MEDICAID ANTI-FRAUD PROGRAMS: THE ROLE OF STATE FRAUD CONTROL UNITS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

NINETY-FIFTH CONGRESS

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CONTENTS

MEDICAID ANTI-FRAUD PROGRAMS: THE ROLE OF STATE FRAUD CONTROL UNITS

TUESDAY, JULY 25, 1978

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 10:08 a.m., in room 1212, Dirksen Senate Office Building, Senator Frank Church, chairman, presiding.

Present: Senator Church.

Also present: William E. Oriol, staff director; Garry V. Wenske, assistant counsel for operations; Alan Dinsmore and Nancy Coleman, professional staff members; Jeff Lewis, minority professional staff member; Marjorie J. Finney, correspondence assistant; Theresa M. Forster, fiscal assistant; and Madonna S. Pettit, research assistant.

OPENING STATEMENT BY SENATOR FRANK CHURCH, CHAIRMAN

Senator CHURCH. The hearing will please come to order.

My opening remarks this morning will be brief since we are going to deal with a very challenging subject and we want to have the fullest discussion possible in our limited time period.

I shall also ask the witnesses this morning to summarize their statements in order to enable the committee to hear fully from everyone and to permit us to move directly to questioning. I would like though, to make a few key points before hearing from you.

First, the Federal Government, in partnership with the States in the medicaid program is the largest purchaser of medical services in this country—and over one-third of the money spent is supposed to purchase vitally needed services for our citizens aged 65 and over.

Unfortunately, investigations and hearings before this committee show that medicaid fraud exists on a massive scale. These proceedings revealed such practices as providers charging medicaid for expensive personal luxury items, kickbacks to nursing home owners by suppliers, and forced contributions by relatives as a condition for accepting a patient.

The first annual report of the Inspector General of the Department of Health, Education, and Welfare estimates losses in the Federal share alone of the medicaid program due to fraud and abuse at approximately $653 million—in fact, the total amount of loss due to fraud, abuse, and waste for all HEW programs is estimated by the HEW Inspector General at a staggering $7 billion. The executive vice president of the Idaho Hospital Association, John D. Hutchison, points out that this figure is over 50 times more than the total 1976 expenses of all Idaho hospitals put together.

My point is this: Whatever the losses to the system are, and we still have only estimates of these losses, the bottom line is a loss to the taxpayers in the States and the Federal Government and, most important of all, reduced medical services to those who can least afford the loss.

My second point is that the hearings and investigations before this committee have revealed a pattern of massive fraud deterred by only patchwork investigation and prosecution. In fact, a recent congressional report revealed that 20 States had never referred a suspected medicaid fraud case to State or Federal law enforcement agencies for prosecution.

On October 25, 1977, the President signed into law the medicare/medicaid antifraud and abuse amendments. This legislation, which became Public Law 95–142, was designed to facilitate Federal and State efforts to identify and prosecute cases of fraudulent and abusive activities and to strengthen penalities for persons convicted of provider related violations.

Section 17, one of the most important provisions of this law, authorizes 90-percent funding for the States to establish investigative fraud control units for a 3-year period. This provision was intended to encourage the creation of a central organization, distinct from the State medicaid agency, with the capacity to detect, investigate, and prosecute medicaid fraud.

This committee is greatly concerned that only nine States are now certified to take part in this program. While we understand that a large number of other States have expressed interest in the program and that a number of these may be certified in the near future, we are also concerned that Federal share funding will expire on October 1, 1980, and we want to examine the consequences of this.

My third point is this: This law gives States 3 years to prove themselves. This is reasonable. However, only one of the nine certified States is in the top five spenders in the medicaid program. New York State's special prosecutor, who is with us this morning, pointed out recently that it took 3 years in the courts to simply gain access to one suspected provider's account books. What about those other States. They may have less than 2 years to prove that their State fraud control unit can work.

The major questions before this inquiry are:

One: Why has so little progress been made in the implementation of the medicare/medicaid antifraud and abuse amendments' call for the creation of these units?

Two: What steps are being taken to encourage the formation of these units?

Three: What will happen after October 1, 1980, when the Federal matching share for the financing of these units expires?

Four: What steps are being taken to implement the provisions of the law which deal with ownership and management disclosure for medicaid providers—a significant aid to the work of the State fraud control units?

Our witnesses, I am sure, will have more to say about this situation and we look forward to your comments and recommendations.

Senator Pete V. Domenici, the ranking minority member of this committee, is unable to be with us this morning. He has, however,

submitted a statement for the record, which will be entered at this time.

[The statement of Senator Domenici follows:]

STATEMENT OF SENATOR PETE V. DOMENICI

Mr. Chairman, I am pleased today that we are holding hearings on the rôle of State fraud control units, an area which I believe we need to reexamine. Although we enacted legislation only last year to establish the medical State fraud control units, to date, only nine States have certified units. This is extremely distressing since the Federal Government is subsidizing 90 percent of the cost for the establishment and operation of these units, and the funding for these units expires on October 1, 1980. Subsequently, I am greatly concerned over why more of these units haven't been established and if a sufficient number will be in operation long enough to effectively evaluate their performances.

This legislation was designed to curb the increasing problem of fraud and abuse in costly, problem-riddled medicaid programs. At the same time, however, we have to be cautious that these State fraud control units don't become federally funded harassment units. I believe we need to explore alternate ways to provide funding for these units; that is, make these units dependent upon their actual recoveries. We are in a time now where we have to begin to truly curb Federal expenditures and Federal subsidizing and force some programs to pay for themselves. That is why I am particularly interested in ascertaining actually how much money these units have been able to recover to date, and how much we can anticipate their being able to recover.

I look forward to hearing from our distinguished witnesses this morning and their response to my questions.

Senator CHURCH. Our leadoff panel this morning consists of Charles Ruff, Deputy Inspector General of the Department of Health, Education, and Welfare; and Frank Beal, Deputy for Operations of the Health Care Financing Administration. Mr. Beal is accompanied by Don Nicholson, Director of the HCFA Office of Program Integrity.

Gentlemen, if you will briefly summarize your statements, the full text of those statements will be included in the record and then we will go to questions.

STATEMENT OF FRANK S. BEAL, DEPUTY ADMINISTRATOR FOR OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, ACCOMPANIED BY DONALD NICHOLSON, DIRECTOR, OFFICE OF PROGRAM INTEGRITY

Mr. BEAL. Thank you, Mr. Chairman.

I am Frank S. Beal, Deputy Administrator for Operations of the Health Care Financing Administration. With me is Don Nicholson, Director of the Office of Program Integrity.

We appreciate this opportunity to discuss with you progress in implementing the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977—Public Law 95–142. This law greatly strengthens the ability of the States and the Federal Government to take action against fraud in the medicare and medicaid programs.

FRAUD CONTROL UNIT STARTUPS

Let me first discuss implementation of section 17. This section provides the incentive of 90 percent Federal matching funds to States which establish independent units to investigate and prosecute medicaid fraud. Because of this provision we are beginning to see a major

infusion of State investigative and prosecutorial resources in the area of medicaid fraud.

The Department met its obligation to publish regulations concerning the establishment and operation of the units within 90 days after passage. Based on comments received and implementation experience acquired since then, we published amended regulations this week clarifying several areas of concern.

At the present time there are nine State fraud control units certified under the provisions of Public Law 95–142. Annual budgets of these units range from $300,000 to $1.5 million, with total annual budgets of $5.3 million. We are presently reviewing applications for certifications from 11 other States. The 20 units which have been certified, or whose applications are being reviewed, cover States which expend 72 percent of medicaid funds.

Many other States are preparing applications and we expect that by the end of this year, or even sooner, at least 35 States will have fraud control units in operation covering 85 percent of medicaid expenditures. Our efforts to encourage States to establish units and to assist them in making applications are having substantial results.

Some States or jurisdictions have indicated that they will not establish independent fraud control units. Several reasons for these decisions have been given.

First, some States do not want to separate the fraud unit from the agency administering the medicaid program as mandated by Public Law 95–142.

Second, some States believe that they do not have the workload necessary to justify establishing a separate unit.

Finally, some States are reluctant to establish a unit in light of the fact that the 90 percent Federal funding expires October 1, 1980.

We believe the decision to place the 3-year limit on increased Federal funding was a sound one. It gives HEW time to evaluate the performance of the program and gives the Congress an opportunity to determine the proper level of Federal support after 1980.

A primary key to the success of a fraud control unit's performance is the relationship of the unit to the State medicaid agency which has a major responsibility through its claims processing and other activities for the detection of provider fraud. We mandate that there be a memorandum of understanding between the fraud unit and the medicaid agency which provides data concerning vendor billing patterns and practices which are necessary to the fraud units investigative work. We will closely monitor this flow of data to insure that fraud units are receiving from medicaid agencies the information they need to investigate fraud.

Improvements in Fraud Detection

Mr. Chairman, you have asked us to address specifically the use of a data system as a tool for deterrence, detection, and investigation of fraud. A sound data system is an indispensable component of a meaningful fraud control program. Such systems are critically important in identifying providers whose billing and practice patterns indicate a potential for defrauding or abusing the medicaid program.

As part of its technical assistance role, the HCFA Office of Program Integrity assists the States in developing systems of prepayment and postpayment controls. The quality of these reviews is a standard feature in our periodic assessment of State medicaid programs.

As part of our effort to improve medicaid management generally, and fraud and abuse detection in particular, HCFA is placing increased emphasis on State development of medicaid management information systems—MMIS. There is a generous Federal financial incentive to such development and we are increasing our technical assistance to the States. To date, 18 States MMIS systems have been certified as meeting all Federal requirements and we expect to certify at least another 7 by the end of this year, and many more in 1979.

Each medicaid management information system contains a subsystem which compares patterns of provider practice and recipient utilization and identifies providers and recipients whose experience is exceptional with respect to established norms. This output is analyzed by State medicaid agency personnel to determine whether the patterns are indicative of fraud or abuse. The output of their analysis is crucial input to the State fraud control unit's investigative activities.

Disclosure Provisions

Mr. Chairman, let me now briefly describe implementation of the disclosure provisions of Public Law 95–142. These sections impose upon providers and contractors disclosure requirements that are central to fraud and abuse detection efforts, including information concerning ownership, subcontractor relationships, supplier relationships, and convictions of owners and others of offenses related to their involvement in our programs.

Proposed rules covering sections 3, 8, 9, and 15 will be published in a few days.

The regulations require providers and contractors routinely to report ownership information. For providers, we will use the medicare medicaid provider certification process to gather this information. This information, and related information required to be made available, will be used to determine the potential for fraud and abuse. The Office of Program Integrity has been charged with developing systems, including data processing systems where useful, to achieve this end.

Mr. Chairman, the last 2 years have seen remarkable advances in HEW's efforts to eliminate fraud and abuse from its health care programs. The creation of the post of HEW Inspector General; the establishment of the Office of Program Integrity in HCFA to integrate medicare and medicaid fraud and abuse detection activities; the passage and implementation of Public Law 95–142; expedited development of medicaid management information systems; and a determination at all levels in the Department to root out fraud and abuse have all contributed.

These efforts will continue to have top priority so that we can strengthen public confidence in the integrity of our health care programs.

Thank you very much.

[The prepared statement of Mr. Beal follows:]

PREPARED STATEMENT OF FRANK S. BEAL

Mr. Chairman, members of the committee, I am Frank S. Beal, Deputy Administrator for Operations of the Health Care Financing Administration. With me today is Mr. Don Nicholson, Director of the Office of Program Integrity.

We appreciate this opportunity to discuss with you the progress in the implementation of the medicare-medicaid anti-fraud and abuse amendments of 1977 (Public Law 95–142). We strongly support this legislation because it strengthens the States' and Federal Government's ability to take action against fraud and abuse in the medicare and medicaid programs. The elimination of fraud and abuse is one of HEW's highest priorities.

SECTION 17—INCENTIVE FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS

Mr. Chairman, as you indicated in your letter of invitation, section 17 is one of the most important provisions of Public Law 95–142. This section, which provides an incentive of 90 percent Federal matching funds to States that establish independent medicaid fraud control units, recognizes that the State is the most appropriate investigator and prosecutor of medicaid fraud. Because of this provision, we are beginning to see a major infusion of State investigative and prosecutorial resources in the area of medicaid fraud. The Health Care Financing Administration's Office of Program Integrity, in cooperation with the Office of the Inspector General, is charged with responsibility for developing the policies necessary to implement section 17 and to evaluate the State operations under that policy. Interim final regulations were published in the Federal Register on January 23, 1978. Final regulations resulting from comments received and from experiences during the initial implementation stages are scheduled for publication this week.

CURRENT STATUS

At the present time, there are nine certified State fraud control units, located in Louisiana, Alabama, Michigan, New Mexico, Connecticut, Rhode Island, New Jersey, Washington State, and Colorado. The annual budgets of these nine units range from $300,000 to $1,500,000, with a total annual funding of $5.3 million. This will fund 164 professional staff—35 attorneys, 45 auditors, and 84 investigators.

In addition, we have received applications from 11 other States and anticipate receiving many more this year. The 20 States whose units have been certified or whose applications are being reviewed for certification account for 72 percent of medicaid expenditures. We expect 35 units to be certified by the end of the year covering nearly 85 percent of medicaid expenditures.

HCFA EFFORTS

We have encouraged every State to set up a special fraud unit and have taken a number of steps in this direction:

We conducted two 2-day training sessions in January for our regional staffs on the section 17 regulations and guidelines. Following that, letters were written to the Governors of each State asking that representatives be sent to special training sessions conducted by our regional staffs—10 sessions were held throughout the country;

Secretary Califano, in a letter to the Governors dated April 5, 1978, encouraged each Governor to become familar with the newly enacted provisions and asked them to support the formation of fraud units;

We made presentations before components of the National District Attorneys' Association and the National Association of Attorneys General to discuss the effects of section 17; and

We have had countless contacts with State officials to explain the provisions of section 17 and help them to establish fraud units.

STATE CONCERNS

Twelve States or jurisdictions have indicated they do not plan to establish fraud and abuse units under section 17. The unwillingness of States to apply for Federal matching has occurred for a variety of reasons:

Some do not want to separate the fraud unit from the agency administering the medicaid program;

Some States of jurisdictions feel they do not have the workload necessary to justify the establishment of a separate unit that meets the requirements mandated by law and regulations;

Finally, some States are reluctant because of the 3-year limitation on 90 percent Federal funding. Calculated over the period of certification, they have concluded that the added Federal revenues do not balance the work involved in establishing the units.

Although some States may be reluctant to file an application for section 17 funding because of the funding limitation, we believe that it was appropriate to place the 3-year expiration of funding clause in the legislation. The performance of States over the next 3 years can thus be evaluated to determine the proper level for continued support. We require periodic reporting by State, fraud units on the volume of cases worked, the amounts of overpayments established, and the number of convictions obtained. The time limit on Federal funding also provides added incentive to fraud units to demonstrate effective performance. Based on our experience with the program over the next 2 years, we will be prepared to recommend appropriate legislative changes.

CERTIFICATION PROBLEMS

For States which do wish to establish fraud control units, our most frequent problem has been in reaching agreement with States on the level of funding. The funding levels are tied to, and limited by, the level of medicaid expenditures in a State. The law provides that a State can be funded at a level up to $125,000 per quarter or one-fourth of 1 percent of the receding quarter's medicaid expenditures, whichever is greater. In order to secure annual funding to the limit of what is allowed by this formula, a State must project its workload figures and manpower needs. Some States have had great difficulty supporting their funding requests, and the resulting need to negotiate has delayed the certification of some fraud units.

The requirement that the expenditure cap for the 90-percent funding be calculated on a quarterly basis has been particularly troublesome. Medicaid expenditures can vary sharply from quarter to quarter. Basing Federal payments for a fraud control unit on the preceding quarter's medicaid expenditures can cause large fluctuations in Federal participation for the unit. We believe that basing Federal funding for a unit on the previous year's medicaid expenditures would allow more predictable budgeting and operation.

RELATIONSHIP TO STATE MEDICAID AGENCY

A primary key to the success of a fraud control unit's performance is its relationship to the agency administering the medicaid program. The law allows the higher Federal funding only for *investigation* and *prosecution* of Medicaid vendor fraud. Detection of the potentially fraudulent vendor is the responsibility of the State medicaid agency. Without identified cases for investigation, there is no need for a fraud control unit to exist. For this reason, it is a condition for certification that a fraud control unit have a memorandum of understanding with the State medicaid agency to assure referrals are made. This memorandum of understanding must also provide for data reflecting vendor billing patterns and practices which may be necessary to the fraud control unit's investigation. We will closely monitor the flow of information from State medicaid agencies to fraud control units to ensure that the units are receiving the data they require to effectively investigate potential program fraud.

DATA SYSTEMS

As a part of its oversite and technical assistance role, HCFA's Office of Program Integrity assists the States in developing and maintaining systems of pre- and post-payment controls. A good postpayment data system is indispensible to any State medicaid agency as a tool in fraud and abuse detection. Although important in medicare, the significance of data in medicaid takes on added importance because the medicaid patient is not required to pay deductible and coinsurance. Under medicare, if there is something amiss with regard to the providers' billing for services, this will often be noticed and reported by the medicare patient who must pay a portion of the bill.

Under medicaid, however, the incentive for patient feedback to the case worker or other responsible medicaid official is not as strong. Therefore, it is critically important that medicaid programs have data systems capable of identifying health providers who demonstrate a potential for defrauding or abusing the program.

Medicaid regulations require each State medicaid agency to have a system of postpayment review. In our ongoing review of State medicaid agencies, one area that we continually focus on is postpayment review and the way that the States are utilizing the data available through those systems to analyze patterns of practice and take corrective or punitive action where appropriate.

MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS)

As part of its effort to improve medicaid management and to improve States' abilities to detect fraud and abuse, HCFA is placing increasing emphasis on the development by States of medicaid management investigation systems.

There are now 18 State mechanized claims processing and information retrieval systems certified as MMIS. Thirteen other States are actively developing MMIS and we expect to certify 7 of these before the end of this year.

MMIS systems can detect fraudulent or abusive use of medicaid services by physicians, pharmacists, and others who provide services as well as by persons who receive services. While the system designs and reporting formats vary from State to State, each system:

Covers all categories of medical services (inpatient hospital, physician, pharmacy, etc.) and all classes of recipients;

Analyzes medicaid utilization experience by means of statistical norms of care;

Compares patterns of provider practice and recipient utilization and identifies providers and recipients whose experience is exceptional and automatically produces summarized information about them.

While the collection of data is necessary for the detection of medicaid fraud, it is not in itself sufficient. The data must be carefully analyzed and it is critical that the analysts at the State agency level have the ability to draw meaningful conclusions from that data. The output of their analysis is the crucial input to the fraud control unit's efforts to investigate and prosecute fraud.

DISCLOSURE PROVISIONS

Finally, Mr. Chairman, I would like to describe briefly our efforts to implement the disclosure provisions of Public Law 95-142. The legislation imposes on providers several reporting requirements that are central to our fraud and abuse detection efforts. A proposed regulation will be published in a few days that will require providers to routinely disclose ownership information as mandated by section 3 of Public Law 95-142. The medicare and medicaid provider certification process will be used to gather this information. This information and related information, required to be made available under the law, will be used to identify potential fraud and corporate interlocks that involve hidden ownership and other practices. We expect that once the new detection system is fully developed, it will complement the fraud and abuse systems and controls currently in place.

Mr. Chairman, we are encouraged by the Federal-State cooperation that we have seen since the enactment of the medicare-medicaid antifraud and abuse amendments. We intend to pursue aggressively our responsibilities to stamp out program abuses and the fraudulent activities that can cripple our efforts to serve beneficiaries and to preserve program moneys.

Mr. Nicholson and I will be happy to answer whatever questions you and your committee members may have.

Senator CHURCH. Please proceed Mr. Ruff.

STATEMENT OF CHARLES F. C. RUFF, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Mr. RUFF. Senator, would you prefer that I follow with a brief summary?

Senator CHURCH. If you have one, why don't you do that and then I will ask questions.

HCFA-INSPECTOR GENERAL RELATIONSHIP

Mr. RUFF. It might be useful just very briefly, although I will try not to duplicate Mr. Beal's statement, to indicate what the relation-

ship has been between the Office of the Inspector General and the Office of Program Integrity of the Health Care Finance Administration in connection with attempts to implement section 17. We, of course, have the statutory mandate of the Inspector General's Office to supervise all fraud detection and enforcement efforts within the Department, and in that connection of course we were eager to see the passage of section 17 of Public Law 95--142 and have welcomed it as a major step forward in what we see as the crucial joint effort between the States and the Federal Government to address the problem.

Although HCFA has the responsibility for funding and certification of these units, we have worked closely together from the beginning to insure that our office had an appropriate role in certifying units, particularly from the point of view of their investigative and prosecutive capacities. Indeed, each application for certification, before it is approved by the HCFA Administrator, must be concurred in by the Office of Inspector General. To date, we have had absolutely no difficulty in working out this joint arrangement and I would expect this cooperation to continue as the remaining States submit their applications.

Now during the period in which the regulations were being drafted and since that time we have met regularly with representatives of both the National District Attorneys Association and the National Association of Attorneys General to discuss the special problems the section 17 regulations pose to them in making these applications in an attempt to offer some informal guidance through the application process. Particularly we were concerned that we implement through the regulations and through the close scrutiny of the application what we viewed as the essential congressional intent to create, wherever possible, a central and continuing body of expertise. Hence our regulations, we think consonant with the statute, create a strong preference for the placement of the fraud control unit in the Office of Attorney General or other statewide prosecutive agency. Even in those States which do not have such a prosecutive authority, we have been very encouraged to see a remarkable cooperation between the attorneys general and the district attorneys to create a unit which meets their needs but still complies with the requirements of the statute and regulations.

Progress at State Level

Our continuing role in the implementation of section 17 is principally that we will serve as liaison between the unit and other Federal law enforcement and prosecutive agencies. We hope to be able to provide some guidance, where necessary, in auditing techniques. We are working at this very moment with representatives of the special prosecutor's office in New York and the attorney general's office in New Jersey to develop a training program for auditors, investigators, and prosecutors, which we hope we will be able to put on in the fall and which we hope will be able to reach out to not only those States which have ongoing efforts in this area but those which have newly come to the medicaid law enforcement business. All in all, I think that our relations with the States over the past several months, as we moved to the implementation of section 17 of the regulations, have been excellent. I am encouraged by the efforts of the States to adjust. Sometimes

there have been difficult jurisdictional problems to solve in order to meet the requirements of our regulations, which we feel are consonant with the legislative intent.

I would be glad to answer any questions that the Senator may have or to explore, if you wish, some of the other aspects of Public Law 95–142.

[The prepared statement of Mr. Ruff follows:]

PREPARED STATEMENT OF CHARLES F. C. RUFF

Mr. chairman and members of the committee, thank you for the invitation to appear before the committee today to discuss the Federal funding of State medicaid fraud control units. We greeted the passage of section 17 of Public Law 95–142 with enthusiasm, and we see the development of State investigative and prosecutive expertise as a major step forward in our joint effort to combat fraud in the medicaid program.

Until recently, State investigation and prosecution of fraud by medicaid providers have been spotty, at best. With the exception of such States as Massachusetts, New York, New Jersey, Colorado, and California, where well-organized investigative and prosecutive offices have existed for some time, the resources needed to deal with sophisticated and complex criminal activity of the type involved in medicaid fraud simply were not available. Nor, it must be noted, was the Federal effort adequate. HEW's investigative staff was minimal, and only in a few of the larger U.S. attorneys' offices was there any substantial enforcement effort.

A change in this picture was first signalled by Congress' creation of the Office of Inspector General at HEW. Over the first 15 months of our existence, as our investigative staff has grown from 10 to almost 80 professionals, we have devoted an ever-increasing amount of our resources to medicaid fraud cases. Further, the Office of Program Integrity, Health Care Financing Administration, has intensified its own efforts to provide support and technical assistance to the States in this area. But we have always recognized that there could be no real impact on the problem unless there was a substantial improvement in the capacity of the States to handle these cases.

Immediately after the passage of Public Law 95–142, the Secretary appointed the Deputy Administrator of HCFA, the Deputy General Counsel, and the Deputy Inspector General to oversee the preparation of the regulations to implement section 17, and they were published a few days before the deadline set in the legislation. HCFA followed with the publication of guidelines, and a number of meetings were held at which Program Integrity and Inspector General's staff briefed the regional personnel who would be responsible for the certification of the fraud control units.

It was clear from the very beginning that, although HCFA had the principal responsibility for administering the certification process and the funding of the units, the Office of Inspector General must play an important role. We agreed that the Inspector General would assist Program Integrity in reviewing State applications to insure that adequate provision was made for the investigative and prosecutive aspects of the unit's operations, and we agreed that the Inspector General's concurrence in the recommendation for certification would be required before the application was finally approved by the HCFA Administrator.

Accordingly, the special agents in charge of our investigations field offices joined with their counterparts in the Office of Program Integrity to provide assistance to the States in developing their applications for funding. In addition, this Office has worked both formally and informally with representatives of interested States, and with such organizations as the National Association of Attorneys General and the National District Attorneys Association to solicit their comments on the draft regulations and guide them through the application process.

In assisting HCFA to draft the regulations, we acted in the belief that Congress intended to encourage the development of a central body of investigative and prosecutive expertise which would prove so valuable that the State would elect to continue its operation after the end of the funding period. Because the legislation had so clearly been modeled on the structure of the New York Special Prosecutor's Office, and because we felt strongly that early and continuing participation by prosecutors was vital to the success of the unit, our regulations created a strong preference for the first of the three alternatives provided by the act—that is, placement of the unit in an agency with Statewide prosecutive authority.

This preference caused difficulties for the district attorneys in some States, and, in response to their concerns, we included a provision for referral by the attorney general of individual cases to district attorneys whose offices had a demonstrated interest and capability in the prosecution of medicaid fraud. The regulations also provide that, where a State has no central prosecutive authority and elects to adopt the alternative method of referring all cases to the local prosecutor, the fraud control unit must consult with the prosecutor at the earliest possible stage in order to insure that the case will be developed in a manner which meets his needs. To date, we have seen an extraordinary effort on the part of such States as Colorado and Washington, to name but two, to coordinate the work of the attorney general and the district attorneys in a way that is adapted to their special requirements, but at the same time complies with the regulations under section 17.

Once the State units are in place, this office will assume responsibility for providing advice, as needed, in investigative and audit techniques and will serve as liaison between the units and other Federal law enforcement and prosecutive agencies. In addition, we have principal responsibility for developing and coordinating training for fraud investigators and prosecutors assigned to the units, and we have begun planning, with the cooperation of some of the more experienced States, to present an extensive training program for unit personnel in the Fall.

We expect the State fraud control units to carry the major burden of enforcement in this State-administered program, but this does not mean that the Federal presence will diminish. The Office of Investigations will continue to work with the Justice Department on the more complex provider frauds, particularly those having multi-State or national implications and those involving either organized criminal influence or public corruption. We intend to pursue, together with the Office of Program Integrity and the States, a variety of fraud detection programs, and we hope that the product of these programs will be of value to both Federal ane State investigators.

In sum, we view the creation of the fraud control units as a major advance in the fight against program fraud, and we feel confident that they will, over the next 2 years, prove themselves to be so cost-effective a law enforcement device that the States will elect, without any hesitation, to continue them even without Federal funding.

Senator CHURCH. Thank you very much.

This program took effect at what time? When was the effective date of the program relating to the State units?

Mr. BEAL. Senator, the regulations relating to the program were published, I believe, on January 23 of this year.

Senator CHURCH. How long was that after the law itself was to take effect?

Mr. BEAL. It was approximately 90 days. The law specifically required that we have regulations published within 90 days, sir.

Senator CHURCH. So the regulations were in effect as of January this year?

Mr. BEAL. That is correct; yes, sir.

Senator CHURCH. And as of now, nine States have set up these special investigative and prosecutorial units?

Mr. BEAL. We have certified, as of yesterday, nine States for this, Senator.

Senator CHURCH. How many States have applications pending?

Mr. BEAL. Eleven States, Senator.

Senator CHURCH. So up until now, only 20 of the 50 States have applied?

Mr. BEAL. Yes. That is, that have formal applications in our office. There are other States that are in the process and are working with us in the preparation and have worked with us over the last months, back and forth.

Senator CHURCH. How many States would you estimate, based on all the data now available, will set up these units by the end of the year?

Mr. BEAL. We have reasonable confidence, Senator, of 35 of the States or jurisdictions. There may well be more than that.

Senator CHURCH. I think that means that, with the 90-percent Federal funding, at least there is considerable interest on the part of the States to participate in the enforcement effort.

Mr. BEAL. Yes, sir.

THE FEDERAL EFFORT

Senator CHURCH. Now in addition to these State units that are being established, what direct investigative and enforcement efforts will you undertake at the Federal level in connection with medicaid fraud itself?

Mr. RUFF. It would be more appropriate if I were to respond to that, Senator. The direct investigation of medicaid fraud falls under the jurisdiction of a number of agencies, principally in HEW, the Office of Inspector General, Office of Investigations. We have grown in the past year from a minimally staffed office of some 10 investigators to almost 80 professional investigators, and assuming that our appropriation makes it the rest of the way through the Congress, we will have authorization for 160 professional investigators in the next fiscal year to get the staff up to that level.

I think it is fair to say that over the past several years the direct Federal investigative involvement in medicaid fraud, as opposed to medicare fraud, has been minimal. There have been a few U.S. attorneys' offices throughout the country—particularly the southern district of New York, the northern district of Illinois, and a few others—which have been very much involved, using the services of the FBI and the postal inspectors, but by and large I think it is fair to say that the direct Federal effort has not been what it should be, which is why we did welcome the State fraud control units.

At the moment I would estimate that perhaps 15 of our man-years in the Office of Investigation are devoted to medicaid fraud and related matters. We would expect that to increase as our staff increases. We would also expect, as I indicated in my prepared statement, that the States will probably bear the burden of the day-to-day enforcement in the medicaid fraud area with the Federal Government playing the role of investigator and prosecutor in the particularly complex multi-State or national investigations or those which have particularly sensitive organized crime or public corruption implications.

JURISDICTION AND DUPLICATION PROBLEMS

Senator CHURCH. So you would see the line of demarcation between the Federal and the State effort being drawn on the basis of the character of the nature of the offense. If it were a multi-State offense that would involve jurisdictional problems for the individual State governments, then it would be appropriately a Federal matter, is that correct?

Mr. RUFF. There is, of course, a Federal jurisdictional interest in any medicaid fraud case given the Federal participation in funding but, yes, when the system is working at its best, I would hope that the line we would be able to draw would place the principal burden on the States and leave to the Federal Government the sensitive area.

Senator CHURCH. I agree with you there because the thing that I think we should strive to avoid is an unnecessary duplication of effort.

Mr. RUFF. I agree, Senator.

Senator CHURCH. And I should think that if the Federal effort would be directed toward the instances of fraud that involved a number of States' operations that extend to a number of States, that would make a good deal of sense. You may get very complex forms of fraud, and that seems to be the way we are trending, that might require specialized skills unavailable at the State level and there Federal assistance might be necessary in cases of that character.

Mr. RUFF. Absolutely, Senator. We would be responsive in any ad hoc situation in which our special skills were required.

Senator CHURCH. I don't want to be too critical in our jump to the premature conclusion because I recognize that you are just beginning to move into this field and you have not had a great deal of time to prove yourselves, but this committee, in my judgment, should establish some benchmarks for determining how effective these stepped-up efforts to deal with the problem of fraud actually prove to be. We need some sort of cost-benefit ratio in determining whether the public is getting its money's worth out of this enforcement and investigative effort.

Now starting at the State level, our objective in passing the law was to give the States incentive to enter the field by providing seed money for the initial establishment of these fraud units, but we will be greatly mistaken, I think, if we don't attempt to furnish the States with sufficient incentive to maintain those units on the basis of State appropriations and work the Federal dole out of the system. Now the only way I can think of for doing this is to provide, by law, for State retention, either all or some part of the recoveries, so that the State agencies can make their case before the legislature on the basis of 3 years of experience. It is clear that this would be money well spent, and the return to the State would be more than sufficient to cover the costs. I think if we don't do that, we are likely to find that the Federal contribution becomes permanent and the cost-benefit ratio will prove to be very disappointing.

I would like to have your own feeling about how we could move toward giving the States this incentive and working the Federal Government out of the picture insofar as a constant Federal subsidy is concerned.

Mr. RUFF. My personal view, Senator, is that your suggestion is a wholly appropriate one. I would have to consult with my brethren to know what the numbers are. That may indeed be the simplest and most straightforward way of continuing the Federal incentive, recognizing that it is indeed a Federal contribution, although perhaps not specifically denominated as such.

We would be giving up the 55-percent—approximately—that otherwise we would be entitled to have. At some point I would like to see that cut off. I think the States ought to bear some burden in this area, but I think the general idea of recoveries being retained by the State at least appeals to me personally without stating the departmental position on it.

Senator CHURCH. What do you have to say about that, Mr. Beal? Do you think it would work, first of all, and do you think it is necessary to yield to the States? Under present law States can recover

their portion, can't they, of whatever may be collected in a fraud case?

Mr. BEAL. Yes, sir, that is correct. The States, of course, contribute to program costs in the medicaid program anywhere up to 50 percent of the cost of that program, so when they recover program moneys properly spent, they share substantially in that recovery, depending on their share, which varies from State to State. They do have that because, in some cases, they are recovering their own State programing funds.

Senator CHURCH. Have you any notion as to whether the inducement would be sufficient to lead these States to appropriate the necessary administrative cost for adequate investigative units if we were to simply follow the present practice of letting the States keep their share of the recovery?

Mr. BEAL. I think, Senator, a great deal of this will depend on how this particular program develops and evolves over the next couple of years if it proves itself, and we have considerable confidence that it will. State medicaid directors and Governors can make the case to their legislatures that in fact this program is paying for itself. But again I think that has to depend to some extent on the experience we see in the next years.

968 CASES UNDER REVIEW

Senator CHURCH. Yes, well, coming to the Federal side, I have an exhibit here which comes from the first annual report of the Office of the Inspector General which determines the cases handled by the Office of Investigation, and this has to do with health care cases, long-term care, hospitals, pharmacies, laboratories and clinics, physicians, other practitioners and beneficiaries, and it shows that presently there are 968 cases under review. Part of these are listed under the Office of the Inspector General and the larger number, in fact, under the OPI. What does OPI stand for?

Mr. RUFF. That is the Office of Program Integrity, Senator, and until the recent months when we have moved to assume full responsibility for criminal investigation of all medicare as well as medicaid cases, the Office of Program Integrity bore the principal responsibility for the investigation of medicare fraud cases.

Senator CHURCH. In addition to the Office of Program Integrity, you have an additional category of Project Integrity that is divided into parts directly monitored. Can you explain that to me?

Mr. RUFF. Yes; Project Integrity is the program that was begun in the spring of 1977, in an attempt to analyze all of the 1976 claims filed by physicians and pharmacists in the medicaid program, to identify billing practices that might be an indication of fraud. We selected 2,500 physicians and pharmacists, approximately 50 in each State, for further investigation. Since that time considerable work has been done by us, by the individual State agencies with whom we cooperated, and by the Office of Program Integrity, so that at this point some 500 cases have been identified as meriting full scale criminal investigation and that is the figure that you see before you.

Senator CHURCH. Now that Project Integrity has been handled by what branch of the Department?

Mr. RUFF. It has been handled by our office through the Office of Program Integrity.

Senator CHURCH. I see.

Mr. RUFF. Our auditors did the computer work; our investigators have done some direct investigations as well as monitoring; and Mr. Nicholson's program has full participation as well.

Senator CHURCH. Now this shows that at the Federal level of the investigation there are just slightly less than 1,000 cases that are under some stage of processing for possible enforcement action and possible prosecution. I have some other figures here which I want to check with you for their general accuracy. Now beginning with the total cases that are being processed—just under 1,000—I have figures here that show that in 1977 the Office of the Inspector General formally referred 19 cases to the Department of Justice and had informal contact with U.S. attorneys in 38 other cases. As of the date of the report, March 1, 1978, six indictments had been returned with convictions in four cases. Seven cases are pending decision by the Department of Justice.

Now I have further information to this effect. During the same period the Office of Program Integrity referred 83 cases to the Department of Justice with 20 indictments returned and 12 convictions. Project Integrity, a special pilot program, has resulted in 197 cases involving civil representation in the amount of $395,000 and, as of this date, none of that money has been recovered. This would show that in 1977 and up to March 31, 1978, about all we have to look at in terms of completed cases are 19 with 19 convictions. Now I assume that at the State level these units have not been set up long enough so that there is any record available.

Mr. RUFF. That is correct, Senator. We did have a very rough figure of something in the neighborhood of, I believe, 129 State medicaid convictions, but it is very difficult to collect that information in any reliable form and I hesitate to use that figure.

WHAT ARE STATES DOING?

Senator CHURCH. Well, I think that we have to find out how to do that. If we are going to monitor this program and determine its effectiveness and decide whether or not the tax money going into it is producing results, we are going to have to have a way to find out what the States are doing. We are going to have to have reliable information concerning both the number of cases and the number of convictions, the amount of money to cover it in the way of penalties, fines, and so forth.

Mr. RUFF. Senator, I think it is clear that once the section 17 units are in place there will be very accurate information about their activities. In addition, as I understand it, the Office of Program Integrity has made some strides in this direction.

Mr. NICHOLSON. We have established a system that we will use to select information on the fraud and abuse cases that are worked by various components at both the Federal and State levels so we can get feedback on a more precise nature in the whole system. The instructions have gone out and we have gotten approval on the forms. We will be in the process of implementing that over the next couple months. I feel confident as a result of the implementation of that reporting procedure that we will be able to provide more accurate information on the success rate of the fraud units that have certified

other contractors in medicare State agencies and their responsibilities in the fraud abuse area.

Senator CHURCH. Well, this committee will be requesting that kind of information as it becomes available so that we can oversee this program and try to make it as effective as possible, and that data will be essential to the committee.

"AN ANEMIC RECORD OF RESULTS"

In the matter of these 19 convictions, that really is a very unimpressive figure and I do not have information as to what was recovered in these 19 cases. I know in the past we have discovered that the courts have been extremely lenient in dealing with doctors, pharmacists, and others who have been actually convicted of fraud. It is a kind of double standard that apparently is at work here and the sentences have tended to be very light—the fines have sometimes been only token fines, very little more than that. In the civil side of our effort there has been no recovery, if this information is correct, so this is sort of an anemic record of results.

Mr. RUFF. Senator, I think first of all the vast bulk of both the investigative and the prosecutive effort in the health care area has been on the medicare side represented by the activities in the program of the Office of Integrity, now being assumed under our office. There has been substantial recovery of the funds on the medicare side. It is true that on the medicaid side neither the Justice Department nor HEW, over the years, has devoted enough resources to investigation, prosecution, and civil recovery of the funds in that area, but we trust that that is going to improve now that we have additional manpower to devote to it, as well as the new thrust that will be given to the effort by the State control units.

Let me just say, by the way, on that score that our current figure of recoveries under Project Integrity—that is the nationwide medicaid State-Federal program—now is in the area of $2.6 million, so I think that our general success in attempting to recoup funds misspent will be more evident next year at this time.

Senator CHURCH. I think it would be well for the staff to calendar another hearing about a year from now so that we can trace this along and see what progress is being made. The figures that we have been using that I have been quoting here deal with the numbers of cases that are under investigation and all relate to the medicaid side, is that correct?

Mr. RUFF. No, that is not correct, Senator. The 1,000 cases represents the entire workload of the Office of Investigation. As I indicated, the principal caseload in the health care area has always been medicare and principally carrying the load has been the Office of Program Integrity. Perhaps Mr. Beal and Mr. Nicholson can be more specific on those numbers, but we are, as I indicated, in the process of bringing that criminal caseload into the Office of Investigation so that next year our report will indicate the full scope of criminal activity by HEW within the Office of Investigation.

Senator CHURCH. Well, the number of indictments and convictions that I referred to covers both medicare and medicaid?

Mr. RUFF. That is correct.

Senator CHURCH. Well, to get back to my earlier conclusion, it is pretty anemic.

Mr. RUFF. I grant you that, Senator, and I think there is considerably more success on that side, both civil and criminal.

Mr. NICHOLSON. We have had, Senator, over the period of our existence as the Office of Public Integrity, approximately 300 convictions for medicare fraud. That is based on the referral of around 800 cases that have been done by the U.S. attorneys. We have had overpayments established in the neighborhood of $31 million over the last several years since we have been actively involved in areas of fraud and program integrity. Of that amount, we recovered about $20 million, so there is still about $10 million outstanding.

Senator CHURCH. I wanted to be sure we have the accurate figures in the record. I thought that the ones I quoted seemed very trivial.

Have you any information as to what this enforcement effect has cost over this period of time as compared to the amount collected?

Mr. NICHOLSON. I could try to provide that information to the committee if you like, Senator.

COST-BENEFITS DATA REQUESTED

Senator CHURCH. I wish you would, and I wish you would include the whole cost involved so that we get some idea of what it is costing us to try and clean up and police this program, compared to the results. It may very well prove to be that we will have to take a different approach in the criminal law enforcement, which is totally inadequate even with State participation. That may be what will happen: I don't know. We may have to cut this whole system and set it up a different way and attempt to find whether there are some structural changes that can be made that will eliminate the incentive to cheat.

Your own estimates of the amount of fraud that exists within the program I have no reason to question, and they are staggering. The attempt to get at these cases and to eliminate this problem is frightening, apparently, because of the size of the profit. Inform us of the public money that is being wasted, that is being skimmed off this whole medical effort by crooked people. I wish you would furnish us with the cost figures and do so in a way that will enable us to identify just what those figures represent so that we can check those figures against the congressional appropriations and try to make some sense out of them.

Mr. NICHOLSON. Yes, sir.

[The following letter was received by the committee:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
HEALTH CARE FINANCING ADMINISTRATION,
Baltimore, Md., August 17, 1978.

Hon. FRANK CHURCH,
Senate Special Committee on Aging,
Washington, D.C.

DEAR SENATOR CHURCH: You may recall during the July 25, 1978, hearings on the DHEW progress in implementing the section 17 medicaid fraud control unit provision, the cost benefit of the Office of Program Integrity's (OPI) fraud and abuse control programs was questioned. The table below demonstrates the cost benefits derived.

	Cumulative Federal dollars identified for recovery through March	Cumulative Federal costs through March 1978—Central office and regional offices
Medicare	[1] $31, 770, 000	[2] $35, 000, 000
Medicaid	[3] 9, 000, 000	[4] 5, 700, 000
Total	40, 770, 000	40, 700, 000

[1] For period January 1970 to March 1978.
[2] Approximate administrative costs for the medicare program integrity effort for period January 1970 to March 1978.
[3] Approximate figure for period January 1976 to March 1978; information reported from the States incomplete. The new fraud and abuse reporting system developed by OPI will correct this situation.
[4] Approximate administrative costs for Medicaid Fraud and Abuse Control Division (Social and Rehabilitation Services) for period January 1976 through March 1978.

It should be noted that prevention and deterrence of fraud and abuse is a primary goal of the HCFA OPI programs. The above table does not reflect any valuation of that deterrence factor.

If you require additional information, please call me.

Sincerely yours,

DON NICHOLSON,
Director, Office of Program Integrity.

"WHO OWNS WHAT"

Senator CHURCH. As I mentioned earlier, there appears to be an escalation and a growing sophistication of the kinds of fraud being practiced. It is no longer a matter of owners buying boats or vacation homes with medicare or medicaid money; we now have instances of multiple ownerships, related businesses, and the contracting for services with a variety of businesses in ways that open the door to complex and hidden manipulations. In fact, one of our committee staff members who specializes in reimbursement in ownership issues feels that it is increasingly difficult to know who owns what, and the first annual report of the Office of Program Integrity to the Inspector General of HEW seems to acknowledge this point when it says, and I quote from the report:

> The new breed of financial manipulators who have invaded the health care industry, particularly the chain organizations, have devised new methods for maximizing program funds which are exceedingly complex, difficult and, in many cases, their action is illegal.

Now I know that you are in the process of drafting regulations to comply with section 3 of the law to require medicare and medicaid providers to supply full and complete information as to the identity of each person with an ownership or control interest in the entity or any subcontractor in which the provider directly or indirectly has a 5-percent or more ownership interest. We have been looking at these draft regulations and some questions have arisen on the basis of our review having to do with this requirement for more complete information with respect to ownership.

I am advised that on the basis of this staff review, the proposed regulations apparently provide no means for validating the information to be supplied by the owners of the contractor providers. Does this mean that the submitted material is to be taken at face value and in no way checked out?

Mr. BEAL. The draft regulations do not specifically provide for validation to the best of my recollection, Senator. However, I am

sure that they will be the basis for monitoring, for checking out, if there is any indication of fraud in the operation.

Mr. RUFF. I think it is fair to say, Senator, that that part of their compliance will be audited by the Office of the Inspector General as we go into the health care providers to check on the accuracy and the validity of their disclosure information. I think it would be unusual to have that kind of provision in a regulation. I don't really believe that the absence of a specific validation function in the regulation really bears directly on the issue. It is something that we are very concerned with because we intend, in the Office of the Inspector General, working with the Office of Program Integrity and HCFA, to make use of that information for criminal investigative as well as auditing purposes, and obviously it is crucial to us as well as to other States and others. We would see both, I suppose, the Office of Program Integrity as well as our auditors spot checking this information as appropriate, Mr. Chairman, to determine whether or not the information was provided accurately.

Senator CHURCH. Well, in looking at these regulations, we were left to wonder whether they were drafted in such a way as to enable you to identify interrelationships and ownership networks that seemed to be the norm. An owner of a nursing home, for example, may own an interest in a pharmacy and possibly a piece of a laundry, a hospital, what have you, construction business, and instead of charging competitive prices at the nursing home, the auxiliary service charges as high a price as possible because of this interconnecting, interlocking ownership network.

Now unless a systematic means of discovering and identifying such patterns is established, hidden ownership may go undetected and the disadvantage for abuse will go unrecognized. Given the fact that we know that the methods for milking the system keep getting more ingenious and less evident, how do you propose to cope with this developing problem?

Mr. NICHOLSON. Senator Church, I think the regulations as they are drafted will give us an opportunity to be able to examine those kinds of interrelationships. The regulations require that if there is a 5-percent or more ownership interest in a particular facility, that information be furnished. That would include not only individual interests, but corporate interests of, let's say, a holding company over a particular group of facilities. I believe it will be able, on the basis of those requirements, to examine to a level of detail and to be able to detect where there is an interlocking arrangement that might suggest a potential for abuse in the program.

Senator CHURCH. Well, you are aware of the problem.

Mr. NICHOLSON. Yes, sir.

Senator CHURCH. And you try to deal with it in devising these regulations.

Mr. NICHOLSON. Yes, sir. Very shortly, as these regulations are proposed, we will be releasing instructions and information to medicare contractors, medicaid State agencies, and to the private community to make sure they understand what these disclosure requirements entail.

Mr. RUFF. I think on that score, Senator, the key is what we do with the information after we get it and we hope we will get it in the course of the next year so that we can, in fact, determine that an

owner of a facility in one State also has an interest in a facility in another State. That really is a matter of how the information is treated once it is gathered.

Criticism: Slow Implementation

Senator Church. We have a letter [1] addressed to me, as the chairman of the committee, from one State attorney general to get its operation approved for participation in its program, and the attorney general has reported to us, to summarize:

> I believe that the general posture in HEW in the substantive areas of how to tackle fraud and what is the appropriate role of a single State agency, vis-a-vis fraud control, is lacking in vision and lacking in aggressiveness. I get the impression that HEW is more concerned with setting up a structure for evaluating grants than in implementing the purposes of the law which, as I understand it, was to encourage aggressive and innovative approaches on the part of States to protect and vigorously prosecute medicaid fraud.

He also says in his letter:

> I can only conclude that HEW is implementing H.R. 3 with people whose sole knowledge of fraud stems from medicare experience and who are trying to force the single State agency and medicaid fraud control unit into a Federal medicare investigative and prosecutorial role. This amounts to the Federal agency substituting its own definition of fraud with a far more encompassing State definition.

Now what about these criticisms?

Mr. Beal. I think there are two, Senator. The latter one, in terms of any effort by us to force a particular pattern or definition of fraud or method for its investigative and detection, I don't think is correct. I think the law very wisely left to the States the responsibility for establishing these units and for operating them under their laws with the Federal involvement limited to the funding of them, the establishment of standards, and the maintenance of records of their performance, which I think we have an obligation to do for the Congress. So I do not think that is a valid criticism. The States are operating these programs and they will continue to do that.

On the other, in terms of aggressiveness, I think we have come a long ways in recent years and in recent months in the efforts by this Department in the whole area of fraud and abuse. I think that is particularly so in the area of establishing these units. We have worked with States and we have encouraged the development of these units. We have, as I say, applications in hand, or States certified, which would cover 72 percent of the medicaid expenditures. It is our objective to get those units into opertation to the extent that it is in the Federal power to do so, and we mean to keep at it.

Mr. Ruff. Senator, I think I just have to comment, without knowing what State that attorney general comes from, but I think he is just dead wrong. I think that first of all we have to begin with a congressional determination that the kind of structure evidenced by the provisions of section 17 is the optimal structure for the investigation of provider fraud—not beneficiary fraud, but provider fraud. This program is modeled directly on the office of the man who will testify later, Deputy Attorney General Hynes. The statute calls for what I think is an appropriate mixture of investigative and auditing functions;

[1] See appendix, item 2, page 37.

indeed we have forced that structure on the States because that is what Congress called for and that is what I believe to be the most effective prosecutive and investigative device. Some States have, in fact, been reluctant to put that kind of an effort together; others have welcomed it.

"No Claim of Perfection"

I think that, yes, there have been delays. We have made no claim of perfection here, but I think by and large we have attempted to work both formally and informally with States to try to meet their special concerns. We look to a State like Colorado, for example, where the attorney general may not have had statewide prosecutive authority and where there was a district attorney's office in Denver which had been active in the medicaid fraud field. I think that State represents a really shining example of their willingness to work with us.

Our flexibility and their willingness to work together helped create a system in which the attorney general and the district attorneys got together and said, "Let's work out a way of addressing this problem and not worry about our special jurisdictional concerns," and I think that is an example of the best of this system. We have had problems and we are working on them, but I think that that characterization of HEW's approach to this issue, as I said, is just dead wrong.

Senator Church. Can you give me an idea of what the average time has been for the certification process? We have one case here—I think it is Wisconsin—where the application has been pending since March 27. I am just wondering how long it takes, once a State formally applies to participate in this program, for it to be certified and for its agency to be set up.

Mr. Nicholson. It normally takes a couple months, Mr. Chairman.

Senator Church. A couple of months?

Mr. Nicholson. Normally it takes a couple months, but it would be around 2 months from the time the application is filed.

Mr. Ruff. I think it is worth pointing out though, Senator, that funding is retroactive to the date of application, so it is not a matter of losing that funding through the period between the filing of the application and actual certification.

Senator Church. How do you determine the amount or what formula has been adopted for determining the amount of the Federal Government's role for making available in a given State? I know it is 90 percent, but does that depend upon how large the local contribution is or does it depend on other factors?

Mr. Beal. The limit, Senator, is spelled out in the legislation, which is $125,000 per quarter or one-quarter of 1 percent of the State's previous quarter's medicaid expenditures, whichever is higher.

Senator Church. I see. Now have you found that that quarterly determination has been unsatisfactory?

Mr. Beal. In some respects it has, Senator, because the medicaid expenditures in the State can fluctuate rather significantly from quarter to quarter and it has not, I think, been the ideal basis on which to do budgeting and planning of expenditures. I think fixing the participation ceiling at, say, some percentage of the previous year's expenditures or something like that would give you a more level Federal participation in the program.

Senator Church. Do you have any other recommendations to make to this committee as to how the present law can be improved?

Mr. NICHOLSON. We do have the item that Mr. Beal mentioned. We are putting together a technical amendment to change it to an annual computation. Aside from that, there is nothing at this point to really come forward with. There have been some problems. One concern, for example, is whether or not the staffing problem that is currently envisioned as being necessary for a fraud unit to function is appropriate for some of the smaller States. We have interpreted the intent of Congress to suggest that we need to have at least full-time individuals as auditors, investigators, and attorneys in order for any unit to be certified, and this is creating a problem as far as some of the smaller States are concerned. That may be an appropriate thing to come forward with.

NEED FOR FLEXIBILITY

Senator CHURCH. Well, I would hope that we can administer the program, at least within permissible boundaries into the law, in such a way as to accommodate the smaller States, and that means showing such flexibility as you can. There are certain standards that are definite that you have to provide and certainly I would not criticize you for doing that; that is your obligation. If that proves to be the case, I wish you would furnish this committee with the recommendations as to what changes in the law would help to facilitate the program and give the flexibility that it needs to accommodate very differing needs of small States as compared to large States. So often in these Federal programs we don't have that flexibility.

I know that in connection with medicare, for example, and nursing homes and little country hospitals in my State we have a dreadful time of trying to get Federal administrators to understand that they are not dealing with Washington Central Hospital or Georgetown Hospital, but with small units that have very limited resources.

All right. I want to thank you for your time. I would hope that as you get additional experience you would feel free to volunteer to this committee whatever recommendations you may have for changes in the law and the views you have to make it more effective.

Mr. BEAL. We will be pleased to do that, Senator.

Mr. RUFF. Thank you, Senator.

Senator CHURCH. Our second panel this morning consists of Charles J. Hynes who is deputy attorney general of the State of New York and special prosecutor for nursing homes, and Stephen Press who is the chief medical officer of the State of Connecticut.

STATEMENT OF CHARLES J. HYNES, DEPUTY ATTORNEY GENERAL, STATE OF NEW YORK, AND SPECIAL PROSECUTOR FOR NURSING HOMES

Mr. HYNES. Good morning, Mr. Chairman.

Senator CHURCH. I am glad to welcome you back. It has been your perseverance and your effort that had so much to do with our coming to establishing a national enforcement program.

Mr. HYNES. Thank you.

Senator CHURCH. We are indebted to you for showing us the way.

Mr. HYNES. If I may, Mr. Chairman, I would like to summarize my statement and offer it for the record.

Mr. Chairman, I believe that Public Law 95–142, particularly section 17, provides a significant tool to the States to properly contain health care fraud. I further believe that the Department of Health, Education, and Welfare has a fundamental obligation to the taxpayers of this country to encourage States to apply for certification, I am distressed, as you are, at the slow pace of certification, particularly since New York State today has not been certified. I think it is going to lead to a 2-year project rather than the 3-year project which is the congressional intent. I earnestly hope that Congress will amend Public Law 95–142 to permit the 3-year period to begin from the date of certification. That makes more sense.

The New York Experience

Now if I may, I would like to briefly discuss some of the changes that have occurred in New York State in the last 3 years. When we began in 1975 we had a medicaid system that was literally riddled with fraud and abuse, a system regulated by an understaffed, underfinanced State health department which, incredible as it seems now, assigned but a dozen auditors to check the books and records of more than 2,700 facilities with medicaid expenditures of $2.5 billion. Today I am happy to report that between our office and the State department of health, there are more than 300 auditors in New York State.

Before 1975, not one single nursing home owner had been prosecuted anywhere in the State of New York, nor was there any serious attempt to recover fraudulent overpayments to providers. Quite simply, health care providers and other similar white collar criminals—the real profiteers in the system—were pushing us toward fiscal and moral bankruptcy in the nursing home industry.

Today 138 institutional providers, and vendors of services to those institutions, have been indicted by our office. Of the 90 cases completed, 7 have had their cases dismissed, 5 have been acquitted and 78 have been convicted. Jail sentences ranging from 6 months to 10 years have been handed down by an increasingly concerned judiciary. We have received, in cash or by assignment of assets, over $6 million in restitution from convicted providers. Moreover, we have discovered overstated expenditures of $64 million, and of this amount our auditors have turned over to the State department of health and to our own in-house civil recovery division audit reports identifying more than $43.5 million in overpayments.

Our civil recovery division, which was established only last September, has brought 23 lawsuits to date which total over $12 million in claims and has recovered three-quarters of $1 million. And finally, in cooperation with the New York State Tax Department, liens of over $4 million have been assessed against providers.

New York's fraud problem, as this committee and the House of Representatives' committee concluded, was not unique. I think that Public Law 95–142 offers the hope so desperately needed to contain health fraud in this country. Yet the elimination of fraud, however critical in the effort to control costs, must not be viewed as a panacea. It is, to be sure, medicaid's most apparent and controversial problem but, in terms of our entire health care system, it is not the only problem.

This Nation has been talking about national health care for many years. Based on present predictions, total annual health expenditures

will go up $85 billion by 1980, reaching a total of $244 billion. By then experts calculate the cost of hospital care will average well over $200 a day and at some major medical centers the rate will probably reach $500 a day. At this very moment it is estimated that 12 cents of every tax dollar goes to health care.

Fraud, Waste Endanger National Health Insurance

With such figures staring us in the face, universal health insurance plans for people of all ages will never be economically feasible and, thus, can never become a reality unless the economics of health care are carefully analyzed with an eye to evaluating and stopping the waste brought about by fraud and mismanagement.

Today, Mr. Chairman, no one knows how much good patient care really costs and I submit that the first priority of all of us concerned with this issue should be to provide that answer for each of our States.

With the passage of Public Law 95–142, we have the opportunity at last to gather essential information as to the cost, the quality, and the distribution of patient care in this country. It is for these reasons that I have proposed that such offices be made permanent.

Thank you.

[The prepared statement of Mr. Hynes follows:]

Prepared Statement of Charles J. Hynes

Senator Church, members of the committee, ladies and gentlemen, for nearly 4 years my office has struggled with the problems of medicaid fraud and mismanagement in New York State. While we have been reasonably successful in identifying fraud and abuse and in beginning the process of administrative reform, it is clear that lasting improvement will require a major overhaul of the ways we deliver and pay for health care in this country. Until we design and implement long-term reforms in our current medicaid system, the crisis in medicaid and in the rest of the health care system will continue to grow.

When we last met in late 1976, I testified that I would have liked nothing more than to tell you that the forces of evil in the health care industry in my State and elsewhere had been vanquished, and that order and justice had returned to the benefit of our elderly people. I also stated that I feared there still existed a climate in this country where the exploitation of old people was a respectable and risk-free profession and that our Nation was in danger of losing far more than Federal and State tax dollars—it was in danger of losing a cornerstone of the American way of life itself.

I now believe that the tide has begun to reverse itself through the efforts of your committee, Representatives Jim Scheuer of New York and John Moss of California, and others, in passing a bill Public Law 95–142, commonly referred to as H.R. 3. This bill, signed into law in October 1977, gives each State, perhaps for the first time since the advent of medicaid and medicare, an opportunity to properly contain health care fraud.

The basic purpose of section 17 of this law is to improve the capacity of State and Federal governments to detect, prosecute, punish, and discourage fraud and abuse by providers participating in the medicare and medicaid programs. Proposals merely to make existing single State agency fraud programs eligible for special Federal funding were rejected, and I believe correctly so, as only providing additional Federal dollars to the status quo.

Congress has wisely concluded, I believe, that without meaningful and independent State programs of criminal prosecution, medicaid fraud could not—and would not—be brought under control. New York State's experience has demonstrated clearly that programs and prosecutions would not mix. The agency responsible for dispersing medicaid and medicare dollars could not be expected to look for criminality in the system.

Further, the average local prosecutor, weighed down with street crimes, muggings, murders, and rapes, could not be expected to prosecute massive white-collar criminal conspiracies. They simply have enough on their hands without the additional burdens imposed by these highly complex and sophisticated schemes.

In its wisdom, Congress provided funding incentives for States to establish medicaid fraud units in their attorney general's offices with statewide investigative and prosecutorial powers over the entire medicaid system.

If they meet the Federal standards, these units will receive Federal reimbursement of 90 percent of their costs for a period of 3 years. Although it is 9 months to the day since this bill was signed into law, only a handful of states—Alabama, Louisiana, Michigan, and New Mexico—have applied and received H.E.W. approval for the Federal funds. A number of other States have submitted applications for the funds and are awaiting similar approval.

With respect to my own State's application, after the promulgation of the regulations and the clarifying of various jurisdictional concerns, New York submitted its application to the Department of Health, Education, and Welfare almost 3 months ago. Having been cited by Congress as the "model agency" for these units, we had hoped for a rapid and affirmative response. This response has not been forthcoming.

Many States that we have contacted are experiencing similar difficulties which can only be blamed on a kind of bureaucratic delay. For example, a "new" unit being set up in a Midwestern State received the following reply in response to its application: "Accompanying your budget by quarters, we will need to know in which quarter each staff member will be hired, the established caseload by quarter, including the delineation by type of case and level of investigation, and a time estimate for case processing by type of case and level of investigation."

What possible answer could be given to such a request by a unit that has yet to undertake the investigation of medicaid fraud within its State? I suggest to you, Mr. Chairman, that had New York been asked for this type of information at the outset of its investigations, the office of the special prosecutor would today be reporting a more moderate story.

Further, the quarterly restrictions and reporting imposed by Public Law 95-142 create a second type of problem. Because the medicaid budget of each State varies from quarter to quarter, there seems to be little, if any, redemption in requesting quarterly reports. The same objectives could as easily be accomplished by annual reports and would, indeed, assist the States in their planning function as well as reduce both Federal and State paperwork and staff time and, hence, dollars expended.

Given the difficulties in establishing or maintaining medicaid fraud control units, it appears that the investigations will actually be funded, then, for a period of 2 years, and not the three as was the original intent. This is not satisfactory in my opinion, Mr. Chairman, when one considers the kind of investigations to which I have been referring.

They are long, they are tedious, and they are difficult. In our office, such an operation is generally begun by sending a team of auditors into a facility or by bringing the books and records of a nursing home or other institutional provider into our office. Usually these particular facilities have been carefully targeted in advance for investigation. Some of the targeting factors we use are as follows:

(1) Operators previously known or believed to be engaged in fraudulent activities;

(2) Affiliation with consultants, vendors, contractors, etc., known or believed to be engaged in fraudulent activites;

(3) Improprieties identified by review of audits conducted by or for other government agencies, referrals from agencies, civic groups, informants, anonymous tips, ect.;

(4) Geographic considerations—certain investigative techniques are more successful in one area than others; certain schemes are more prevalent in certain areas;

(5) Type of facility (voluntary, public, proprietary);

(6) Size of facility;

(7) Medicare/medicaid percentage;

(8) Cost analysis;

(9) Multiple ownership (interlocking ownership in separate free standing hospitals, nursing homes, health-related facilities, etc.);

(10) Multiple facilities—hospitals, nursing homes, health-related facilities, etc.—combined in one facility.

Once the subjects of investigation have been selected, our auditors, using a variety of techniques developed, tested and refined from the inception of our office over 3 years ago, make preliminary judgments as to the validity of the expense claims submitted by the facility to the State. This initial audit work generates leads which are handed over to investigators who operate under the

direction of an experienced prosecuting attorney assigned to the case from the beginning.

All manner of books and records must be obtained by subpena, search warrant, or consent and carefully examined. And I refer not only to the books and records, but also to the myriad of public and quasipublic documents that can often yield substantial investigative leads, such as the following:

(1) Corporate papers;
(2) Title searches, mortgages, etc.;
(3) Professional licenses and applications to the State education department can prove pertinent background data;
(4) Records of credit card companies (D & B); and
(5) Bank records.

These crimes are "paper crimes," and there is rarely an eyewitness. The only "smoking gun" we are likely to find is a set of phony books and records. We must often rely on circumstantial evidence, but evidence that must be more than sufficient to prove criminal knowledge and to rebut the all-too-common defense that "My accountant did it," or "I had nothing to do with the daily financial operation of the home," or "I'm a doctor; I only care about patient care—not books and records." All of these defenses must be anticipated and negated from the outset.

Our investigations to date make it clear that medicaid fraud in New York State prior to 1975 existed on a massive scale. What kind of frauds have we found? We have found everything from the most obvious to the most highly sophisticated criminal scheme. Among the less sophisticated, we have uncovered:

(1) The outright theft of funds by an owner or employee;
(2) The intermingling of patient funds with the proprietor's accounts;
(3) Double billing for items included in the medicaid rate;
(4) Requiring donations from patients and families as condition of admission to the home. In one of the more heinous cases yet uncovered, a Buffalo nursing home operator named Trippi was extorting under-the-table cash payments from family members on the threat of lodging their relatives in the antiquated and ill-kept wings of his facility. The owner, Frank Trippi, was convicted and was himself lodged in the State correctional facility at Attica for nearly 2 years.
(5) The retention of interest on patient accounts; and
(6) The retention of deceased patients' funds. Only slightly more sophisticated are the following schemes:
(1) Billing the State for patients who have died or moved; and
(2) "No-show" or "phantom" employees who are usually relatives of the operator, and who are often carefully disguised as "consultants."

More significantly, we have found vendor frauds that are equally pervasive and even more difficult to detect. My previous testimony before this committee details the types of schemes which, generally, result in cash kickbacks ranging from 5 percent to 33⅓ percent of a facility's gross monthly billing with a particular vendor. In addition to these vendor frauds, which to date have yielded some 50 indictments, we have also seen a dozen more subtle schemes, including phony construction costs, hundreds of thousands of dollars in falsely inflated accruals, and concealed ownership of related companies.

To develop these cases, I have selected and trained a staff of capable lawyers who are, for the most part, former prosecutors. This group works closely with our auditors and our special investigators, who are generally former police detectives, ex-FBI agents, and the like. We conduct frequent in-house seminars. We have invited prominent members of the legal profession, in and out of law enforcement, who have lectured to the staff and kept them current on the latest developments in the law, strategy, and techniques. All this in the pursuit of a standard of excellence which is necessary to cross swords with the best lawyers that white-collar criminals can buy.

From the beginning, our office has proceeded from the principle that there is no pride in authorship—that cooperation among agencies in and outside of New York must be the cornerstone of any hoped-for success.

Our office and the State health department—the State agency responsible for monitoring and setting nursing home rates and standards—have entered into a memorandum of agreement designed to insure that our work dovetails with and complements the programmatic and monitoring work of the department of health. We provide the State health department with technical assistance and up-to-date training in the art of fraud auditing.

We have provided information and expertise beyond New York State, as well. We have encouraged and will continue to encourage law enforcement agencies throughout the country to avail themselves of our experience and intelligence

information—and they have done so on a regular basis. Certainly, no arm of government has a right to think that it can achieve success in an arena of these dimensions without such regular candid exchanges.

In addition to these efforts, we also initiate and support legislative recommendations which will help to eliminate the problems which infect the medicaid program. Similarly, we have an active community liaison program which reaches out to citizen groups in the communities to aid us in enacting remedial changes in the law and in gathering critical intelligence information.

Now let me tell you briefly about some of the changes that have occurred in New York in the last 3 years.

When we began in 1975, we met a medicaid system that was literally riddled with fraud and abuse. A system regulated by an understaffed, underfinanced State health department which, incredible as it now seems, assigned but a dozen (between 11 and 26) auditors to check the books and records of more than 2,700 facilities with medicaid expenditures of $2 billion.

Today I am happy to report that between our office and the State health department there are more than 300 auditors in New York State—a formidable army to contain health fraud.

Before 1975, not a single nursing home owner had been prosecuted anywhere in the State of New York. Nor was there any serious attempt to recover fraudulent overpayments to providers. Quite simply, health care providers and other similar white-collar criminals—the real profiteers in the system—were pushing us toward fiscal and moral bankruptcy in the nursing home industry.

And where are we today? Today 138 institutional providers, and vendors of services to those institutions, have been indicted by our office. Of the 90 cases completed, 7 have had their cases dismissed, 5 have been acquitted, and 78 have been convicted. Jail sentences ranging from 6 months to 10 years have been handed down by an increasingly concerned judiciary, to whom our attorneys have advocated the need for strong deterrent sentencing. We have received in cash or by assignment of assets over $6 million in restitution from convicted providers.

We have discovered overstated expenditures of $64 million and of this amount our auditors have turned over to the State department of health, and to our own in-house civil recovery division, audit reports identifying more than $43.5 million in overpayments.

Our civil recovery division, which we established only last September, has brought 23 lawsuits to date which total over $12 million in claims and has recovered more than three-fourths of a million dollars.

Finally, in cooperation with the New York State Tax Department, liens of over $4 million have been assessed against providers. Twelve defendants have been indicted specifically on tax charges. To date, six have been convicted. There have been no dismissals or acquittals. I might add, parenthetically, that before we began our investigations, there had hardly been a single prosecution anywhere in New York State for violation of the State, as opposed to Federal, tax laws. This extremely valuable weapon against the white-collar criminal had become a dusty relic on the statute books.

Today in New York—at least in the nursing home industry—I believe that we have made fraud a very precarious activity. We have done this, not with mirrors or any other magic, it has been accomplished with resources—the same resources that will now be available to all States under Public Law 95–142.

The medicaid system in this country has been a hostage to fraud and so, too, has been our entire health care system. Yet the elimination of fraud, however critical in the effort to control costs, must not be viewed as a panacea. It is, to be sure, medicaid's most apparent and controversial problem. But in terms of our entire health care system, it is not the only problem.

This Nation has been talking about national health care for many years. Based upon present predictions, total annual health expenditures will go up $85 billion by 1980, reaching a total of $244 billion. By then, experts calculate, the cost of hospital care will average well over $200 a day, and at some major medical centers the rate will probably reach $500. Physicians, already higher paid than members of any other profession, will probably be earning a median income of over $80,000 a year. At this very moment, it is estimated that 12 cents of every tax dollar goes to health care.

With such figures staring us in the face, universal health insurance plans for people of all ages will never be economically feasible and, thus, can never become a reality, unless the economics of health care are carefully analyzed with an eye to evaluating and stopping the waste brought about by fraud and mismanagement.

For the past 3 years, our office has immersed itself in the economics of medicaid and, in turn, the health care system. We have learned that State and Federal

laws which require reimbursement based upon so-called reasonable costs of doing business and prudent buyer concepts are meaningless in practice. The fact is that reimbursement is based upon costs submitted by individual providers who are given little, if any, incentive to economize. Cost ceilings, where they exist, are generally based upon operator versus operator comparisons, often fraudulent operator versus fraudulent operator comparisons, and nothing more. As a result, today no one knows how much good patient care really costs. I submit that the first priority of all of us concerned with this issue should be to provide that answer for each of our States.

With the passage of H.R. 3, we have the opportunity, at last, to gather essential information as to the cost, the quality, and the distribution of patient care in this country. And, it is for these reasons that I have proposed that such offices be made permanent. Among reasonable men and women, the deterrent nature of the operation, as well as its cost-effectiveness, could lead to no less a conclusion.

In closing, Mr. Chairman, I would like to quote something to you: "Beyond the specific instances of fraud and deceit as they may be revealed and must be dealt with, we are bending every effort to produce constructive results that will prevent recurrence of cheating and misrepresentation: Results that will strengthen the administration of regulatory and medical care programs of city departments, and above all, results that will upgrade proprietary nursing homes in respect to operational effectiveness and quality of patient care—all in the public interest."

These words were spoken some 18 years ago by Louis J. Kaplan, then New York City's investigation commissioner and author of the celebrated "Kaplan Report." Those same fraudulent providers found by Kaplan 18 years ago, who were not prosecuted and were allowed to repay their ill-gotten gains at 10 and 20 cents on the dollar, have in the last 3 years been prosecuted and convicted by my office.

New York is committed to seeing to it that our elderly and our poor receive that to which they are entitled and that the scandal of the 1960's, and the scandal of the 1970's, does not become the scandal of the 1980's. And New York stands ready to assist anyone who shares this same concern.

I thank you and will welcome any questions you might have.

Senator CHURCH. Thank you very much for your statement.

STATEMENT OF STEPHEN H. PRESS, HARTFORD, CONN., CHAIRMAN, PROGRAM INTEGRITY SUBCOMMITTEE, NATIONAL COUNCIL OF STATE PUBLIC WELFARE ADMINISTRATORS

Mr. PRESS. Mr. Chairman, as you indicated, I am the head of the Connecticut program. I am also the chairman of the Program Integrity Subcommittee of the National Council of State Public Welfare Administrators. I hold one more distinction which is probably quite unique and has something to do with the statement that I would like to make here today. That is contained in the fact that my medicaid program has within it a successful program integrity unit. Funding for the unit was recently terminated by the Connecticut State Legislature in the current session.

While this action may not have been meaningfully carried out by the legislature and has already been partially revised, it points out one of the problems of operating the medicaid program on the State level. That is that the Federal Government may set its mandates, but Governors and State legislatures will determine how those mandates will be carried out.

In the case of Public Law 95–142, the fact that Congress voted 90 percent financial participation for State fraud units was very effective in putting weight in our State and other States behind prosecutorial functions. However, it ignores the basic function of the single State agency in investigating basic fraud, and particularly in the area of abuse.

In our own State I would say that 90 percent of the collectible cases are in the area of abuse and I would say that this figure is effective throughout the country. The program integrity units or surveillaince and utilization review units are funded with Federal participation from 50 to 75 percent, depending upon whether the State involved has a certified medicaid management information system or not.

Now my State legislature and several others took 95–142 to mean that they no longer had to continue surveillance and utilization review efforts or program integrity units because the State fraud units would do the job. Well, the State fraud units are supposed to do the job of investigating fraud and, as I indicated before, a major part of the collectible dollars in States like my own are in the abuse area.

Senator CHURCH. Could you distinguish between fraud and abuse for purposes of the record?

Mr. PRESS. Well, really what it comes down to is, in many cases, abuse is where intent cannot be proved, where fraud cannot be proven, and in a great extent of the cases this is the fact. Where there is no intent to defraud, with built-in errors of any type, a fraud case cannot be made. In fact, the original program integrity action by HEW—Project 500—is a situation where the bulk of the cases are involving civil recovery and nonindictment because they are not provable fraud cases.

In fact, in my testimony I wanted to mention the fact that Secretary Califano issued a statement a year ago indicating that he has stopped the program integrity computer program because it already had spit out the names of some 47,000 potentially fraudulent providers. The fact is I think that there has been possibly 10 indictments out of the computer list and I think all the situation did is face the State people against angry providers who seemed to be feeling the statement as one which blanket indicted large numbers of physicians. I would have to say that indictments and convictions are much more effective tools for fighting fraud than public relations.

RECOMMENDATIONS

In terms of this situation I would recommend that the State fraud units be continued beyond its 3 years in general because I feel that they are and can be an effective deterrent against fraud. I do not personally believe that they will pay for themselves, particularly in States where a 50–50 match is involved, and I have spoken to attorney generals in other States than New York who agree with that position, such as New Jersey. I have gotten a feeling that they themselves feel that abuse is the more effective area for collection of dollars than fraud.

Beyond that, I heard mentioned earlier the fact that the reimbursement under 95–142 may be retroactive. This is not necessarily helpful because we have a variety of States, unlike New York, which do not have fraud units and will not be given the State go-ahead to start up until they get Federal approval of their programs because their proposals contain staffing requirements. Therefore, they are going to be waiting for approval before they start.

Connecticut did not start its hiring process until it got approval of its grant. Even though it is one of the nine States with certification, it has not yet put its people on board and has not gotten underway, and

I would say that effectively would even shorten the program from what Mr. Hynes just stated earlier. So if we are going to have 26 more States certified at the end of this year, well, then maybe it will be a 1½-year program rather than a 3-year program.

In addition, I would like to recommend that the SUR function within the single State agency be funded at least at the 75-percent level as opposed to its 50-percent level. In terms of this unit, this unit in my State and in most other States is a major source of referral for cases to the State fraud agency. Now if you don't have that unit operating, it essentially would cut down the effectiveness of the State fraud unit and, as I will indicate, they provide the principal preliminary investigative source for the State fraud unit. In my own State this unit operates at a cost-benefit ratio of about $7 to every $1 spent. The unit has only been functioning since last October. It has collected about $100,000 a month and operates at a cost of about $150,000 a year.

Senator CHURCH. Can you explain just how that program operates? Is that a computer operation?

Mr. PRESS. Yes. I was going to get into that.

Senator CHURCH. Good.

Mr. PRESS. We operate on everything from a variety of sources, everything from tips to medicare referring the cases to us. We also have in being right now a system called Amoeba, which essentially is a table-driven system which ranks deviated providers by the amount of deviation. In other words, if they perform more than one first office visit, if they perform too many lab tests, give too many prescriptions, whatever particular example we use in the system, they will be ranked by the system in the order that they perform these deviations.

This essentially is nothing more than additional tips for investigations. It provides us a place to start investigations along with a number of dollars that the provider has received. This is equivalent to, but probably not as effective as, the MMIS systems. We expect this to be in operation next year in Connecticut. I would mention in terms of the MMIS system that there are some States that have certified systems which do not necessarily get the maximum benefit from them.

One of the problems in one big Western State is that they have a system which reports all the deviations by providers from that State in a single month but it does not rank them. In other words, it has 10,000 pages of reports indicating what doctors have deviated, but it does not say which are the worst and which are the best. Essentially you have to go through the 10,000 pages to determine who the worst offenders are. The fraud and abuse unit in that State is not using the system except as backup. In other States they have got the same extensive reporting system, but no staff.

Without staff at the surveillance and utilization review level, the reports pile up in the corners of rooms and again the system is not effective. I point this out because it is important within the State agencies themselves that they have staffing to do the job of preliminary investigation. Out of those preliminary investigations frequently come the fraud referrals to the State fraud units. Now without the 90 percent funding incentive, the States have not worked as well, and I say they may not do their job in the future. Again I would urge that some thought be given to raising the funding level of these units which operate within the single State agency.

Senator CHURCH. In these civil recoveries that the surveillance program assists in the endorsement, how is the recovery treated as between the States and the Federal Government?

Mr. PRESS. It is essentially the same as under the State fraud unit. The recovery is divided by the percentage to which the State participates in the program, so it is essentially 50–50 recovery. I should add that in most cases the recovery is done fairly simple. In some cases we have to exercise State regulation which allows us to withhold the provider's payments and potentially remove him from the program on civil grounds for violating the regulations of the State agency so that we do have those powers.

I know that HEW has drafted regulations which would force those States to carry out that kind of methodology, but it is in effect in a good number of the States of the country, this civil process which allows the suspending of payments and potentially the suspending of the provider itself for the abuse rather than just for fraud.

"TIGHTROPE" BETWEEN SERVICE, DETECTION

I wanted to point out another factor that we suffer from in the medicaid program. The goal of the medicaid program is to provide services to recipients, not just to catch fraudulent providers, and we sort of walk a tightrope between providing the services and trying to eliminate from the program those providers who are treated poorly. Developing claims processing systems to capture fraudulent providers and abusers may be a good thing, but if paperwork drives frustrated providers from the program, its goals will not be met, especially if bill payment is slow as well. We want to keep those providers in the program and we want to make sure that we throw out the bad apples, but we want to retain the rest of the providers in the program as well as we can.

That is why I mentioned that statement before about the 47,000 providers in terms of project integrity who are potential fraud cases. I think we have to be a little bit more careful about what we say. Many of the statements made in terms of fraud, including inspector general reports, were large guesstimates and not necessarily accurate at all. I know that on the floors of Congress there is a great feeling of horror when those figures are announced, but they are just guesstimates.

I know there is a great deal of fraud and I feel there is a great deal of fraud, but I don't feel it is necessarily within the kinds of figures that have been spoken about nationally. I think that what it should be called, even the collectibles that have been mentioned to you this morning, is frequently really what I call abuse, because these are cases which they started investigating on the fraud basis and are kicked back to other State agencies for collection because there are no indictments possible in a particular case.

I guess I have gone through a good deal of what I was going to say. One other area that you did mention was the area of exposure of ownership interests in nursing homes and I did want to indicate that I felt that this was not an area where computer systems would be particularly effective. On the other hand, I think this is an area where it is the major answer and that essentially State and Federal investiga-

tors, as mentioned before, will still need to research facility and land records to come up with the vital information.

Again I would like to stress the importance of keeping providers in the program in terms of providing recipients the proper care. With that I would be happy to answer any other questions you might have.

Thank you.

[The prepared statement of Mr. Press follows:]

PREPARED STATEMENT OF STEPHEN H. PRESS

I am an attorney, a medicaid director of a program with a successful program integrity unit, and the chairman of the Program Integrity Subcommittee for the National Council of State Public Welfare Administrators. I hold one more distinction which is probably quite unique. That is contained in the fact that the Connecticut State Legislature recently voted to eliminate funds from the program integrity or fraud and abuse unit which I oversee. While this action may not have been meaningfully carried out by the majority of our legislature and has already been partially revised, it points out just one of the problems of operating a medicaid program on the State level.

First of all the direction of State medicaid programs is dependent upon Governors and State legislatures. Regardless of the direction of the Federal Government and its mandates, if the State government is of a different mind, that mandate will not be carried out. This is certainly the case in the area of fraud and abuse where many States have ignored the function at lower levels of Federal financial participation—FFP. The fact that Congress voted 90 percent FFP for independent State medicaid fraud units essentially strengthened the case for prosecutorial units, but did little to assist the basic investigatorial units within, State agencies.

The new State fraud units will be a major deterrent against future fraud, and I see this as their major benefit. While collections through them may be considerable, I don't believe they will be able to be self-supporting operations. The reason is the difficult task they face, plus the fact that the bulk of potentially recoverable dollars in the medicaid program are in the abuse area which is still the province of the single State agencies. The abuse function is generally handled by surveillance and utilization review units who received Federal financial participation of from 50 to 75 percent. This was perhaps overlooked by the drafters of Public Law 95–142 who spoke only of 90 percent FFP for the fraud units. This encouraged States to develop the new units but did nothing to encourage the strengthening of the fight against abuse, which is where the dollars are. In addition, State legislators, like my own, viewed the units as a reason for eliminating their ongoing surveillance and utilization review operations. If that would have occurred in Connecticut, the State fraud unit would have been seriously hindered because the S/UR unit will be its major referral source and does much of the basic investigation prior to a determination that fraud may exist.

HEW has since recognized the importance of the SUR units and has asked States to continue to maintain this function. I would recommend, however, that the S/UR function be funded at a minimum of 75 percent FFP if not at the same level as the State fund units. In addition, I would recommend that 90 percent FFP continue to be provided to State for their fraud units after the 3-year period, provided under 95–142, expires. The benefit of these functions is just as important to the Federal Government as the States and in these days of restrictive State budgets, the States must be encouraged to maintain their vigilance against fraud and abuse.

It should be noted that in Connecticut an excellent relationship exists between the single State agency and the new State fraud unit. We expect to work very closely together. Perhaps this is because the relationship is between attorneys. I do know that in some States the relationship is less satisfactory. That possibility may be caused by the fact that the fraud unit is taking over a function previously handled by the single State agency. In Connecticut, referrals for prosecution were always made to an outside agency.

Beyond the problem of interacting with State government is the problem of maintaining sufficient provider participation to insure that medicaid recipients are receiving the services they require. Developing claims processing systems to capture fraudulent providers and abusers may be a good thing, but if the paperwork drives frustrated providers from the program, program goals will not be met. The fact that boycotts of services have arisen in several States gives evidence of this kind of problem. But even more important for the States are the thousands

of providers who silently leave the program and refuse to service recipients because of too much paperwork or they see as harassment. We must walk a tightrope with these providers while trying to eliminate the bad apples and retaining the good ones. Thus, most medicaid directors shuddered when Secretary Califano indicated that HEW had discovered thousands of fraudulent physicians as part of Project 500. First, because we did not believe there were that many provable cases and, second, because of the problems it would cause the States in trying to maintain the level of provider participation in our medicaid program. Fighting fraud via public relations is not as effective as indictments and convictions.

The relationship between provider groups and the State medicaid agency frequently mandates the approach the State takes toward the question of fraud and abuse. In Utah a dental organization reviews and authorizes all dental services, a medical foundation carries out review of physician services, and there is a strong feeling at the State level that strong provider participation in the program, as well as a more-than-adequate fee schedule, mitigates against fraud and abuse by the professional provider. In Connecticut we do refer questionable cases to our State medical society's medical liaison committee, but make fraud referrals based on our medical staff's recommendations. There are a variety of other approaches that States have utilized to ferret out and deal with fraud and abuse. I would like to touch on some of them.

In my own State, several of these approaches are being utilized or are in the planning stage. As mentioned earlier, we do have a surveillance and utilization review or program integrity unit. This unit has been identifying fraud or abuse dollars at the rate of about $7 to every $1 spent on its operation. This unit of nine staff carries out basic investigations based on complaints from a variety of sources from a complaint hotline to medical consultants to medicare. They work with recipient and physician profiles which are provided by our data processing system.

When their investigations are completed, they may recommend the case be referred to the State prosecutor's office for a fraud investigation or sent to our agency's audit unit for collections. We collect almost all of these claims without further problem, but we can use State law and regulations to collect or withhold payment from providers, or to suspend them for violation of our regulations. We also continually use the findings of this unit to tighten and improve our medical policy.

We have recently had Amoeba installed by the Control Analysis Corp. under a Federal grant. This is a table-driven surveillance and utilization review system which provides us with a ranked listing of providers who deviate from the norm in the way they provide services. Such a listing will tell us what doctors are providing more than the average number of lab tests per office visit, or initial office visits, etc. While these factors are not proof of fraud, just like the tips we may receive over our hotline, they pvovide us with a likely place to begin investigations, particularly where the derviating provider bills the State heavily.

Like many other States, we are developing a medicaid management information system. This sophisticated computer system is aimed at providing a quality preaudit on all claims submitted to the State. It also provides a postaudit on claims, similar to the Amoeba system mentioned above, through its surveillance and utilization review subsystem. Many States already have federally approved MMIS systems in operation but some do not use the surveillance and utilization review system effectively. In some cases it is because they are not sufficiently staffed to be able to review the reports turned out by the system. It should be obvious that the computer makes the job of locating deviating providers mush easier, but human beings must investigate to determine whether the deviation is improper or not. In the case of one State, highly staffed in the area of fraud and abuse, their MMIS surveillance and utilization review system provides little assistance. The State staff continues to use other sources of information to begin investigations. This is because their computer system reports all deviations but does not rank providers in the order in which they deviate from the norm. An investigator would have to read thousands of pages in reports to determine who the worse offender is.

Many of the States have contracted their MMIS systems or like systems out to private contractors who operate the system, pay claims, but refer questionable cases to State agencies for prosecution and investigation.

In addition to the kinds of approaches I have already mentioned, several States, like my own, have recently developed medicaid fraud units in their attorney general or States attorney's office. Some States, such as New York, New Jersey, and Massachusetts, had such units prior to Public Law 95–142 which offered major Federal funding for such units. These units have organized significant

resources to bear against fraudulent practices. Some States, such as New Jersey, have enacted legislation which has authorized the collection of treble damages, interest, and other penalities against abusing practitioners.

Public Law 95–142 called for the disclosure of provider ownership as a condition of medicare or medicaid provider certification. This is an important element of the fight against fraud and abuse in the nursing home area. It is something that several States required prior to 95–142. However, by itself it will not be a significant factor in dealing with the nursing home fraud. An effective audit system, both desk and field, coupled with effective regulation plays a much more important role in this area. Once again the Federal penalties may be a major deterrent in preventing hidden ownership in nursing homes. It is unlikely MMIS or equivalent systems will be of any help in uncovering this information. State and Federal investigators will still need to research facility and lend records to come up with the proper information.

Senator CHURCH. Thank you very much, Mr. Press.

CHAIN OWNERSHIP

Mr. Hynes, what kind of ownership disclosure of regulations are we going to have to deal with the chain operations in connection with fraud investigations? We are attempting, as you know, to determine ownership of nursing homes and other facilities. We are beginning now on this committee to look at the chain operations in the nursing home and we find that some of these chains are huge—many thousands of beds. The largest number is nearly 21,000 beds. Some of these are owned, some are leased, some are owned by others but managed by the chain, and finding out who owns that becomes exceedingly difficult. Have you any ideas based upon your own experience that might be helpful?

Mr. HYNES. I don't think that there is any particular evil attached to a chain. It is obvious what we are all concerned about is the non-arm's-length problems that deal with application for reimbursement. We have had a number of cases. I know one case in particular that comes to mind which may interest my friend from Connecticut—a New York operator who was supporting our Connecticut home on New York rates. I think the disclosure provisions in Public Law 95–142 will be an investigative tool. I hope we are certified so that we can get that information into the office.

I don't really know what you are getting at, Senator. I cannot be helpful except to state that we are always concerned in our investigation to insure that the owners of the facilities don't have ancillary services, that they are charging as arm's-length transactions.

AMENDMENT FOR 3-YEAR TEST PERIOD?

Senator CHURCH. I think you testified that because of the time delays in starting up these State units it would be advisable to change the law in the 3-year test period as of a date of certification. I think that is a very good suggestion and it will then give each State fully 3 years of testing and experience. I think that that 3 years is about the minimum time to get some notion of what will be accomplished.

Mr. HYNES. It really depends on the kind of staff that is on board and, in some instances, the type of the investigation. New York, of course, has a history of nursing home fraud dating back to 1960 and 1961 with the New York City commission investigation finding the wholesale fraudulent patterns but, unfortunately, no one had the resources in New York from 1961 to 1975 to do anything about it.

I think 3 years is a good time period. We thought that was the time frame when I first began coming to Washington to suggest these kinds of programs, but it is critical and certainly makes more sense. I believe it falls within the congressional intent that it runs from the date of certification.

Senator CHURCH. I am going to ask the staff to select from these hearings this morning certain statistics that have been made with regard to possible amendments to the law so that this committee can take those suggestions up with the Finance Committee that has the legislative power and see if we cannot work these amendments into the law. I think your recommendation is a very good one.

HOSPITAL FRAUD UNDER REVIEW

Mr. Hynes, you have an HEW grant for investigative fraud and abuse serving New York medicaid and medicare patients. It is my understanding that this investigation is oriented toward a termination of how much growing hospital costs are due to mismanagement and criminal fraud. What are you discovering in this particular area?

Mr. HYNES. I am afraid at this point, Senator, I cannot respond. We have active grand jury investigations in a number of institutions in New York State and it has been our constant policy not to comment while those investigations are on. I will be leaving my current assignment shortly, but I will be happy to pass on to my successor as soon as we have significant developments and assist you in any way I can.

Senator CHURCH. I wish you would do that because we wondered, having looked thoroughly into nursing home abuses, as to what extent these abuses may affect actual hospital operations.

Mr. HYNES. Senator, I share the concern that Mr. Press has that we have to be very careful in this area lest there be an inference that we have the same kinds of problems that we apparently had in nursing homes in New York State, but it was never contemplated by either HEW or the New York office that we would necessarily find fraud in hospitals. It was a concern of both of our agencies that in view of the rising health cost that there will be a survey for a 2-year period to determine whether it is fraud, mismanagement, or waste. I hope to have a report for HEW when the Congress convenes at the first of the year.

Senator CHURCH. Well, I think those categories are, of course, the ones we know about—fraud, mismanagement, and waste—but it would also be helpful to know if there is any noticeable difference between privately owned hospitals that are operated for a profit and nonprofit hospitals that are either publicly owned or are church connected.

Mr. HYNES. Mr. Chairman, we investigated a proprietary hospital, and the indictment alleged kickbacks of a substantial amount of money approaching $2 million, but I have not drawn any inference that is necessarily a pattern in New York. That is the point of the project in HEW, in my office, to determine.

Senator CHURCH. Well, we will look forward to your report and to your successor. Are you moving out of government entirely, or are you——

Mr. HYNES. No, I have been nominated for another position.

Senator CHURCH. You have been nominated for another position.

Mr. HYNES. Yes.

Senator CHURCH. Well, we wish you well.

Mr. HYNES. Thank you.

Senator CHURCH. I appreciate very much your coming down and testifying. Both of your contributions have been very helpful.

Mr. HYNES. It is always a pleasure, Senator. I think the record should disclose that you and your committee have made a tremendous contribution together with, of course, the House of Representatives, and the taxpayers are in your debt.

Senator CHURCH. Thank you very much. I hope that our efforts prove to be successful. We will have to wait and see.

Thank you.

Actually we finished on time this morning which is unprecedented.

The hearing is adjourned.

[Whereupon, at 11:55 a.m., the hearing adjourned.]

APPENDIX

Correspondence Relating to Hearing

Item 1. Letter and Enclosure From Senator Frank Church, Chairman, Senate Special Committee on Aging, To Frank S. Beal, Deputy Administrator For Operations, Health Care Financing Administration, Department of Health, Education, and Welfare, Dated August 9, 1978

Dear Mr. Beal: Thank you very much for your testimony at our recent hearing on medicaid fraud and the role of the State fraud control units. I am glad that you could participate and I look forward to a close working relationship with personnel from the Health Care Financing Administration as the committee pursues its agenda on medicaid fraud and related issues.

I have compiled a list of questions and requests either made at the hearing or added since. We would like to have this additional material by August 25 for inclusion in our hearing record. If it is not possible to give a final statement on any individual matter, I would be glad to have an interim response indicating when the additional information will become available.

With best wishes,

Sincerely,

Frank Church.

Enclosure.

Questions For Frank S. Beal, Deputy Administrator For Operations, Health Care Financing Administration

At the present rate of certification it would appear that, for the bulk of the States, this will be a 2-year program. Does this give sufficient time for evaluation of the performance of the program and for recommendations to be made to the Congress regarding the proper level of Federal support after 1980?

Given this rate of certification, would any significant problems be posed if Public Law 95-142 were amended to permit a 3-year period of Federal funding from the date of certification rather than the date of enactment?

What recommendations can you make with regard to congressional action on this matter?

I have suggested that we provide by law for State retention of either all or some additional part of the recoveries made by these units as a means of assuring adequate levels of funding after the expiration of the Federal share. It would be helpful if you would indicate appropriate initiatives in this area.

Item 2. Letter and Enclosure from Senator Frank Church to Frank S. Beal, Deputy Administrator for Operations, HCFA, HEW, Dated August 10, 1978

Dear Mr. Beal: During the course of your testimony at the July 25 hearing of this committee on medicaid fraud, I asked for your comments on issues concerning the State fraud control unit certification process raised in a letter from Wisconsin Attorney General Bronson La Follette.

Because you did not have an opportunity to review the full text of the letter during the hearing, I have enclosed a copy for your reference. This letter will be made a part of the hearing record.

If you wish to have your comments on the issues raised by Attorney General La Follette made a part of the hearing record, I would be pleased to have them by the August 25 record closing date.

With best wishes,

Sincerely,

Frank Church.

Enclosure.

STATE OF WISCONSIN,
DEPARTMENT OF JUSTICE,
Madison, Wis., July 24, 1978.

Hon. FRANK CHURCH,
Chairman, Senate Special Committee on Aging,
Washington, D.C.

DEAR SENATOR CHURCH: I understand that you are chairing a hearing that will soon be held by the Senate Special Committee on Aging for the purposes of evaluating HEW's implementation of H.R. 3.

Wisconsin is an applicant for H.R. 3 medicaid funds and expects to receive HEW's approval for funding in the very near future. As you can imagine, the process of securing such funds was not fraught without the trials and tribulations associated with a large bureaucracy, and while I am tempted to fully elaborate on those problems, I believe it may be more productive to comment on the substantive areas of H.R. 3.

We have received several indications of changes in policy on the part of HEW that are of real concern. First, HEW seems to have substantially confused the appropriate role of the single State agency, vis-a-vis the medicaid fraud control unit. It was my clear understanding that section 17 of H.R. 3 contemplated the fraud control unit would have a substantial role to play in the detection and investigation as well as prosecution of suspected fraud. Specifically section 17(q)(3)'s provision for the "conducting [of] a statewide program for the investigation and prosecution of violation of applicable State laws * * *" seemed to authorize, if not mandate, substantial investigative capabilities within the unit. We contemplated that the unit could solicit complaints, and once received could exercise discretion on whether to follow through with more detailed investigations. We contemplated further that if these investigations revealed the potential for prosecution of criminal fraud, or an action for damages of civil fraud theories, the prosecution unit's attorneys would pursue the matter to fruition.

We further contemplated that the unit's attorneys would in many cases be involved at the initial stages in the investigation, in order to direct the investigators to appropriate leads, and advise as to legal ramifications of the investigation at various stages. In any event, we anticipated that the "statewide * * * investigation" capability would permit our unit to do a substantial amount of detection of fraud on the basis of complaints received from district attorneys, social service agencies, etc., with referrals being made to the single State agency for administrative action only after the potential for suspented fraud had been excluded. We further contemplated that the definition of fraud, both civil and criminal, would be as provided by State law.

Such an integration of investigation and prosecution in the fraud control unit seemed sensible. While our single State agency functions well, it lacks the necessary resources, having a limited staff, no statutory authority to prosecute and substantial program administration responsibilities that have nothing to do with fraud. In addition, the single State agency's investigative unit does not have the independence from medicaid administration that is required by H.R. 3. Furthermore, since our relationships with the single State agency have been excellent, we thought an appropriate working relationship could evolve without any difficulties.

What Office of Program Integrity seems to say, however, is something vastly different. The Office of Program Integrity officials have, on many occasions and in many different contexts, sought assurances that the principal investigative role would remain within the single State agency. While not excluding the possibility that our "fraud control unit could follow through with independent investigations of complaints received directly, the suggestion has been made very strongly and vociferously by Region V representatives that Congress intended the single State agency to have the principal statewide investigative powers, whereas by contrast the fraud control unit was supposed to operate in a secondary fashion upon referrals from the single State agency. We have received strong suggestions, and have been requested to provide assurances to the effect, that complaints of suspected fraud received by the fraud control unit would be forwarded for further evaluation to the single State agency, a concept which seems totally foreign to H.R. 3 and also unworkable in view of the limited resources and statutory powers held by the single State agency.

I assure you that if the fraud control unit must take second chair to the single state agency (or to any other agency having multiple responsibilities and obligations) for the initial detection and workup of initial complaints, H.R. 3 is doomed to failure. True, obvious frauds by small providers may be detected by such a reduced effort. But the more sophisticated patterns of frauds, especially those in

the institutional areas such as nursing homes and large provider groups, requiring evaluation of massive amounts of documents, and extensive time in John Does or before Grand Juries, will be totally beyond the reach of such single State agencies or any groups. When you deprive the fraud control units of that initial investigative capability, you deprive the States of the ability to work an investigation up to the level of suspected fraud.

In discussing with our staff, the HEW representatives have indicated their concern that permitting the fraud control unit to follow up on investigations directly may enocurage States to strip investigation resources from the single State agency which receives 50 percent Federal funding. While this may be true, there are better ways to deal with such incentives than closing the door to aggressive fraud control investigations where, as in Wisconsin, the unit and the single State agency coordinate their efforts.

HEW personnel also convey the belief that a substantial portion of the complaints received will be with respect to something called "program abuse", which, they say, is not fraud, and should not be within the jurisdiction of the fraud control unit. The term "program abuse" is foreign to the Wisconsin law of fraud. As best as can determine "program abuse" has meaning primarily in the medicare program, where it is defined as an instance of overutilization of medical services, or of billings for more services than were actually provided, and where the Medicare investigators have concluded that they cannot prove the specific intent necessary to prosecute for criminal fraud. Almost every example that HEW has provided of HEW has provided of program abuse is something that would probably be prosecutable as fraud in Wisconsin, either criminally or civilly. Thus, while program abuse may have relevance in other States for defining the proper allocation of investigative resources between the single State agency and the fraud control unit, it has no such relevance in Wisconsin.

I can only conclude that HEW is implementing H.R. 3 with people whose sole knowledge of fraud stems from the medicare experience, and who are trying to force the single State agency and medicaid fraud and control unit into a Federal medicare investigative and prosecutorial role. This amounts to the Federal agency's substituting its own definition of "fraud" for the far more encompassing Wisconsin state definition.

I fear that HEW's disinterest in strong initial investigation by the fraud control unit will function to create an insurmountable bureaucratic barrier against Wisconsin's unit even being able to investigate such potential areas of fraudulent activities as what the medicare people call program abuse, and those patterns of sophisticated institutional-related fraud which greatly exceed the capacities of the single State agency to detect or investigate even at the preliminary stages.

I urge you to consider drafting amendments to section 17(g)3 of H.R. 3 which further define the meaning of the "statewide * * * investigation," with respect to the role that the Congress contemplates for the single State agency. I propose that you make it plain that the medicaid fraud control unit has initial jurisdiction to undertake whatever investigations are necessary to evaluate fraud, and that it in no way takes second chair to the single State agency in investigating fraud complaints.

I would further commend to your attention the need for further refinements in the definition of fraud to make it plain that State definitions govern and that "program abuse" has no role in implementation of H.R. 3.

I understand that you are also considering the question of whether the expiration date of H.R. 3 will come too early for any meaningful development of a vigorous fraud and control unit in States such as Wisconsin, which has only recently developed a medicaid fraud program. We anticipate a minimum elapsed time of 9 months to a year from the date of receipt of an initial complaint of any kind of. sophisticated fraud to commencement of appropriate prosecution, civil or criminal Depending on the number and nature of motions and appeals which may occur after commencement of prosecution, the elapsed time from commencement to verdict may take up to an additional year or two. As a result, it seems reasonable to conclude that the time period for assessing the effectiveness of fraud units created under H.R. 3 should be extended for another 2 to 3 years beyond 1980.

We also anticipate that significant time may be consumed at the investigative level in processing the substantial volumes of records that can be accumulated in a fraud investigation, to identify patterns of conduct. For example, if initial investigation reveals that a provider has billed for services not provided, we would ordinarily ask our investigators to obtain and evaluate as many of the provider's records as possible for the purpose of determining whether and to what extent the pattern is systematic and repeated. This evaluative process is now done manually by our investigators and auditors, a process that has consumed

in several cases months of painstaking investigative man-hours. This time could have been reduced to days if the material had been placed initially in a computerized data bank and then evaluated with the assistance of an analyst. In addition, once the materials obtained from an investigation are placed in the data bank, the materials are readily available for retrieval in many different relevant formats (e.g., all claims filed by that provider for one recipient, all claims filed in a specific category by chronological dates, etc.), a procedure which lends itself to far more exhaustive and sophisticated analysis than can be done manually. We believe, therefore, that the fraud control unit must have access to computer time, system analysts, and programers.

While this need for investigation—specific computer assistance should seem obvious, our informal requests have fallen on deaf ears in HEW's Office of Program Integrity. HEW apparently believes that this is the sort of function that the single State agency is supposed to be conducting, and that Congress did not intend the fraud control units to get into the areas of computer assisted investigations.

While I hope to eventually convince HEW that we stand a much better chance of accomplishing Congress' objectives if we have substantial computer oriented investigative capabilities. I sense that the agency's reluctance to willingly accept this concept derives from the same apparent lack of understanding on HEW's part that the agency having statewide prosecutorial capability must also be the lead investigative agency, and that some States such as Wisconsin are willing to prosecute as fraud matters which HEW prefers to consider as something less than fraud.

To summarize, I believe that the general posture of HEW in the substantive areas of how to tackle fraud and what is the appropriate role of the single state agency vis-a-vis fraud control unit is lacking in vision and lacking in aggressiveness. I get the impression that HEW is more concerned with setting up a structure for evaluating grants than in implementing the purpose of H.R. 3 which, as I understand it, was to encourage aggressive and innovative approaches on the part of states to detect and vigorously prosecute medicaid fraud.

I want to close this letter with a caution. We hope that fraud is not out there. We make no promises on numbers of prosecutions or dollars to be recovered. We will be delighted to prove the absence, and not just the presence of medicaid fraud in Wisconsin. At the same time, unless we are given sufficient authority and encouragement to structure an aggressive and innovative unit, I am afraid that we will reach 1980 having come to no conclusions, because we were deprived of sufficient resources to make the necessary investigations to determine whether or not the alleged fraud had taken place.

For these reasons, I strongly encourage you to consider amendments which would provide the medicaid units with sufficient resources from the onset to conduct the kinds of thorough and comprehensive investigations necessary to determine whether or not there is fraud and, if so, vigorously pursue it from that point onward. This will require, at the very minimum, a change in attitude on HEW's part, if not further legislative revisions.

Sincerely yours,

BRONSON C. LA FOLLETTE,
Attorney General.

ITEM 3. LETTER FROM FRANK S. BEAL,[1] DEPUTY ADMINISTRATOR FOR OPERATIONS, HCFA, HEW, TO SENATOR FRANK CHURCH, DATED SEPTEMBER 21, 1978

DEAR SENATOR CHURCH: This is in response to the list of questions regarding medicaid fraud control units you submitted to the Health Care Financing Administration in your letters of August 9 and 10. We have also incorporated our response to the issues raised by Wisconsin Attorney General Bronson La Follette in his July 24 letter to the committee. The Health Care Financing Administration appreciates the opportunity to aid the committee in improving legislation to control fraud and abuse in the medicaid program.

Our responses to your specific questions are as follows:

Question. At the present rate of certification it would appear that, for the bulk of the States, this will be a 2-year program. Does this give sufficient time for evaluation of the performance of the program and for recommendations to be made to the Congress regarding the proper level of Federal support after 1980?

Response. Since the date of the hearings, fraud control units have been certified in six additional States (Hawaii, New York, Wisconsin, Massachusetts, Cali-

[1] See statement, page 3.

fornia, and Pennsylvania). This makes 15 units now certified and we expect a total of approximately 35 units to be certified by the end of the year. Thus, we anticipate that a majority of States will have operating fraud control units for at least a period of approximately 2 years even if the law is not amended to extend the funding period. We believe that this period of time and the number of units certified should provide ample evidence on which to evaluate the value of such units. The time limit on Federal funding also provides an additional incentive to the fraud units to make an effort to demonstrate effective performance.

The Health Care Financing Administration recently implemented new forms and procedures for reporting cases of medicaid and medicare fraud and abuse. These reporting procedures will provide accurate data on the number of fraud and abuse cases being investigated, the number of indictments, the number of convictions obtained, and the extent of overpayments established. These reporting requirements, together with the various reports required from the fraud control units, should provide an accurate and sufficient data base to evaluate the unit's effectiveness. Thus, we feel sufficient time will exist to evaluate the performance of the units and to recommend appropriate Federal levels of support to the program after 1980.

Question. Given this rate of certification, would any significant problems be posed if Public Law 95–142 were amended to permit a 3-year period of Federal funding from the date of certification rather than the date of enactment?

Response. Amending the legislation to provide for 90-percent funding from the date of certification would result in significant Federal outlays. It appears somewhat premature to recommend additional funding at this time.

Question. What recommendations can you make with regard to congressional action on this matter?

Response. We do not recommend congressional action at this time.

Question. I have suggested that we provide by law for State retention of either all or some additional part of the recoveries made by these units as a means of assuring adequate levels of funding after the expiration of the Federal share. It would be helpful if you would indicate appropriate initiatives in this area.

Response. States now retain the portion of recovered overpayments that reflect the State share of medicaid expenditures. In effect, States recover 100 percent of the moneys they spend for the medical assistance program. In addition, any criminal or civil fines and/or penalties imposed by the State courts are retained by the States. The Health Care Financing Administration feels that the present method of distributing recovered overpayments is sufficient incentive for the States to engage in an active program to identify and investigate and prosecute cases of medicaid fraud or abuse.

The letter addressed to you from Attorney General La Follette of Wisconsin raises several issues upon which the Health Care Financing Administration would like to comment for the record, as follows:

First, we believe there will be enough States certified during 1978 to make an adequate evaluation of the concept at the conclusion of the funding period.

He also expressed concern that HEW's suggested definitions of "fraud" and "abuse" will limit the jurisdiction of the fraud control unit in Wisconsin. The HEW operating definitions of "fraud" and "abuse" are certainly not intended to and do not restrict State authorities in investigating and prosecuting possible criminal acts of medicaid fraud or abuse. Rather, these definitions are simply an effort to generally provide for consistent and understandable application throughout the country. If practices labeled "abusive" by HEW are prosecutable as fraud under Wisconsin's or any other State's law, either civilly or criminally, the State is certainly free to investigate and prosecute these practices as fraud. The section 17 statute explicitly states that the unit's function is to ". . . prosecute violations of all applicable State laws regarding any and all aspects of fraud . . ." in the medicaid program.

Attorney General La Follette seems very concerned over the Department's interpretation of the unit's functions in the "investigation" and "prosecution" vis-a-vis the State agency function in the "detection" of medicaid fraud. Our interpretation in this matter has been solely based on the statute and existing regulations and is not meant to impede, infringe, or undercut in any manner the effectiveness of the State fraud control unit. However, it should be noted that whether or not a State establishes a fraud control unit, the State medicaid agency has, and should continue to have, certain responsibilities for the prevention, detection, and control of fraud and abuse. The current HEW medicaid regulations (42 CFR 450.80) require that a State agency must establish methods to identify situations of fraud in the medicaid program. The realization that to simply identify

situations of fraud and then do nothing to curtail this fraud is unproductive and led directly to the creation of section 17 of Public Law 95-142. The units established under this section would investigate these indentified fraudulent situations, prosecute those engaged in them, and generally act as a deterrent to future attempts to defraud the system.

Attorney General La Follette also contends that the Health Care Financing Administration intended that the "principal investigative" role would be the responsibility of the State agency. This is not correct. Again, it was the realization that the State agencies were doing too little in investigating incidences of potential fraud that created the section 17 units. The units' primary function, as required by statute, is to investigate and prosecute incidents of medicaid fraud. As attorney General La Follette has pointed out, the State units are certainly allowed to engage in independent investigation of complaints received directly by them. The regulations have been amended to require that the State agency "refer all cases of suspected (provider) fraud to the unit." This does not preclude a unit from independent investigation based on leads from other sources. The relationship between the State agency and the fraud control unit should be one of cooperation in an effort to eliminate medicaid fraud or abuse. Moreover, we do not believe that the statute of our regulations preclude exchange of information from the fraud unit to the medicaid agency or that a unit may not request the cooperation of the agency on a particular case.

Finally, Attorney General La Follettee feels that the fraud units should have their own computer capability. Our interpretation of the statute does not prohibit the units from utilizing programers or computers to aid in their investigatory efforts. Many, if not all, of the State agencies already have the hardware and the data resources that the fraud units may require, when appropriate. It is our position that a State fraud unit development of an independent computer system and data bank would be a duplication of valuable resources. The State fraud unit may utilize a programer to devise programs that utilize the data and systems maintained by the State agency. Additionally, the Health Care Financing Administration believes that computer screening, to detect possible cases of fraud or abuse, remains the responsibility of the State agency, State fraud units, however, are encouraged to work with the State agencies to point out how such systems can be improved or expanded.

We appreciate this opportunity to present recommendations and comment for inclusion in the committee's hearing record. We will certainly be available for any additional information or comments you may require.

Sincerely yours,

FRANK S. BEAL.

ITEM 4. LETTER AND ENCLOSURE FROM SENATOR FRANK CHURCH TO CHARLES F. C. RUFF, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, DATED AUGUST 7, 1978

DEAR MR. RUFF: Thank you very much for your testimony at our recent hearing on medicaid fraud and the role of the state fraud control units. I look forward to a close working relationship with personnel from the Office of the Inspector General as our study of medicaid fraud and related issues continues.

I have compiled a list of questions and requests either made at the hearing or added since. The hearing record remains open for 30 days, and we would like to have the additional material by August 25, If it is not possible to give a final statement on any individual matter, I would be glad to have an interim response indicating when the additional information will become available.

With best wishes,

Sincerely,

FRANK CHURCH.

Enclosure.

QUESTIONS FOR CHARLES F. C. RUFF, DEPUTY INSPECTOR GENERAL, HEW

Public Law 95-142 calls for the Federal share to expire on the first of October, 1980, This leaves a very short time for the evaluation of this program. What benchmarks are you proposing for the evaluation of these units' continued eligibility for Federal funding during that period, and will this evaluation provide recommendations to Congress with regard to the status of this program after the scheduled expiration data of Federal funding?

In his testimony, New York Deputy Attorney General Charles J. Hynes called for an amendment to Public Law 95–142 to permit the 3-year period to begin from the date of certification. Mr. Frank Beal testified that it is hoped that some 35 States comprising 85 percent of medicaid expenditures will be certified by the end of this year. In light of Mr. Beal's statement, what is your opinion of Mr. Hynes' suggestion? What recommendations can you make with regard to congressional action on this matter?

In your full statement for the record, you state that your office is confident that these units will prove themselves to be so cost-effective a law enforcement device that the States will elect, without any hesitation, to continue them even without Federal funding. What evidence does your office now have to indicate this cost effectiveness?

I have suggested that we provide by law for State retention either all or some part of the recoveries made by these units. You have indicated that this is an appropriate suggestion. It would be helpful if you would indicate appropriate initiatives in this area.

It would be helpful to the work of this committee if you would update the information contained in the annual report of the Office of the Inspector General regarding the number of medicaid cases, the number of convictions, and the amount of money recovered in the way of penalties and fines, particularly with regard to the cost of this enforcement effort as compared to the amount collected.

ITEM 5. LETTER FROM CHARLES F. C. RUFF,[1] DEPUTY INSPECTOR GENERAL, HEW, TO SENATOR FRANK CHURCH, DATED AUGUST 25, 1978

DEAR MR. CHAIRMAN: In reply to your letter of August 7, I have set out in the following paragraphs my responses to the additional questions you posed concerning the State medicaid fraud control units.

Question. Public Law 95–142 calls for the Federal share to expire on the first of October, 1980. This leaves a very short time for the evaluation of this program. What benchmarks are you proposing for the evaluation of these units' continued eligibility for Federal funding during that period, and will this evaluation provide recommendations to Congress with regard to the status of this program after the scheduled expiration date of Federal funding?

Response. Neither the Office of Program Integrity, HFCA, nor the Office of Inspector General has as yet set any firm guidelines for evaluation of the "success" of the State fraud control units, nor will such a judgment really be feasible after only 1 year of operation. Eligibility for continued funding, on the other hand, will be the subject of periodic review by both our offices. Recommendations for annual recertification will be based less on the number of investigations conducted, indictments returned and convictions obtained, than on a showing that the unit has performed the statutorily required functions in compliance with the law and regulations.

We will, of course, inquire into the manner in which the unit has pursued the investigation of medicaid fraud, the relationship between the unit and the State medicaid agency, the use of budgeted funds, and other key indicia of effective administration. We will also be compiling, on a regular basis, statistical information concerning the work of the unit, including the amounts of Federal and State funds saved or recovered as the result of the unit's work, and these figures will provide the Congress with some basis for its judgment as to the need for an extended funding period. We would expect to be able, by early 1980, to make recommendations to the Congress on this question with some greater assurance as to the effectiveness of the States' efforts.

Question. In his testimony, New York Deputy Attorney General Charles J. Hynes called for an amendment to Public Law 95–142 to permit the 3-year period to begin from the date of certification. Mr. Frank Beal testified that it is hoped that some 35 States comprising 85 percent of medicaid expenditures will be certified by the end of this year. In light of Mr. Beal's statement, what is your opinion of Mr. Hynes' suggestion? What recommendations can you make with regard to congressional action on this matter.

Response. I do not agree with Deputy Attorney General Hynes that it would be appropriate to provide for funding for 3 years after certification, for I believe that the States should be given some incentive to make their applications at an early date. I do agree, however, that some flexibility in the existing limitation is necessary in order to afford this Department and the Congress a realistic oppor-

[1] See statement, page 8.

tunity to evaluate the success of the program. I would recommend, therefore, that the Congress consider a 1-year extension of the funding period up to October 1, 1981, which would provide 2 full years of experience for the bulk of the States involved and still leave a full session of the Congress in which any appropriate action could be taken.

Question. In your full statement for the record, you state that your office is confident that these units will prove themselves to be so cost-effective a law enforcement device that the States will elect, without any hesitation, to continue them even without Federal funding. What evidence does your office now have to indicate this cost effectiveness?

Response. My judgment that the State units will prove sufficiently cost-effective to convince the States to continue them without Federal funding is not founded on a firm statistical base but does represent my evaluation of the problem that now exists in the medicaid program and the impact that a coordinated enforcement effort, supplementing effective management, can have on reduction of program losses. In our annual report we estimated that $653 million in Federal medicaid funds were lost through fraud and abuse in 1977. This represents a parallel loss of approximately $534 million in State funds. If the maximum statutory allotment is spent by all the States, the cost of the fraud control units will be approximately $20 million and if that investment results in a reduction of only 4 percent in State program losses, the units will have paid for themselves.

The test, however, will be not only whether the units' work results in the actual recovery of fines or overpayments sufficient to meet their budgets. Their impact will include the removal of defrauding practitioners from the program and the deterrence of fraud by others—an effect that is not quantifiable but is nonetheless real. Beyond this, the very presence of the units bespeaks the willingness of government to take action to insure the integrity of public benefit programs, and without evidence of that willingness there can be no continued public support for those programs.

Question. I have suggested that we provide by law for State retention either all or some part of the recoveries made by these units. You have indicated that this is an appropriate suggestion. It would be hlepful if you would indicate appropriate initiatives in this area.

Response. Deputy Administrator Beal has commented on your suggestion that the States be permitted to retain the Federal share of recovered overpayments, expressing his belief that the recovery of the State's share of medicaid expenditures, in addition to any criminal or civil fines that may be imposed, is sufficient to encourage an active fraud control program. HCFA is, of course, the agency responsible for the administration of the medicaid program and has the greatest expertise in dealing with the States in this area, but my personal view remains that a plan of the type you suggest represents a feasible solution to the problem of continued funding of the State units.

To the extent that there may be some concern about the amount of overpayments that would accrue to the States, much of the problem could be dealt with by placing a ceiling on the recoveries that could be held by the State similar to the existing ceiling on section 17 funds.

In any event, no judgment can be made on the need for alternative forms of funding nor on the manner in which such funding would be implemented until we have had sufficient experience with the operation of the units under section 17 to determine the level of their success and the program savings they may create.

Question. It would be helpful to the work of this committee if you would update the information contained in the annual report of the Office of the Inspector General regarding the number of medicaid cases, the number of convictions, and the amount of money recovered in the way of penalites and fines, particularly with regard to the cost of this enforcement effort as compared to the amount collected.

Response. The statistics in our annual report cover calendar year 1977 and, unhappily, very little information is available on State activity during 1978. The Office of Program Integrity has implemented, effective on July 1, 1978, a new statistical system which should provide more rapid and accurate information on both State and Federal activitiy in the medicare and medicaid areas, but as of this date the only data available to us on State medicaid prosecutions covers the first quarter of the year. During that period the States reported only that they had 1,076 medicaid cases under criminal investigation, that they had recovered $3,318,000, and that there had been no convictions.

We do have separate statistics for cases developed under Project Integrity, and there, as of August 11, 1978, 539 cases have been designated for full criminal investigation; 759 cases have been designated for recovery or other administra-

tive action; and recommendations for recovery now total $2,900,000. In addition, 13 indictments have been returned in Project Integrity cases, resulting in 5 contions and 1 acquittal, with 7 cases pending trial. Although the Office of Investigations does not maintain records which are formally divided into medicare and medicaid prosecutions, our files indicate that during 1978, of the 26 individuals convicted of medicare or medicaid fraud in cases handled by the Office of Investigations, working alone or in cooperation with other Federal or State agencies, five were charged with medicaid violations.

You also asked in your letter of August 10 for my thoughts on Attorney General LaFollette's letter to the committee. Although the bulk of the attorney general's letter is directed toward positions taken by the Office of Program Integrity, and Deputy Administrator Beal has, I believe, adequately responded to the issues raised, I would like to make a few comments for the record.

There may simply have been a misunderstanding between representatives of Program Integrity and of the State of Wisconsin, but it is clear in the regulations issued by HEW and in the guidelines provided to the States that responsibility for the criminal investigation of medicaid fraud is vested in the section 17 unit. It is equally clear, however, that the State medicaid agency must continue to bear the responsibility for claims screening and other detection methods designed to uncover illegitimate billings and aberrant practices indicative of fraudulent or abusive conduct. The section 17 unit cannot undertake the agency's administrative and review duties, although it can, and should, offer guidance on more efficient methods for the detection of fraud and is specifically empowered to obtain from the agency provider profiles and other claims data in both computerized and manual form. Similarly, the State agency cannot assume the criminal investigative functions of the unit, but it must, if the system is to work efficiently, scrutinize billing practices and be able to identify those cases where the potential for fraud is sufficient to warrant the attention of the unit and its limited investigative resources.

The attorney general also suggests that HEW is attempting to impose its own definitions of fraudulent conduct on the State. As Mr. Beal has noted in his response, this is not the case; those acts encompassed by any State's criminal code may, of course, be prosecuted as such. It is important to note, however, that the distinction between fraudulent and abusive conduct is not, as the attorney general suggests, unique to the medicare program. There are practices in both medicare and medicaid that fall on the borderline between the legal but unreasonable and the clearly illegal, and both State and Federal prosecutors have regularly encountered difficulty in prosecuting practices which seem illegitimate but which are not so clearly prohibited by the law or regulations as to support criminal charges. We continue to believe that, although a vigorous criminal enforcement effort will deter much conduct that is "abusive" as well as that which is criminal, the primary vehicle for attacking abuse must be strong and effective management, adequate screening procedures, and, most importantly, rapid administrative or civil action to recover overpayments and to remove abusive providers from the program.

In sum, let me assure you that both the Office of Inspector General and the Health Care Financing Administration are committed to the development of "aggressive and innovative approaches" to the detection and prevention of medicaid fraud, and we look forward to a close and productive working relationship with all the State fraud control units.

Thank you for the opportunity to testify before the committee and for the opportunity to respond to these additional questions. If there is anything further that this Office can do to be of assistance to you or the committee, please let me know.

Sincerely,

CHARLES F. C. RUFF.

ITEM 6. LETTER FROM SENATOR FRANK CHURCH TO STEPHEN H. PRESS, DIRECTOR, MEDICAL CARE ADMINISTRATION, STATE DEPARTMENT OF SOCIAL SERVICES, HARTFORD, CONN., DATED AUGUST 9, 1978

DEAR MR. PRESS: Thank you very much for your testimony at our recent hearing on medicaid fraud and the role of the State fraud control units. I am glad that you could participate, and I have asked that the staff of this committee work closely with you and the National Council of State Public Welfare Administrators as the committee pursues its agenda on medicaid fraud and related matters.

I appreciate the points you raise concerning the role of the single State medicaid agency and its relations with the State fraud control unit. I would be very interested to know if the decision made by Connecticut reflects the wider view of other States.

Your comments concerning program abuse are also well taken. In your remarks before the committee and your written statement you comment that program abuse is the more effective area for collection of dollars than fraud. I am intrigued by this point and I would appreciate a more complete explanation.

I would like to have this additional material by August 25 for inclusion in our hearing record.

With best wishes,

Sincerely,

FRANK CHURCH.

ITEM 7. LETTER FROM STEPHEN H. PRESS,[1] DIRECTOR, MEDICAL CARE ADMINISTRATION, HARTFORD, CONN., TO SENATOR FRANK CHURCH, DATED AUGUST 23, 1978

DEAR SENATOR CHURCH: This letter is in response to your letter of August 9. Pardon my delay in responding as I just returned from vacation.

My response and testimony is derived from more than my experience in Connecticut. It includes the feelings of my colleagues from New Jersey, Texas, and other States who participate on the National Medicaid Directors' Program Integrity Committee which I chair. In my testimony I indicated that the investigation of medicaid abuse involves a far larger amount of dollars nationally than that of medicaid fraud. The simple reason for this is that the vast number of investigations of wrongful medicaid provider acts do not bring about indictments because they do not involve provable cases of fraud. The bulk of the cases investigated, outside of nursing homes, are where physicians or other providers bill for procedures which are more expensive than the ones they have actually performed. The bulk of indictments are obtained where the provider has billed for a service he has not performed. The former situation rarely leads to an indictment unless the provider has been previously notified by the State that his practices were improper and the State can prove an absolute pattern. Even where an indictment is brought, it frequently involves only the most obviously wrongful practices leaving the rest for civil recoveries. It is likely, nationally, that more than 90 percent of the cases of wrongful provider cases investigated involve only abuse with a like percentage of the potentially collectible dollars.

Since State medicaid fraud units are designated under Public Law 95–142 only to investigate medicaid provider fraud the single State agency's program integrity unit, if there is one, is still left the responsibility of investigating abuse and recipient fraud as well as the original workups on most fraud cases. In fact, without referrals from the program integrity units most of the State fraud units would have very little work to do. As I stated at the hearing, the program integrity unit is funded by HEW at a far lower level of Federal reimbursement (50–75 percent) than the State Fraud Unit (90 percent). It appears to me, therefore, that the Congress has continued to ignore a far more lucrative area than fraud in its funding of the medicaid program. The lack of parity in funding has already caused disruptions in operations in the fraud and abuse area. In New Jersey funding for their existing State fraud unit has doubled while the program integrity unit has stayed the same size. In Connecticut funding for the program integrity unit has lessened while a 19-member fraud unit has been established.

This letter in no way is aimed at denigrating the value of the State fraud unit which is an important deterrent against fraud. I support its continued funding. If, however, Congress was aiming at stopping the flow of errant dollars from the program it should have provided the States with greater financial incentives to develop their program integrity units because that is where more than 90 percent of the errant dollars can be stopped.

Very truly yours,

STEPHEN H. PRESS.

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[1] See statement, page 28.

ITEM 8. LETTER AND ENCLOSURE FROM WILLIAM M. HERMELIN, ACTING ADMINISTRATOR, GOVERNMENT SERVICES DIVISION, AMERICAN HEALTH CARE ASSOCIATION, WASHINGTON, D.C., TO SENATOR FRANK CHURCH, DATED JULY 24, 1978

DEAR SENATOR CHURCH: The American Health Care Association (AHCA) would like to call to your attention several issues for consideration at the hearings of the Senate Committee on Aging on implementation of section 21 of Public Law 95-142. This section provides that States will be eligible for 90 percent Federal funding for the creation of medicaid fraud control units to investigate and prosecute fraud in their medicaid programs.

AHCA, a national federation of providers of nursing home services, with more than 7,500 facility members, supports State and Federal efforts to detect and eliminate fraudulent and abusive practices in medicaid. We believe the attention the Aging Committee has given to fraud and abuse in Federal health programs has contributed to the development of effective programs to control this serious problem. We also believe that the hearings on State fraud control units will provide an opportunity to more clearly define the objectives and improve the operation of this Federal grant program.

We urge the committee to address three issues in these hearings and have enclosed documents relating to State fraud control units which AHCA prepared several months ago. The issues are as follows:

(1) Whether the establishment of a separate and independent State fraud control unit is cost-effective. It is our contention that fraud is not so widespread as the media and self-appointed reformers would have the public believe and that, except in a limited number of instances, the moneys recovered under a system of special medicaid fraud control units would not justify the costs of operation. We believe this would be particularly true where a State established a prosecuting agency but failed to provide an administrative mechanism for the recovery of overpayment.

(2) Whether the conditions imposed by departmental regulations are so restrictive in certain areas and so ambiguous in others that States fail to see the advantages of participating in the program. It is our view that the regulations should emphasize Federal responsibilities to oversee fraud control unit operations (see (3) below) rather than impose conditions on the structure and functions of these agencies. Enclosed is an AHCA memorandum prepared several months ago citing deficiencies in the implementing regulations.

(3) Whether the statute should be modified so as (a) to impose minimum standards on the operation of these units, and (b) to permit the States flexibility in establishing the structure of fraud control units.

AHCA believes that the statute and regulations should address due process implications by requiring that fraud control units adopt certain criteria for the conduct of their investigations. These criteria, which would be set forth in regulations, should be designed to assure that audits and investigations are conducted fairly and objectively with due recognition of the rights of the public, the recipient and the provider of services.

Enclosed is a copy of a manual prepared by AHCA entitled "Procedures for Handling Medicare/Medicaid Fraud and Abuse Audits and Investigation." This document suggests areas which should be addressed by regulations governing investigative techniques. For example, the procedures cover notice as to the nature, scope, and estimated duration of the investigation, rights of recipients, providers, employees and vendors, findings required upon completion of an investigation and other due process considerations.

We hope this nformation has been helpful and request this letter and the enclosed memorandum and procedures manual [1] be included as part of the hearing record.

Sincerely,

WILLIAM M. HERMELIN.

Enclosures.

[1] Manual retained in committee files.

MEMORANDUM

To: State Association Presidents and Executives.
From: William Hermelin, acting Administrator, Governmental and Legislative Services.
Subject: State medicaid fraud control units.

INTRODUCTION

This memorandum is designed to bring to your attention certain aspects of the recently adopted Federal regulations of the Department of Health, Education, and Welfare (HEW) governing Federal funding of a State medicaid fraud control unit.[1] These regulations set the terms and conditions upon which a State may receive 90 percent Federal funding for the investigation and prosecution of fraud in the State administered medicaid program.

AHCA supports State and Federal efforts to investigate and prosecute those who defraud the medicaid program. AHCA believes, however, that State officials and legislators should be advised of certain conditions and limitations of the regulations which bear on the advisibility of establishing such a unit. In this regard, the following comments of AHCA, as well as the comments of State officials relating to these conditions and limitations, will assist you in acquainting your State officials with the regulatory requirements.

SUMMARY OF THE REGULATIONS

The duties of a State fraud control unit are to (1) conduct a statewide program for investigation and prosecution of suspected criminal violations pertaining to fraud in all aspects of administration of the medicaid program and the provision of medical assistance, and (2) review complaints alleging abuse and neglect of medicaid patients in health care facilities. The latter includes investigating any complaint which indicates substantial potential for criminal prosecution.

The regulations require:

(1) Establishment of a unit which is separate and independent from the State medicaid agency;

(2) Execution of an agreement between the unit and the agency; and

(3) Employment of a minimum staff.

The regulations require that the unit be located in either the office of the State attorney general or other State department having statewide prosecutorial authority. When located outside the office of the State attorney general, the unit must have an agreement with that office which establishes formal procedures for referring suspected criminal violations. That office must agree to assume responsibility for prosecuting such referrals, or, where appropriate, forward such referrals to the appropriate authority for prosecution while maintaining oversight responsibility for such prosecution.

The regulations prohibit any official of the State medicaid agency from either reviewing or monitoring the investigations or referrals of the unit. The unit must, however, have a formal working agreement with the State medicaid agency. This agreement requires the State medicaid agency to:

(1) Refer all cases of suspected fraud to the unit.

(2) Comply promptly with any request for access to, and free copies of, any records or information in the possession of either agency or its contractors.

(3) Comply promptly, and without charge, with any requests for computerized data stored by the agency or its contractors.

(4) Initiate any appropriate administrative or judicial actions available to recover sums identified by the unit as having been improperly paid to a provider.

(5) Arrange for access to any information or record kept by a provider of services to which the agency is authorized access.

The unit must employ at least one person in the following categories:

(1) An attorney experienced in the investigation or prosecution of civil fraud or criminal cases.

(2) An experienced auditor capable of supervising the review of financial records and advising or assisting in the investigation of alleged fraud.

(3) A senior investigator with substantial experience in commercial or financial investigation, capable of supervising and directing the investigative activities of the unit.

Once such conditions are met and the unit is certified by HEW, it may be reimbursed by an amount equal to 90 percent of the costs incurred, except those

[1] 42 C.F.R. 450.80(a)(8), 450.310. A copy of the regulations is included as appendix A.

costs attributable to (1) investigation of nonfraudulent abuse, failure to comply with applicable laws and regulations, or (2) programmatic screening and early detection activities required of the agency. The maximum amount of Federal financial funding will be the greater of $500,000 per fiscal year, or 1 percent of all the sums expended by Federal, State, and local governments during the previous fiscal year in administration of the medicaid programs of that State. The certification of the unit must be renewed annually by HEW and the unit must submit annual reports to HEW delineating its actions.

1. Establishment of a fraud control unit separate from the office of the State attorney general.

One consideration involving the establishment of a unit separate from the prosecutorial arm of State government, which in most states is the office of the State attorney general, relates to the ability of your State to delegate criminal investigative functions to the unit. Under the regulations, a unit which is separate from the office of the State attorney general is required to embark on statewide criminal investigations and establish a formal procedure for referral of criminal cases it has developed to that office. Such a delegation of criminal investigative functions may run afoul of your State constitution, or other State statute, establishing that prosecutorial arm of State government. Usually, such laws require that the prosecutorial and investigative functions be lodged solely in one arm of State government.[2]

Another consideration involves the absence of accountability of the State fraud control unit for its investigative activities. Under the regulations, a unit which is separate from the office of the State attorney general is apparently not accountable to anyone in State government for its investigative activities. The only check by State authorities upon the investigations of such a unit is for the Governor not to approve the request for annual certification of the unit, or the office of the State attorney general not not prosecut certain cases referred for prosecution by that unit. AHCA believes that the unit should be accountable to the office of the State attorney general for its investigative activities. AHCA is not alone in this belief. Several States have formally expressed concern over the lack of accountability of the unit, and the lack of coordination among the unit and other State agencies and officials, in comments submitted to HEW on these regulations.

Another area of concern is that your state medicaid agency must provide the fraud control unit with computer records and other data, in such amounts and in such form as the unit deems necessary, without cost.[3] AHCA believes that because no provision is made under either the statute of the regulations for reimbursement for such services of the agency,[4] the operations of a unit could significantly affect the budget of the State medicaid agency as well as its administration of health care to the residents of your State. Indeed, many States, in comments on these regulations submitted to HEW, have expressly noted that this condition will, in all probability, adversely affect the medicaid budget.[5]

2. Lack of coordination

HEW maintains that the requirement in the statute that such unit be "separate and distinct" from the State medicaid agency proscribes any official of that agency from reviewing or monitoring the activities of the fraud control unit. AHCA believes that neither the legislative history, nor the language of the statute, necessarily require such a stringent separation from the agency. All the statute requires is the establishment of a separate and distinct unit.

Again, AHCA is not alone in this belief. Several States have expressly noted the potential problems inherent in the requirement that the unit be "separate and distinct" from the State medicaid agency in comments submitted to HEW.[6] In general, these comments make it clear that many States believe there should be cooperation between the unit and the agency in order to coordinate the administration of the State's medicaid program. Some States have expressed the opinion that the overall administration of the medicaid program would be much more effective if the regulations required the agency and the unit to operate as partners not adversaries.

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[2] Many States have voiced this concern in comments submitted to HEW.

[3] 42 C.F.R. 450.30(a) (8) (ii) and (iii).

[4] 42 C.F.R. 450.310.

[5] One State noted that the cost of a computer printout of only payments made to a medium scale pharmacy provider exceeds $1,000.

[6] Some States have noted that this condition will reduce the effectiveness of preexisting fraud control units. Because of this condition, these States have indicated that they may not establish such a unit.

The lack of coordination inherent in these regulatory requirements involves more, however, than a conflict with the State medicaid agency. Some States have preexisting mechanisms for investigating alleged incidents of patient abuse. By making the duty to investigate possible criminal patient abuse a condition of certification, the functioning of the unit will duplicate the functioning of such separate preexisting units. Some States have suggested that the unit should be required to refer such complaints to other such agencies. These States have noted that nothing in the statute or legislative history expressly precludes such referrals.

Another instance of lack of coordination involves the relationship of the unit to the Bureau of Surveillence and Utilization Review, Provider Standards Review Organization, the State survey agency, or any other agency in your State charged with similar responsibilities. Because the function of your State's agency may be very similar to that of the fraud unit, AHCA believes that such agency and unit may have redundant duties. Some States have expressed concern over whether establishing such a fraud control unit will usurp the function of such other agencies. AHCA believes that such concern is legitimate because this issue is not resolved by the regulations. Therefore, your State officials and legislators should give careful consideration to the effect of establishing such a unit on the other State agencies.

3. Fraud in recipient applications

HEW states that not all criminal investigations of the unit relating to the "provision of medical assistance" qualify for Federal funding. HEW believes that investigations into possible criminal conduct relating to a recipient's application for medicaid does not qualify because such conduct "cannot properly be construed as fraud 'in the provision of medical assistance,' since only providers may thus defraud the medicaid program." [7] In HEW's view, only investigations into instances of possible criminal conspiracy between a provider and recipient to defraud the medicaid program qualify for Federal funding.

AHCA believes this position is erroneous. The legislative history states: "The entity must also conduct a statewide program for the investigation and prosecution of violations of all applicable State laws relating to fraud in connection with the provision of medical assistance and the activities of medicaid providers. Such unit is not however required to examine potential instances of recipient fraud; this function may continue to be the responsibility of the State medicaid agency. H.R. Rept. 393, 95th Cong., 2d sess. 81 (1977)."

ACHA believes that it is clear that nothing in the statute or legislative history precludes such a unit from investigating recipient fraud and qualifying for Federal funding for such investigations.

4. Access to records

As a mandatory condition of certification, the fraud control unit is to have access to any records in the possession, custody, or control of the State medicaid agency, any of its contractors, and providers. No consent is required. The regulations contain no guidelines governing the use or disclosure of such records by the fraud control unit, except with reference to patient records.[8] Confidentiality of business records is a necessary adjunct to any privately owned and operated business. In the area of medicaid providers, unauthorized use or disclosure of such records could have serious business repercussions particularly when the investigators are not accountable to the people they investigate. You should advise your State officials to consider instituting controls on the use and disclosure of all records available to the unit to insure only the legitimate use and disclosure of the records, and to preclude breaches of confidence.[9]

5. Recovery of overpayments

The regulations are unclear regarding the recovery of alleged overpayments made to providers of health care. In one section, the fraud control unit is to initiate such action or refer the matter to the appropriate State agency.[10] In yet another section, the agreement between the unit and the State medicaid agency indicates that the agency is required to initiate such action after appropriate referral.[11] In

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[7] 43 Fed. Reg. 3118, 3120 (Jan. 23, 1978).

[8] The regulations provide that the privacy rights of patients must be protected. *See* 42 C.F.R. 450.80(a)(8)(v).

[9] Some suggested controls are found in "Procedures for Handling Medicare and Medicaid Fraud and Abuse Audits and Investigations," prepared by AHCA's legal counsel, Pierson, Ball, and Dowd. AHCA has distributed copies of this handbook to State association executives.

[10] 42 C.F.R. 450.310(f)(3).

[11] 42 C.F.R. 450.89(a)(8)(iv).

still another section, the State fraud control unit must report to HEW how many actions were referred, and how much was collected, by the unit and the agency.[12] In comments previously submitted to HEW, many States have noted that such provisions are not only apparently internally inconsistent, but also are inconsistent, with certain previously enacted State recovery mechanisms.

In addition to such ambiguity, AHCA notes that many States do not have any recovery procedures. The Health Care Financing Administration of HEW has published suggested procedures for States to adopt for recovering overpayments.[13] AHCA believes these suggested procedures are deficient in a number of respects, especially in the area of the provider's due process rights and has submitted formal comments to HEW requesting that such deficiencies be corrected.[14]

6. Staffing requirements

Some States have questioned the staffing conditions of the regulations by pointing out that the minimum requirements relating to the full-time employment of attorneys, investigators, and auditors cannot be justified in their States because of limitations on the number of State employees or the increased costs and wasted manpower to the State stemming from such full-time employment. AHCA agrees with these States. AHCA believes that such decisions relating to staffing should be left to the discretion of individual States. To require otherwise not only erodes States' rights but also infringes the ability of a State to tailor a fraud control unit to its specific needs.

7. Fraud unit participation in administrative procedures

One State has suggested in comments submitted to HEW that an attorney of the fraud control unit should participate in any administrative hearing against a provider for sanctions or termination for alleged abusive practices. The rationale for this suggested participation is that such an attorney would be in a better position to develop the requisite evidence of intent necessary for a subsequent criminal prosecution for fraud against the provider and its personnel.

AHCA believes that such tactics are unwarranted because of their elemental unfairness. Without being given advance notice of basic constitutional rights, a provider and its personnel may unknowingly make statements which could be the basis for a subsequent indictment for alleged fraud. Although such an indictment may subsequently be quashed, the case dismissed, or the provider and its personnel acquitted at trial, the harm to the provider and its personnel will have already occurred.

AHCA believes that because of the inherent potential for abuse in such tactics,[15] you should urge your State officials and legislators to prohibit their use. In lieu of such formal prohibition, you should acquaint members of your association with the possible use of such tactics and advise them to obtain competent legal advice before testifying at an administrative hearing or voluntarily producing documents for such a hearing. AHCA believes that the use of such tactics will erode the confidence of providers and their personnel in all State officials.

8. Federal financial participation

The statute and regulations declare that 90 percent Federal funding for State fraud control units will only be available through fiscal year 1980. Due to the lead time that may be necessary to establish such a unit in your State, including the time required for legislative action, the prospect of certifying such a unit in fiscal year 1978 may be remote. By that time, the amount and duration of Federal financial participation available may not be cost-effective to establish such a unit in your State.

Another consideration involves the budget of the unit. Potentially, its budget may be very large: the greater of either $500,000 per fiscal year, or 1 percent of all the amounts expended on medicaid by the Federal, State, and local governments in the State. Conceivably, this could run in the millions of dollars. After fiscal year 1980, however, the State would have to provide greater fiscal support for the actions of such a unit.

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[12] 42 C.F.R. 450.310(i)(1) (i), (iii), and (iv).
[13] HFCA Action Transmittal No. 77-105.
[14] A copy of AHCA's comments has been distributed to you.
[15] AHCA notes that such tactics may not be confined to administrative hearings, but may also be used in audits or investigations. In this regard, AHCA's handbook, "Procedures for Handling Medicare and Medicaid Fraud and Abuse Audits and Investigations," should be consulted. The recommendations contained in that handbook may be adapted to situations involving administrative hearings.

A third consideration involving the budget of the unit relates to the precise scope of Federal funding. In one section of the regulations, the fraud control unit is charged with the duty to investigate all cases of suspected fraud.[16] In another part of the regulations, however, it is stated that: "[Federal financial participation] * * * is not available * * * for expenditures attributable to: (i) Investigation of nonfraudulent abuse or of failure to comply with applicable laws and regulations; or (ii) programmatic screening and early detection activities required of the medicaid agency * * *." [17]

In comments submitted to HEW, several States have voiced concern over these apparently contradictory regulatory provisions. These comments indicate that such conflicting requirements make it unclear whether the unit will be reimbursed for its activities relating to collection of overpayments when the State gives the unit authority to initiate such nonfraudulent activities. Yet other States have expressed concern whether any reimbursement will be available for any efforts of the unit which fall short of criminal prosecution, regardless of whether the unit is authorized to collect such overpayments. AHCA notes that these concerns are legitimate because the regulations leave unresolved the question of whether, or in what amounts, a unit will be reimbursed for its nonfraudulent efforts.

A number of States, in comments addressed to HEW, have rejected the argument that the savings engendered by the operations of such a State fraud control unit will enable the unit to become self-sufficient by 1980. AHCA agrees. AHCA believes that the addition of yet another layer of bureaucracy to a States' medicaid program cannot be justified on the basis of cost-effectiveness. AHCA concurs with the concern of some States that the budget of a unit could exceed the costs of administrative recovery of alledged overpayments.

9. Scope of authority of a fraud control unit

AHCA notes that there are other conditions in the regulations which leave unresolved certain issues relating to the authority of a fraud control unit. These unresolved issues concern the functioning of the unit. The first unresolved issue relates to the scope of its authority. Such a unit is authorized to investigate suspected criminal violations relating to provider fraud and patient abuse. It is unclear, however, of the extent of such authority. For example, it is unclear if such a unit has the authority to require the State medicaid agency to submit any or all program materials, such as provider contracts, policy statements, manuals, bulletins and regulations, to the unit for prior approval. Several States have voiced concern over such a possibility. AHCA believes that your State should carefully delineate the exact scope of the authority of a fraud control unit sought to be established in order to preclude such a possibility.

10. Proposed guidelines for conducting audits or investigations by State medicaid fraud control units

If your State establishes a fraud control unit, the potential for misunderstandings between providers and State auditors and investigators is great. There is also the possibility of violations of provider and patient constitutional rights if there are no specific guidelines for State fraud control unit auditors and investigators to follow when conducting such audits or investigations. In this regard, AHCA urges you to review the material contained in a handbook, entitled "Procedures for Handling Medicare and Medicaid Fraud and Abuse Audits and Investigations," which will be published by AHCA shortly. AHCA suggests that you attempt to have the recommendations contained in the handbook adopted as a manual for the personnel of any State fraud control unit. In lieu of official adoption of such guidelines, AHCA advises you to acquaint all members of your State association with these materials to preclude any misunderstandings between providers and State officials.

[16] 42 C.F.R. 450.310(f).
[17] Id. at 450.310(j)(5).

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