in any area, including the prevention and detection of fraud. In California, the single state agency is the Department of Health Services. The Federal Court's ruling essentially requires an unnecessary duplication of functions in state government. For example, under the court's ruling, state governments are prohibited from using the long established,

and often state constitutional, functions of other offices. In California, the court ruling requires the Department of Health Services to establish an audit function similar to that of my office as well as an investigative function duplicative of the California Department of Justice.

Certainly, it was never contemplated that the single state agency would not be allowed to utilize the existing resources in state government and would relegate the state constitutional functions of other state offices to a nullity.

Other state Controllers and state Auditors have expressed concern that the federal court determinations could be used to undermine their authority as well, and detract from their efforts to fight fraud and abuse in their Medicaid programs. In order to solve this problem, and allow states to adequately combat fraud, I request that Congress take action to review and amend the Single State Agency law to allow recognition of the State's constitutional role of its elected officials and allow me to once again carry out my independent duties and responsibilities as the state's fiscal watchdog. The amendment should allow me to exercise discretion in analyzing the Medi-Cal program to identify fraudulent trends, initiate audits to identify overpayments, take actions to withhold payments, make referrals for criminal prosecution, and develop recommendations to increase fraud prevention and detection activities.

Such an action on the part of Congress would send a clear message to criminals considering committing Medicaid fraud and undermining the program goals that both federal and state government are serious about prevention, detection, and prosecution, and that such criminal activity would have its consequences.

Thank you for your inviting me to address you today. I am happy to answer any questions you may have.

Mr. UPTON. Thank you.

Mr. Cates.

#### **TESTIMONY OF J. ALAN CATES**

Mr. CATES. Thank you, Mr. Chairman, and honorable members of the committee. My name is Alan Cates. I am the chief of the new Medi-Cal Fraud Prevention Bureau in the State of California's Department of Health Services. It is my pleasure to be here today and give you an update on our efforts to combat fraud in Medi-Cal, specifically to update you on our new provider enrollment processes and our innovative approach to eradicating fraud in our provider network.

I would want to point out that until last year, fraud was indeed bilking a billion dollars from the State of California's health care service system. Concealed by an inherent trust of medical professionals along with a long recession that limited oversight resources, fraud had flourished in California. Providers that were caught were typically apologizing and promising to do better next time. Many times they did. We had one that was identified as taking \$200,000. They were ordered to repay it. They were closed down, but they instead opened two new stores and took over \$12 million in just over a year. Fortunately, they're now in prison.

Working with eight special agents of the Sacramento office of the FBI and one assistant United States attorney, we were able to identify and stop \$200 million in durable medical equipment fraud in 1998, 1999. That was approximately a \$20 million-per-person return rate. However, we did not even get to half of the fraud, and more resources were desperately needed.

That's when, in 1999, Governor Davis put up \$1.2 million for a new Medi-Cal Fraud Prevention Bureau, and implemented the Medi-Cal Fraud Task Force. The Medi-Cal Fraud Prevention Bureau is essentially a civil authority within the Department of Health Services that uses existing administrative authority within the Medi-Cal program to specifically detect and document fraud.

The Governor's Medi-Cal Fraud Task Force is primarily interested in combining the resources of the various law enforcement and civil authorities within the State of California, including HCFA, Office of Inspector General, FBI, U.S. attorney, State Controller's office, and State Department of Health Services to focus entirely on fraud within the health care program in the State of California.

The Medi-Cal Fraud Prevention Bureau launched a new three-step focus on fraud approach to put fear back into fraud. Step one was a survey, a risk assessment survey approach where you went onsite to each of the providers. In the State of California, I might mention we have over 100,000 providers of Medi-Cal services. However, we have approximately 5,000-and-some targeted groups, which include durable medical equipment that present a little bit more of a problem for us than some of the other provider groups. So we're focusing on approximately 5,000 of those providers, and then approximately 15- to 20,000 doctor clinic operations that, due to their claim patterns, we are also focusing on. That's for the onsite risk assessment survey.

Step two we call "trust—but verify." We do a follow up review of those high risk providers to identify actual evidence of fraud. The first step just indicates indicators, "fraud flashers" we call them in the business. Step two, we're actually documenting evidence of fraud by looking at their books and records.

Step three is immediate payment withhold to stop the payments and to refer them for criminal prosecution.

That three-step process has proved effective. Ten Medi-Cal fraud prevention specialists in the field have already completed over 14,000 onsite surveys, documenting 2,000 high risk providers, stopping \$50 million in payments, and referring over 100 providers to law enforcement for prosecution.

As you heard earlier, currently the Sacramento office of the FBI and the U.S. attorney alone are investigating 350 fraud cases, having charged 115 with \$60 million in health care fraud, convicting 70 of those 115 and recovering \$21 million through asset forfeiture and criminal restitution. All that in just a little over a year.

Special Agent Ed O'Donnell, the lead agent on that case, was recently awarded outstanding criminal investigation of the year for his role in the phony form operation. The Medi-Cal Fraud Prevention Bureau's role has now been expanded to provider enrollment. In addition to new ChoicePoint examinations, before they can be turned on and \$50,000 fidelity bonds, new and reenrolled providers must first pass an onsite fraud prevention review. In place of the old pay and chase, California now uses a lock-and-load system where we go in and lock in what the provider's business practices are, how they intend to operate that business, what their capabilities are based on their current business structure; we lock that in and then we load it into a computerized system that will trigger us within 90 days, or, if they exceed their parameters that we reasonably set for them when we did the initial review. Within that 90 days, or if they hit the trigger, we go right back in and perform a fraud prevention follow-up review where, again, we look at actual business records, primarily bank records. We use source documents to determine what is really happening at the business.

The lock-and-load procedures are designed to assist the new honest providers, while at the same time, demonstrate to fraudulent providers that fraud detection will be swift and certain.

We have other antifraud efforts going on at the Department, including pre-check write processes that identify questionable claims before they are paid and are field reviewed before payment is released. We are aggressive with fraud, but not the vast majority of honest providers that help us deliver the health care system to the people that need it the most.

Thank you, your Honor.

[The prepared statement of J. Alan Cates follows:]

PREPARED STATEMENT OF J. ALAN CATES, CHIEF, CALIFORNIA MEDICAL FRAUD  
BUREAU

Mr. Chairman and honorable members of the Committee, my name is J. Alan Cates. I am the Chief of the Medi-Cal Fraud Prevention Bureau for the California Department of Health Services (Department). Thank you for the opportunity to testify, and pursuant to your request, I have prepared written testimony for inclusion in the record, as if read. It is my pleasure to be here today to give you an update on the efforts of the State of California to combat fraud and abuse in the Medi-Cal program. Specifically I would like to update the committee on our new provider enrollment process and our new innovative approaches to curb fraud and abuse.

*Background*

Following a decade of a limited number of oversight resources and concerted efforts to encourage provider participation with easy application processes, fraudulent providers were slipping in and were stealing millions of dollars. Stealing doctor identities and professional license numbers, and using illegally obtained Medi-Cal beneficiary data, fraudulent providers were bilking millions from California's Health Care Program. Employing complex, but essentially cookie-cutter fraud schemes, they concealed the fraud with perfected paper trails and cleverly cooked books. Since only a few were ever caught, the pervasive scope of the problem went undetected. That is, until recently.

*Governor Davis Declares War on Fraud*

Remembering his days as State Controller and his active role in fighting fraud with Medi-Cal supply providers, Governor Davis declared all-out war on those who would steal from programs serving the most vulnerable. Within months of his inauguration in 1999, Governor Gray Davis took decisive steps in the State Budget to reduce fraud in the Medi-Cal program by tightening the provider enrollment process, establishing the Medi-Cal Fraud Prevention Bureau, and convening a Governor's Medi-Cal Fraud Task Force with both State and Federal representation. Since taking office, Governor Davis has added more than 230 new positions and more than \$17.5 million to California's Medi-Cal fraud prevention efforts.

*Provider Enrollment*

Durable medical equipment (DME) was found to have a high incidence of fraud and the number of new providers of these services was growing at an alarming rate. A moratorium on the enrollment of new DME providers was established in early 1999. In July 1999, a legislative initiative proposed by the Governor was enacted which for the first time gave the Medi-Cal program the statutory authority to verify a provider applicant's identity and background prior to enrollment and to deny enrollment, or sanction existing providers, who did not meet the enrollment criteria. This legislation extended the authority to impose enrollment moratoriums to all provider types, and precluded the enrollment of providers convicted of fraud for a period of 5 years. The statute also authorized the Program to make unannounced inspections of the provider's place of business prior to and after enrollment.

With the new statutory authority and enabling regulations, the Medi-Cal provider enrollment process underwent significant changes. New, more extensive enrollment applications, provider agreements and ownership disclosure statements were developed. Current providers in five particularly problematic provider categories (durable medical equipment, independent pharmacy, non-emergency medical transportation, prosthetic, and orthotics providers) were subject to a review of their qualifications for continued enrollment. Each continued enrollment review included at least one on-site inspection by the Medi-Cal Fraud Prevention Bureau. The Department also

contracted with ChoicePoint, a nationally recognized on-line tracking company, to access background information on providers seeking enrollment or for those providers subject to continued enrollment review.

The provider enrollment staff was augmented and tighter internal controls were instituted to assure that no one individual would have the ability to review and approve a provider's application and to assure adequate supervisory oversight. Physical security was tightened to prevent provider access to enrollment staff and document tracking mechanisms were improved. As investigators uncovered new fraud schemes, provider enrollment practices have been altered to look for specific risk factors associated with those schemes. For example, stolen identities often involve very new physicians, so enrollment staff now gives special scrutiny to recent medical school graduates. The California Department of Health Services is working with ChoicePoint, to develop on-line access to the State motor vehicle records and other public records to enhance the Department's background check capabilities. California is also working to implement surety bond requirements for non-licensed provider categories.

As keeping fraudulent providers out of the Program is the most effective way to eliminate fraud, California, under the Davis Administration, is committed to a careful, thorough review of a provider's qualifications for Medi-Cal participation while being responsive to the legitimate provider's expectation for timely enrollment processing.

#### *Medi-Cal Fraud Prevention Bureau*

Using a new innovative approach to combating fraud and abuse the *Medi-Cal Fraud Prevention Bureau* was created by Governor Davis and initially staffed with 16 civil service positions, including ten *Fraud Prevention Specialists* trained in the Focus on Fraud method of fraud prevention. In operation only nine months, they have completed 14,000 on-site surveys; detected over 2,000 providers with unacceptable risk for fraud; initiated 200 follow-up reviews that documented evidence of fraud in almost 100 cases to date; and, implemented administration sanctions to withhold \$50 million in Medi-Cal payments with a dual referral to the State Department of Justice, Medi-Cal Fraud and Elder Abuse Division and to the FBI *Phony Pharm* operation.

#### *Focus on Fraud Approach*

Determined to put fear back into fraud, a team of ten State auditors and Certified Fraud Examiners initiated a special *Focus on Fraud* pilot designed solely to detect and document fraudulent service providers.

In one year, Focus on Fraud was able to expand coverage to review over 450 providers, in place of the normal 40 resource-consuming compliance audits. These 450 reviews resulted in the documentation of evidence of fraud in over 100 cases, involving \$34 million in Medi-Cal payments. While these cases were prosecuted, the real benefit was that the pervasive scope of the fraud problem was finally demonstrated.

Also demonstrated was the efficiency and effectiveness of the *Focus on Fraud* approach. While not intended to replace compliance audits, this *three-step* system proved it could quickly separate honest from dishonest providers, then professionally pierce complex fraud schemes to document the evidence of fraud necessary for prompt prosecution.

*Step One (Fraud Flashers)* was an on-site risk assessment survey to detect and document systemic fraud indicators. Requiring only minutes to complete, surveys proved effective in detecting providers at high risk for fraud. For example, a provider that does not accept bankcards may be uninterested in real customers and/or fear bank background checks.

*Step Two (Trust—But Verify)* was a prompt follow-up review of actual business records of providers with high fraud risk. Requiring only hours to complete, follow-up reviews proved effective in documenting actual *evidence* of fraud. For example, bank records of Medi-Cal deposits withdrawn in cash can evidence money laundering and health care fraud.

*Step Three (Eradication)* was immediate application of administrative sanctions. For example, withholding of Medi-Cal payments and referral to law enforcement.

#### *Medi-Cal Anti-Fraud Operation in Los Angeles*

The Department of Health Services has uncovered an increasing number of cases in which physicians are knowingly or unknowingly having their medical license numbers and/or Medi-Cal ID numbers used to bill the Medi-Cal program fraudulently. Two key types of provider fraud schemes include: (1) "Physician Identity Theft"—Physicians unknowingly having their medical license numbers and/or Medi-Cal Provider Numbers stolen and used to bill the Medi-Cal program; (2) "Rent a Doctor"—Physicians knowingly selling their medical license number or Medi-Cal

Provider Number. In addition, recent anti-fraud efforts in Los Angeles identified beneficiaries being paid for the use of their Medi-Cal cards for fraudulent Medi-Cal claiming. The fraudulent providers continually look for creative ways to develop Medi-Cal beneficiary patient bases to support the fraudulent claims that are being submitted for reimbursement to the Medi-Cal program.

Under Governor Davis' leadership, the California Department of Health Services recently developed an innovative approach to address suspected fraudulent or abusive activities to reduce unnecessary expenditures of Medi-Cal funds and to more importantly protect California's Medi-Cal population. A rapid response team consisting of a medical professional and an investigator conduct on-site visits at suspicious Medi-Cal provider locations with follow-up reviews of the claim information and verification of medical necessity. A recent focused operation in the Los Angeles area has resulted in sanctions of over 200 Medi-Cal providers who used "cappers" to recruit patients and improperly bill the Medi-Cal program over \$75 million. Medi-Cal fraud has gone beyond false billing to treating Medi-Cal beneficiaries. It is common knowledge that children and disadvantaged adults are becoming anemic because of the frequency of unnecessary blood draws. Recently, a major fraud scheme in Los Angeles was uncovered that used unlicensed technicians to perform unnecessary dental procedures on hundreds of patients, including the unnecessary drilling and filling of children's permanent teeth.

*The Governor's Medi-Cal Fraud Task Force*

The *Governor's Medi-Cal Fraud Task Force*, chaired by Dr. Diana Bonta, State Director of the Department of Health Services, focuses its attention on the combined resources of the FBI, US Attorney Civil and Criminal Divisions, the Health Care Financing Administration, Health and Human Services Office of Inspector General, State Attorney General, and State Controller in a coordinated effort to eliminate health care fraud in California. This group meets on a quarterly basis and has established sub-committees to develop a clearing house for information regarding investigations of fraud and abuse, preparing a directory of contacts and representatives for state and federal anti-fraud and abuse programs and discussing collaborative efforts to deal with new areas of fraud not yet explored.

*Provider Anti-Fraud Strategic Plan*

With strong support of Governor Gray Davis, including the addition of over 200 new positions, the State Department of Health Services (DHS) has also implemented a *Provider Anti-Fraud Strategic Plan*. This maximizes the DHS effort to eliminate fraud within all DHS programs and services. Some of the new anti-fraud initiatives include:

- Doubling of the Medi-Cal Fraud Prevention Bureau
- New proposed legislation to expand criminal penalties, require enrollment for third party billers, and tighten requirements for laboratory providers.
- Pre-check write on-site reviews to verify claim propriety prior to payment
- Automated payment system edits to quickly identify unusual claim patterns
- Formal focus on *mosquito labs* that draw blood for fraud purposes only
- Verifying a doctor's identity before approving a request for new locations
- Expanded provider enrollment oversight
- Monitoring of Medi-Cal Managed Care under-utilization

Eradication of health-care fraud is a high priority for California Governor Gray Davis.

Thank you for the opportunity to address this committee and share with you information regarding the successes of the Medi-Cal Fraud Prevention Bureau under Governor Davis. I would be pleased to answer any questions you may have regarding California's efforts to combat Medi-Cal fraud.

Mr. UPTON. Thank you.  
Mr. King-Shaw, welcome.

**TESTIMONY OF RUBEN J. KING-SHAW, JR.**

Mr. KING-SHAW. Thank you.

Mr. UPTON. Just put the mike a little bit closer.

Mr. KING-SHAW. Thank you and good morning, Mr. Chairman, distinguished Members, ladies and gentlemen. My name is Ruben Jose King-Shaw, Jr., and I am the Secretary of the Florida agency of the Health Care Administration. And just to give you a word about the agency, we are the chief health care finance, planning

and regulatory agency of the State of Florida. The health care industry to Florida is like the automobile industry to the State of Michigan, Congressman Stupak, I think you can understand that, and in the sense of its size and scope and complexity and growth.

Included beyond the Medicaid operation that we regulate hospitals, nursing homes and about 20,000 facilities, we investigate quality-of-care complaints against practitioners and facilities, regulate managed care organizations for quality of service and medical care and operations. So we have a great deal of leverage. And as we talk about some of things we've done to curb Medicare fraud in our enrollment, particularly keeping in mind the leverage that we have over the health care delivery system as a whole, it makes a very powerful opportunity for us.

The State of Florida is a very diverse State. We have a great deal of our State still rural, but of course, the majority of Medicaid recipients are concentrated in the urban areas, which for us is primarily southeast Florida, Dade County, Miami Dade County with the city of Miami, Broward County with the city of Ft. Lauderdale, and going into Palm Beach County, city of West Palm Beach. It's about an \$8 billion operation, the Medicaid program is, and serves about 1.5 million Floridians, and we don't want any of that money going to fraudulent providers.

There was a concept of acceptable level of fraud tossed around earlier this morning. We believe there is no acceptable level of fraud, and our objective is to root it out all together.

We have some very aggressive folks in the State who spend all their waking hours thinking of ways to steal our money. Our position is we need to stay up an hour later than they do figuring out ways to keep them from doing so. So we have an 82-person-staffed integrity unit, and we also work throughout the agency with other parts of State government to protect the public's funds and the best interests of the patient.

I'd like to share with you some of things that we've done, particularly in our provider enrollment, that we think have been quite effective in deterring fraud, and as I run through them, I may go back during your question-and-answer period to answer some questions about them, but, for example, we require that all officers, directors, physicians, and principals who own at least 5 percent of the operation applying for a Medicaid number, to be disclosed in the application, and every single one of them have to sign it. There can be no hidden providers. There can be no providers covered under the contract that are not explicitly established in the contract. We do not allow any retroactive enrollment of providers into the Medicaid program.

Our contracts all have expiration dates, which means that at a certain point they must be re-examined, reprofiled, recredentialed, and readmitted. We have a surety bond ability. We can require a surety bond, or letters of credit, to providers as a condition of applying for the Medicaid program for high risk providers, which are primarily the durable medical equipment, nondoctor-owned medical practices, independent labs and transportation companies. The value of the surety bond is that it requires—no bond agency is going to go and offer that kind of coverage to a facility or provider unless they have gone in and looked at them themselves first.

So it's a no-cost operation of the State, but it does bring another set of eyes to go look, on a prospective basis, at a potential Medicaid participant.

It requires notice of change of ownership of a Medicaid provider once in the program. We do regular criminal background checks. It is not a property right, the Medicaid provider number. It doesn't transfer, cannot be sold or traded, doesn't travel with a change of ownership necessarily. We have located the venue for all legal actions to a single county in the State, which is important because we get to know, you know, the bench, if you will, in that county.

We have established a prepayment schedule for any overpayments. Regular license verification, and perhaps the most powerful tool we have of all of these is the fact that we have a provision in all of our Medicaid contracts that allow us to cancel that contract with 30-day notice without cause.

Now, we regularly go through periods of reenrollment, and we can talk about that if you like. Our last reenrollment period was between January 1996 and July 1997, where every noninstitutional provider was asked to reapply, reenroll in the Medicaid program, which gave us a chance to look at them again for quality and performance. We have adopted site visits, and we do that for, again, those high risk providers, durable medical equipment, nonphysician-owned practices, transportation companies, independent labs, and now pharmacies. And as you would expect, we have uncovered a great number of vacant lots and storefronts and PO boxes, just by the practice of going out and performing those site visits.

We also have been able to save quite a bit of money, \$100 million overall, through a combination of all these things, including about 10,000 lines of edits in our computer system. We do a series of statistical analysis and trend analysis to identify aberrant billing patterns that may lead to fraud. We can then zero in on those targets to do some more analysis, to determine what is going on there. We have saved \$19 million in DME alone, \$7 million in independent lab and X-ray expenses, and every 2 months we do a sweep of our data base to see if any of the providers, physician providers and other providers in the Medicaid program, turn up on our list of folks who have been indicted or prosecuted for violation of laws.

My time is out—in fact, I'm a minute over—so I'll curtail my comments with the very last comment. One of the things that we have the ability to do is to competitively bid our network, and we have the ability to accept or deny practitioners or applicants into the Medicaid program, based on our identification of need, be that geographic or quality or a certain skillset. That gives us an enormous opportunity to, on the front end, admit only quality providers in the Medicaid program with the specialty and the geographic distribution that we need.

Hopefully we'll get a chance to do some more conversation through the Q-and-A period. I will defer the rest of my time to my colleague. Thank you very much.

[The prepared statement of Reuben J. King-Shaw, Jr. follows:]

PREPARED STATEMENT OF RUBEN J. KING-SHAW, JR., SECRETARY, FLORIDA AGENCY  
FOR HEALTH CARE ADMINISTRATION

Chairman Upton, distinguished members, ladies and gentlemen, I am Ruben J. King-Shaw, Jr., Secretary of the Florida Agency for Health Care Administration.

Thank you for this opportunity to talk about how Florida fights fraud and abuse among providers seeking to enroll in our Medicaid program.

Florida is a very diverse state. Much of it is rural. Dade and Broward Counties are the most heavily populated areas. They encompass Miami and Ft. Lauderdale where a quarter of our Medicaid recipients live. Not surprisingly, this densely populated area is also where a majority of provider fraud and abuse occurs.

Combined state and federal Medicaid spending in Florida exceeds eight billion dollars. Every month a million and a half Floridians are eligible to receive Medicaid benefits. We do not want a single dollar that could be going to legitimate health care diverted by unscrupulous people trying to steal from Medicaid by posing as health care providers.

The fight requires aggressive measures. Unscrupulous individuals are good at finding holes in the system. Our job is to find those holes before they do. Today I want to talk about what we have done over the past several years to fight this kind of crime.

Our focus has been on prevention. If you prevent dishonest people from enrolling as providers, you have won half the battle.

Our first line of attack is the Medicaid provider application. In 1995 we began requiring more information from provider applicants. We also rewrote our provider agreement to beef up standards and make providers more accountable. Here are some of the things we require:

- Disclosure of all officers, directors, physicians and principals who own five percent or more of the business. All of them have to sign the provider agreement;
- No "hidden" providers. The application must identify every practitioner who will be participating in Medicaid;
- No retroactive enrollment;
- Contracts that expire;
- Surety bonds or letters of credit for certain high-risk provider types;
- Notice of change of ownership;
- Criminal background checks;
- No "property right" in a Medicaid provider number;
- Venue for all legal actions in a single county;
- Repayment schedule for overpayments;
- Regular license verification.

Between January 1996 and July 1997 every non-institutional provider had to re-enroll under the new agreement. When we started, we had more than 82,000 enrolled providers. When it was over, there were 55,000 left. By giving every agreement an expiration date, we guarantee that providers are periodically re-examined to ensure their continuing fitness to be in the program. Our next re-enrollment is beginning now and will continue through the first quarter of calendar year 2003.

Since 1996 we have been doing site visits of durable medical equipment suppliers, non-physician owned physician groups, transportation companies, and independent laboratories. We are adding pharmacies this year. You would be amazed at how many vacant lots, empty storefronts, and shell businesses this turns up. A site visit costs about fifty dollars, but that one simple step can save a million dollars.

Between 1996 and 1998 our fraud and abuse initiatives reduced annual Medicaid spending by more than \$100 million. We terminated more than 120 South Florida clinics and physicians suspected of fraud. A combination of on-site reviews, a \$50,000 surety bond, and new computer edits reduced Medicaid durable medical equipment spending by more than \$19 million. We saved another \$7 million using anti-fraud controls to target independent laboratories and x-ray service providers.

A word about surety bonds. No bonding company is going to issue a bond without doing its own investigation of the provider. The state spends nothing and at the same time potentially avoids losing millions to fraud.

We make it a point of following up on those criminal background checks. Every two months, a contractor notifies us about any providers convicted of a crime since the last check. The state's Department of Health, which regulates the health professions, does quarterly license checks so we will know if a provider has lost a license or if proceedings are under way to revoke a provider's license.

Obviously, enrollment initiatives alone won't do the job. We do believe in the "use it or lose it" philosophy. Any provider that doesn't bill Medicaid for twelve consecutive months is dropped from the program. Reinstatement requires going through the full enrollment process again.

In addition we use our Medicaid Management Information System to identify inappropriate billings through edits. We have more than 10,000 automated, hard edits. It is a good thing that Medicaid and the computer age grew up simultaneously. Can you imagine how many people it would take to examine paper claims

to make sure someone isn't trying to bill Medicaid for a non-covered service, twice for the same service, conflicting procedures or perhaps a hysterectomy for a man?

We do aggressive pharmacy audits and have been able to remove some bad providers. We expect to remove more. This year the Florida Legislature added to our arsenal by giving us the additional authority we need to deny provider applications based on the best interests of the Agency. We have been able to beef up our pharmacy credentialing requirements and are now able to impose a moratorium on pharmacy enrollment and enroll providers only where we identify a need.

We built a map of pharmacy locations in south Florida and stuck in a pin for each pharmacy. In some areas we couldn't find room for all the pins. With this new legal authority, we're ready to tackle that problem. As a companion effort we will be watching pharmacy use by Medicaid recipients. Those who abuse their drug benefit will be locked into a single pharmacy.

Right now we are seeking proposals from private contractors to help us profile providers who demonstrate potential for fraud and abuse. We already have begun comprehensive profiling of recipient drug therapies by beneficiary and prescriber.

Because responsibility for dealing with the bad guys is shared by a lot of agencies, it is sometimes easy to miss the big picture. In Florida we have worked hard to form strong interagency partnerships that focus on anti-fraud strategies. My agency works closely with the Attorney General and his Medicaid Fraud Control Unit, with the Department of Law Enforcement, with the Statewide Prosecutor, with the Federal Operation Restore Trust, our practitioner regulatory agencies, the provider professional associations, local law enforcement agencies, and others.

We can never assume we don't have a problem. We can't even assume we know what form fraud and abuse might take. We do know that our efforts are paying off. We will keep working hard, and we take satisfaction that we are improving service for Medicaid recipients and making life very hard for the people trying to take money they don't earn.

Again, thank you for allowing me to appear today. I would be happy to answer questions.

Mr. UPTON. Thank you.

Mr. Wagoner.

#### **TESTIMONY OF DOUG WAGONER**

Mr. WAGONER. Thank you, Mr. Chairman, and members of the subcommittee. Good morning, my name is Doug Wagoner. I am here today representing ChoicePoint. ChoicePoint is the Nation's leading provider of on-line and on-demand information services to business and government. Headquartered outside of Atlanta, ChoicePoint has over 3,500 associates working in over 40 locations nationwide.

I have been the vice president of ChoicePoint's public sector division for almost 3 years. Through the public sector division, ChoicePoint provides low risk, low investment information-based solutions to prevent and thus reduce the cost of fraud and abuse in publicly funded health care systems. Additionally, we support law enforcement, child support enforcement and other entitlement programs to reduce fraud. On behalf of ChoicePoint, thank you for your generous invitation to appear here today.

I am proud to say that all the participants here on this panel, the GAO, the FBI, the States of California and Florida, are clients of ChoicePoint. ChoicePoint's philosophy has been that stringent reviews of provider applications coupled with onsite and unannounced inspections, will go far in preventing fraudulent claims from entering the system, and thus preventing fraudulent payments that have to be investigated on the back end with little chance of recovery. Again, your mother was right, an ounce of prevention is better than a pound of cure.

Working together with our government clients, we are progressing in joint efforts to prevent those who would engage in

health care fraud from entering the public systems. Allow me briefly to reference these projects. As part of HCFA's Operation Restore Trust, ChoicePoint combined onsite inspection services with our extensive data resources to verify the existence and legitimacy of community mental health centers, or CMHCs, in Florida. The initial phase of inspections found that over 60 percent of the CMHCs were not in compliance with Federal regulations. Several months and 300 inspections later, this rate got down to 20 percent as word had gotten out on the street about these inspections. During this project, ChoicePoint found fraudulent providers in adult video stores, people's homes and even an airport runway that was given as an address for one provider.

ChoicePoint has also been working with HCFA on the durable medical equipment, or DME, inspection program. As a part of this effort, ChoicePoint has inspected about 45,000 of the 110,000 Medicare DME's. As a result of this program, the number of suspected fraudulent providers is going down substantially each year. In addition, the knowledge that an inspection will occur at some point serves as a deterrent for those applying to be a fraudulent DME in the first place. One such fraudulent provider, as the chairman mentioned earlier, was located on the 10th floor of a nine-story building. The cost of the ChoicePoint's inspection service averages about \$130, and takes less than 30 minutes of the provider's time. We estimate that the annual savings of ChoicePoint's services through HCFA's program has created about a \$1 billion savings a year. The inspection program results in significant return on investment for the Federal Government considering the low, relatively low cost of ChoicePoint.

ChoicePoint has been supporting HCFA's Medicare provider enrollment process since 1998. HCFA's fiscal intermediaries and carriers are required to use an independent third party information provider to verify the information from providers applying to the Medicare program. The vast majority of FIs and carriers have chosen to use ChoicePoint's data on a daily basis to verify the legitimacy of providers entering the Medicare system. ChoicePoint's Internet-based solutions allow the FI or carrier to confirm professional license data, education, sanctions, disciplinary actions and business ownership to name a very few of the data bases.

Efforts like these have led, and will continue to lead, to significant cost savings for programs that HCFA administers. Based upon our experience from across the country, we would like to make three recommendations for the committee to consider.

First, we recommend that HCFA conduct a competition of data providers and contract with one company to provide all of its provider enrollment for compliance needs. This would provide a consistent nationwide approach to verifying applicant data while pooling the purchasing power of HCFA to get the best price.

In addition to this, we also believe that HCFA should mandate a criminal background check program as part of the provider enrollment process for both Medicare and State Medicaid programs.

Second, a nationwide inspection program for State Medicaid DME, similar to what HCFA has done for the Medicare system, would help prevent provider fraud at a State level, similar to what we've experienced for Medicare on a nationwide basis.

Finally, as with State inspection services, ChoicePoint believes that additional front end prevention can be achieved through using on-line data services on a consistent nationwide basis. Thus, we recommend that HCFA require each State Medicaid program to use these types of on-line data services to prevent fraud. California and Florida are examples and models for this program.

We thank the subcommittee for this opportunity to appear here today and to tell you about ChoicePoint and what our company has been doing to protect our health care systems. We are proud of our record and look forward to working with the subcommittee in the future. I would, of course, be pleased to answer any questions you may have. Thank you very much.

[The prepared statement of Doug Wagoner follows:]

PREPARED STATEMENT OF DOUG WAGONER, VICE PRESIDENT, PUBLIC SECTOR,  
CHOICEPOINT, INC.

Mr. Chairman and Members of the Subcommittee, good morning, I am Doug Wagoner. I am here today representing ChoicePoint, Inc. ChoicePoint is the nation's leading provider of decision-making intelligence to businesses and government. Through the identification, retrieval, storage, analysis and delivery of data, ChoicePoint serves the informational needs of the property and casualty market, life and health market, and businesses, including Fortune 1000 corporations, asset-based lenders and professional service providers, and federal, state and local government agencies. Headquartered outside of Atlanta, ChoicePoint is a publicly-traded company with over 3,500 employees in more than 40 locations nationwide.

I have been the Vice President of ChoicePoint's Public Sector Division for almost three years. Through the Public Sector Division, ChoicePoint provides low-risk, low-investment, information-based solutions to prevent and thus reduce the cost of fraud and abuse in publicly funded medical programs and services. On behalf of ChoicePoint, thank you for your generous invitation to appear here today.

I am proud to say that most of the other participants on this panel—the General Accounting Office, the Federal Bureau of Investigation, the State of California, and the State of Florida—are ChoicePoint clients. A more complete list of ChoicePoint's government clients is contained in the Appendix to this testimony. Today, we are working together to share ideas and solutions to solve a problem that impacts us all. Our common goal is to reduce healthcare fraud in publicly funded programs. In previous hearings, this Committee has done an excellent job of defining the scope and breadth of this pressing problem. I want to commend the Committee for again directing its attention to the issue of provider fraud in the Medicaid system because there is still much work to be done to eliminate fraud in our federal and state health programs. We also appreciate the Committee's willingness to hear from both the private and public sector, including state and federal agencies.

On prior occasions, this Committee has investigated the possibility of using public sector data sources not only to reduce the cost of fraud in the health care system, but also to reduce the risk to citizens of poor performing health care providers. ChoicePoint supplements these data sources with our over 10 billion public records and our site investigators. Our goal is to enhance government's ability to reduce health care fraud. ChoicePoint's solutions are relatively low cost, require no up-front investment by the government, have minimal impact on the provider, and can be implemented by a state Medicaid program in days, not years. ChoicePoint's solutions are also targeted at the front-end of the problem. Our philosophy has been that stringent reviews of provider applications—coupled with on-site, unannounced inspections—will go far in *preventing* fraudulent claims from entering the system, and thus *preventing* fraudulent payments that have to be investigated on the back-end with little chance of recovery.

CHOICEPOINT PROVIDES VALUABLE INSPECTION SERVICES TO THE FEDERAL  
GOVERNMENT

ChoicePoint has been working to reduce public health care fraud since the company's inception in 1997. I would like to detail the various provider enrollment verification services that we have been supporting as a part of this effort. While our customers have primarily been involved in the Medicare program, ChoicePoint also serves several state Medicaid programs.

### *Operation Restore Trust*

In 1997, we began supporting the Health Care Financing Administration's ("HCFA") Operation Restore Trust ("ORT") program. This program was one of the first large-scale task forces assembled to identify and reduce Medicare/Medicaid fraud. ORT was a concentrated, joint state-federal program that focused on Community Mental Health Centers ("CMHCs") in key southeastern states. To begin using ChoicePoint's site inspection services, the ORT team provided ChoicePoint with a list of approximately 300 CMHCs primarily located in Florida. ChoicePoint's site inspectors then used our extensive data resources to verify the existence and legitimacy of these businesses. Although ChoicePoint inspected all of the businesses targeted by ORT, those businesses that did not match our data-verifying tests were given priority for inspection. Starting in south Florida and working north, ChoicePoint conducted the CMHC inspections. The purpose of the inspections was to collect and confirm such information as the name of the business, its hours of operation, photographs of the establishment, what inventory was on hand, and other related business information. These inspections were conducted during regular business hours and are completed in less than thirty minutes, but they are done without prior notice to the ownership in order to prevent the masking of violations.

The findings from our experience in ORT are staggering. During the initial phase of the inspections in south Florida, we found that over 60% of the CMHCs were not in compliance with federal regulations. The second round of inspections—carried out several months later throughout the state—found that the problem rate had decreased to 40%. Finally, after the third round, the non-compliance rate had decreased to 20%. During its inspections, ChoicePoint located CMHCs that were actually adult video stores, private homes, mail forwarding services, or locations with no physical presence at all. We believe the decline in the problem rate can be attributed in some degree to the very fact of our inspections. Word of mouth from one operator to another gave fraudulent operators an opportunity to close their doors prior to our inspector's arrival after they learned that one of their cohorts received a visit from our inspectors. We also discovered that owners that were shut down after failing an earlier inspection would relocate to another Florida city and open another fraudulent CMHC, only to be inspected again under ORT.

### *Durable Medical Equipment Inspection Program*

Shortly after ORT was underway, ChoicePoint began working on HCFA's nationwide Durable Medical Equipment ("DME") inspection program. We have been part of this program for three years. ChoicePoint has inspected about 45,000 of the estimated 110,000 Medicare DMEs in the United States. The goal is for every new DME applicant in the country to pass an initial inspection prior to receiving a billing number and be subject to re-inspection every three years. Similar to ORT, these inspections are unannounced, take less than thirty minutes of a provider's time, and collect various data depending on the type of facility. Our inspectors arrive with a letter from HCFA explaining the inspection program and asking for the provider's cooperation with the inspector. The inspector provides identification to demonstrate the legitimacy of the request, and then begins a consistent, process-driven inspection as directed by HCFA. It is important to note that it is not ChoicePoint's role to distinguish a "bad" DME from a "good" DME at the time of inspection. Our job is to objectively collect the data required by HCFA and deliver it to HCFA for evaluation and action.

Often, providers attempt to cover up problems or ask an inspector for feedback, but ChoicePoint's professional inspectors are trained to keep their composure and collect the data as needed without comment. If the inspector has any doubts in the course of the inspection process, it is ChoicePoint's policy to take a photograph to document the evidence. This was made particularly difficult when one inspector visited a DME whose address was listed as the 10th floor of a 9-story building.

Despite these types of incidents, we are finding that the number of suspected fraudulent providers is going down each year the program continues. Not only do these inspections identify and shut down fraudulent or potentially dangerous DMEs, the knowledge that an inspection will occur at some point serves as a deterrent to applying as a fraudulent DME in the first place. Additionally, HCFA wisely requires our inspectors to inspect the inventory of the DME, so those individuals who attempt to set up a fraudulent company must make a substantial initial investment in inventory in order to pass the inspection.

### *Cost Savings*

The cost of these inspection services average around \$130 per inspection. Although it is impossible to accurately determine the value of the fraud prevented by this program, we can extrapolate some numbers from the findings of ORT. Prior to

the commencement of the ORT program, we were told that an inspection would be triggered for those DMEs that billed federal health care programs between \$250,000 and \$300,000 per year. Thus, DME owners could fraudulently invoice just under that amount, close the business, and then start another fraudulent front company. Since ChoicePoint does not make any determinations as to the validity of DMEs, we do not maintain the official numbers associated with fraudulent suppliers, such as the number of denied applications and the number suspended from federal programs. Based on information that we were provided in the past, we estimate that the annual savings ChoicePoint's services create for this program is *over \$1 billion a year*. This dollar figure is based upon a conservative estimate that 10% of the supplier population is (or would be) fraudulent, and that each of these fraudulent DMEs would have invoiced up to the \$250,000 threshold prior to starting another DME and re-applying to the program. If these numbers are accurate—and we believe that they are conservative—this inspection program results in significant financial savings for the federal government, even after considering the annual cost for the ChoicePoint inspections.

Given these estimated savings, ChoicePoint believes that the DME inspection program implemented by HCFA gives United States taxpayers a dramatic return on their investment. However, this program's capabilities have not been fully utilized because it has only been implemented with respect to Medicare's DMEs. Based upon the numbers from ORT and our estimates of DME fraud, it seems safe to assume that a similar consistent, process-driven, nationwide program focused on the inspection of state Medicaid providers would yield similar or even greater results. This Committee has learned not to underestimate the criminals in this industry. It is our educated assumption, given years of experience inspecting fraudulent behavior, that the criminals will soon figure out that while HCFA has closed the door to DME fraud in the Medicare program, the door is still wide open in many state Medicaid programs.

#### *Inspections of Independent Diagnostic and Test Facilities*

In addition to DME inspections, ChoicePoint has recently begun working with one of HCFA's Fiscal Intermediaries ("FIs") to inspect Independent Diagnostic and Test Facilities ("IDTFs"). Although ChoicePoint does not make official determinations regarding the validity of a facility, our inspectors found absolutely no existence of an IDTF in 10 of the first 14 inspections performed. This may have been coincidence, or it may be strong evidence that fraudulent DME providers of the past have moved into a new field—IDTFs. While fourteen cases is not a large enough sample upon which to base a definite conclusion, we believe it would be wise to expand this first round of inspections in order to determine the true level of fraud in Medicare's IDTFs.

#### CHOICEPOINT SUPPORTS THE MEDICARE PROVIDER ENROLLMENT PROCESS

In addition to our on-site inspection services, ChoicePoint has been supporting the Medicare provider enrollment process since 1998. HCFA requires providers applying to join the Medicare program to fill out a "Form 855" to collect information about the applicant provider. Additionally, HCFA requires their Fiscal Intermediaries ("FIs") and Carriers to verify the information on the Form 855 via an independent third-party information provider. Although HCFA does not mandate the use of a particular on-line information service, we are proud to say that the vast majority of FIs and Carriers have selected ChoicePoint as providing the most cost-effective solution for complying with HCFA's requirements. These contractors use our data on a daily basis to verify the legitimacy of providers entering the Medicare system.

For applicants to Medicare Part A, ChoicePoint supplies the data necessary to verify address, business ownership, directors and executives, secretary of state information, bankruptcy, and sanctions by the General Services Administration ("GSA") or the Department of Health and Human Services ("HHS"). Additionally, our Internet-based searches reveal hidden owners who may have been omitted from the Form 855 application. Our Address Inspector algorithms compare the address of the Part A applicant with our database of over 2 million high-risk and fraudulent business addresses. This data is available from all 50 states.

The Medicare Part B Form 855 verification process allows the provider enrollment specialist at a Carrier to compare the applicant provider's information with our independently derived data from various government sources, including all 67 physician licensing boards and 50 state chiropractor licensing boards. We plan to add additional health care professional license data from all fifty states by the end of the year. In addition to physician license data, we are able to confirm American Medical Association status, colleges and universities attended, board certifications, HHS sanctions, DEA licenses, and most important, disciplinary and sanction data. In the

near future, ChoicePoint will add GSA disbarment information to both the Part A and B searches.

There is no record of exactly how many fraudulent providers have been stopped from entering the Medicare system, because the verification processes are so decentralized among HCFA's FIs and Carriers. However, we receive constant feedback from customers that suggests that scam artists are still trying to enter the system each day. I will submit for the Subcommittee's record a computer printout of a ChoicePoint Part A search where our data and search capabilities uncovered an owner that was not listed on the application to enter the Medicare program. This owner had been disbarred for previous fraudulent behavior in Medicare, which is why his colleagues conveniently omitted him from the next application. This case demonstrates that the perpetrators of fraud do not stop, but try every door into the system until they find one that is unlocked.

Our data is delivered via the web, and the searches take about 45 to 180 seconds to be delivered, depending upon the amount of data on the provider. This almost-instant delivery of critical data allows the fraudulent or dangerous provider to be detected prior to obtaining that all-important billing number and entrance into the system. The cost for instant access to data that can uncover a fraudulent provider is between \$10 and \$30, depending on the type of search. This is not software or a special system that has to be purchased at a high cost. This is a web page ([www.providerscreen.com](http://www.providerscreen.com)) that any FI/Carrier can access from a standard, simple Internet connection. The web page is identification and password protected in order to verify the user and assess billing. There is no up-front investment to begin using the service, and a user can be productive in preventing fraud after a 2-3 hour training class that ChoicePoint provides at no cost.

#### RECOMMENDATIONS

HCFA should be commended for their provider enrollment standards, their auditing of compliance with those standards, and their requirement of independent data verification of provider supplied information. Nevertheless, we believe that the program can be enhanced. And we would be proud to work with them on this.

However, since HCFA has placed the responsibility for provider enrollment and compliance with their standards on the FIs and Carriers, companies such as ChoicePoint must contract directly with each of the many and ever-changing FIs and Carriers. Maintaining many varied contracts raises our cost of providing the data service. Therefore, we recommend that HCFA conduct a competition for data providers and contract with ONE company to supply this data nationwide. This would provide a consistent approach to verifying the applicant data and would pool the buying power of HCFA in order to lower the cost of providing this data across the Medicare program. With the advent of HCFA's PECOS system in the provider enrollment process, ChoicePoint also believes that this data can then be verified electronically to increase accuracy while lowering the enrollment time and cost.

In addition, we recommend that FIs and Carriers be required to investigate providers' criminal histories prior to their enrollment in the Medicare program. We believe that if HCFA were to mandate criminal background checks as part of the provider enrollment process, many fraudulent providers could be identified before they are allowed to enter the federal system and continue their criminal activities. Currently there is legislation pending in the Senate to require background checks as part of the enrollment process.

While HCFA has taken proactive steps to increase the front-end detection of fraudulent providers on a nationwide basis, there is no such program for most state Medicaid programs. Some states, such as Florida, California and Connecticut, use ChoicePoint or similar services to review a provider's background. Many others, however, only rely on information from within their state. With a transient population, these intrastate-only searches could fail to uncover fraudulent, illegal or dangerous behavior that occurred in a neighboring state. As with the site inspection services, ChoicePoint believes that additional front-end fraud prevention can be achieved by utilizing on-line data services on a consistent nationwide basis for state Medicaid programs. This comprehensive yet targeted approach will help lock all possible doors to the public health care system to those who wish to defraud it and divert scarce resources from those in need.

We thank the Subcommittee for this opportunity to appear here today and to tell you about ChoicePoint and what our company has been doing to protect our health care systems. We are proud of our record and look forward to working with this Subcommittee in the future. I would, of course, be pleased to answer any questions that you may have. Thank you very much.

## APPENDIX

## CHOICEPOINT FEDERAL GOVERNMENT CLIENTS AS OF JUNE, 2000

Bureau of Alcohol, Tobacco & Firearms; Bureau of Public Debt; Commodity Futures Trading Corporation; Department of Commerce; Department of Defense; Department of Energy; Department of Housing & Urban Development; Department of Health & Human Services—Office of Child Support; Department of Interior; Department of Justice; Drug Enforcement Agency; Environmental Protection Agency; Executive Office of United States Attorneys; Federal Bureau of Investigation; Federal Deposit Insurance Corporation; Federal Election Commission; Federal Emergency Management Agency; Federal Public Defenders; Federal Reserve; FinCen; FreddieMac; General Accounting Office; General Services Administration; Health Care Financing Administration Fiscal Intermediaries and Carriers; Immigration & Naturalization Service; Internal Revenue Service; INTERPOL; National Aeronautics & Space Administration; National Credit Union Agency; Office of National Drug Control Policy—High Intensity Drug Trafficking Areas; Office of Personnel Management; Pension Benefit Guarantee Corporation; Secret Service; Small Business Administration; United States Customs; United States Marshals; United States Postal Service; and the World Bank.

Mr. UPTON. Well, thank you all, and as you saw in the first round with our first panel, we'll rotate here and try to limit our questions and answers to 5 minutes, and we'll do—my guess is probably a couple rounds.

I have a lot of questions, and again, I appreciated your testimony, and I guess I should start with Ms. Aronovitz. Would you say that as we listened to California and Florida tell about their programs, that they're about average in terms of the other States, or better or worse in terms of going after fraud and abuse?

Ms. ARONOVITZ. I would say that based on the activities that they describe that they're pretty much in the forefront.

Mr. UPTON. At the top?

Ms. ARONOVITZ. Yes. In our survey of the 56 State Medicaid programs, and of course that includes the territories and the District of Columbia, we found that only nine States do what we would consider comprehensive checks, or checks in four areas and we found that a lot of States—

Mr. UPTON. These are among the nine?

Ms. ARONOVITZ. Yes. We found—and this is self-reported information from our survey that many States do very little in the way of provider enrollment activities. We were actually surprised by this.

Mr. UPTON. That information sort of jumped off the page in terms of the draft statement that I read last night. You indicated that only 16 States or 16 jurisdictions, when you count D.C., et cetera, only 16 reported that HCFA staff visited their agency to review their fraud and abuse control activities during their most recent fiscal year. That's on page 11 of your draft that you provided.

Ms. ARONOVITZ. HCFA's very involved in the Medicare program in activities like provider enrollment and other program integrity activities. HCFA's position in terms of Medicaid and overseeing States is more of a facilitator and a partner and a helper. We do give them a lot of credit for working with States in their national initiative on Medicaid fraud and abuse control efforts. These fraud and abuse control efforts really are designed more to encourage States and to help States learn about what they can do, but ultimately, HCFA does not mandate very much in terms of Federal re-

quirements, and in fact, these are voluntary activities on the part of States.

Mr. UPTON. Now, you indicated—one of the things we've heard from both—well, certainly from Florida, and I think California does this as well—is that they do the criminal background check of their enrollees, California does as well. What percent of the enrollees that you have looked at actually have a criminal background in their past, do you know?

Ms. ARONOVITZ. We do know that in our survey, 23 of the 56 programs indicated that they do some type of criminal background check.

Mr. UPTON. But of those that they check out, how many of them actually have a criminal background red flag that will pop up?

Ms. ARONOVITZ. In many of these cases, it will be on selected providers. My understanding is that Florida does criminal background checks on all producers, but many of these other States use a risk approach, which we think is a prudent approach when you have limited funds and you have a good risk assessment.

Mr. UPTON. Right.

Mr. King-Shaw, do you know what—how many actually get flagged?

Mr. KING-SHAW. Approximately 1 to 2 percent every time we run the query, which is every 2 months.

Mr. UPTON. Ms. Aronovitz, you indicated in your statement that you said that not all States view, in essence, the site visits as cost effective. I mean, as I listen to California and Florida talk about range of between \$50 and \$130 per visit, only about what, a half hour, an hour in terms of visit, what States, I mean, if there's something that sort of jumps off the page, it's that statement that many States don't utilize some type of site visit.

Ms. ARONOVITZ. Well, we know that in response to an audit report, Colorado felt that site visits were not cost effective for them. We don't know why. But in Texas, which did a pilot of site visits, we do have some indication that they found that their site visit, first of all, was much more intense than the site visit that lasted 30 minutes. They checked medical records in detail and did a lot of reviews. They also had to pay to travel to distant places in the State.

But the other reason that Texas found this to be not cost effective, in our opinion, had to do with the circumstances of their pilot. It was at a time when HCFA was putting a moratorium on new home health agencies entering the Medicare program. Home health agencies, which were among the groups targeted for the pilot, were not applying to be providers at the time.

In addition, there was a lot of publicity about this pilot site visit program in Texas, and it was supposed to go on for several months. So we think there's a possibility that some of the providers decided to hold off until this pilot site visit check was finished before they applied to the program. As a result, only nine providers during this pilot actually applied, and all of them were reviewed and found to be absolutely qualified to provide services in the opinion of the Texas inspectors.

So, in those cases, based on that pilot test, the Texas program decided that it was not cost effective.

Mr. UPTON. Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman. How would you, Ms. Aronovitz, how would you assess California's and Florida's anti-fraud efforts now?

Ms. ARONOVITZ. We haven't been there to be onsite, but we certainly believe that a lot of the activities that they describe are ones that we would say are key activities in any type of provider enrollment program. So in fact, we think that these States are very aggressive.

Mr. STUPAK. Is there any other suggestions you would have for them? If they're one of the top two, are there any other suggestions that would help them along?

Ms. ARONOVITZ. Not in the provider enrollment program per se, I think, especially in Florida. They have a pretty comprehensive program.

Mr. STUPAK. Ms. Connell, you indicated in your testimony and I missed it, and I asked Chris here and he missed it. You said there's a bill right now that you are hopeful to get through the Senate and legislature, but you did not believe it would.

Ms. CONNELL. It's the Corbitt bill which is an attempt to deal with the formulary, and it has run into opposition, largely from those who provide the drugs, the pharmacists. What we were attempting to do is put a restriction on the prices of selling drugs in California under the Medi-Cal program, and this is, of course, hit with tremendous opposition by those who sell the drugs, and I am not certain the bill is going to make it out of the legislature. We were fortunate to have three bills that we authored on Medi-Cal reform pass last year, and one, which is a cleanup bill, which appears to be going through this year. This other bill just seems to be stalled in committee because of the kind of opposition that it has received.

Mr. STUPAK. It would really be from the pharmaceutical companies, not necessarily the pharmacists?

Ms. CONNELL. That's correct.

Mr. STUPAK. Mr. Wagoner, you indicated California and Florida, they're part of your clients, right?

Mr. WAGONER. Yes, sir.

Mr. STUPAK. In any other States that contract with you?

Mr. WAGONER. Yes. Right now for the on-line data services, to verify the data that's involved in an application, Connecticut uses our data as well, and we are right now talking to several other states, but right now those are the only three States that are using that.

Mr. STUPAK. Other States that have not contracted to provide your service, do they have someone else doing it? What are the reasons for not doing what you are—

Mr. WAGONER. Many of the States depend upon intrastate data, so they may look at their own Secretary of State data, they may look at their own criminal data, not realizing that a lot of these providers do move quite often, they do move State to State, and they just don't take a nationwide approach. Other States have indicated that there's legislation that prevents them. The only thing they can do is look at and verify data within their State. So if a provider had done something illegal or sanctioned in one State,

other States would not be able to prevent them from entering that State's Medicaid program is what we have been told.

Mr. STUPAK. I see. Mr. King-Shaw you mentioned in your testimony in the State of Florida requires either surety bonds or letters of credit for certain high risk providers. So two questions, how do you define a high risk provider, and what is the amount of bond that is required?

Mr. KING-SHAW. Well, we define high risk provider based on our historical experience of fraud and have narrowed that down to durable medical equipment companies, transportation companies, nonphysician-owned medical group practices, independent labs, and now we've added pharmacies to that list, and again, that's been based on experience, just where the fraudulent behavior seems to rear its ugly head the most. The level can be between \$50,000 or a year's worth of historical billings or estimated billings to the Medicaid program, and so we can adjust it anywhere within that range.

Mr. STUPAK. What's been the reaction of the providers to the bond or letters of credit?

Mr. KING-SHAW. They haven't loved it but I think the bottom line is, it's hard to argue that they don't want to provide all the documentation to demonstrate that they are a credible provider. I mean, what would their basis be for refusing—that they're going to go commit fraud? They don't have much of an argument or much of a fight to put up, but I can't say if it were up to them, that they would have voluntarily posted a surety bond. I don't think they would have.

Mr. STUPAK. Mr. Cates, you indicated in your lock and load that you looked at bank records.

Mr. CATES. Correct.

Mr. STUPAK. When you get to look at those bank records, are those only under providers that are being investigated or do you have something in your contract that allows you, upon your own suspicions, to get into these bank records?

Mr. CATES. Our focus on fraud approach, within that 3- to 5-minute survey that we conducted, every one of our providers we look at and we request a copy of their business bank account, and the reason we do this is that we are trying to level the playing field so that the honest providers do not have to compete with the dishonest providers. We have found that the compliance rate for providing that business bank record is right at 100 percent.

Mr. STUPAK. But how do you get to the bank records? Don't they object that these are our personal records, you can't look at them? How do you get to them?

Mr. CATES. It's interesting. If you lay it out ahead of time in a letter, like we did, letting them know exactly what we've been doing in the fraud prevention review, the honest providers do not mind cooperating, the dishonest providers are afraid to draw attention to themselves. All I can tell you is while we believe that we have the authority in existing law to review all business records as it relates to the program, we have only had 1 or 2 provider attorneys call us up and say what's that about. I tell them and they go, okay, my client wants to provide it.

Mr. STUPAK. Thank you, Mr. Chairman.

Mr. UPTON. Mr. Burr.

Mr. BURR. Mr. Kubic, is it safe to say for the FBI, targeting and prosecuting fraud in the Medi-Cal system has sort of been like shooting fish in barrel?

Mr. KUBIC. I think that's safe to say, yes.

Mr. BURR. Has it been fairly easy to identify where there's legitimate fraud and abuse?

Mr. KUBIC. Yes. One of the key things here and what I think worked really well stemmed from the fact that the audit reports provided by the State of California were kind of like the road map. I mean, if you look at a provider who's billed and that same provider does not have the inventory to ship those materials, it's a pretty straightforward case, and a large number of these cases did not go to trial. I mean they were pretty much a prima facie case, when a provider comes in with his attorney and you make a case presentation and a review.

Mr. BURR. And in most cases, were moneys reimbursed to the State?

Mr. KUBIC. Yes, it was. Reimbursements total about 20 million just on the ones that have been adjudicated.

Mr. BURR. Ms. Connell, let me go to that piece of legislation Mr. Stupak asked you about that you suggested probably would not get out of the legislature. You said that has to do with drug pricing. We have a Federal statute under HCFA for Medicare best pricing on drugs. Was that bill on something other than pricing or was it—

Ms. CONNELL. It will require the Department of Health Services, which runs Medi-Cal in California, to modify the Medi-Cal formulary to take advantage of the lower cost of generic products of prices.

Mr. BURR. This is legislation to affect the formulary?

Ms. CONNELL. Right.

Mr. BURR. And not to alter in any way pricing?

Ms. CONNELL. No, no. We're trying to get the advantage of discounted prices.

Mr. BURR. I don't disagree with you that there ought to be control of formularies, but it's really important to draw the distinction that we already have a Federal statute that says that Medicaid, regardless of the State, buys at the best negotiated price that exists in the marketplace. So it isn't in fact—I think somebody led it to believe that it was the pharmaceutical companies on a pricing issue. It may be the pharmaceutical companies on an inclusion issue, but—

Ms. CONNELL. Whether they be brand or generic?

Mr. BURR. Correct. Let me ask you, it seems at least in North Carolina it would be unusual for the auditor or the controller to be an active participant in the legislative process, but I conclude from what you have said by using the word "we," that the controller's office has been initiating legislation through the general assembly. Is that, in fact, correct?

Ms. CONNELL. Congressman, what occurs when we complete an audit, if there are improvements that we can make in any program, whether it's charter schools or public schools or Medi-Cal, we then introduce the concept to a legislator, and a legislator will carry the

State controller audit legislation for us. So the legislation that passed, I referred to it as the Romero bill, was carried by Assemblywoman Romero. The Corbitt bill is being carried by Assemblywoman Corbitt.

Mr. BURR. Let me ask you and Mr. Cates, if you will, just to comment, where is the Department of Health Services in all of this?

Ms. CONNELL. Well, let me just do it historically and Alan can do it currently. The Department of Health Services is, in my view, the reason we've had this high level of Medi-Cal fraud, which has gone undetected and initially unobserved in California. When we began auditing them in 1995 and 1996, they had no control system in place to really deal with many of these issues that are being discussed by your committee today. We recommended those changes. Those changes did not occur in 1996 and 1997, and 1998. We began to see some changes in the latter part of 1997 and 1998, but they were really not at the level that we had anticipated and hoped. With the change of administration in 1999, we have had a restructuring of the Department of Health Services, and Mr. Cates represents the new Medi-Cal fraud unit in the Department of Health Services, which is a subset of the Department of Health Services. The Department of Health Services is the single State agency in California that runs Medi-Cal. So they are a huge agency.

They were focused in fairness to them on different priorities than we thought they needed to be focused on. They were focused on the Medi-Cal fraud on the beneficiary level. We were focused on Medi-Cal fraud on the provider level. We don't even audit Medi-Cal fraud on the beneficiary level obviously. And that's where they were using their resources. So they were heading in a different direction. At the time we felt there was an explosion in Medi-Cal fraud on the part of pharmacists and doctors and durable medical providers, their interest was in another venue.

Mr. BURR. Mr. Cates, just because it was mentioned by our last witness, I have to ask you. How many adult day care facilities have you investigated already?

Mr. CATES. The adult day care centers that we have formally investigated would only No. 2. The adult day care centers that we have reviewed surreptitiously is more like about 40.

Mr. BURR. Are adult day care centers licensed by the Department of Health Services?

Mr. CATES. They are licensed by the State Department of Aging under a contract with the Department of Health Services. I can tell you that the approach of the Fraud Prevention Bureau is focused on preventing fraud. We will detect and eradicate existing fraud, but our primary function is to prevent it.

In order to do that, we first need to have a full understanding of exactly what it is that is going on. In the case of adult day health care, I would just advise the committee that at this point in time, it's an interesting program and that we clearly see benefits of the program. People that might otherwise be in nursing homes, the quality of life is infinitely better in these adult day care centers. However, there's enough laxness in the program right now as it's being carried out in California that we need to tighten it because the fraud really isn't always fraud, meaning, we are paying \$63 a day in the State of California for a program that lasts ap-

proximately 4 hours. So to correct the earlier witness, it's not an all-day program, it's a 4-hour program.

Mr. BURR. My time has run out, but I want to ask for a clarification from California. In Mr. King-Shaw's testimony, one of the things he pointed to in Florida was the reenrollment period that providers had to go through. Has California done a reenrollment for its providers?

Mr. CATES. On our targeted provider groups in order, yes, we have. We have already reenrolled, out of 1,300 or 1,400 durable medical equipment providers, only about 800 elected to reenroll, and we are currently doing nonemergency medical transportation, and pharmacies are scheduled next year.

Mr. BURR. Let me commend Florida, specifically Mr. King-Shaw, for their whole process, because it seems to be a model, and my hope is that you will share that model with more, and Ms. Aronovitz, if for some reason we have not conveyed to HCFA some of the horror stories that exist in California where we, on a Federal level, can be more aware of the potential of Medicaid fraud and abuse that exists, but also the potential areas that we might ought to look at that are future fraud and abuses and adopt the Florida principle of prevention versus prosecution, I would think that we would make Mr. Kubic's day by adopting that across this country. With that I'd yield back, Mr. Chairman.

Mr. UPTON. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. Ms. Aronovitz, I thought something you said was one of the most salient points in this hearing, and that is that we have to remember as Congress that Congress has—while HCFA has more oversight perhaps of Medicare, we have really given Medicaid to the States, and therefore, HCFA's historical effort at least has been to try to work in an advisory capacity more than an oversight capacity.

And you know, in Congress we like to say, or many of us who came from State legislatures like to say, we are sort of States rights types, but the bad thing that happens is then you get some States like California and Florida that do a better job than other States, and HCFA then has to figure out what is its appropriate role for, say, States like my own State of Colorado and Texas that don't do site visits?

I am wondering if you can comment very briefly if you think—if GAO thinks that there are ways that HCFA can take a more proactive role, particularly in States that do not have a good record on fraud prevention.

Ms. ARONOVITZ. I'd like to first clarify two things that have been said. With regard to Texas particularly, I did not want to give the impression that the State does not believe that site visits could be useful in a selected, targeted way. I think the program that was contemplated for that State was going to be to do site visits on all providers. I think the State felt that was not cost effective.

But—and the other thing I wanted to say is that you're very correct in that HCFA has seen the payoff in focusing on prepayment activities. It's much more expensive to try to get involved in pay and chase or trying to collect overpayments later. In the Medicare program, there's a lot of evidence where HCFA has done much to try to encourage contractors to involve themselves in prepayment

activities. Where HCFA has a balancing act is in the Medicaid program. It's very important to HCFA's ability to help States to not create so much of a regulatory burden on them that it becomes impossible for all States to be able to meet whatever Federal standards are imposed upon them. HCFA walks a very clear line.

Ms. DEGETTE. Let me interrupt because I only do have 5 minutes. My question is, is there something HCFA could be doing?

Ms. ARONOVITZ. Yes.

Ms. DEGETTE. If you could answer that question.

Ms. ARONOVITZ. Absolutely. We feel that at a minimum, HCFA needs to know a lot more about what all States are doing, and even if it's by encouragement rather than a regulatory environment, they really need to work harder to encourage States that they know are not doing the minimal amount of activities.

Ms. DEGETTE. So you still think that a carrot-versus-the-stick approach may work if they take an active role?

Ms. ARONOVITZ. I think they need to take a much more active role in understanding what all States are doing and they need to continue to be aggressive in trying to help States learn.

Ms. DEGETTE. Mr. King-Shaw, I was struck by your testimony on these site visits because as you said, you don't visit every site, you take the higher risk areas and then you do it. What percentage of your providers would you say you do these site visits on, and do you do them preenrollment or is that what you do?

Mr. KING-SHAW. Yes. We have two types of site visits. One is the preenrollment as a part of the application process where we confirm that they are a physical location, that the providers that they say are a part of the work group are there and that the inventory they say is there, that they have all their licensure and that kind of thing. We have follow-up site visits that are more like audits, and there we do confirm that if we have billing records on a beneficiary that would suggest certain utilization at a pharmacy or a DME, we then try to match that up to the records located at the facility to see that they do, in fact, fit together. If they do not, there's suspicion of fraud somewhere and we can then go deeper into an analysis of the beneficiary or of the provider itself. What percentage? Approximately 100 percent of those five categories that I spoke of before up front.

The audits that we have on an ongoing basis, that depends, and that could be physicians and medical groups as well. It really is a matter of what do we detect through our very rigorous statistical analysis when we find that the historical billing patterns which show one curve, and all of a sudden there's a spike.

Ms. DEGETTE. How many of these site visits does your Department do annually?

Mr. KING-SHAW. All right. Just a minute. Approximately 5,000 a year.

Ms. DEGETTE. Okay. And one more question, Mr. Chairman. Texas, and I don't know what is Colorado's excuse, but I guess I can probably find out, but one of the things they had thought was that it was not cost effective in the pilot program that they did to do these site visits. I guess I would like to hear yours and Mr. Wagoner's quick responses to that.

Mr. KING-SHAW. We find them extremely cost effective. For \$50 or what it costs to do a site visit, you can save potentially hundreds of millions of dollars in many, many years of fraudulent activity. The deterrent factor when, you know, when every provider in the State knows that the site visit is a part of the application process, there's a screening out right there, but when you can identify a fraudulent practice early on and exclude them from the program, then you're talking about a compounding effect of all the things and cost avoidance that is a benefit to the Medicaid program with that \$50 investment.

Mr. WAGONER. Our experience with doing inspections of Medicare facilities, DME facilities mirrors what Mr. King-Shaw said as far as return on investment, as far as reducing fraud, but also knowing that that is coming, that that inspection is going to come, deterring fraud. One of the things that Medicare does is to require all new DME providers to have that inspection before they're allowed that billing number, and that every 3 years they're going to get another unannounced site inspection.

One of the things, and I'm not familiar with Florida's program, but one of the things that may have happened is they were in a mode where they had to hire State employees, or they had to augment State employees to do this. One thing about using a contractor is they should have staff in place that you can leverage across many different clients, and that's what should bring the cost down on a per-search basis.

Ms. DEGETTE. Thank you.

Mr. UPTON. Mr. Bilbray.

Mr. BILBRAY. Yes, Mr. Chairman. Ms. Connell, you mentioned your little difficulty with the court system. Would you think it's appropriate for Congress to address that issue and initiate legislation to try to give you jurisdiction to try to identify the fraud issue?

Ms. CONNELL. I would certainly hope that would be one of the considerations of this committee. We did receive support from Donna Shalala's office prior to our second appeal hearing at the court, and she clearly stated that she felt our interpretation of a single State in California should allow the Department of Health Services to contract with the State controller to do the audit and the investigation, and the court said we're not interested in what Ms. Shalala's interpretation is of single State agency law, and short of legislation, we're going to continue this interpretation that we have.

Mr. BILBRAY. Would you like to use today as a chance to be able to request that this Congress address the issue?

Ms. CONNELL. I did request it in my written remarks, and I would certainly like to again request it on record that Congress take action to review and amend the single State agency law to allow recognition of the State's constitutional role of its elected officials and allow me to once again carry out my independent duties.

Mr. BILBRAY. Would your office be willing to work with this majority and minority to draft and to move legislation that would affect that?

Ms. CONNELL. Absolutely. And in my conversation with State controllers around the country, they would welcome the opportunity as well.

Mr. BILBRAY. Thank you.

Mr. King-Shaw, let me, I appreciate all the dialog you have had with my office. Let me just sort of open this up to whoever wants to get into it, because one of the things we have to do here is—first, wait a minute. Let me go over to Mr. Cates and Ms. Connell and say, do you have any reason why California plays the brand name game?

Ms. CONNELL. I will let him answer so I don't have to get into the political issue, but I'll be happy to answer it for you as well.

Mr. CATES. From a fraud prevention perspective, brand name versus specifications, the fact of the matter is if you go with brand name products, generally you would not have as much fraud, simply because you're dealing with a product that even the company that markets—

Mr. BILBRAY. Either is or isn't.

Mr. CATES. Right. It either is that product or it's not, and you get a private company out there protecting its own label. When you get into a private spec, the problem with that is that, you know, somebody develops a product based on specifications, and the State gets into the business of trying to always determine is this new product that's just hitting the market, is it truly meeting the specifications, or is it not, and you end up with a lot of people manufacturing that product and getting the price that's been established per a specification listing.

This is an old argument. It's not an easily solved one. My personal preference as a fraud prevention specialist is I like to go with the brand name but keep the bidding open so that you have multiple companies bidding and you get a fair and good price as opposed to opening it up to anybody that wants to say, I manufacture that product, I may do it in a country you've never heard of, but it's that product, yes, really it is, that type of thing.

Mr. BILBRAY. I'll not bring in imported drug issues. That's a separate whole issue.

Mr. King-Shaw, one of the responsibilities we have in the legislature is not only to do oversight on the implementation, but also to make sure that the law itself, implementation package is designed to be able to minimize the potential for fraud and maximize the ability to detect it. Talking about this adult day care issue, one of the things that's been used successfully by the private sector and in California, to some degree, is this issue of a very small stipend of a copay of the participant, so that when somebody claims grandmother was there every day for the last 3 months, they get at least a bill so they can blow the whistle and say no way. Do you think the implementation of a small stipend of a copay may help to be able to get—raise one more way to be able to raise the red flag, or do you think the administrative problems with that are too great?

Mr. KING-SHAW. Well, I think that the administrative problems are too great. I don't think that's the most effective way to control fraud or overbilling for adult day care specifically. We have a moderate adult day care program in Florida. We have something called the "Cares" system. These are teams of case managers that assess regularly the medical, social, developmental needs of the elderly

and go through a process of placement and recommending a treatment plan based on the needs of that patient.

So we don't open the flood gates to allow just anyone to utilize adult day care. There needs to be some needs, if you will, that are assessed and then recommended or prescribed. I think where we are in Florida is we like to make sure that the patient receives the right amount of medical care, social services, whatever it is, each according to their need, and that that be a clinical base and social base model as opposed to a financial incentive model. The financial incentives can work, but often—and you can just look at the cost of prescription drugs, but what often happens is people make economic decisions that override their health care needs, and down the line that does not produce, I think, a good outcome and a good result.

Mr. BILBRAY. I understand my time is up. I'd ask unanimous consent for 30 seconds just to do a follow-up on that.

Mr. UPTON. Okay.

Mr. BILBRAY. I'm just saying I have seen, the copay is used in the private sector so extensively, even among the poor, and in California we've integrated a lot of that into our Medicare and Medicaid in a successful manner, and Mr. Cates, what better program we have than to have the families or the recipients of the benefits actually participate in part of the oversight, and do we have any vehicles in California to be able to do that?

Mr. CATES. To my knowledge, I am not aware of a copay requirement in California which is a model that you describe. I do agree that given the fact that we have 5 million beneficiaries in California, if you get into a copay scenario, while I certainly appreciate the detection ability that that gives because you get somebody saying I didn't get that service, I don't want to pay that copay, they tell me administratively it's a nightmare. Now, is it? Is it not? I think that's a type of pilot project that should be attempted, and I would think that California is a good proving ground for any type of pilot like that.

I will certainly be pursuing something like that on a pilot basis. It has been brought up in our fraud committee meetings, which is another thing we have now in California. We have monthly fraud steering committee where that's all we do is focus on those types of things. I will certainly keep you posted if we do establish such a pilot and give you the feedback.

Mr. BILBRAY. Thank you very much. I appreciate it, Mr. Chairman, and I think we got a good insight of maybe a vehicle to at least investigate down the line. I yield back whatever's left.

Mr. UPTON. No time is remaining.

Mr. Cox.

Mr. COX. Thank you very much. I'd like to welcome each of our witnesses and thank you for your testimony this morning, in particular, our witnesses from California, where I and Mr. Bilbray are especially concerned.

In both of your testimonies this morning, Ms. Connell and Mr. Cates, you describe the efforts that California is making, and in particular, Ms. Connell, you referred to the problems that recent Federal court decisions are providing to your office. You mentioned four areas in which these judicial decisions are constraining. The

first is that they are inhibiting your ability to conduct audits of fraud; second, they are inhibiting your ability to withhold payment when fraud is suspected; third, they are constraining you from referring fraud cases to the Department of Justice; and fourth they are preventing you from reporting any conclusions of fraud or suspected fraud to the Department of Health Services.

Have you provided the committee or Congress at all, or has the State of California or has the Department of Health Services provided us with proposed legislative language to remedy those court decisions?

Ms. CONNELL. My general counsel has prepared some legislation that he thought, or legislative language he thought would help resolve this. We thought it was presumptuous to give it to the committee today. We wanted to someone perhaps request it, and I would be happy to provide it. I didn't know if that was appropriate on my part. We can provide that for you.

Mr. COX. If you are that far along can you tell us what it is that you suggest that we amend the United States code, which portions of the law?

Ms. CONNELL. It is the single State agency law, and specifically it is the law that says there can be only be a single vehicle in each State. As that law has now been interpreted by the Federal courts in California, we are not allowed to be part of the process of Medi-Cal fraud evaluation. Our counsel believes, as does the Attorney General who defended us in court, that if we could get legislation that would amend the single State agency law and say it is the decision of the agency—of the State and its single agency, if it wishes to contract out for these services to other agencies, to other private sector participants or to constitutional offices a part of that role, that that would be sufficient.

Mr. COX. Inasmuch as these are executive branch actions within the State of California and every other State, Florida and elsewhere, would it not make sense to empower the Governor to allocate among State agencies responsibilities that comport best with relative—

Ms. CONNELL. That would be perfectly fine with us. We would have no problem with that. In fact, the legislature has continued with the Governor to increase the amount of funding we have for Medi-Cal audit activities. The difficulty is that we're not able to be as aggressive in those activities.

Mr. COX. Ms. Aronovitz, in your view, would it inhibit, in any way, the goals of the Federal program to permit Governors to make those allocations and responsibilities in fighting fraud?

Ms. ARONOVITZ. I am not a lawyer, and I am actually not that familiar with the single-State agency statute. So I'd rather defer to others to get you an answer to that.

Mr. COX. Let me ask Mr. King-Shaw, do you have a view about this in Florida?

In California, apparently our problem is that we have competing agencies and Mr. Cates' agency is building up competency to deal with these things. The Controller's office has complementary resources, and the Controller is telling us that she'd like to continue the participate in fighting fraud in the State of California. Do you have similar issues in Florida?

Mr. KING-SHAW. No. Our fraud and auditing capabilities within the agency, within Medicaid, are superior to what would be outside of the agency. Our single-State agency program in Florida works very well. The Medicaid Fraud and Control Unit, which prosecutes cases of identified fraud, is in the Attorney General's Office. But I'll tell you candidly that we have built up expertise and resources and data mining capabilities and auditing capabilities, both financial and clinical, within the agency that I think would be, you know, inappropriately diffused if there were some other agency involved in that effort.

Mr. COX. If Congress were to empower the Governor of the State of Florida to allocate within a single agency of the State of Florida or, in your case, to share that responsibility with the Attorney General or some other office for the purpose of fighting fraud as best he saw fit, would that help or hurt Florida?

Mr. KING-SHAW. I think that the empowerment is good. I think that, just as there are variants of issues within a State, there are variations of issues among States. So the power for every State to organize its effort for Medicare fraud to its own need and ability I think would be fine. I don't think we would have any changes within Florida, but I think Florida, like any other State, would appreciate the freedom to organize that effort in a way most appropriate for any State.

Ms. CONNELL. Mr. Cox, I have just been reminded by my counsel that, indeed, if the Federal court ruling in California was applied to Florida, the Attorney General's Office would have that difficulty carrying forth any audits. That is the problem. If this ruling is applied in any other State, they're going to find the same kind of restrictions that are now occurring in California.

Mr. COX. Mr. Cates, I won't ask you to speak for Governor Davis, but, speaking for your agency, would you support legislation that would empower the Governor to allocate responsibilities within the State of California?

Mr. CATES. I believe this Governor would support all efforts to eradicate and prevent fraud within the health care program within California. I believe that the Controller's points are well taken, especially as it related to a couple of years ago when it was virtually only the Controller's office taking an aggressive stand against health care fraud in the State.

But I also want to point out with that statement that fraud is an act of concealment. The Department of Health Services was primarily interested in the health program and in the health of its citizens. They just were not geared to address concealed fraud. They are today.

Mr. COX. I thank you. Thank you, Mr. Chairman.

Mr. UPTON. Thank you.

I have just a couple of more questions, and then I presume that my colleagues may have some as well.

Surety bond issue. Ms. Connell, you talked—I think \$25,000—

Ms. CONNELL. Yes that's correct.

Mr. UPTON. [continuing] is the level that was established. And in Florida, I think it's what, \$50,000?

Mr. KING-SHAW. Fifty or a year's expected billings.

Mr. UPTON. How many other States have a surety bond like Florida and California?

Ms. ARONOVITZ. I am not sure. I am not sure we asked that specifically on our questionnaire.

Mr. UPTON. But do you all feel that it was a pretty good tool?

Ms. ARONOVITZ. Yes. We think surety bonds definitely serve a purpose but they will not be the end-all because they don't in any way assure quality care. Nor, if you're an honest provider and you enter the program and you later decide to commit some type of fraud, a surety bond wouldn't stop you from doing that. But, clearly, they are screening tools; and used in conjunction with other tools, they certainly could be useful.

Mr. UPTON. I just remember when I first saw the story on Medical on 60 Minutes, I guess it was, I wonder why California might not have taken a little higher level when you look at other States.

Ms. CONNELL. Maybe I can respond to that. When we suggested the 25,000, we even hit resistance at that level, and the feeling was that we would put the 25,000 into effect and see if it was having the necessary impact. Many people in the legislature felt that, for small businesses, a \$25,000 bond was a difficult deterrent and that it would encourage responsible behavior, and the legislature I don't think was willing to go any higher. We tested a higher amount, and it fell back down to \$25,000 level in hearings.

Mr. UPTON. I know that Mr. Cox explored the single-State agency quite a bit in his last questions. I want to say, too, that my office has been working on legislation that we are hoping to introduce in the near future, and this is obviously one plank that I'd like to welcome as part of our package, and I appreciated that as part of your testimony this morning.

I guess the last question—Mr. Kubic, I visited with my local FBI agents in Michigan a number of times looking at their efforts. Their offices are literally across the street, across the parking lot from where my office is. And I was glad to see that you all have increased, I think you indicated, from 115 to 500 agents looking into this. How many do you need?

Mr. KUBIC. That's a great question. Basically, most field offices, everywhere they have looked in terms of health care fraud have been able to find similar schemes that we've been discussing this morning, and I think the bottom line needs assessment is that we were looking for, through the fiscal year 2002 cycle, an additional 200 agents nationally. You know, going through the process internally, through the Department of Justice and through other cuts, that tends to be reduced.

Mr. UPTON. Now, when I look again at my own little operation, my county that I live in has one field office. It is—about 175,000 people live in the county. They have three or four agents that are there. Do they then work—and they have worked with the U.S. Attorney's Office in the Western side of the State. We have two in our State. Do they work very closely then with the State Medicaid offices? I mean, how do they go about coming up with their target list?

Mr. KUBIC. Sure. I can tell you, as the former agent in charge of the Salt Lake City Division, which covered Idaho, Montana and Utah, it was absolutely essential to work with your State counter-

parts in the Medicaid Fraud Control Units to develop an active exchange of information dialog to do joint investigations. With the wide coverage that the Bureau has nationally, it does evolve to some fairly small operations, some two-man resident agencies where there's 1 agent or 2 who are covering the full range of criminal violations. So you're right. You absolutely have to work together.

Mr. UPTON. Well, thank you.

Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman.

Ms. Aronovitz, we've heard about California and Florida. What top two steps should all States be taking to fight State Medicaid fraud?

Ms. ARONOVITZ. In our survey, we found that there were actually several States that answered in a way that made us feel like they're doing a pretty good job. One was Texas, despite its concern about site visits. They were doing a lot of other very positive things. Connecticut, New Jersey and Georgia are also taking steps. Some of the things they're doing which we feel are very important are things like changing the provider agreement to assure that the provider has to sign the agreement and understands what the requirements are, and including a termination clause so that both parties could terminate the contract for no cause without too much due process. We think it's very important that site visits be considered even if it's on a risk approach, and also we feel that re-enrolling providers on an ongoing basis is important.

Mr. STUPAK. Well, on some of these steps they just seem like common, good things to do. Why aren't other States doing them? Is it they don't have the resources, lack of will? Exactly what is going on in those other States?

Ms. ARONOVITZ. I think every single State has its own story, and I think it's fascinating to hear about California and, actually, Florida before 1995, but I think that the budget has some role in this. I think management commitment plays a part but I think there's also another answer. There's a real tension between making sure in Medicaid that providers want to participate in the program, to assure good access to high-quality care so there's a concern that States don't hassle good providers in a way that they might not want to participate. So I think there's also that balance that State Medicaid programs have to consider.

Mr. STUPAK. Mr. Cates, it looks like you want to jump in on that one.

Mr. CATES. I sure do. One of the things—I've been in the Medical fraud program many, many years. And I can remember when I was first hitting the diaper scam in California in the 1990's, the State Department of Health Services at that time candidly was letting me know, you know, Alan, for every time you go out there and identify a hundred thousand dollars that might be fraudulent, we are required under HCFA guidelines to report that hundred thousand immediately to them within 60 days. At that point, they take back their 50 percent share, regardless of whether or not the State of California ever actually collects a dime.

While, right now, we are so aggressive with fraud in California we're identifying literally hundreds of millions. HCFA is getting

half. The U.S. prosecutor, because we are so successful, is getting the money back. HCFA is getting half of that. Guess what? HCFA's coming out way ahead. If we don't change that, all I can tell you is States have a built-in disinterest to identifying fraud and problems in their programs, and that is—

Mr. UPTON. If the gentleman will yield for a second, we picked that up in our earlier hearing we had on this. In legislation that I'm looking at doing, which will be bipartisan, we're going to fix that.

Mr. CATES. Excellent. Thank you.

Mr. STUPAK. Let me, if I may, I asked earlier if GAO would do a report on what happened and lessons learned in California and policy breakdown. Because it looks like California, since 1994, apparently has been well aware of it and has been doing a good job, so you could probably teach us something. But I'm really looking for GAO to do a detailed report as to what happened there. They have done this survey, but really—

Ms. CONNELL. We'd be happy to provide that information. It's been detailed in many reports to the legislature. All of our audit reports are public, and we'd be happy to make that available to the GAO.

Mr. STUPAK. That would be helpful for GAO to just take a look at it. We'd just like—it sounds like you've had a bad problem, you made it into a good problem—not a good problem but certainly you have cleaned it up a lot, and we'd like to learn a more about it, especially if—do you agree that the adult day care center may be the next big area of fraud?

Ms. CONNELL. Well, I think there are many areas of fraud, and we could list them all here today. I almost don't like to do that publicly. I try to restrain myself for fear that I'm just directing entrepreneurial talent into these new fields. Certainly that is an area of concern.

Mr. STUPAK. Thank you.

Mr. UPTON. Ms. DeGette.

Ms. DEGETTE. Thank you, Mr. Chairman. I'd like to follow up a little bit on questions the chairman was asking about surety bonds.

Mr. King-Shaw, you testified and also in your written testimony you talked about the surety bonds and letters of credit that Florida uses. How do you determine who you will impose that requirement on? Who's a high-risk provider in Florida?

Mr. KING-SHAW. We do it by provider type. So it's, again, those five groups that I talked about—durable medical equipment, transportation, pharmacies outlets themselves has been added this year, independent labs and nonphysician-owned group practices. Because, historically, that's where the fraud have been detected and the recoveries have come.

Ms. DEGETTE. And what amount of bond does Florida use?

Mr. KING-SHAW. \$50,000 is the base. We can expand it beyond that to be an estimated year's worth of billings.

Ms. DEGETTE. Do you have problems—I know I've talked to providers in my State, for example, particularly small providers. They say a \$50,000 surety bond or, in their view, even a \$25,000 bond would be prohibitive for them to obtain it. And what they say is

that it is freezing some of these, you know, honest but small providers out of the market.

Mr. KING-SHAW. That is a real issue. You know, when you have barriers to entry that are too high for a small operator they may not be able to get into the field. We have a great relationship with our legislature on these issues. I think that's one of the critical parts of our success. And they have really supported the agency in our efforts, we've understood that, but I think it's important that if we're going to talk about a quality health care delivery system that has a strong financial base that we look at the resources of the providers who are going to provide the care, and it does take a certain amount of financial stability and maturity and commitment in order to earn the trust of the State to take care of the Medicaid population. I would argue it would be the same for Medicare.

So, yes, it will screen out some of the marginal startup players, but, on the flip side of that, we know that we are entrusting our funds and our patients with a health care provider base that is worthy and substantial and able, financially and otherwise, to care for that patient.

Ms. DEGETTE. I mean, I think about what Ms. Connell was talking about and others about the adult—the coming adult day care, you know, if you said that's a high-risk group, you know you don't need a lot of capitalization to start an adult day care center.

Mr. KING-SHAW. That's very true. And we have similar issues in our ALF, our adult living facilities, because that's another one that doesn't require a lot of startup capital. It's another service need of the elderly. Regulating them is just as challenging, and it's just as prone to fraud, but we need to be able to anticipate that issue and respond to it aggressively, and so we do.

Ms. DEGETTE. Thank you. Thank you, Mr. Chairman.

Mr. UPTON. Well, thank you very much.

Again, this has been one of those continuing hearings that we've conducted over the last number of months, and I think it's very helpful, as we look now at pursuing legislation to provide better tools to the States in building, strengthening the partnership between the Federal Government and the States, to weed out fraud and abuse.

I would ask unanimous consent to include a number of letters for the record from Chairman Bliley that he sent to several States about their provider enrollment efforts and the States' responses.

We may have members on this panel that may have additional questions they may submit to you in writing. So watch the mail.

We appreciate your testimony very much and look forward to working with you in the future.

Thank you. Hearing is adjourned.

[Whereupon, at 12:30 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

## ONE HUNDRED SIXTH CONGRESS

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JAMES E. DERDERIAN, CHIEF OF STAFF

U.S. House of Representatives  
 Committee on Commerce  
 Room 2125, Rayburn House Office Building  
 Washington, DC 20515-6115

June 22, 2000

Mr. Gary Crayton  
 Director of Medicaid  
 Agency for Health Care Administration  
 2727 Mahan Drive, Bldg. 3  
 Tallahassee, FL 32308

Dear Mr. Crayton:

I write to you today to learn what actions the State of Florida has taken to prevent fraud in its Medicaid program, and specifically what efforts are being made to review the enrollment of new providers to screen out individuals with potentially questionable backgrounds.

As you may know, the Committee on Commerce is responsible for overseeing the Medicaid program, which finances health care services for more than forty million Americans. During my tenure as Chairman of the Committee, I have been particularly concerned about the effectiveness of the current efforts being made to detect and combat fraud and abuse within the program. In response to these concerns, the Committee has held hearings that focused on what the Federal government, States and the private sector are doing to combat this growing problem. In addition, I have requested that the General Accounting Office undertake a major survey of the state of current efforts to curb fraud and abuse in this important program.

The Committee's investigation into these issues has revealed that, in many instances, very basic safeguards against fraud are not being effectively employed. One such safeguard, which has demonstrated a capacity to significantly deter fraud, is the utilization of rigorous provider controls. Such fraud controls can be used to screen and identify potentially questionable providers, before they are able to submit false claims to a State Medicaid program. Rigorous provider controls, utilizing site visits and background checks can identify applicants with lengthy criminal records, businesses that lack basic equipment and patient information and alleged provider offices that operate exclusively out of post office boxes.

In the limited number of instances where provider controls have been used in government funded health care programs, disturbing patterns of potential fraud were revealed. The Office of Inspector General (OIG) at the Department of Health and Human Services reported in 1997 that a review of applicants seeking to become durable medical equipment suppliers for the Medicare program revealed that eleven percent of the applicants lacked a required physical address and forty percent of the applicants failed to satisfy at least one of the basic qualifications necessary to become a Medicare provider. As a result of this survey, the OIG concluded that additional enrollment review procedures, including on-site verification of application information was necessary to deter fraud. Similar results were also uncovered by contractors working with certain State Medicaid agencies to review applicants seeking to become new Medicaid providers.

In order to better assess the effectiveness of current efforts to control fraud in the Medicaid program and identify potential solutions for this growing problem, I request, pursuant to Rules X and XI of the U.S. House of Representatives, that you provide the following information no later than June 30, 2000:

1. Please identify what efforts are being taken to verify the qualifications of providers applying to enroll in the Medicaid program.
2. Please identify whether a criminal background check, and specifically a review of prior criminal convictions, is performed prior to allowing a provider to enroll in the Medicaid program.
3. Please identify whether site visits to a provider's place of business are used to independently verify the validity of enrollment information supplied by an applicant.
4. Please identify what efforts are made to assess the level of potential threat of fraud posed by particular types of health care provider (e.g. durable medical equipment supplier, home health agency operator, etc.), and whether provider enrollment control efforts are ever tailored to focus on areas that are identified as potentially posing the greatest risk.
5. Please identify whether providers, once enrolled in the Medicaid program, are ever subject to regularly scheduled reviews of their qualifications.
6. Please identify what actions are taken to cancel or suspend the billing number of a provider who has not submitted a bill to Medicaid for a specific period of time.
7. Please identify what efforts have been made to utilize non-government contractors to verify the qualifications of providers applying to enroll in the Medicaid program.

If you should have any questions, please contact Mr. Charles Clapton, Committee Counsel, at (202) 226-2424. I appreciate your cooperation in this matter.

Sincerely,

  
Tom Bliley  
Chairman

cc: The Honorable John D. Dingell, Ranking Minority Member



JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., EXECUTIVE DIRECTOR

June 30, 2000

The Honorable Tom Bliley, Chairman  
 U.S. House of Representatives  
 Committee on Commerce  
 Room 2125, Rayburn House Office Building  
 Washington, DC 20515-6115

Dear Congressman Bliley:

Thank you for your letter of June 22 regarding provider enrollment practices in the Florida Medicaid program. Beginning, in 1995, we instituted new enrollment procedures to help us combat the entry of fraudulent providers into our program. Many of the procedures are exactly the types of controls you asked about in your letter, such as background checks and site visits. While Medicaid provider enrollment practices are certainly not the only fraud and abuse measures that should be employed, we firmly believe that they are the first of a series of checks that must be performed to maintain the integrity of the program.

As described below, I believe that Florida Medicaid may have one of the most comprehensive and ambitious Medicaid anti-fraud initiatives in the nation. As part of this effort, we have taken numerous steps to control the Medicaid provider network as indicated in our response to the questions included in your June 22<sup>nd</sup> letter.

1. *Please identify what efforts are being taken to verify the qualifications of providers applying to enroll in the Medicaid program.*

The Non-Institutional Medicaid Provider Agreement, Revised July 1999, (3) states (see attached agreement):

“The provider agrees that the submission for payment of claims for services will constitute a certification that the services are provided in accordance with local, state and federal laws, as well as rules and regulations applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA.”

2727 MAHAN DRIVE \* MAIL STOP #11  
 TALLAHASSEE, FL 32304  
 (850) 488-3560  
 FAX 488-2520



VISIT AHCA ONLINE AT  
[WWW.FDHQ.STATE.FL.US](http://WWW.FDHQ.STATE.FL.US)

The Honorable Tom Bliley, Chairman  
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 June 30, 2000

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Section 409.907, Florida Statutes, regarding the Medicaid provider agreement states:

"(2) Each provider agreement shall be a voluntary contract between the agency and the provider, in which the provider agrees to comply with all laws and rules pertaining to the Medicaid program when furnishing a service or goods to a Medicaid recipient.... Each provider agreement shall be effective for a stipulated period of time, shall be terminable by either party after reasonable notice, and shall be renewable by mutual agreement."

When a provider submits an application to become a Florida Medicaid provider, several steps are taken to determine that the provider is qualified.

- When applicable, the Florida Department of Health is contacted to verify that the provider has a valid license to practice in the State of Florida.
  - Beginning in September 1996, state criminal background checks (Level 1) were required of most types of Medicaid provider applicants, including owners and operators, as a condition of enrollment. Beginning in December 1997, FBI background checks (Level 2) were added to the provider enrollment process.
  - Business and occupational licenses are checked to see if the provider is registered to conduct business at their location.
  - In December 1995, pursuant to s. 409.907(7), Florida Statutes, a \$50,000 surety bond is required of all new durable medical equipment suppliers, private transportation companies, non-physician owned physician groups, independent laboratories and home health agencies (see attached application).
  - In September 1996, Florida Medicaid began conducting on-site visits prior to enrollment of selected provider types, including DME suppliers, non-physician owned physician groups, transportation companies and independent laboratories, to verify the existence and capability of the provider.
  - Other qualifications are required in regards to provider type.
2. *Please identify whether a criminal background check, and specifically a review of prior criminal convictions, is performed prior to allowing a provider to enroll in the Medicaid program.*

Level 1 and 2 background checks (state and national checks) are performed in accordance with section 409.907 (9) and (10), Florida Statutes. If a criminal background check on a provider reveals a conviction, their application is routinely denied.

3. *Please identify whether site visits to a provider's place of business are used to independently verify the validity of enrollment information supplied by an applicant.*

The Honorable Tom Bliley, Chairman  
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 June 30, 2000

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Prior to enrollment of selected provider types, on-site visits are conducted to see that the business is actually in operation at the address included on the application.

A checklist is used to assess provider capabilities, depending on the provider type, such as: business was open, inventory available, patient records available, and other indicators of ability to do business and meet Medicaid requirements (see attached checklist).

4. *Please identify what efforts are made to assess the level of potential threat of fraud posed by particular types of health care providers (e.g. durable medical equipment supplier, home health agency operator, etc.), and whether provider enrollment control efforts are ever tailored to focus on areas that are identified as potentially posing the greatest risk.*
  - The Medicaid program uses a number of analytical techniques to look at expenditure trends, billing patterns by provide type etc., to identify areas where the risk of fraud or abuse may be higher. Also, work in the field by our investigators gives us valuable insight into where identifiable fraud is actually occurring. This does allow us to identify areas in which fraud is more prevalent, such as durable medical equipment, non-physician owned clinics, etc., and we do employ additional controls for these provider types, such as site visits and surety bonds.
5. *Please identify whether providers, once enrolled in the Medicaid program, are ever subject to regularly scheduled reviews of their qualifications.*

Medicaid providers are periodically re-enrolled. The next re-enrollment process will start in the third quarter of calendar year 2000 and will continue until the second quarter of calendar year 2003 (see attached re-enrollment letter). During this process more than 70,000 non-institutional providers will be required to re-enroll. Re-enrollment follows the same guidelines as enrollment, including background checks and on-site visits. Every two months, a contractor provides Florida Medicaid with notice of any providers that have been convicted of a crime since the last check. Quarterly licensure checks are performed by the Department of Health to determine if a provider has lost its license or proceedings are underway to revoke a provider's license.

The process for re-enrollment is as follows:

- Current providers are mailed a re-enrollment package that includes a re-enrollment sheet; disclosures of criminal background, ownership, the site(s) where services are provided and the custodian of records; information on the necessity of posting a surety bond or letter of credit; a new provider agreement; an FDLE background check package; and provider-specific information (e.g., physicians receive a group practice information sheet requiring the disclosure of every treating provider in the group).
- The applicant sends the agreement and other forms to Consultec, the Medicaid fiscal agent.
- Consultec posts receipt of the application and enters data in its tracking system.

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- If the fiscal agent deems the enrollment package complete, the re-enrollment application is scheduled for review and the criminal background sheet is sent to the Florida Department of Law Enforcement.
- If the package is incomplete, it is returned to the provider.
- Consultec reviews the re-enrollment forms to determine if the provider is qualified for re-enrollment, including a review of criminal background checks.
- If there is a negative criminal background check, the application and FDLE sheet are routed to the Agency for final review and disposition.
- If the provider fails the criminal background check, the provider is terminated as a Medicaid provider.
- If the provider fails to file a complete re-enrollment package by the termination date, the provider is terminated.
- If the provider qualifies for re-enrollment, the provider is re-enrolled.

| <b>Medicaid Provider Enrollment Reductions<br/>Selected Providers (as of 3/5/97)</b> |             |
|--|-------------|
| Provider Type  | % Reduction |
| DME Suppliers  | 60%         |
| Home Health Agencies   | 32%         |
| Transportation Operators   | 75%         |
| Physicians   | 26%         |
| Laboratories/X-ray Providers   | 65%         |

Over a two-year period (1996-1998) Medicaid fraud and abuse initiatives reduced annual Medicaid spending by more than \$100 million. The re-enrollment process conducted in FY 1996-97 reduced the Medicaid provider network by more than 20,000 providers. Annual physician services spending was reduced by more than \$55 million when new Medicaid computer edits were installed to restrict non-medically necessary therapies. A special investigation by the Agency for Health Care Administration terminated more than 120 South Florida clinics and physicians suspected of fraud. A combination of on-site reviews, a \$50,000 surety bond, and new computer edits reduced Medicaid durable medical equipment spending by more than \$19 million; durable medical equipment supplier enrollment declined by nearly 50 percent due to re-enrollment. Another \$7 million was saved from anti-fraud controls targeting independent laboratories and x-ray service providers.

6. *Please identify what actions are taken to cancel or suspend the billing number of a provider who has not submitted a bill to Medicaid for a specific period of time.*

Any provider that has not submitted a bill for payment in 12 months is dropped from the Medicaid provider list and their provider number is cancelled. A provider applying for reactivation of its provider number must go through the complete enrollment process again.

The Honorable Tom Bliley, Chairman  
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June 30, 2000

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7. *Please identify what efforts have been made to utilize non-government contractors to verify the qualifications of providers applying to enroll in the Medicaid program.*

Non-government contractors assist in the completion of criminal background checks and pharmacy audits.

Continuing efforts are being made to make the provider enrollment process even more efficient and timely. The current enrollment process is being evaluated, and the provider enrollment application will soon be offered online through Consutec's Internet web site. The Florida Legislature in its session that ended in May 2000 also provided the Agency for Health Care Administration with additional authority needed to deny provider applications based on the best interests of the Agency and require surety bonds in amounts based on Medicaid billings.

Although your letter asked us to focus on Medicaid provider enrollment activities, we use many other controls to limit Medicaid fraud, abuse and waste. We have expanded Medicaid Management Information System edits to identify inappropriate billings. Our system now includes more than 10,000 automated, hard edits. We have an aggressive pharmacy audit program that has resulted in the termination of several fraudulent pharmacy providers. The on-site review requirement prior to enrollment will be extended to pharmacies in the near future. Recipients who abuse their drug benefit will be locked into a single pharmacy. The 2000 Florida Legislature also authorized the agency to enhance pharmacy credentialing requirements, to enroll providers based on need, and impose a moratorium on pharmacy provider enrollment. In addition, the state is currently soliciting proposals from private contractors for a program that uses the latest software to profile providers for potential fraud and abuse. Comprehensive profiling of recipient drug therapies by beneficiary and prescriber has already been implemented.

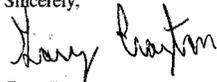
Finally, a successful Medicaid fraud and abuse initiative depends on strong interagency partnerships, case coordination and the development of coordinated anti-fraud strategies among various entities with fraud detection and prosecution responsibilities. In Florida, the Agency for Health Care Administration has worked closely with the Attorney General, the Medicaid Fraud Control Unit, the Florida Department of Law Enforcement, the Statewide Prosecutor, Operation Restore Trust and the Inspector General of the federal Department of Health and Human Services, local law enforcement agencies, and various state and federal prosecutors.

The Honorable Tom Bliley, Chairman  
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June 30, 2000

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I hope that this information is helpful to you and your committee as you continue your efforts to reduce fraud and abuse in the nation's Medicaid programs. If I can be of further assistance, please feel free to call me at (850) 488-3560.

Sincerely,



Gary Crayton  
Deputy Director for Medicaid

cc: Ruben J. King-Shaw, Jr

GC/BS/sjm

Attachments

Non-Institutional Medicaid Provider Agreement - MPA, Revised July 1999  
Medicaid Provider Bond Application  
On-Site Review Checklist DME  
Letter to Medicaid Providers re re-enrollment with Profile Verification



**NON-INSTITUTIONAL  
MEDICAID PROVIDER AGREEMENT**



The Provider agrees to participate in the Florida Medicaid program under the following terms and conditions:

- (1) **Discrimination.** The parties agree that the Agency for Health Care Administration (AHCA) may make payments for medical assistance and related services rendered to Medicaid recipients only to a person or entity who has a provider agreement in effect with AHCA; who is performing services or supplying goods in accordance with federal, state, and local law; and who agrees that no person shall, on the grounds of sex, handicap, race, color, national origin, other insurance, or for any other reason, be subjected to discrimination under any program or activity for which the provider receives payment from AHCA.
- (2) **Quality of Service.** The provider agrees that services or goods billed to the Medicaid program must be medically necessary, of a quality comparable to those furnished by the provider's peers, and within the parameters permitted by the provider's license or certification. The provider further agrees to bill only for the services performed within the specialty or specialties designated in the provider application on file with AHCA. The services or goods must have been actually provided to eligible Medicaid recipients by the provider prior to submitting the claim.
- (3) **Compliance.** The provider agrees that the submission for payment of claims for services will constitute a certification that the services were provided in accordance with local, state and federal laws, as well as rules and regulations applicable to the Medicaid program, including the Medicaid Provider Handbooks issued by AHCA.
- (4) **Term and signatures.** The parties agree that this is a voluntary agreement between AHCA and the provider, in which the provider agrees to furnish services or goods to Medicaid recipients. Provided that all requirements for enrollment have been met, this agreement shall remain in effect for five (5) years from the effective date of the provider's eligibility unless otherwise terminated. This agreement shall be renewable only by mutual consent. The provider understands and agrees that no AHCA signature is required to make this agreement valid and enforceable.
- (5) **Provider Responsibilities.** The Medicaid provider shall:
  - (a) Possess at the time of the signing of the provider agreement, and maintain in good standing throughout the period of the agreement's effectiveness, a valid professional, occupational, facility or other license appropriate to the services or goods being provided, as required by law.
  - (b) Keep, maintain, and make available in a systematic and orderly manner all medical and Medicaid-related records as AHCA requires for a period of at least five (5) years.
  - (c) Safeguard the use and disclosure of information pertaining to current or former Medicaid recipients as required by law.
  - (d) Send, at the provider's expense, legible copies of all Medicaid-related information to authorized state and federal employees, including their agents. The provider shall give state and federal employees, including their agents, access to all Medicaid patient records and to other information that can not be separated from Medicaid-related records.
  - (e) Bill other insurers and third parties, including the Medicare program, before billing the Medicaid program, if the recipient is eligible for payment for health care or related services from another insurer or person.
  - (f) Within 90 days of receipt, refund any moneys received in error or in excess of the amount to which the provider is entitled from the Medicaid program.
  - (g) Be liable for and indemnify, defend, and hold AHCA harmless from all claims, suits, judgments, or damages, including court costs and attorney's fees, arising out of the negligence or omissions of the provider in the course of providing services to a recipient or a person believed to be a recipient.

(h) Accept Medicaid payment as payment in full, and not bill or collect from the recipient or the recipient's responsible party any additional amount except, and only to the extent AHCA permits or requires, co-payments, coinsurance, or deductibles to be paid by the recipient for the services or goods provided. This includes situations in which the provider's Medicare coinsurance claims are denied in accordance with Medicaid's payment.

(i) Agrees to submit claims to AHCA electronically and to abide by the terms of the Electronic Claims Submission Agreement.

(j) Agrees to receive payment from AHCA by Electronic Funds Transfer (EFT). In the event that AHCA erroneously deposits funds to the provider's account, then the provider agrees that AHCA may withdraw the funds from the account.

(6) AHCA Responsibilities. AHCA:

(a) Is required to make timely payment at the established rate for services or goods furnished to a recipient by the provider upon receipt of a properly completed claim.

(b) Will not seek repayment from the provider in any instance in which the Medicaid overpayment is attributable solely to error in the state's determination of eligibility of a recipient.

(7) Termination For Convenience. This agreement may be terminated without cause upon thirty (30) days written notice by either party.

(8) Ownership. The provider agrees to give AHCA sixty (60) days written notice before making any change in ownership of the entity named in the provider agreement as the provider. The provider is required to maintain and make available to AHCA Medicaid-related records that relate to the sale or transfer of the business interest, practice, or facility in the same manner as though the sale or transaction had not taken place, unless the provider enters into an agreement with the purchaser of the business interest, practice, or facility to fulfill this requirement.

(9) Complete Information. All statements and information furnished by the prospective provider before signing the provider agreement shall be true and complete. The filing of a materially incomplete, misleading or false application will make the application and agreement voidable at the option of AHCA and is sufficient cause for immediate termination of the provider from the Medicaid program and/or revocation of the provider number.

(10) Interpretation. This agreement shall not be construed against either party on the basis of this agreement having been prepared by one of the parties.

(11) Governing Law. This agreement shall be governed by and construed in accordance with the laws of the State of Florida.

(12) Amendment. This agreement, the application and other documents being executed and delivered pursuant hereto constitute the full and entire agreement and understanding between the parties hereto with respect to the subject matter hereof. No amendment shall be effective unless it is in writing and signed by each party.

(13) Severability. If one or more of the provisions contained in this agreement or application shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired.

(14) Agreement Retention. The parties agree that AHCA may only retain the signature page of this agreement, and that a copy of this standard provider agreement will be maintained by the Director of Medicaid, or his designee, and may be reproduced as a duplicate original for any legal purpose and may also be entered into evidence as a business record.

(15) Funding. This contract is contingent upon the availability of funds.

THE PARTIES AGREE THAT THIS AGREEMENT IS A LEGAL AND BINDING DOCUMENT AND IS FULLY ENFORCEABLE IN A COURT OF COMPETENT JURISDICTION. THE SIGNATORIES HERETO REPRESENT AND WARRANT THAT THEY HAVE READ THE AGREEMENT, UNDERSTAND IT, AND ARE AUTHORIZED TO EXECUTE IT ON BEHALF OF THEIR RESPECTIVE PRINCIPALS OR CO-OWNERS. THIS AGREEMENT BECOMES NULL AND VOID UPON TRANSFER OF ASSETS; CHANGE OF OWNERSHIP; OR UPON DISCOVERY BY AHCA OF THE SUBMISSION OF A MATERIALLY INCOMPLETE, MISLEADING OR FALSE PROVIDER APPLICATION UNLESS SUBSEQUENTLY RATIFIED OR APPROVED BY AHCA.

ALL PRINCIPALS, PARTNERS AND SHAREHOLDERS HAVING AN OWNERSHIP INTEREST OF FIVE PERCENT (5%) OR GREATER ARE REQUIRED TO SIGN THIS AGREEMENT. FAILURE TO DO SO WILL MAKE THIS APPLICATION, AGREEMENT AND PROVIDER NUMBER VOIDABLE BY AHCA.

|                         |       |
|-------------------------|-------|
| FOR OFFICE USE ONLY     |       |
| The provider's name is: | _____ |
| The facility's name is: | _____ |
| The provider number is: | _____ |

IN WITNESS WHEREOF, the undersigned have caused this agreement to be duly executed under the penalties of perjury, swear or affirm that the foregoing is true and correct.

\_\_\_\_\_  
Signature of Provider                      Date

\_\_\_\_\_  
(legibly print the above signature) Title

\_\_\_\_\_  
Signature of Provider                      Date

\_\_\_\_\_  
(legibly print the above signature) Title

\_\_\_\_\_  
Signature of Provider                      Date

\_\_\_\_\_  
(legibly print the above signature) Title

\_\_\_\_\_  
Signature of Provider                      Date

\_\_\_\_\_  
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Signature of Provider                      Date

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Signature of Provider                      Date

\_\_\_\_\_  
(legibly print the above signature) Title

\_\_\_\_\_  
Signature of Provider                      Date

\_\_\_\_\_  
(legibly print the above signature) Title

\_\_\_\_\_  
Signature of Provider                      Date

\_\_\_\_\_  
(legibly print the above signature) Title

\_\_\_\_\_  
Signature of Provider                      Date

\_\_\_\_\_  
(legibly print the above signature) Title

\_\_\_\_\_  
Signature of Provider                      Date

(USE ADDITIONAL PAGES IF NECESSARY)

**STATE OF FLORIDA  
AGENCY FOR HEALTH CARE ADMINISTRATION  
MEDICAID PROVIDER BOND**

SURETY BOND      BOND NO.:

KNOW ALL MEN BY THESE PRESENTS THAT \_\_\_\_\_ (provider name) of \_\_\_\_\_ (provider business name), City of \_\_\_\_\_, County of \_\_\_\_\_, State of \_\_\_\_\_, as principal, and \_\_\_\_\_ (surety name), a corporation organized and existing under the laws of the State of \_\_\_\_\_, with a place of business at \_\_\_\_\_ (surety address), City of \_\_\_\_\_, County of \_\_\_\_\_, State of \_\_\_\_\_, and licensed to transact a surety business in the State of Florida, as surety, are indebted to the State of Florida, Agency for Health Care Administration (AHCA), in the penal sum of Fifty Thousand Dollars (\$50,000), for which payment principal and surety bind ourselves and our legal representatives and successors, jointly and severally.

The condition of this obligation is that principal is a Medicaid provider as defined in §409.901(11), Florida Statutes (Fla. Stat.), and is required by the Agency, pursuant to §409.907(5), Fla. Stat., to post a surety bond in the amount of \$50,000 to insure compliance with the attached provider agreement, pursuant to §409.907, Fla. Stat.

If principal and all of principal's agents and employees faithfully conform to and abide by the provisions of the above statute, implementing regulations and bulletins, together with all amendatory and supplementary acts, now and hereafter enacted, and if principal honestly and faithfully applies funds received, and faithfully and honestly performs all obligations and undertakings made pursuant to the provisions of such statute in the conduct of providing Medicaid services by principal and by principal's agents and employees, then this obligation shall be null and void; otherwise, it shall be in full force and effect.

1. The total aggregate liability of the surety shall be limited to the sum of \$50,000 Dollars.
2. This bond and the obligation under the bond shall be deemed to run continuously, and shall remain in full force and effect for one year until and unless the bond is terminated and canceled in the manner provided, the Medicaid provider agreement expires, or as otherwise provided by law.
3. The Agency, acting through the Director, reserves the right, at any time, to terminate this bond, except as to any liability already incurred or accrued, by written notice of such termination to the surety delivered or mailed by certified or registered mail. On expiration of the period designated in such notice, which period shall be not less than sixty (60) days from the time the notice was mailed, this bond shall terminate and be of no further force or effect except as to any liability incurred or accrued prior to such termination.
4. Surety reserves the right to terminate this bond at any time, such termination to be effected by surety's giving sixty (60) days written notice, including reason, by certified or registered mail to: The principal and State of Florida, Agency for Health Care Administration, Medicaid Program Development, Post Office Box 12600, Tallahassee, Florida 32317-2600. The liability of surety on this bond shall cease sixty (60) days after receipt of the termination notice by Agency and principal, or on the filing and acceptance of a new bond whichever first occurs; and the bond shall terminate and be of no further force or effect, except as to any liability, debt, or other obligation incurred or accrued prior to the effective date of such termination. The principal insured under the bond shall, within thirty (30) days of the filing of the notice of termination, provide the Agency with a replacement bond.
5. In the event principal and surety, or either of them, is served with notice of any action brought against principal or surety under this bond, written notice of the filing of such action shall be immediately given by principal or surety, as each is served with notice of the action to: The State of Florida, Agency for Health Care Administration, General Counsel's Office, Post Office Box 12600, Tallahassee, Florida 32317-2600.
6. In the event any actions or proceedings are initiated with respect to this bond, the parties agree that the venue shall be Leon County, State of Florida.
7. Should any proceedings be necessary to enforce this bond, AHCA shall be allowed to recover an attorney fees, in addition to other sums found due.

8. It is agreed that this bond shall be governed by and construed in accordance with the laws of the State of Florida.

9. Neither this bond nor the obligation of this bond, nor any interest in the bond, may be assigned without the prior, express, and written consent of surety.

10. No right of action shall accrue on account of this bond for the use or benefit of any individual, partnership, corporation, or other entity, other than AHCA.

The premium for which this bond is written is \_\_\_\_\_ Dollars (\$\_\_\_\_\_).

In witness whereof, each party to this bond has caused it to be executed at the place and on the date indicated below.

MEDICAID PROVIDER

SURETY COMPANY

\_\_\_\_\_  
Principal Representative

\_\_\_\_\_  
Surety Company's Representative  
(address)

SIGNED and SEALED in the presence of:

\_\_\_\_\_  
Witness

\_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_

By: \_\_\_\_\_  
President

By: \_\_\_\_\_  
Secretary

Executed at \_\_\_\_\_, Florida, this \_\_\_\_ day of \_\_\_\_\_,  
19\_\_\_\_\_.

By: \_\_\_\_\_  
Florida Resident Agent of Surety Company

(Note: Attach to this Bond a properly certified copy of the Agent's Power of Attorney.)

**Medicaid Provider Services  
On-Site Review Checklist  
Durable Medical Equipment (DME)**

Provider Name \_\_\_\_\_

Full Business Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Medicaid Provider # \_\_\_\_\_ Medicare Provider # \_\_\_\_\_

Federal Tax I.D. # \_\_\_\_\_ Business Telephone (Area Code)/Number \_\_\_\_\_

**SITE INSPECTION FOR SUPPLIER LOCATION**

**Purpose:** This inspection is for the State of Florida Medicaid. The purpose of these visits will be to verify that the providers business is fully operational and meets the standards for a DME provider. During the site visits, photographs of the business will be taken on an as needed basis to be used as proof of compliance or non-compliance with supplier standards. Our customer, State of Florida, will use this data to assist with validation of providers.

1. Date and time of visit. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_/\_\_\_\_ AM PM (circle one)  
 Second Visit Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_/\_\_\_\_ AM PM (circle one)  
 Third Visit Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_/\_\_\_\_ AM PM (circle one)

2. Make sure you interview an authorized representative of this business. Make sure you indicate whom you have interviewed. \_\_\_\_\_

Telephone #, if not shown above (\_\_\_\_) - \_\_\_\_\_

3. Is the location an appropriate site (i.e. not a drop box or answering service)? YES \_\_\_\_ NO \_\_\_\_  
 If no, please explain and provide photo \_\_\_\_\_

Do they share space with other suppliers or other businesses? YES \_\_\_\_ NO \_\_\_\_ If they share space with other suppliers or businesses, list them. \_\_\_\_\_

4. Do they have an inventory or contracts to purchase equipment or supplies? YES \_\_\_\_ NO \_\_\_\_  
 If no, please explain \_\_\_\_\_

Ask them to show you their contract and obtain a copy of this contract.

Ask them where the equipment is located. \_\_\_\_\_  
 If equipment is stored off site, ask them to see this location at time of your visit. Comment regarding this secondary location \_\_\_\_\_

5. Are the staff members knowledgeable about the DME (Durable Medical Equipment) business? YES \_\_\_\_ NO \_\_\_\_ If no, please explain \_\_\_\_\_

6. Does the supplier have records that include certificates of medical necessity, prescriptions from the ordering physician, and delivery receipts? Ask the supplier to show these records. If they refuse or they have none available, document in your report YES \_\_\_\_ NO \_\_\_\_ If no, please explain \_\_\_\_\_

DME cont.

7. Does the supplier have valid license as applicable to their business in the office? If this license is not posted, comments in the section below. YES\_\_\_ NO\_\_\_ Obtain copy of Current Occupational License for this business address. If no, please explain below.

8. Does the supplier provide oxygen? YES\_\_\_ NO\_\_\_ If yes, obtain copy of current Medical Oxygen Retailer License FOR THE CURRENT BUSINESS ADDRESS (it is issued by the Department of Health and Rehabilitative Services). YES\_\_\_ NO\_\_\_

9. If the supplier provides oxygen or oxygen equipment, is there a Registered Respiratory Therapist, Registered Nurse, or Certified Respiratory Therapy Technician on staff or under contract? Obtain copy of the contract and/or the 1099 if the therapist is contracted, or a copy of the W4 if employed by them. If on staff, also obtain copy of their license. Check off items obtained below.

Copy of License \_\_\_; Copy of Contract \_\_\_; Copy of W4 \_\_\_;  
Copy of 1099 \_\_\_

If neither obtained, indicate name of therapist, whether employee or contractor and why documentation not obtained? \_\_\_\_\_

10. Does the provider bill both Medicaid and Medicare? Check one block below

Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Both Medicare and Medicaid \_\_\_\_\_

11. Is there a copy of information provided to patients that contains a business telephone number and instructions for after hours contact? YES\_\_\_ NO\_\_\_ If so, obtain a copy \_\_\_\_\_

Based on the site visit, this provider appears to be a viable business? YES\_\_\_ NO\_\_\_

I.N. \_\_\_\_\_

**Medicaid Provider Services  
On-site Review Checklist  
DME**

Provider Number \_\_\_\_\_  Applicant OR  Current Provider

Provider Name \_\_\_\_\_

Provider Address \_\_\_\_\_

Medicaid Area Office # \_\_\_\_\_

On-site visit date(s) being reviewed: \_\_\_\_\_

Previous on-site review dates: \_\_\_\_\_

| Yes | No | Medicaid Requirement   |
|-----|----|--|
|     |    | Business was open  |
|     |    | Inventory available  |
|     |    | Patient records available  |
|     |    | Copy of current occupational license for the current business address  |
|     |    | Copy of current retail oxygen license from the Department of Health, Pharmacy Services for the current business address  |
|     |    | Evidence that qualified professionals are providing oxygen services.   |
|     |    | <input type="checkbox"/> Federal W4 = employed by provider   |
|     |    | <b>OR</b>  |
|     |    | <input type="checkbox"/> yes <input type="checkbox"/> no--Contract with RRT, CRTT or RN included?<br>or <input type="checkbox"/> n/a because owner is a RRT, CRTT or RN.   |
|     |    | If yes, then does the contract include all the following elements?   |
|     |    | <input type="checkbox"/> yes <input type="checkbox"/> no--Written  |
|     |    | <input type="checkbox"/> yes <input type="checkbox"/> no--Dated  |
|     |    | <input type="checkbox"/> yes <input type="checkbox"/> no--Signed by both parties   |
|     |    | <input type="checkbox"/> yes <input type="checkbox"/> no--Term of contract specified   |
|     |    | <input type="checkbox"/> yes <input type="checkbox"/> no--Consideration to be paid specified   |
|     |    | <input type="checkbox"/> yes <input type="checkbox"/> no--Consideration is responsibility of contracting parties language  |
|     |    | <input type="checkbox"/> yes <input type="checkbox"/> no--"Oxygen and Oxygen Related Equipment" language   |
|     |    | <b>AND</b>   |
|     |    | <input type="checkbox"/> Copy of current license of registered respiratory therapist (RRT), certified respiratory therapy technician (CRTT) or registered nurse (RN) belonging to the owner, staff or person under contract to provider oxygen services. |

Approved  Approval Memo to Unisys - dated \_\_\_\_\_  
 Not Approved  Termination/Denial Letter to Provider - dated \_\_\_\_\_  
 Reviewer \_\_\_\_\_ Review Date \_\_\_\_\_  
 Additional Information Received \_\_\_\_\_  
 Approved  Approval Memo to Unisys - dated \_\_\_\_\_  
 Not Approved  Termination/Denial Letter to Provider - dated \_\_\_\_\_  
 Reviewer \_\_\_\_\_ Review Date \_\_\_\_\_



JEB BUSH, GOVERNOR

RUBEN J. KING-SHAW, JR., EXECUTIVE DIRECTOR

July 1, 2000

Dear Medicaid Provider:

It is time for you to re-enroll as a Medicaid provider. Enclosed is a Profile Verification that reflects your current Medicaid provider information. If you have more than one Medicaid provider number, at the appropriate time you will receive a Profile Verification for each number. *You must re-enroll each provider number.* Please follow all instructions carefully, and be sure to include any additional required documentation.

**If you do not return the completed Profile Verification within 60 days from the date of this letter, the Agency will be forced to terminate your Medicaid provider number** as required by Chapter 59G-5 of the Florida Administrative Code. *I highly recommend mailing the completed packet within 45 days* to allow time for mailing and processing.

The re-enrollment process is one of the ways we are able to eliminate fraud and abuse in the Medicaid program. I certainly understand that, at best, the process is an inconvenience for you, and I appreciate your cooperation, understanding and assistance, just as I appreciate the service you provide to our Medicaid members.

If you have any questions, please call the Consultec Enrollment Unit at 1-800-377-8216 for assistance. I look forward to continuing our work together.

Sincerely,

Gary Crayton  
Deputy Director for Medicaid

Enclosures



**Florida Medicaid Re-enrollment  
Facility Profile Verification**

**SAMPLE**

This is the information as it appears in your Provider File as of mm/dd/yyyy.  
Please review and update if necessary using the space provided.

|  |   |   |
|--|---|---|
| <b>Provider Number and Type</b>                      | 9999999999  | Transportation  |
| <b>Provider Name</b>                                 | Medical Associates, P.A.  | _____   |
| <b>Doing Business As Name</b>                        | Medical Pros  | _____   |
| <b>Business Address</b><br>(P.O. Boxes not accepted) | 123 Main Street<br>Suite 200<br>Tallahassee, FL 32301                   | <input type="checkbox"/> One or more of my addresses have changed. Please send a serialized Change of Address form to the address below:<br>_____<br>_____<br>_____ |
| <b>Payment Address</b>                               | Medical Pros Billing<br>P. O. Box 1234<br>Tallahassee, FL 32301-1234    |   |
| <b>Correspondence Address</b>                        | Medical Pros Administration<br>123 Main Street<br>Tallahassee, FL 32301 |   |
| <b>County of Operation</b>                           | Leon  |   |
| <b>Telephone Number</b>                              | 850-222-1111  | _____   |
| <b>Tax ID Number</b>                                 | 99-9999999  | _____   |
| <b>Payment Method</b>                                | E = Electronic  | (Attach a copy of SS-4)<br><b>If M = Mail, you must include a completed EFT agreement.</b>  |

**Background Screening**

It is the responsibility of the provider to know the provisions of Section 409.907, Florida Statutes, and to be certain that the names and appropriate identifying information for all provider personnel on whom criminal history checks are required are submitted with this Profile Verification. Please list below all partners or shareholders with ownership interest of five percent or more and all officers, directors, billing agents, and managers of this business. Use an additional sheet if necessary.

| Print Each Name | SSN   | License # | % Own | Previous Background Screening Completed? |
|-----------------|-------|-----------|-------|--|
| _____           | _____ | _____     | _____ | Yes No                                   |
| _____           | _____ | _____     | _____ | Yes No                                   |
| _____           | _____ | _____     | _____ | Yes No                                   |
| _____           | _____ | _____     | _____ | Yes No                                   |

**SAMPLE**

**Verification:**

- Yes**  **No** Have all managers, billing agents, officers, directors and principle owners (five percent or more) of this business submitted fingerprints within the last 12 months for background screening as outlined in Section 409.907, Florida Statutes? **If not then submit a completed fingerprint card with a check for \$39 made payable to Consultec for each person. Include these cards and checks with your Profile Verification.**
- Yes**  **No** Do you provide services using a fully operational physician vehicle, unit, trailer or office that travels to different locations for the provision of physician services and is not a stationary physician unit or office? **If yes, please attach a copy of your contract with a county health department, federally qualified health center, or rural health clinic and return with your Profile Verification.**
- Yes**  **No** Have you attached proof of current bond coverage? **This applies only to DME and Home Health Agency providers.**
- Yes**  **No** Has this facility had a change in ownership? **If yes, give the date of change in ownership.** \_\_\_\_\_
- Check here if...**all partners or shareholders with ownership interest of five percent or more and all officers, directors, billing agents, and managers have signed the enclosed Medicaid Provider Agreement. **Please submit the original signed document with your Profile Verification.**

I have reviewed this information and have made any necessary updates. I understand that it is my responsibility to notify Medicaid's fiscal agent of any change to the information in my provider file, including but not limited to, a change of address, group affiliation, ownership, officers, directors, or tax identification number. All attachments required to update my file are included with this re-enrollment packet.

I further understand that under Section 409.920(2)(f), Florida Statutes, the filing of materially incomplete or false information with this re-enrollment verification is a third degree felony and is sufficient cause for termination from the Florida Medicaid Program.

\_\_\_\_\_  
Authorized Agent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of signatory above

\_\_\_\_\_  
Title

**The Final Step:**

Mail your re-enrollment packet and any required attachments to the address below. If you have any questions, please call the Consultec Enrollment Unit at 800-377-8216.

CONSULTEC  
Provider Enrollment  
P. O. Box 15800  
Tallahassee, FL 32317-3800

**Florida Medicaid Re-enrollment  
Individual Profile Verification**

**SAMPLE**

This is the information as it appears in your Provider File as of mm/dd/yyyy.  
Please review and update if necessary using the space provided.

|  |   |   |
|--|---|---|
| <b>Provider Number and Type</b>                      | 999999999   | Transportation  |
| <b>Provider Name</b>                                 | Medical Associates, P.A.  |   |
| <b>Business Address</b><br>(P.O. Boxes not accepted) | 123 Main Street<br>Suite 200<br>Tallahassee, FL 32301                   | <input type="checkbox"/> One or more of my addresses have changed. Please send a serialized Change of Address form to the address below:<br>_____<br>_____<br>_____ |
| <b>Payment Address</b>                               | Medical Pros Billing<br>P. O. Box 1234<br>Tallahassee, FL 32301-1234    |   |
| <b>Correspondence Address</b>                        | Medical Pros Administration<br>123 Main Street<br>Tallahassee, FL 32301 |   |
| <b>County of Operation</b>                           | Leon  |   |
| <b>Telephone Number</b>                              | 850-222-1111  |   |
| <b>Payment Method</b>                                | E = Electronic  | <input type="checkbox"/> If M = Mail, you must include a completed EFT agreement or EFT Exception form.   |
| <b>Group Affiliation(s)</b>                          | (Limit of 15)   |   |
|  | 111111111                      222222222                                | 333333333   |
|  | 444444444                      555555555                                |   |
| _____  | _____   | _____   |
| _____  | _____   | _____   |
| _____  | _____   | _____   |

**Social Security Number (SSN) or Tax ID Number:** 123-45-6789 \_\_\_\_\_  
 If this number is incorrect, you must provide proof of correct SSN or, if individually incorporated, provide a copy of SS-4 issued *in your name only*.

See Verification section on next page. Signature is required.

**SAMPLE**

**Verification:**

- Yes**  **No** Have you submitted fingerprints for background screening within the last 12 months as outlined in Section 409.907, Florida Statutes? **If not then submit a completed fingerprint card and a check for \$39 made payable to Consultec with your Profile Verification.**
- Yes**  **No** Do you provide services using a fully operational physician vehicle, unit, trailer or office that travels to different locations for the provision of physician services and is not a stationary physician unit or office? **If yes, please attach a copy of your contract with a county health department, federally qualified health center, or rural health clinic and return with your Profile Verification.**
- Check here if...** you signed and dated the enclosed Medicaid Provider Agreement? **Please submit the original signed document with your Profile Verification.**

I have reviewed this information and have made any necessary updates. I understand that it is my responsibility to notify Medicaid's fiscal agent of any change to the information in my provider file, including but not limited to, a change of address, group affiliation, ownership, officers, directors, or tax identification number. All attachments required to update my file are included with my Profile Verification.

I further understand that under Section 409.920(2)(f), Florida Statutes, the filing of materially incomplete or false information with this re-enrollment verification is a third degree felony and is sufficient cause for termination from the Florida Medicaid Program.

\_\_\_\_\_  
Provider's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of signatory above

\_\_\_\_\_  
Title

**The Final Step:**

Mail your re-enrollment packet and any required attachments to the address below. If you have any questions, please call the Consultec Enrollment Unit at 800-377-8216.

CONSULTEC  
Provider Enrollment  
P. O. Box 13800  
Tallahassee, FL 32317-3800

ONE HUNDRED SIXTH CONGRESS

|   |  |
|---|--|
| TOM BLUYEV, VIRGINIA<br>J. J. BULLY, TEXAS<br>MICHAEL G. ONLEY, OHIO<br>MICHAEL BURKES, FLORIDA<br>JOE BARTON, TEXAS<br>FRED UPTON, MICHIGAN<br>JEFF SESSIONS, ALABAMA<br>PAUL B. DUNN, OHIO<br>JAMES C. GIBSON, TEXAS<br>CAR STROMER, CALIFORNIA<br>VAHARA DIAL, GEORGIA<br>STEVE LARGENT, OKLAHOMA<br>RICHARD BERRY, NORTH CAROLINA<br>BRIAN P. BILIRAY, CALIFORNIA<br>ED WHITFIELD, KENTUCKY<br>ORES GAMBRE, OHIO<br>CHARLIE NORWOOD, GEORGIA<br>TONYA COLEMAN, OKLAHOMA<br>RICK LAZIO, NEW YORK<br>BARBARA CLIBURN, WYOMING<br>JAMES E. ROGAY, CALIFORNIA<br>JOHN SHIMMUS, ILLINOIS<br>HEATHER VOLESKY, ILLINOIS<br>JOHN B. SHADDOX, ARIZONA<br>CHARLES W. TOOF, MISSISSIPPI<br>VITO FOSSELLA, NEW YORK<br>ROY BLUNT, MISSOURI<br>ED BRYAN, TENNESSEE<br>ROBERT L. ENGLISH, JR., OREGON | DONALD GARDNER, MICHIGAN<br>HENRY A. HARTMAN, CALIFORNIA<br>EDWARD J. MARKEY, MASSACHUSETTS<br>RICHARD M. ROBERTS, TEXAS<br>RICK SCOTT, ARIZONA<br>ED LAPHAM, TEXAS<br>FRANK RALPH, TEXAS<br>SUSANNE BRIDGES, OHIO<br>BART GORDON, TENNESSEE<br>PETER DEUTSCH, FLORIDA<br>BOBBY L. RUSH, ILLINOIS<br>JONAS S. BEARD, CALIFORNIA<br>RON KLARK, PENNSYLVANIA<br>BERT STURAK, MICHIGAN<br>ELIOT ENGEL, NEW YORK<br>THOMAS E. SAWYER, OHIO<br>ALBERT R. WYNN, MARYLAND<br>GENE GREEN, TEXAS<br>KAREN HILGERT, MISSOURI<br>TED STRICKLAND, OHIO<br>DIANA GILLETTE, COLORADO<br>THOMAS M. BARNETT, VIRGINIA<br>BILL LUTHER, MINNESOTA<br>LOS CAMPS, CALIFORNIA |
|---|--|

U.S. House of Representatives  
 Committee on Commerce  
 Room 2125, Rayburn House Office Building  
 Washington, DC 20515-6115

June 22, 2000

JAMES E. DERDEPIAN, CHIEF OF STAFF

Ms. Jaqueline Romer-Sensky  
 Director  
 Ohio Department of Human Services  
 Rhodes Tower  
 30 East Broad Street, 32nd Floor  
 Columbus, Ohio 43266-0423

Dear Ms. Romer-Sensky:

I write to you today to learn what actions the State of Ohio has taken to prevent fraud in its Medicaid program, and specifically what efforts are being made to review the enrollment of new providers to screen out individuals with potentially questionable backgrounds.

As you may know, the Committee on Commerce is responsible for overseeing the Medicaid program, which finances health care services for more than forty million Americans. During my tenure as Chairman of the Committee, I have been particularly concerned about the effectiveness of the current efforts being made to detect and combat fraud and abuse within the program. In response to these concerns, the Committee has held hearings that focused on what the Federal government, States and the private sector are doing to combat this growing problem. In addition, I have requested that the General Accounting Office undertake a major survey of the state of current efforts to curb fraud and abuse in this important program.

The Committee's investigation into these issues has revealed that, in many instances, very basic safeguards against fraud are not being effectively employed. One such safeguard, which has demonstrated a capacity to significantly deter fraud, is the utilization of rigorous provider controls. Such fraud controls can be used to screen and identify potentially questionable providers, before they are able to submit false claims to a State Medicaid program. Rigorous provider controls, utilizing site visits and background checks can identify applicants with lengthy criminal records, businesses that lack basic equipment and patient information and alleged provider offices that operate exclusively out of post office boxes.

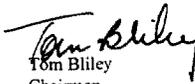
In the limited number of instances where provider controls have been used in government funded health care programs, disturbing patterns of potential fraud were revealed. The Office of Inspector General (OIG) at the Department of Health and Human Services reported in 1997 that a review of applicants seeking to become durable medical equipment suppliers for the Medicare program revealed that eleven percent of the applicants lacked a required physical address and forty percent of the applicants failed to satisfy at least one of the basic qualifications necessary to become a Medicare provider. As a result of this survey, the OIG concluded that additional enrollment review procedures, including on-site verification of application information was necessary to deter fraud. Similar results were also uncovered by contractors working with certain State Medicaid agencies to review applicants seeking to become new Medicaid providers.

In order to better assess the effectiveness of current efforts to control fraud in the Medicaid program and identify potential solutions for this growing problem, I request, pursuant to Rules X and XI of the U.S. House of Representatives, that you provide the following information no later than June 30, 2000:

1. Please identify what efforts are being taken to verify the qualifications of providers applying to enroll in the Medicaid program.
2. Please identify whether a criminal background check, and specifically a review of prior criminal convictions, is performed prior to allowing a provider to enroll in the Medicaid program.
3. Please identify whether site visits to a provider's place of business are used to independently verify the validity of enrollment information supplied by an applicant.
4. Please identify what efforts are made to assess the level of potential threat of fraud posed by particular types of health care provider (e.g. durable medical equipment supplier, home health agency operator, etc.), and whether provider enrollment control efforts are ever tailored to focus on areas that are identified as potentially posing the greatest risk.
5. Please identify whether providers, once enrolled in the Medicaid program, are ever subject to regularly scheduled reviews of their qualifications.
6. Please identify what actions are taken to cancel or suspend the billing number of a provider who has not submitted a bill to Medicaid for a specific period of time.
7. Please identify what efforts have been made to utilize non-government contractors to verify the qualifications of providers applying to enroll in the Medicaid program.

If you should have any questions, please contact Mr. Charles Clapton, Committee Counsel, at (202) 226-2424. I appreciate your cooperation in this matter.

Sincerely,

  
Tom Bliley  
Chairman

cc: The Honorable John D. Dingell  
Ranking Minority Member

Bob Taft  
Governor



Jacqueline Romer-Sensky  
Director

Ohio Department of Human Services  
32 East Broad Street, Columbus, Ohio 43260-2221

July 11, 2000

The Honorable Tom Bliley, Chairman  
Committee on Commerce  
U.S. House of Representatives  
Room 2125, Rayburn House Office Building  
Washington, DC 20515-6115

Dear Chairman Bliley:

I am responding to your letter of June 22, 2000 requesting information about fraud prevention activities in the State of Ohio's Medicaid program, especially around provider enrollment. Your letter listed seven specific questions that you wanted information about.

Before responding to your specific questions I want to take a moment to lay out Ohio's general approach to running its Medicaid program, including the issue of program integrity. Ohio's vision is to act as a value purchaser in the marketplace, accountable to consumers and taxpayers.

Ohio's value purchasing strategy focuses on balancing the issues of access to care, quality of care, and cost. This strategy involves us focusing intensely on issues affecting consumers, performance, and information.

We must ensure that our consumers have access to quality health care services. We also have a need to ensure our program is as friendly and easy to participate in as possible for our consumers. At the same time, we want to meet the needs of our consumers in as cost effective a manner as possible to provide the greatest value for each dollar invested in this health plan by Ohio's taxpayers.

Program integrity is a critical component of our accountability. Ohio understands and appreciates the importance of employing effective controls and strategies to minimize the risk of fraud and abuse. Ohio has an active Surveillance and Utilization Review (SURS) unit and a Provider Enrollment unit within its Medicaid program. Ohio also has an active Auditor of State (AOS) section that focuses on Medicaid issues and a Medicaid Fraud and Control Unit (MFCU) in its Attorney General's Office.



An Equal Opportunity Employer

The Honorable Tom Bliley  
July 11, 2000  
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Our SURS unit and the AOS section conduct numerous provider audits each year. Many of these audits come about as the result of individual provider profiling. Some are generated based on overall provider type profiling, focusing on areas where we anticipate there may be greater risk of fraud and abuse activities occurring. Findings from these audits help us to decide if we need any changes in policy and in reviewing the impact of recent policy changes that affect provider behavior.

Ohio Medicaid staff have been a member of the HCFA Fraud and Abuse Control technical assistance group (TAG) since its inception. This participation allows us to learn about best practices from other states. It also allows us to share our experiences with our peers.

Ohio Medicaid is continually looking at ways that we can improve our program integrity functions. We are focusing renewed attention to our relations with our providers, seeking to develop an effective strategy that facilitates both program integrity and quality improvement.

In addition, we have just finished a Request for Information process to hear from vendors who have decision support tools that could help us in multiple areas, such as SURS, provider profiling, and disease management. Staff are now developing a white paper and an RFP around purchasing such tools. We are hopeful to be able to obtain new, state-of-the-art tools to enhance our decisionmaking, quality improvement, and program integrity functions.

While we understand and do focus on program integrity as a key function of a health plan, we also experience the day-to-day reality that comes with balancing program integrity and other functions. We have many areas of our state that have a limited pool of providers of one or more types of health care services. We need to make sure that we do not establish an unnecessarily burdensome program integrity process that drives away good providers from participating in the program.

We also want to make sure that the provider-focused strategies that we employ help us with our quality agenda. Given that our ultimate customer is the consumer, our goal is to identify provider enrollment and ongoing network management strategies that foster improved quality care and assured access for our consumers.

With regards to your specific questions around provider enrollment and monitoring functions, our responses follow.

**Question 1. Please identify what efforts are being taken to verify the qualifications of providers applying to enroll in the Medicaid program.**

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Ohio recently revised its provider application form to include disclosure and ownership/control interest questions. Applicants working in a licensed area must include current copies of license and license renewal documents with the enrollment application. Ohio does not allow P.O. and drop boxes for the provider's physical and mailing addresses.

Ohio tries to assess the status of providers before enrolling them on the program. This effort is easier to pursue for providers who work in areas that require licensure, certification, or accreditation. For instance, Medicaid's provider network management staff contact the following license boards via phone and/or web sites to verify the applicant's license:

- Medical.
- Psychology.
- Optometry.
- Dental.
- Physical Therapist.
- Chiropractic.
- Ambulance.
- Nursing, and
- EMT.

Provider relations staff access information from different sources to verify license, accreditation, or Medicare status and to check on sanction status, including:

- Medical Boards web sites for Arizona, California, Colorado, Florida, Georgia, Iowa, Kansas, Maine, Massachusetts, Minnesota, Nebraska, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, and Vermont.
- The OIG Sanction List web site at: <http://www.dhhs.gov/progorg/oig/cumsan/>.
- HCFA's OSCAR file to verify CLIA lab certifications.
- A current copy of Medicare's certification letter, for those provider types requiring Medicare certification.
- A copy of the certification of accreditation, for those provider types requiring accreditation.

Ohio has also applied for access to the National Provider Data Bank.

Finally, Ohio once required that home health agencies maintain surety bonds. Ohio established this requirement because Medicare had such a requirement. Ohio ended this requirement at the time that Medicare decided the requirement was no longer needed for this provider type.

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**2. Please identify whether a criminal background check, and specifically a review of prior criminal convictions, is performed prior to allowing a provider to enroll in the Medicaid program.**

In 1997, Ohio enacted state law requiring that employees who have hands-on contact with our most vulnerable populations, such as home health workers or nursing home staff, undergo a criminal background check before being hired. The responsibility for this background check lies on the employer of the employee. Ohio's Medicaid program requires that independent providers and/or the agency employing staff demonstrate that there has been a criminal background check performed, submitting a copy of that background check as part of their application process.

The provider types where Ohio Medicaid requires confirmation of criminal background checks are:

- 17 - Independent Daily Living Aide
- 18 - Independent Daily Living Non-Aide
- 38 - Independent Home Care Nurse
- 45 - Waiver Provider of Home Delivered Meals, of Minor Home Modifications, Center Based Day Health Service, Supplemental Transportation, Out of Home Respite, Emergency Response Systems
- 76 - Supplemental Adaptive and Assistive Devices for Waiver Consumers

**3. Please identify whether site visits to a provider's place of business are used to independently verify the validity of enrollment information supplied by an applicant.**

Based on findings from our retrospective audit process of provider types, Ohio Medicaid's Surveillance and Utilization Review Section (SURS) & Provider Enrollment units developed an on-site inspection/educational outreach program to monitor Ambulette provider compliance and verify the validity of enrollment information. The field team inspects vehicles, equipment, documentation, licenses and certification requirements. The program includes follow up visits and sanctions.

Ohio Medicaid plans to evaluate the effectiveness of this program and explore expanding this activity to other provider types if the results prove effective.

**4. Please identify what efforts are made to assess the level of potential threat of fraud posed by particular types of health care provider (e.g. DME, home health agency operator, etc.) and whether provider enrollment control efforts are ever tailored to focus on areas that are identified as potentially posing the greatest risk.**

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Ohio has an active program integrity effort that involves the Ohio Medicaid SURS unit, the Auditor of State (AOS), and the Medicaid Fraud Unit in the Office of the Attorney General. The SURS unit tailors its exception profiling system to focus on a category of service or provider types that profile as a high risk potential. These providers are targeted for monitoring, referrals to enforcement and/or licensing agencies, auditing, etc. These reviews serve as one source of information that results in modifications to existing rules or policy or the creation of new rules and policy.

During the past year, Ohio Medicaid SURS and AOS have focused special attention on the ambulette provider type. In the coming year, these two groups plan to put an emphasis on provider audits of the DME provider type. Also, in 1999, AOS did a large program audit of Ohio's Home Care program for the time period of 1995 through 1997. Ohio has reformed its Home Care program, in part, to reduce the opportunity for abuse and improve efficiency in the system.

In addition to provider profiling and retrospective audit, Ohio Medicaid has an active prior authorization requirement for specified medical procedures or requests. These prior authorization requirements include durable medical equipment and medical supplies above the established maximum allowable units for the particular service.

**5. Please identify whether providers, once enrolled in the Medicaid program, are ever subject to regularly scheduled reviews of their qualifications.**

Ohio's Medicaid program does ongoing monitoring of its providers. This review is easier to do for providers who are licensed, certified, or accredited. For these provider types, Ohio Medicaid is able to periodically ascertain the status of the provider's license, certification, or accreditation. For instance, staff conduct a tape matching of medical license status with Ohio's State Medical Board through out the calendar year. The Psychology and Pharmacy Boards also send license status listings which we review and use to update our provider files.

In addition, Ohio Medicaid attempts to keep track of criminal proceedings that are in process against any of our providers. In such cases, staff put a hold/suspend in the system to monitor the claims activity of that specific provider using prepayment review techniques.

**6. Please identify what actions are taken to cancel or suspend the billing number of a provider who has not submitted a bill to Medicaid for a specific period of time.**

During May and June 2000 Ohio Medicaid sent 19,000 letters to providers who were identified as having not submitted a bill to Ohio Medicaid within the past three years. To date, we have received 2,312 responses; 1,207 have requested voluntary termination.

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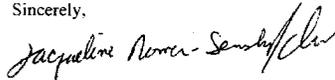
Whenever Ohio Medicaid determines that our system has an incorrect address for a provider, usually through returned mail, staff input a "6 edit" for bad address. This edit preempts claim payment until the provider updates address information.

**7. Please identify what efforts have been made to utilize non-government contractors to verify the qualifications of providers applying to enroll in the Medicaid program.**

Ohio Medicaid contracts with private agencies referred to as Health Service Facilitators (HSFs) in its Home Care program. These HSFs conduct a preliminary review of Ohio Home Care provider applications to serve the home care population. Ohio does not contract with any other vendors to verify qualifications for other providers.

If you require additional information, please contact me.

Sincerely,



Jacqueline Romer-Sensky, Director  
Ohio Department of Job and Family Services

