Y 4
W36
WMCP
95-6
GOVERNMENT
Storage
1028

JOINT COMMITTEE PRINT { WMCP: 95–6

SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS

AND

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE
U.S. HOUSE OF REPRESENTATIVES

Fraud and Abuse in the Medicare and Medicaid Programs



MARCH 3, 1977

Prepared by staff for use by the Subcommittee on Health, House Committee on Ways and Means, and the Subcommittee on Health and the Environment, House Committee on Interstate and Foreign Commerce, with the assistance of the Congressional Research Service, Library of Congress

---

Note.—This document has been printed for informational purposes only. It has neither been considered nor approved by the committees.

U.S. GOVERNMENT PRINTING OFFICE

83-092 WASHINGTON : 1977

AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

COMMITTEE ON WAYS AND MEANS

AL ULLMAN, Oregon, *Chairman*

JAMES A. BURKE, Massachusetts
DAN ROSTENKOWSKI, Illinois
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
JAMES C. CORMAN, California
SAM M. GIBBONS, Florida
JOE D. WAGGONNER, JR., Louisiana
OTIS G. PIKE, New York
J. J. PICKLE, Texas
CHARLES B. RANGEL, New York
WILLIAM R. COTTER, Connecticut
FORTNEY H. (PETE) STARK, California
JAMES R. JONES, Oklahoma
ANDY JACOBS, JR., Indiana
ABNER J. MIKVA, Illinois
MARTHA KEYS, Kansas
JOSEPH L. FISHER, Virginia
HAROLD FORD, Tennessee
KEN HOLLAND, South Carolina
WILLIAM M. BRODHEAD, Michigan
ED JENKINS, Georgia
RICHARD A. GEPHARDT, Missouri
JIM GUY TUCKER, Arkansas
RAYMOND F. LEDERER, Pennsylvania

BARBER B. CONABLE, JR., New York
JOHN J. DUNCAN, Tennessee
BILL ARCHER, Texas
GUY VANDER JAGT, Michigan
WILLIAM A. STEIGER, Wisconsin
PHILIP M. CRANE, Illinois
BILL FRENZEL, Minnesota
JAMES G. MARTIN, North Carolina
L. A. (SKIP) BAFALIS, Florida
WILLIAM M. KETCHUM, California
RICHARD T. SCHULZE, Pennsylvania
BILL GRADISON, Ohio

JOHN M. MARTIN, JR., *Chief Counsel*
J. P. BAKER, *Assistant Chief Counsel*
JOHN K. MEAGHER, *Minority Counsel*

SUBCOMMITTEE ON HEALTH

DAN ROSTENKOWSKI, Illinois, *Chairman*

JAMES C. CORMAN, California
OTIS G. PIKE, New York
CHARLES A. VANIK, Ohio
OMAR BURLESON, Texas
WILLIAM R. COTTER, Connecticut
MARTHA KEYS, Kansas
HAROLD FORD, Tennessee
WILLIAM M. BRODHEAD, Michigan

JOHN J. DUNCAN, Tennessee
PHILIP M. CRANE, Illinois
JAMES G. MARTIN, North Carolina
BILL GRADISON, Ohio

COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

HARLEY O. STAGGERS, West Virginia, *Chairman*

JOHN E. MOSS, California
JOHN D. DINGELL, Michigan
PAUL G. ROGERS, Florida
LIONEL VAN DEERLIN, California
FRED B. ROONEY, Pennsylvania
JOHN M. MURPHY, New York
DAVID E. SATTERFIELD III, Virginia
BOB ECKHARDT, Texas
RICHARDSON PREYER, North Carolina
CHARLES J. CARNEY, Ohio
RALPH H. METCALFE, Illinois
JAMES H. SCHEUER, New York
RICHARD L. OTTINGER, New York
HENRY A. WAXMAN, California
ROBERT (BOB) KRUEGER, Texas
TIMOTHY E. WIRTH, Colorado
PHILIP R. SHARP, Indiana
JAMES J. FLORIO, New Jersey
ANTHONY TOBY MOFFETT, Connecticut
JIM SANTINI, Nevada
ANDREW MAGUIRE, New Jersey
MARTIN A. RUSSO, Illinois
EDWARD J. MARKEY, Massachusetts
THOMAS A. LUKEN, Ohio
DOUG WALGREN, Pennsylvania
BOB GAMMAGE, Texas
ALBERT GORE, JR., Tennessee
BARBARA A. MIKULSKI, Maryland

SAMUEL L. DEVINE, Ohio
JAMES T. BROYHILL, North Carolina
TIM LEE CARTER, Kentucky
CLARENCE J. BROWN, Ohio
JOE SKUBITZ, Kansas
JAMES M. COLLINS, Texas
LOUIS FREY, JR., Florida
NORMAN F. LENT, New York
EDWARD R. MADIGAN, Illinois
CARLOS J. MOORHEAD, California
MATTHEW J. RINALDO, New Jersey
W. HENSON MOORE, Louisiana
DAVE STOCKMAN, Michigan
MARC L. MARKS, Pennsylvania

W. E. WILLIAMSON, *Clerk*
KENNETH J. PAINTER, *Assistant Clerk*
LEWIS E. BERRY, *Minority Counsel*

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

PAUL G. ROGERS, Florida, *Chairman*

DAVID E. SATTERFIELD III, Virginia
RICHARDSON PREYER, North Carolina
JAMES H. SCHEUER, New York
HENRY A. WAXMAN, California
JAMES J. FLORIO, New Jersey
ANDREW MAGUIRE, New Jersey
EDWARD J. MARKEY, Massachusetts
RICHARD L. OTTINGER, New York
DOUG WALGREN, Pennsylvania
HARLEY O. STAGGERS, West Virginia
(Ex Officio)

TIM LEE CARTER, Kentucky
JAMES T. BROYHILL, North Carolina
EDWARD R. MADIGAN, Illinois
JOE SKUBITZ, Kansas
SAMUEL L. DEVINE, Ohio (Ex Officio)

CONTENTS

	Page
Introduction	1
I. Disclosures of fraud and abuse in particular settings	2
A. Shared health facilities	2
B. Clinical laboratories	4
C. Nursing homes	7
D. Prepaid health plans (HMO's)	11
E. Independent practitioners	13
F. Pharmacies	15
II. Fraud and abuse control activities of the Department of Health, Education, and Welfare	15
A. General	15
B. Medicare	16
C. Medicaid	17
D. Inspector General	19

FRAUD AND ABUSE IN THE MEDICARE AND MEDICAID PROGRAMS

Introduction

In recent years, numerous hearings, studies, and investigations, undertaken by the Congress and by others, have demonstrated that there is considerable provider fraud and abuse associated with the provision of health services financed by the medicare and medicaid programs. It is the purpose of this document to catalog some of the dimensions and scope of such activities in each of the two programs. This document also describes administrative tools now available to the Department of Health, Education, and Welfare to deal with fraud and abuse in medicare and medicaid.

At the outset, three caveats should be stated relating to the preparation of this document. First, though recipient fraud does exist, it is usually associated with a misrepresentation of personal circumstances in order to secure program eligibility or entitlement, and is more appropriately considered in that context. Second, this document is not designed to be a complete catalog of fraud and abuse in the Federal health financing programs. It merely summarizes the results of significant oversight and investigative activities by congressional committees and others in this area. Just as the contents of this document should not be construed as an indictment of every clinical laboratory or shared health facility operating in an urban setting, neither should omissions from it be construed to exempt from review every hospital, home health agency, fiscal agent, or subcontractor, who, although an integral part of the medicare and medicaid programs, are omitted from this report. Oversight and investigative activities in these areas have either yet to be undertaken in any significant detail or are presently underway with no conclusive findings publicly available to date. Finally, in detailing the types of wrongdoing that have been revealed, it is important to stress that stricter administrative enforcement of existing statutes and regulations might well be the best way to address many of the problems that are summarized in the following pages. Other problems might best be approached by changes in existing law. This preliminary summary does not attempt to draw distinctions in this regard.

Fraud involves an intentional deception or misrepresentation, with the intent of receiving some unauthorized benefit for the individual engaged in fraud. In the health area, examples of fraud may include: billing for services not rendered, misrepresentation of services rendered, kickbacks, deliberate duplicate billing, false or misleading entries on cost reports, and so forth. Providers engaged in fraudulent activities are subject to criminal penalties under present law.

Program abuse is less clearly defined and includes activity wherein providers, practitioners, and suppliers of services operate in a manner inconsistent with accepted, sound medical or business practices resulting in excessive and unreasonable financial cost to either medicare or medicaid. Included in the area of abuse are the provision of unnecessary health services and the provision of necessary care in unnecessarily costly settings. Persons abusing programs such as medicare or medicaid expose themselves to various administrative and legal actions, short of criminal prosecution, such as recovery of funds paid and exclusion from program participation.

I. Disclosures of Fraud and Abuse in Particular Settings

A. SHARED HEALTH FACILITIES

Many of the more flagrant examples of fraud and abuse activities have been uncovered in so-called "shared health facilities," also referred to as medicaid "mills." Typically, these are unregulated, unlicensed, and poorly equipped storefront units located in ghetto areas of large metropolitan cities. Such mills derive their primary business from welfare patients.

In 1976, the Senate Special Committee on Aging, Subcommittee on Health and Long-Term Care, conducted an extensive investigation of such facilities in New York City. The results of this examination were presented in a subcommittee staff report. [1]

Mills were characterized as "holes-in-the-wall." Their highly visible exteriors set them apart from the other structures located in a dilapidated part of town. Inside, treatment rooms were generally cramped and available supplies and equipment were often minimal. The facility usually posted an extensive multilingual list of available medical disciplines, ranging from internists to chiropractors, podiatrists, allergists, and psychiatrists. The doctors tended to be young foreign medical graduates who had no private practice. Many in fact could not find any practice before the proliferation of mills. Many mills employed "hawkers" who rounded up customers for treatment. Several administrators admitted to Senate investigators that they bribed social workers at hospitals or discharge planners at State mental hospitals to send them business. The committee found that in New York City, an estimated 66 to 75 percent of all individual medicaid providers, including virtually every high volume medicaid practitioner, are located in such facilities. They further noted that 7 percent of medicaid physicians (most of whom practice in mills) received 50 percent of all medicaid funds for physician services. Similar patterns were revealed in staff investigations in Illinois, California, and New Jersey. In Michigan, 3 percent of medicaid doctors, generally working in mills, earned 25 percent of total payments for physician services.

Owners of these facilities are usually individuals who have joined together in a partnership or corporation arrangement. Some may own more than one facility. Some may also be providers on the facility premises or at another location. They may also own pharmacies or laboratories which are often used as the exclusive lab or pharmacy service by all practitioners in the facilities. In certain instances the

---

[1] U.S. Congress. Senate. Special Committee on Aging, Subcommittee on Health and Long-Term Care. Report. Fraud and abuse among practitioners participating in the medicaid program. 94th Cong., 2d sess. August 1976.

committee also found overlapping ownership between medicaid mills and factoring companies.

Senate investigators found that medicaid mills are particularly lucrative for their owners. Many medicaid practitioners in urban areas, with little working capital and often holding foreign medical degrees, turn to medicaid mills. These are usually owned by real estate operators who have sufficient capital to purchase the land, office space, and equipment necessary to operate a medical practice. In turn, the average practitioner will pay from 30 to 40 percent of gross income as rent, will lose 12 percent of his income to the factoring agency, and in a large number of cases be asked to divide the remaining net 50–50 with the mill owner. In some mills, the practitioners' total medicaid income is turned over to the mill operator and the practitioner receives a commission based on dollar volume (an average of 20 to 40 percent to the practitioner and 60 to 80 percent to the mill operator).

The Senate investigators found that the most common violations in the mills include:

(1) "ping-ponging"—referring of patients from one practitioner to another within the facility even though there is no medical reason for doing so;

(2) "ganging"—billing for multiple services to relatives who accompany a family member who alone had sought treatment at the mill;

(3) "upgrading"—billing for a service more extensive than that actually provided;

(4) "steering"—directing a patient to a particular pharmacy, a violation of the medicaid program's policy of freedom of choice; and

(5) billing for services not rendered—either adding services not performed onto an invoice carrying legitimate billings or submitting a totally fraudulent claim.

Other documented violations included billing for work performed by others or by unlicensed practitioners; making multiple copies of medicaid cards, apparently for multiple or fictitious billing; soliciting, offering, or receiving kickbacks; billing twice or more for the same service; and billing both medicare and medicaid for the same service.

The committee found that fee splitting and percentage lease arrangements, common practices in New York, New Jersey, Illinois, California, and Michigan, went hand-in-hand with medicaid mills. It concluded that percentage lease arrangements are the basic economic incentive to form these facilities. Percentage lease arrangements give the landlord a percentage of the provider's gross income in return for office space, equipment, shared waiting rooms, laboratory services, custodial and office help, and often administrative services. In New York City, each practitioner usually had a separate lease which in most cases was oral, not written. The average percentage lease in New York City appeared to range from 30 to 40 percent of the providers' gross fees for most medical disciplines. While the American Medical Association has ruled this practice unethical, it is not considered illegal in most States and is not prohibited under Federal law or regulations.

83-092—77——2

The committee also concluded that operators of these facilities virtually demand "kickbacks" from pharmacies, clinical laboratories, and other suppliers in exchange for the exclusive right to the business generated by the facility. Almost every facility visited by the committee staff dealt exclusively with one pharmacy in return for an average kickback of 25 percent. In order to recoup money paid for kickbacks, pharmacists resort to a number of practices including shorting the prescription, substituting generic for brand name drugs, forging physicians' signatures on prescriptions, and issuing drugs without prescriptions to addicts.

Factoring is also a very common practice associated with medicaid mills in New York City. Although factoring was outlawed under the Social Security Amendments of 1972, factoring firms have evaded statutory intent by working under a power of attorney arrangement. The committee observed that those practices were most common in New York and Illinois where medicaid payments characteristically lagged 3 to 6 months.

The committee staff concluded that medicaid mills spawned a host of frauds and abuses that were designed to increase dollar volume and that resulted in decreases in the quality of health care. The staff found that the average visit in these facilities lasted 3 minutes. In over 90 percent of the cases observed by the staff, the medical care rendered was judged to be inadequate.

The Senate Committee staff learned that the problems in the New York State medicaid program have been known for a number of years and have been the subject of over 100 major reports in the last 10 years. Despite the accumulated evidence, the committee noted that fraud and abuse continued in a blatant manner.

B. CLINICAL LABORATORIES

Both medicare and medicaid provide coverage for laboratory services provided by independent clinical laboratories. Over the past several years, there has been increasing concern over the potential for fraud and abuse among clinical laboratories, particularly for services funded by the medicaid program. Several State commissions and legislative investigative committees have focused attention on this issue. At the Federal level, two congressional committees and the General Accounting Office have also examined service and billing patterns in these facilities.

The House Committee on Interstate and Foreign Commerce reviewed the question of fraud and abuse in clinical laboratories within the context of overall improvements needed in such facilities. Testimony presented to the committee by the executive director of the New Jersey State Commission of Investigation indicated that physicians often determined which laboratories would do the test work for their medicaid patients by the amount of the kickbacks and rebates offered by the laboratory. Testimony before the committee's Subcommittee on Oversight and Investigations indicated that these kickbacks are in the neighborhood of 25 percent. The Commission found instances where work was carried on in converted garages or basements where even minimum sanitary and test quality standards were not met.

Frequently the laboratory where the physician sent the tests never actually did the test work, but would in turn send it on to another laboratory facility. At each stage in this process, there was a markup on the charge for the test performed. New Jersey found it could reduce its fee schedule for laboratory tests by 40 percent, without harmful effects, if it eliminated the excess amounts built into the fee which encouraged high markups and kickbacks.

Similar instances of widespread fraud and abuse in clinical laboratories are presented in a recent report, "Fraud and Abuse Among Clinical Laboratories," by the Subcommittee on Long-Term Care of the Senate Special Committee on Aging. Although the subcommittee's investigation was concentrated in Illinois, it also received considerable evidence from other States (including New Jersey, New York, Michigan, Pennsylvania, and California) showing similar patterns of questionable and outright fraudulent practices.

The actual number of laboratory offenders identified in the Senate investigation were small; however, they represented a substantial percentage of public funds spent for lab services. In New York, 16 clinical laboratories controlled 70 percent of the medicaid business. In New Jersey, 12 labs controlled more than 60 percent, while in Illinois 21 labs controlled over 80 percent. The subcommittee investigation confirmed the New Jersey State Commission finding that kickbacks are so prevalent that laboratories refusing to make them are practically unable to secure the business of physicians or clinics treating medicaid patients.

Kickbacks take a number of forms including cash, long-term credit arrangements, gifts, supplies and equipment, and the furnishing of business machines. The most common practice, however, involves the "rental" of a small office space in a medical clinic for amounts which are far in excess of the reasonable value of the space. Frequently, the "rent" is determined by paying a percentage of the business sent to the laboratory, often in amounts as high as 30 to 45 percent of the medicaid billings of the physician or clinic sent to the laboratory.

The Senate subcommittee further outlined a number of billing techniques used by laboratories which constituted abuse or actual fraudulent practices. These included:

(1) charging medicaid for services not ordered by the physician;

(2) charging medicaid for questionable tests, i.e., tests that were inappropriate for the disease diagnosed by the physician;

(3) charging medicaid more than private patients;

(4) billing medicaid patients for component parts of automated laboratory tests; and

(5) use of forms supplied by the laboratory which encourage over-utilization by making it impossible for physicians to order certain lab tests without ordering related tests.

Further contributing to the excessive costs for lab services under medicaid and medicare is the use of widely varying and outdated fee schedules. The Senate subcommittee noted that in California there is a separate price list for each of 28 geographical areas. The principal problem cited, however, was that most of the rates were established 8 to 10 years ago, prior to the development and common usage of sophisticated automated analytical equipment. While the actual cost

of performing most tests is now a fraction of earlier costs, the subcommittee noted that the cost savings had not been passed on to the medicaid program. Instead these savings were channeled into "educational programs," "incentive marketing plans," "rebate referral programs," and profits to providers of kickbacks. Some States, notably New Jersey, have attempted to pay differential rates based on how the test is performed; this is, however, difficult to monitor.

The medicaid statute gives "freedom of choice" to recipients in selecting providers who will serve them. Recently, New York City attempted to control lab reimbursement by entering into fixed price contracts with one lab in each borough where all lab services would be provided for a fixed cost proposed by the lowest bidder. The lower court in New York ruled that this appeared to violate medicaid's freedom of choice provision, but suggested that the plan be tried as a demonstration project in one borough. The State has submitted a draft demonstration proposal and has not implemented the plan in any borough at this time.

Excessive charges for laboratory services were the subject of a report issued by the General Accounting Office on August 4, 1976. This report entitled, "Tighter Controls Needed Over Payments for Laboratory Services under Medicare and Medicaid," concluded that medicare and medicaid often pay substantially more for laboratory services than the prices charged by independent laboratories. In some instances, physicians will obtain the services from independent laboratories for the lower prices but receive program payments which include large markups. GAO examined billings and payments records for 182 independent laboratory services obtained by physicians or physician groups in Florida, Georgia, California, and Arizona. Ten of the services were not covered by medicare and markups were either not made or not allowed on an additional 17 services. For the remaining 155 services, physicians paid the independent laboratories $776 for services billed to medicare at $1,950. The markups allowed for payment totaled $1,013 or 131 percent more than charged by the labs. In the metropolitan Washington, D.C., area, GAO found that the amount allowed by medicare for specified laboratory services was 116 percent more than the prices charged by independent laboratories where such services were generally obtained. In the same metropolitan area, medicaid fees generally exceeded the highest lab prices for the same services. The largest differential was in Virginia where the medicaid fee of $79 for nine procedures exceeded the highest independent laboratory price by $36.25 or 85 percent. The report further noted the wide discrepancies among carriers and fiscal agents in the treatment of physicians handling charges. GAO stated that HEW's efforts to eliminate unnecessary markups to the medicare program have been ineffective and recommended that the Department should exercise its authority to limit amounts allowed for laboratory services under both programs to the lowest levels at which such services are widely and consistently available. HEW has recently issued proposed rulemaking (September 20, 1976, for medicare and January 11, 1977, for medicaid) which would implement this recommendation and permit, as an alternative to payment of reasonable charges, for negotiated rates for lab services.

GAO also stated that there are inadequate controls to assure that laboratory services are provided by approved facilities. Most carriers and fiscal agents generally assumed that services were performed in physician offices when claims did not otherwise indicate. In some cases, therefore, services may be paid for by laboratories not certified to provide the service. Where an independent laboratory was specified, some carriers and fiscal agents determined that it was on the list of certified providers but did not determine whether it was certified to perform the particular test.

In addition to concerns regarding the widespread incidence of fraud and abuse in clinical laboratories there is the concern over the quality of many of the services provided. The Center for Disease Control estimates that nationwide 15 percent of all laboratory test results are in error.

C. NURSING HOMES

Nursing home fraud and abuse has also been the subject of extensive study and investigation. Numerous reports and hearings have been published by congressional committees, Federal agencies, and State commissions which document such activities as patient abuse, substandard homes, deceptive real estate practices, false cost reporting, and kickback practices.

Abuses relating to patient care, for the most part, result from unethical practice by homes which are not in compliance with prescribed Federal standards. Examples of this kind of abuse include inadequate diets, nursing staff, therapy and recreation programs, linen and laundry service; as well as infrequent physician care, poor controls on the administration of drugs and medications; and actual physical mistreatment and neglect.

Fraudulent and abusive practices relating to program costs involve the intentional misrepresentation or falsification of the costs involved in providing patient care. These practices may take many forms. Examples include: deceptive real estate practices which artificially inflate property costs, false or misleading cost reports which hide non-allowable costs, inadequate accounting procedures which prohibit effective auditing, kickbacks from vendors, and failure to disclose ownership interests.

A number of investigations into fraud and abuse in State medicaid programs describe various methods of artifically inflating property costs for the purpose of increasing a nursing home owner's income where reimbusement rates are based, in part, on the actual selling price of the property.

One method, known as "kiting," involves the rapid sale or transfer of facilities between related parties to continually increase the "sales price" of the home. These transactions result in higher depreciation allowances and higher "equity returns" for property owners:[2]

Real estate kiting is the practice of selling a piece of real property and/or the improvements thereon many different times in succession, each time at an inflated price and each time to a person or corporation who is connected with the original seller. The end result is that the original seller will still maintain sub-

---

[2] Report of Investigation by Francis B. Burch, attorney general of Maryland, into allegations of criminal misconduct or irregularities involving the licensing, accreditation, and certification of health care facilities by the State department of health and mental hygiene as well as other phases of the operation of health care facilities including nursing homes, hospitals, and after-care facilities. 1976. P. 89.

stantial control over the property and will have received the same property back in the end, but the cost of the property well may be inflated to three or four more times the original selling price. The medicaid problem arises because medicaid reimbursement can be based, in part, upon the selling price of the real property.

Another practice involves transactions between related parties involving the sale of a facility that is then leased back to the seller. This can create certain "lease costs," which, in some States, may become part of the reimbursement formula and result in higher reimbursement rates.[3]

Still another real estate practice involves the rapid sale of a nursing home facility between nonrelated parties to inflate reimbursement rates. This type of transaction was described in the report of the New York State Moreland Commission:[4]

It has been a matter of grave concern to the Public Health Council that operators who have applied for establishment, upon successfully obtaining a franchise and often before the first patient is served, would proceed to sell the nursing home property at arms-length to another and unrelated operator at a sales price which might be well above construction cost. This practice is one of several forms of transactions which have come to be known familiarly as "trafficking" in nursing homes. The department has identified 22 instances of such rapid sales. In basing its reimbursement on such sale prices rather than on original project cost, the department has encouraged the trafficking phenomenon, for new owners have been willing to pay a sales price that exceeds construction cost so long as they have been assured of sufficient future property cost reimbursement to make the purchase at that price worthwhile.

However, the resulting increases in reimbursement rates, are, in effect, payments of "costs" which do nothing to increase the quality or quantity of care available at the facility. They merely amount to a bonus for the original franchisee.

Other fraudulent activities, uncovered by recent investigations, involve the practice of charging State medicaid programs for the costs of services and items entirely unrelated to the provision of patient care. Examples include charging the program for expensive luxury cars such as Cadillacs and Rolls Royces, dues for yacht and country club memberships, tuition for school expenses, advertisements in nonhealth related publications, restaurant meals, and travel.[5]

In a related example, operators were discovered charging the program for the salaries for individuals who did not work, or worked rarely for the facility. Often these individuals were family members related to the nursing home operator. Called "no-show or seldom show jobs" the New York State Stein Commission gave this example:[6]

Early in the investigation it became apparent that many nursing home operators who filed for salaries with the State Department of Health and received them for work supposedly rendered, did not or rarely spent time at their facilities. The first instance we cited was that of Anne Weiss Bergman. Mrs. Bergman who was receiving $11,605 from the Oxford Nursing Home (Brooklyn) was not even known by many of the Oxford staff. The head nurse, who had worked at the facility for 16 years, recalled that she had met Mrs. Bergman only once in that time. In addition to her salary at Oxford, Mrs. Bergman was earning for administrative work $25,041 at the Towers Nursing Home. There, too, staff members were doubtful as to the last time they had seen Mrs. Bergman. . . .

---

[3] Report of the New York State Moreland Act commission on nursing homes and residential facilities. "Reimbursement of Nursing Home Property Costs: Pruning the Money Tree." January 1976. Report 2. P. 10.

[4] Ibid. P. 11.

[5] U.S. Congress. Senate Committee on Government Operations. Subcommittee on Federal Spending Practices, Efficiency, and Open Government. Hearing. 94th Cong., 2d Sess. August 17, 1976. P. 59; and Report on nursing homes and health related facilities in New York State by the temporary State commission on living costs and the economy. April 1975. P. 95.

[6] Report on nursing homes and health related facilities in New York State by the temporary State commission on living costs and the economy. April 1975. Pp. 93–94.

At another hearing and in interviews (see transcript of January 31, 1975) a former city department of health inspector revealed an instance where a wife of an administrator, Mrs. Stern (Bronx Nursing Home), served, even though untrained, as recreational director. On each of the inspector's numerous visits, she was told that Mrs. Stern had just left and would soon return. The inspector never did meet the ephemeral recreation director.

Other fradulent activities by nursing home owners and operators include: [7]

(1) *Deceptive non-arms-length transactions.*—Increased medicaid reimbursement can result from failure to disclose a "non-arms-length transaction" for services, realty or goods provided to the nursing home. This type of transaction is defined as an arrangement in which the nursing home operator has at least a 10 percent interest in the equity of a company providing real property, goods, or services to the facility. Vendors providing services and goods in non-arms-length transactions are not allowed, under medicaid reimbursement procedures in New York State, to bill medicaid for any profit that the related organization may have been paid in providing the goods, real property, or services to the facility.

(2) *Improper characterizations of withdrawals of equity.*—If funds are withdrawn from a nursing home, then the owner's equity is decreased. Since the owner's profit from medicaid can be based on the amount of equity in the home, withdrawal of funds decreases profit. Investigations found that owners withdrew substantial amounts from their homes and termed these withdrawals "loans." By characterizing such withdrawals as loans, the owner's equity position was left intact.

(3) *Reporting other business expenses on the nursing home's books.*—Some nursing home owners attempted to put the expense of other business interests on the nursing home's records. These included real estate taxes, maintenance supplies, and insurance and fuel expenses.

(4) *Unauditable books and bulk postings.*—The books of some nursing homes are practically unauditable. One owner kept one set of books for three of his homes with records so jumbled that according to the State auditor "they defied all ordinary auditing procedures." Another nursing home operator was apparently engaging in the practice of bulk posting or mixing postings together which makes "it exceedingly difficult to determine the charges to an individual expense account in order to ascertain the true state of the nursing home accounts." [8]

(5) *False classification of administrative salaries.*—To evade reimbursement limits on administrative salaries, nursing home owners were charging portions of these salaries to other costs. Almost $10,000 of one assistant administrator's salary was reported on the books as a housekeeping expense.

(6) *Loans and exchanges.*—Nursing home loans and exchange accounts can be used to conceal non-interest-bearing loans from the facility to the proprietor or his family.

(7) *Improper reporting of days of care.*—Nursing home operators have understated the number of days of patient care in order to increase per diem costs: "The number of days of care becomes the denominator in the reimbursement rate calculation, where the total allowable costs are

---

[7] Ibid. Chapter 7.
[8] Ibid. P. 89

divided by the number of days of care to arrive at a per diem operation cost. The same per diem cost is also used as a basis for future reimbursement. Thus, if the denominator is decreased, the rate of reimbursement is increased." [9]

Several investigations have uncovered evidence of kickbacks to nursing homes from vendors as a condition of doing business with the facility. Recent reports in particular deal with the problem of pharmacist kickback activities. In general, this type of kickback is an arrangement between the pharmacist and the nursing home involving practices such as the following: The pharmacist agrees to pay a certain percentage of the price of a prescription drug, or agrees to provide cash payments, gifts, or services to the administrator or owner of a nursing home in return for the privilege of providing prescription drug services to patients within the home. One pharmacist, testifying at a hearing, had this to say about kickback activities: [10]

> In many cases, the pharmacist is not allowed to service a facility regardless of the type of service he provides unless he is willing to accommodate either the proprietor or the administrator of that facility. I, myself, have been approached many, many times and was asked to approach the administrators of several facilities by the nursing staffs because they were not able to get a hold of their pharmacists at night and on the weekends and holidays and so forth.
>
> I was told by the administrator after I had discussed with him the scope of services to be, that I could provide the service if I were willing to give him 25 percent. Now, that money has to come from somewhere.

One Senate subcommittee surveyed about 4,500 pharmacists, mainly in the State of California, to determine the extent, if any, of kickback activities. The results showed that 63 percent of those pharmacists responding to the survey "indicated an actual experience or positive belief that they were widespread." [11]

Nursing homes that agree to provide care to medicaid patients are required to accept medicaid's rate of reimbursement as payment in full for the cost of providing medical services to that patient. It is illegal under the terms of the law for the home to require additional financial contributions from the patient's family or others to supplement medicaid's payment. Investigations in the State of Florida, however, indicate that the practice of requiring relatives to contribute or donate funds in order to admit the patient to a nursing home may be widespread: [12]

> Both through reports to the Department by individuals and through audit procedures, it has been determined that the practice of eliciting contributions from relatives of medicaid patients is widespread, and that the requests or demands for these contributions are generally oral and very infrequently is there any written documentation to evidence the practice. The situation arises in two general factual situations:
>
> First, a relative determines that he or she can no longer care in the home for a medicaid-eligible client and seeks to place this client in a nursing home under medicaid. A given nursing home will then require of the relative a contribution to the nursing home as a condition of admission.

---

[9] Ibid. P. 92.

[10] U.S. Congress. Senate Special Committee on Aging. Subccmmittee on Long-Term Care. Hearing. 94th Cong., 2d sess. Medicare and medicaid frauds. Part 2. Washington, D.C., Nov. 13, 1975. P. 262.

[11] U.S. Congress. Senate Special Committee on Aging. Subcommittee on Long-Term Care. Committee print. 94th Cong., 2d Sess. Nursing home care in the United States: Failure in public policy. Supporting paper No. 2. Drugs in nursing homes: misuse, high cost, and kickbacks. January 1975, p. 285.

[12] U.S. Congress. Senate. Committee on Government Operations. Subcommittee on Federal Spending Practices, Efficiency, and Open Government. Hearing. 94th Cong., 2d Sess. Fraudulent payments in the medicaid program. Aug. 17, 1976. Pp. 72–73.

Second, a person will be placed in a nursing home from a hospital under medicare and when the medicare expires and prior to the nursing home being willing to sign a medicaid agreement for the patient with the Department, they will require the relative to agree to make a contribution to the nursing home. Reports have indicated that the contributions range from $50 to as high as $350 and seem to be primarily based upon the relative's ability to contribute. The most difficult aspect of this situation is where a husband and wife maintain their primary support from social security income and one of the parties is unable to be cared for at home and must be placed in a nursing home and is further eligible for medicaid. The nursing home still requires an agreement from the spouse to pay a contribution to admit the patient.

A General Accounting Office investigation of 30 nursing home facilities in five States showed widespread misuse of patient personal funds.[13] GAO investigators found facilities that were charging patient's personal funds for items which should have been provided as part of routine medical care such as wheelchair rentals, restorative services, and routine medical supplies. Other examples as reported by GAO included: improper maintenance of records of receipts and disbursements of patients' funds, use of patient funds to meet operating expenses, commingling of patient funds with operating funds, use of patient's funds as collateral for a loan for operating expenses, retaining for the home interest earned on patient funds.

D. PREPAID HEALTH PLANS (HMO'S)

Prepaid health plans or health maintenance organizations are organized groups which provide comprehensive services and are compensated on a predetermined per capita rate basis. The major reviews of prepaid health plans have occurred in California, which has been a leader in using the HMO concept under its medicaid program. Major problem areas have included the adequacy of the ratesetting process and enrollment procedures.

A GAO report to the Senate Committee on Finance found that procedures used to set per capita rates were not sufficiently refined, resulting in higher payments than anticipated.[14] Payments exceeding average fee-for-service costs were noted in some cases. A follow-up GAO report in August 1975 confirmed this finding, pointing out that the ratesetting procedure did not reflect differences in use of services among the plans enrollees and fee-for-service recipients. One specific problem was that institutionalized medicaid recipients, who account for a great deal of cost in the fee-for-service system, were normally not enrolled in the prepaid plans. No adjustments in rates were made to account for this difference.[15]

Problems in enrollment practices have also been noted. High start-up costs for prepaid plans have resulted in pressure to enroll individuals quickly. The GAO report in September 1974 noted numerous complaints because of misrepresentation during enrollment.[16] Marketing firms and door-to-door solicitors were employed to enroll individuals,

---

[13] U.S. Congress. Senate Special Committee on Aging. Subcommittee on Long-Term Care. 94th Cong., 2d Sess. Hearing. Medicare and medicaid frauds. Pt. 2. Pp. 221–227.

[14] U.S. General Accounting Office. Report to the Senate Finance Committee, U.S. Senate. Better controls needed for health maintenance organizations under medicaid in California. Sept. 10, 1974.

[15] U.S. General Accounting Office. Report to Senate Finance Committee, deficiencies in determining payments to prepaid health plans under California's medicaid program. Aug. 29, 1975. Pp. 12–13.

[16] U.S. General Accounting Office. Better controls needed for health maintenance organizations under medicaid in California. Op. cit., Sept. 10, 1974.

and were paid on an incentive basis. High rates of disenrollment were also uncovered with an average monthly recipient turnover rate of 6.2 percent.

Recent Senate hearings described some of these abuses in detail:[17]

Beginning in November 1972, a scant 6 months after the first PHP contract was in force, the pattern of abuses was already identified. A Los Angeles Times account on November 10 showed that several plans were sending their enrollees to unaccredited hospitals and overcrowding nursing homes to save money.

There followed in the next few months accounts of PHP emergency clinics closed during evening hours. PHP investors turning 3,000-percent profits on their initial investments and high-pressure enrollment tactics.

Other stories followed, one after another.

In May 1973 it was reported that the Federal organized crime strike force in Los Angeles had been joined by State and local intelligence officials to probe possible Mafia activity in prepaid health and dental plans.

In July 1973 it was reported that the Los Angeles grand jury had indicted a PHP solicitor on 14 counts of forgery for signing the names of Medi-Cal eligibles on PHP enrollment forms after the persons he visited refused to join voluntarily.

In November 1973 a State legislative analyst's report was released showing "widespread abuse, deception and illegal practices" in the prepaid health plans and condemning the State health department for failing to compile thorough background checks on providers.

* * * * * * *

There are no limits placed on plan administrative costs. There are no requirements setting forth just how much of the welfare funds obtained from the State government must actually be spent on health care.

Through review of subpenaed documents, interviews, and sworn statements to the subcommittee, we learned that Federal-State welfare funds in the PHP program have been spent on luxury automobiles with mobile telephones; on trips; on excessive salaries; and other items that effectively depleted plans of money intended for patient care.

In April 1974, the State of California auditor general surveyed 15 prepaid health plan contractors. The auditor general found that of $56.5 million in welfare moneys going to these plans, only an estimated $27.1 million or 48 percent was actually spent on health care service. The balance, $29.4 million, went for administrative costs and profits.

Net profits, according to the report, ranged from 6 percent of gross welfare fund payments to the plans to 33 percent.

At the request of the permanent Subcommittee on Investigations, the staff of the General Accounting Office outlined the corporate structure of five prepaid health plans in California, and the relationship between the nonprofit health plans and their for-profit affiliates.[18] The chairman of the subcommittee described the study as follows:[19]

. . . the complicated corporate mazes that lie beneath the surface of the altruistic, beneficient-appearing nonprofit corporations under contract to the State may be only schemes to make audits nearly impossible and to distribute profits.

---

[17] U.S. Senate. Prepaid health plans. Committee on Government Operations. Permanent Investigations Subcommittee. Hearings. Prepaid health plans. Testimony by David P. Vienna, staff investigator. Mar. 13–14, 1975. Pp. 13–15.

[18] U.S. General Accounting Office. Study by the Staff of the U.S. General Accounting Office. Relationships between nonprofit prepaid health plans with California medicaid contracts and for profit entities affiliated with them. November 1, 1976.

[19] Senator Sam Nunn. Opening statement, Prepaid health hearing before the Permanent Subcommittee on Investigations. December 14, 1976.

E. INDEPENDENT PRACTITIONERS

An independent practitioner's income from medicaid and medicare is based in part on the volume and complexity of the services he provides. Thus, for the practitioner, program fraud and abuse covers a broad spectrum of practices, ranging from the rendering of services of arguable medical necessity to such criminal offenses as filing false claims.

There is much less evidence of fraud and abuse among practitioners than by nursing homes, medicaid mills, and independent laboratories. However, there is no way to estimate the extent to which fraud and abuse by practitioners has gone undetected. Much of the evidence that has been collected in these other areas has been based on the testimony of associates, a review of business records, and other investigative techniques that are impractical or less suitable for the review of an individual practitioner's activities. Detection and proof of fraud or abuse by an individual practitioner must often depend on the patient, who may well be both old and sick, and without medical knowledge. In any case, whatever its true extent might be, it is clear that the potential for exploitation exists for those practitioners that choose to cheat medicaid and medicare.

The August 1976 staff report[20] prepared for the Subcommittee on Long-Term Care of the Senate Special Committee on Aging provides numerous examples of the forms of fraud and abuse that have been detected in the medicaid program. Perhaps the most flagrant fraud involves billings for patients whom the practitioner has not treated. Last year, for example, a Brooklyn chiropractor was indicted and charged with billing medicaid for treating people who were dead, men in prison, and others whom he had not seen. In 1975, a New York physician was charged with spending less than 3 hours a day in his office and yet billing the program for more than $150,000—a rate approaching one patient every 2 minutes. Three psychiatrists in Nassau County, N.Y., last year fraudulently billed for more than $100,000 including bills for 500 patients they never treated. The Chicago Tribune reported in an extensive July 14, 1976, article on fraudulent activities by participating optometrists and opticians that bills had been sent to medicaid for hundreds of patients who said that they had never been to an eye doctor in their lives.

A related form of fraud involves claims for services to a practitioner's patients that were not actually furnished and intentionally billing more than once for the same service. For example, a New York dentist was indicted on 471 counts, including submitting invoices for services never rendered, soliciting signatures on invoices before the work was performed, forging patients' signatures on invoices, billing repeatedly for the same service, and billing for work performed by another dentist.

---

[20] U.S. Congress. Senate. Special Committee on Aging. Subcommittee on Health and Long-Term Care. Report. 94th Cong., 2d sess. August 1976. Pp. 76–80.

In Illinois, a professor of dentistry, asked in 1975 to evaluate the billings submitted to the Illinois Department of Public Aid by a high-volume medicaid dentist, concluded that there was obvious fraud in approximately 20 percent of all bills. The IDPA was billed in excess of $6,000 for professional services which were possibly not rendered, services that were double and triple billed, and treatments of very questionable value.

Practitioners also misrepresent the nature of the services they furnish so as to qualify for a higher fee. For example, a New York psychiatrist was charged with "upgrading" his counseling sessions, billing the medicaid program for an hour's counseling when the sessions had, in fact, lasted some 15 minutes. Similarly, a Manhattan podiatrist was charged with billing for custom-made appliances while furnishing mass-produced items.

Practitioners can also exploit medicaid by rendering services of shoddy quality. An Illinois mother and her nine children each were given three sets of glasses, within 1 year's time, because the mother said, "the glasses kept falling off our faces." Hundreds of recipients who actually sought and obtained glasses complained to investigators that the glasses were cheap, kept breaking, and in some instances were nothing more than "window glass."

Furnishing excessive services is probably the most costly non-criminal abuse faced by health benefit programs. At the same time, it is relatively difficult to prove and correct. Since the medical needs of a particular patient can be highly judgmental, it is difficult to identify program abuse as a practical manner unless the overutilization is grossly unreasonable. Such was clearly the case with the New York psychiatrist who ran a methadone clinic and was charged with distributing methadone indiscriminately to anyone possessing either a medicaid card or cash. Similarly, a New York dentist recently developed a technique for getting around New York's requirement of prior approval for major dental work. Before he was discovered by authorities, he was drilling holes in perfect teeth and X-raying the teeth with the newly created cavities. The X-rays were kept to justify the fillings which the dentist then installed in the once healthy teeth.

In 1975, a Brooklyn podiatrist was charged with consistently examining all members of a family despite the fact that only one member had sought treatment. He was also charged with requiring patients to return when the diagnosis did not warrant it. Physicians have also been found to be "family ganging"—the practice of seeing each family member who may be present at the time the patient is seen in the practitioner's office or in the patient's home. A Michigan physician was charged with "family ganging," billing for excessive services, billing for as many as 140 home visits a day, and billing separately for as many as 8 or 10 recipients at a given address. Physicians also have been found making gang visits in nursing homes—seeing all the patients without regard to their medical needs.

Another example of overdelivery is provided by the Illinois optician who issued a medicaid patient three pairs of glasses, explaining that she should always have extra pairs for emergencies. The Illinois medicaid program paid for 26 pairs of glasses for one medicaid patient within the space of 6 months.

Medicare has been subject to similar kinds of abuses as medicaid. Medicare experience would suggest that physicians' most frequent criminal offense involves claims for services that have not in fact been rendered. The most frequent complaints of abuse received from beneficiaries (more than 10,000) result from a physician charging beneficiaries more than he has agreed to as a condition of being paid directly under an assignment by the program (rather than by the patient).

F. PHARMACIES

The kinds of financial exploitation that pharmacies practice in medicaid involve fairly straightforward misrepresentations. For example, a Brooklyn pharmacist was charged with forging prescriptions; 20 out of 160 prescriptions sampled were forged. A Washington State pharmacist dispensed drugs without even forged prescriptions to justify his bills.[21] Some pharmacists have also routinely billed for expensive versions of legitimately prescribed drug entities while furnishing the patient with a less expensive brand.

In some cases, pharmacists have changed the prescription form so as to show a larger drug supply than the one that was actually prescribed and furnished. This practice, called "kiting," is carried out by adding, say, a zero to the number of units the physician prescribed. Double billing has also become a somewhat common practice as has falsifying bills to represent noncovered drugs as drugs for which payment can be made under the State program. The various abuses that are mentioned above are sometimes practiced in order to recoup kickback payments to nursing homes and shared health facilities.

II. Fraud and Abuse Control Activities of the Department of Health, Education, and Welfare

A. GENERAL

Fraud and abuse control activities of the Department of Health, Education, and Welfare are divided into two general areas: Departmentwide fraud and abuse audit and investigative activities for all HEW programs, and individual activities carried out by each program. The Office of Investigations of the Department investigates allegations of criminal violations in HEW programs. Department testimony in September 1976 reported that this Office was combined with the HEW Audit Agency to create a new Office of Audits and Investigations in an effort to strengthen the Department's fraud and abuse activities.[22]

* * * Secretary Mathews, on September 13, directed that an Office of Audits and Investigations be established, combining the functions being carried out by the Office of Investigations and the HEW Audit Agency. The Director of this new Office will report directly to the Secretary, and will operate under a broad

---

[21] U.S. Congress. Senate. Special Committee on Aging. Subcommittee on Health and Long-Term Care. Report. "Fraud and Abuse Among Practitioners Participating in the Medicaid Program." 94th Cong., 2d sess. August 1976, p. 80.

[22] U.S. Congress. House. Committee on Interstate and Foreign Commerce. Subcommittee on Health and the Environment. Hearings. Medicare-Medicaid Anti-Fraud Act. September 22, 1976; P. 58.

mandate with the authority to conduct and supervise audits and investigations relating to the programs of HEW. In addition, it will have a major role in activities designed to promote economy and efficiency in the administration of these programs. This change will provide a single-management focus for day-to-day oversight and coordination of audit and investigative functions in all program areas. Additionally, to deal with the peculiar facets of health financing, we intend to develop some specialized capabilities to support the specific efforts to prevent, detect, and investigate fraud and abuse in medicare and medicaid.

A total of 74 positions are available to the Office of Investigations. As of the beginning of 1977, 68 slots were filled with 6 pending. Of the 68 staff members, 44 were investigators in the field.

As of November 30, 1976, the Office of Investigations had 206 cases under active investigation. Of these, 81 were title XVIII or title XIX cases, and 20 were in other health programs.

B. MEDICARE

The medicare program relies almost entirely on private insurance organizations for claims processing and bill settlement and has benefited from their experience in administering health benefit programs. Also, the Federal Government, through the Bureau of Health Insurance (BHI), has the authority to direct its medicare fiscal agents to follow detailed policies and meet specific administrative standards. Thus, for example, all medicare fiscal agents are required to carry out specific claims review procedures to prevent paying duplicate claims. They are required to notify beneficiaries of any benefits that are paid to protect the program against bills for services that were not furnished. When problems emerge—as was the case several years ago, for example, with kiting of nursing home asset values and gang visits to nursing homes—special review and payment policies can be implemented on a national basis. The medicare fiscal agents' compliance with the program's policies and procedural requirements is monitored by BHI personnel working in the BHI headquarters, in the 10 regional offices, and on the premises of the fiscal agents.

It should also be noted that medicare is not exposed to certain areas of fraud and abuse. Medicare does not cover the services of dentists and optometrists nor outpatient drugs. The coverage of chiropractors' services, podiatrists' services, skilled nursing facility services, and home health care are covered on only a restricted basis.

Medicare has relied heavily on its administrative policies and procedures to deter and detect fraud and abuse. BHI has also maintained a special program integrity unit, centered at the Bureau's Baltimore headquarters (about 50 people), and its 10 regional offices (about 160 people). The central staff is responsible for the direction of the regional staff, as well as guidance to the program's fiscal agents.

As part of its efforts to identify aberrations and departures from norms that might indicate the presence of fraud or abuse, the program integrity unit annually reviews physicians who have generated medicare billings in excess of a specified amount, and who have an atypical pattern of practice. Since 1971, it has identified 15,296 physicians for reviews and established approximately 1,000 abuse cases with overpayments exceeding $5.5 million. In addition, approximately 250 fraud investigations have resulted from the payment review project.

The regional office staff is responsible for following through on leads supplied by fiscal agents and beneficiary complaints. It is their job to develop individual cases to the point where a decision can be made as to whether the case should be referred to the Department of Justice for criminal prosecution.

It is the policy of BHI's program integrity program to follow through on every lead coming to the attention of the agency. In most cases, only a preliminary investigation of a questionable case is needed before it can be concluded that the complaint stemmed from a misunderstanding on the part of the beneficiary rather than an erroneous or improper action by the physician or provider. Where the preliminary investigation substantiates an erroneous action by the physician or provider, the investigation is expanded to address the question of intent. For example, where a physician has billed for a service he has not provided, a number of beneficiaries for whom similar services have been claimed will be interviewed. Where additional instances are found, a full-scale investigation is mounted to develop the case for possible submission to a U.S. attorney. About 10 to 15 percent of all suspect incidents reach the full-scale stage of development, but in only 1 to 2 percent of all such incidents is the evidence sufficient to warrant a recommendation for prosecution by a U.S. attorney.

As of September 30, 1976, the BHI regional office program integrity staffs had investigated approximately 24,200 incidents or situations of possible fraud, and approximately 21,000 instances of possible program abuse. Of these, 655 cases were referred to the Department of Justice recommending criminal prosecution. There have been 189 convictions, 24 acquittals, and 27 dismissals. In 174 instances, the U.S. attorneys declined prosecution. The balance of cases were awaiting either trial or action by the U.S. attorneys.

The seemingly modest achievements of the medicare fraud and abuse activities might be explained in part by deterrents to fraud and abuse that have been built into the medicare claims processing system and by the limited coverage of the program. On the other hand, it could be argued that the current level of medicare program review activity is inadequate, and that a fuller and more determined investigative effort would expose an unreasonable amount of fraud and abuse. In any case, it is clear that there is no sound basis at the present for estimating how much fraud and abuse in the medicare program has gone undetected.

C. MEDICAID

The States have primary responsibility for the administration of the medicaid program, within certain broad Federal requirements and guidelines. The Federal role is generally to assure that the States are meeting the standards set, and to assist them in performing effectively. The Federal activities in the area of fraud and abuse are primarily the responsibility of the Division of Fraud and Abuse Control in the Medical Services Administration.

A number of activities are currently in progress as part of the Federal effort at controlling fraud and abuse in medicaid. In March of 1976 a program was established to send field teams of Federal and State medicaid examiners into selected States to identify fraud and

abuse and refer specific violations to the State for further criminal investigation. Thus far, these field teams have operated in three States—Massachusetts, Ohio, and Georgia. Reports of the those reviews are not yet available.

Assistance is being provided to Georgia in setting up a special task force, including medicaid examiners and attorneys from the U.S. Attorney's Office, to follow up on allegations of fraud and abuse uncovered by the field teams. A similar form of assistance in Colorado was provided through the Denver regional office and the Denver District Attorneys Association. An intergovernmental personnel transfer was arranged to transfer six positions for 6 months to audit and investigate fraud in the medicaid program. Staff support has also been provided to U.S. attorneys in New York in their fraud and abuse investigations.

The Medical Services Administration has contracted with a private organization for the development of a series of manuals to assist examiners in identifying potential abuses. Draft guides have been prepared for physicians' services, pharmacy services, laboratories, and nursing homes; a guide for hospitals is currently in development. In addition to these manuals, assistance is being provided to the Justice Department to develop a manual for prosecutors investigating medicaid and medicare fraud.

The HEW regional offices are currently conducting detailed assessments to determine the capabilities of the States to deal with fraud and abuse in the State administered program and the States' procedures to control such activities. This assessment is expected to be finished in June 1977.

A total of 112 staff positions are authorized for fraud and abuse control: 68 are in the central office and 44 in the regional offices. As of December 31, 1976, 88 of these positions were filled, with 50 persons in the central office and 38 in regional offices.

The Medical Services Administration has instituted a reporting system to monitor fraud detection and prosecution. A summary of fiscal year 1976 statistics as compiled by the Division of Fraud and Abuse Control is as follows:

Summary of fraud detection and prosecution, fiscal year 1976

Number of complete investigations begun	3, 383
Number of cases closed:	
Referred to law enforcement officials	269
Without referral to law enforcement officials	2, 372
Law enforcement actions completed: Number of convictions	56
Total dollars recovered:	
From administrative actions	$1, 269, 700
From prosecution	350, 300
Total	1, 620, 000
Number of providers terminated or suspended	414

The Department has stressed that one of the major long-term contributors to fraud and abuse control is effective management of the medicaid program by the States. As a result of the Social Security Amendments of 1972, 90 percent Federal matching is available for development of complete claims processing and information retrieval

systems, and 75 percent matching for operation of such complete systems. The Medical Services Administration has developed a model system, the Medicaid Management Information System, to assist the States in improving program operations. As of the end of 1976, 11 States had such systems certified and in operation, with an additional 33 States in some stage of the development process.

D. INSPECTOR GENERAL

In the closing days of the 94th Congress, legislation was passed (Public Law 94–505) creating a new Office of Inspector General in the Department of Health, Education, and Welfare. The language establishing the new office specified that: [23]

> In order to create an independent and objective unit—
>
> (1) to conduct and supervise audits and investigations relating to programs and operations of the Department of Health, Education, and Welfare;
>
> (2) to provide leadership and coordination and recommend policies for activities designed (A) to promote economy and efficiency in the administration of, and (B) to prevent and detect fraud and abuse in, such programs and operations; and
>
> (3) to provide a means for keeping the Secretary and the Congress fully and currently informed about problems and deficiencies relating to the administration of such programs and operations and the necessity for and progress of corrective action; there is hereby established in the Department of Health, Education, and Welfare an Office of Inspector General.

The duties and responsibilities of the new Inspector General are defined as follows: [24]

> It shall be the duty and responsibility of the Inspector—
>
> (1) to supervise, coordinate, and provide policy direction for auditing and investigative activities relating to programs and operations of the Department;
>
> (2) to recommend policies for, and to conduct, supervise, or coordinate other activities carried out or financed by the Department for the purpose of promoting economy and efficiency in the administration of, or preventing and detecting fraud and abuse in, its programs and operations;
>
> (3) to recommend policies for, and to conduct, supervise, or coordinate relationships between the Department and other Federal agencies, State and local governmental agencies, and nongovernmental agencies with respect to (A) all matters relating to the promotion of economy and efficiency in the administration of, or the prevention and detection of fraud and abuse in, programs and operations administered or financed by the Department, or (B) the identification and prosecution of participants in such fraud or abuse; and
>
> (4) to keep the Secretary and the Congress fully and currently informed, by means of the reports required by section 4 and otherwise, concerning fraud and other serious problems, abuses, and deficiencies relating to the administration of programs and operations administered or financed by the Department, to recommend corrective action concerning such problems, abuses, and deficiencies, and to report on the progress made in implementing such corrective action.

The statute also requires that a staff be established which is specifically responsible for health programs: [25]

> The Inspector General shall establish within his office an appropriate and adequate staff with specific responsibility for devoting their full time and attention to antifraud and antiabuse activities relating to the medicaid, medicare, renal disease, and maternal and child health programs.

---

[23] Section 201 of Public Law 94–505.
[24] Section 203 of Public Law 94–505.
[25] Ibid.

The functions of the HEW Audit Agency and the Office of Investigations are transferred to the new office. Regulations implementing the provisions of the new law are in development.[26]

---

[26] On February 9, 1977, in testimony before the Labor-HEW Subcommittee of the House Appropriations Committee, the Department of Health, Education, and Welfare requested an increase in their fiscal year 1977 appropriation to fund 123 additional positions in the General Management Department: 110 positions are for the Office of Inspector General and 13 positions are designed to strengthen the accounting operations in the Office of the Comptroller.

○


A11600 798179