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# FAX TRANSMISSION

**U.S. Department of Health and Human Services**
**Office of the Secretary**

**DATE:** 5/16

**TO:** Jen Klein

**FAX:** 456-2878

**PHONE:**

**FROM:** Richard Sinai
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**TOTAL NUMBER OF PAGES TRANSMITTED:** 7

**COMMENTS:**

**200 Independence Avenue, S.W., HHH Bldg., Room 638-E, Washington, D.C. 20201**

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Washington, D.C. 20201

# MEMORANDUM

To: Chris Jennings, Jennifer Klein

From: Richard Sorian

Subject: Draft Op-Ed on Operation Restore Trust

Date: 5/16/96

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Attached is a draft Op-Ed on the one-year anniversary of Operation Restore Trust along with today's editorial from the Dallas Morning News. We would like to place this Op-Ed in papers in key cities in the five states being targeted by ORT. Please review the draft and return your comments/clearance to me by 12 Noon, Friday, May 17. My fax is 632-1096.

Thank you.

Op-Ed

Donna E. Shalala

Secretary of Health and Human Services

"Zero Tolerance for Health Care Fraud"

As we work to balance the federal budget we must be sure that every dollar of government funds that we spend for the health care needs of the elderly, poor, and disabled is spent for medical services that improve the length and the quality of the lives of all Americans. In fact, it is our moral and fiduciary responsibility to do everything we can to eliminate fraud and abuse in the health care system. Yet too many Americans fear that their tax dollars are being wasted on fraudulent health care practices.

Since the Clinton Administration took office in 1993, fighting health care waste, fraud, and abuse has been a top priority. Across the government we have worked to separate out the few bad apples who seek to spoil our high-quality health care system. As a result, more than $15 billion has been saved in only three years. Working together, the Department of Health and Human Services and the Justice Department have aggressively confronted the cheaters and the frauds and brought them to justice.

For the past 12 months, the Administration has been working even harder to crack down on waste, fraud, and abuse in the health care system. Our credo is quite simple: Zero tolerance for fraud. In May of 1995, the Department of Health and Human Services launched Operation Restore Trust, a five-state demonstration program aimed at rooting out waste, identifying fraud, and eliminating abuse of both Medicare and Medicaid.

When he announced the creation of Operation Restore Trust at the 1995 White House Conference on Aging, President Clinton said, "This is a win-win situation for everybody except the perpetrators of fraud. And it's about time they lost one."

We began this effort in five states -- New York, Florida, Illinois, Texas, and California -- that account for nearly 40 percent of Medicare beneficiaries and 34 percent of those on Medicaid. We combined the firepower of the Health Care Financing Administration, the Office of the Inspector General, and the Administration on Aging to target individuals and institutions who are trying to bilk these programs of their precious revenues. HHS also worked closely with the Justice Department, the U.S. attorneys offices, state and local government officials, private businesses, and health care consumers themselves. We focused our attention on three areas that represent the fastest growing expenditures under Medicare and Medicaid -- home health care, nursing home care, and medical equipment and supplies.

The results have been nothing short of remarkable. In 12 months, with the expenditure of only $4 million, we have produced $42.3 million in restitutions, fines, settlements, and recovery of overpayments, a return of more than $10 for every dollar we spent. That's what I call getting a big bang for the buck! These savings include $38.6 million in money returned to the Medicare Hospital Insurance Trust Fund and another $3.7 million returned to the general treasury.

Since March 1, 1995, we have obtained 35 criminal convictions and 18 civil judgements in cases involving health care fraud. A total of 93 individuals and corporations have been excluded from participation in Medicare and Medicaid because of their fraudulent behavior and nearly 300 cases of potential health care fraud are being pursued in these target states.

Let me share with you one example of this success. A nursing home owner and operator in California was found guilty of 28 counts relating to a multi-million dollar Medicare fraud scheme in which he billed Medicare about $3.5 million for nonexistent medical supplies for his nursing home. In January 1996, this owner/operator was sentenced to 11 years and 3 months in jail, fined $300,000, and ordered to pay Medicare $3.2 million in restitution. Three other individuals were also convicted and sentenced in connection with this scheme.

Achieving these results required an unprecedented level of cooperation with local communities and consumers. The Health Care Financing Administration opened a satellite office in Miami that has been working closely with that community to alert the public and local businesses to health care fraud schemes. And our Inspector General, June Gibbs Brown, has established a toll-free Hotline (1-800-HHS-TIPS) to receive information on potential waste, fraud, and abuse.

Now it's time to take the next logical step. We must expand Operation Restore Trust from a five-state demonstration program to a 50-state national effort to eradicate waste, fraud, and abuse from our health care system. The President has proposed just that in his plan to balance the federal budget by 2002. By spending a relatively small amount of additional money -- $158 million in fiscal year 1997 -- we could save the American taxpayers another $3.5 billion, a return of seven to one.

Bruce Vladeck, head of the Health Care Financing Administration, estimates that we can save another $1 billion by using what we have learned in the last 12 months to enact changes in Medicare and Medicaid laws and regulations to prevent this kind of fraud across the country.

As children, our mothers taught us to "waste not, want not." Today, it's time for Congress to put some real teeth in our anti-

fraud laws and make zero tolerance the law of the land.

# # #

Pam - Yea! Kirk gets... Peter
20 A — ... Kudos for helping make this happen. P

The Dallas Morning News
Thursday, May 16, 1996



## EDITORIAL

# MEDICARE FRAUD

## Anti-cheating pilot project deserves kudos

For all the carping over the looming crisis in Medicare funding, Congress and President Clinton have yet to fix it. But give credit where credit is due. When it comes to fighting waste, fraud and abuse in Medicaid and Medicare, the administration is beginning to administer first aid.

Implemented last May by the Health and Human Services Department, Operation Restore Trust is being directed jointly by that department's inspector general, the Administration on Aging and the Health Care Financing Administration. The initiative's goals include the following:

- Identify and penalize those who willfully defraud Medicare or Medicaid.
- Identify systemic problems and special vulnerabilities to fraud and abuse in the Medicare and Medicaid programs.
- Alert the public and health care sector to health care fraud schemes.
- Promote voluntary disclosure of evidence of fraud.

Operation Restore Trust has recovered $42.5 million in the five states featuring more than a third of all Medicare and Medicaid beneficiaries: New York, Florida, Illinois, Texas and California. The operation has proved its cost effectiveness by returning at least $7 for every $1 spent in implementation.

In fiscal year 1997, Mr. Clinton wants to spend $997 million for a nationwide anti-fraud initiative for Medicare and Medicaid, a $188 million increase over current funding levels. The payoff in savings is estimated to be $9.3 billion over seven years.

Abusers of the system can be found among home health agencies, nursing homes and medical equipment suppliers. Texas faces special scrutiny. It has the most home health agencies in the Southwest, the highest home health reimbursement rates and the highest levels of suspected program abuse, according to the Health and Human Services Department.

In truth, controlling waste, fraud and abuse will certainly not stave off the budgetary disaster facing Medicare. That problem stems from the growing number of eligible claimants. Yet, for the government to fail to monitor expenses would be deeply wrong. Indifference in this area is not only an affront to taxpayers, but a certifiable health threat to the lawful and needful users of Medicare and Medicaid.

# HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Monday, May 13, 1996

CONTACT: HHS Press Office
(202) 690-6343

## HHS REPORTS PROMISING FIRST YEAR FOR "OPERATION RESTORE TRUST" INITIATIVE

HHS Secretary Donna E. Shalala today marked the first-year anniversary of HHS' anti-fraud initiative, Operation Restore Trust, saying new approaches in the pilot program have already produced $42.3 million in recoveries. This constitutes a return of $10 in recoveries for every $1 spent on the project.

The pilot project is operating in five states, and the Clinton Administration has proposed expanding it to all 50 states in the coming fiscal year.

"Operation Restore Trust has pioneered new partnerships within the federal government, new cooperation with states, and new ways of targeting and stopping fraud in the Medicare and Medicaid programs," Secretary Shalala said. "In its first year, Operation Restore Trust has proved its value, and the President wants to extend its reach to every state in the nation."

With first-year targeted demonstration project funds of $4.09 million, Operation Restore Trust has produced $42.3 million in restitutions, fines, settlements and recovery of overpayments. This includes $24.5 million returning to the Medicare Trust Fund from criminal restitutions, fines and recoveries; $14.1 million returning to the Trust Fund as a result of civil judgments, settlements and penalties; and $3.7 million returned to the Treasury as a result of services inappropriately billed or medically unnecessary services rendered.

HHS Inspector General June Gibbs Brown said that "Operation Restore Trust is proving what it was meant to prove: that a new focus on fraud and abuse, and new cooperative approaches, can help us to better protect federal Medicare and Medicaid dollars."

The initiative was announced by President Clinton last May at the White House Conference on Aging. It is aimed specifically at fraud, waste and abuse in three high-growth areas of Medicare and Medicaid: home health agencies, nursing homes, and durable medical equipment suppliers.

- MORE -

Inspector General Brown said that out of 272 Medicare and Medicaid cases currently under investigation in the three targeted payment areas, 244 are new cases that were opened as a result of the Operation Restore Trust initiative. She said 64 of the cases are joint efforts with other law enforcement agencies.

Operation Restore Trust is focused on five states (New York, Florida, Illinois, Texas, and California) which account for 38.5 percent of Medicaid beneficiaries and 34 percent of Medicare beneficiaries.

New approaches being tried under the initiative include:

- Use of sophisticated statistical methods to target providers for investigations and audit
- Use of teams of HCFA data staff, IG auditors and nurses from state agencies to conduct comprehensive reviews of rehab and skilled nursing facilities with unusually high Medicare reimbursement rates. Reviews looked both at facility-specific issues as well as potential systemic problems
- Increased emphasis on concerted planning and executing of investigations with the Department of Justice and other law enforcement agencies
- Use of public forums both to disseminate information to beneficiaries and providers about known fraudulent techniques, and to gather information from them
- Training and empowering state Aging Ombudsmen to detect and report fraud and abuse in nursing homes
- Use of state survey officials who regularly monitor care in home health agencies to help identify inappropriate and fraudulent billing (see separate press release).

Other accomplishments during the first year include:

- o 35 criminal convictions and 18 civil judgments have been obtained since March 1, 1995, in cases folded into the ORT project and benefiting from the increased attention, focus, and support provided by ORT. In addition, 93 program exclusions of individuals and corporations have been taken.
- o A new HCFA satellite office has been established in Miami which, in addition to its other activities, is heavily involved in outreach to the local community to alert the public and local businesses to health care fraud schemes.

- o A toll-free Hotline ("HHS-TIPS") has been established to receive information on possible waste, fraud and abuse.

Bruce Vladeck, administrator of the Health Care Financing Administration, said, "The object of Operation Restore Trust is not only to punish fraud and abuse, and to recover funds, but more important to identify areas of vulnerability and prevent fraud before it happens."

Vladeck said that a number of significant potential program changes have been identified as a result of Operation Restore Trust, which could result in substantial savings by preventing fraud, waste and abuse before they occur. The potential changes are being developed as legislative, regulatory, and administrative actions.

The HHS Office of Inspector General, the Health Care Financing Administration and the Administration on Aging are the three agencies within HHS which are jointly carrying out the Operation Restore Trust initiative. The project has also involved an intergovernmental team comprised of federal and state personnel, including the Department of Justice and the United States Attorneys' offices across the country.

HHS Assistant Secretary for Aging Fernando Torres-Gil said, "Seniors are among the most vulnerable persons to be targeted by unscrupulous health care providers. It is up to us to educate and inform them and others of fraudulent practices so that critically needed services and programs are there for them and future generations when they are needed."

Services targeted by Operation Restore Trust were chosen because they are three of the fastest-growing cost areas in Medicare and Medicaid.

Under President Clinton's FY 1997 budget proposal, the approaches successfully piloted in the demonstration project would become part of a nationwide initiative. The President's budget also contains proposals for providing increased and more stable funding for anti-fraud efforts in Medicare and Medicaid. Altogether the President's proposals for a nationwide anti-fraud initiative for Medicare and Medicaid would involve FY 1997 spending of $597 million, an increase of $158 million over current funding levels. The total saving expected from the additional spending is $3.5 billion over seven years (1997-2003).

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# A Successful Year One

- $42.3 million returned
- 10 to 1 return ratio
- 244 new criminal cases
- Potential major program savings
- Plans to take 5-state pilot National


# Innovations

- Teamwork across agencies and the private sector
- State survey agency partnerships
- Community presence in high prevalence areas

# HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Monday, May 13, 1996

Contact: HCFA Press Office
(202) 690-6145

## PILOT PROGRAM IN TEXAS SAVES MEDICARE DOLLARS BY EXPOSING FRAUD AND ABUSE

Austin, Texas -- The Department of Health and Human Services announced today the results of a six-month pilot project directed by the Health Care Financing Administration. The project employed state surveyors in Texas to help assure appropriate payment for home health services.

"We are very excited about the success of this pilot," said HCFA Administrator Bruce C. Vladeck. "Survey and certification staff regularly perform on-site visits at home health agencies in order to monitor quality of care. Using them in this added capacity -- to document instances of inappropriate billing -- has proven to be highly effective and cost-efficient. While the cost of the pilot was $116,527, more than $790,000 were recovered -- a return of 7:1 for every dollar spent."

HCFA worked in partnership with key state and private agencies on the Texas pilot. The pilot is part of Operation Restore Trust, the HHS initiative announced last year by the President to prevent and detect health care fraud in three of the fastest growing areas in Medicare, including home health care.

The pilot project focused on Texas because this state has the most home health agencies in the region, the highest home health reimbursement rates, and the highest levels of suspected program abuse. Texas is also one of the five states targeted by Operation Restore Trust. The other Operation Restore Trust target states include California, Florida, New York, and Illinois.

"Even though Medicare is a federal program, it makes sense to have the state involved. We were already under contract with the federal government to assess quality of care. We welcomed the opportunity to use these same investigators to ferret out fraud and financial abuse," said David Smith, M.D., Texas Commissioner of Health. "We owe it to the taxpayers and to those who legitimately depend on Medicare."

In the six-month period during which the pilot was conducted, April 1995 through September 1995, reviews for 740 beneficiaries were completed in 74 different home health agencies. Major findings from the pilot include the following:

- More -

- 39 percent of all the beneficiaries reviewed were denied services.
  - ~ 30 percent of the denials were made because medically unnecessary supplies were claimed.
  - ~ 70 percent of the denials were made because the beneficiary was not homebound.

- Approximately 96 percent of the dollars denied were attributed to beneficiaries who did not meet homebound requirements.

- Approximately 89 percent of the home health agencies had some or all services denied while under review.

"This pilot program encouraged surveyors from state agencies in Texas to help contractors detect home health agency fraud and medically unnecessary services. Expansion of this pilot program would give the federal government and the contractors a potent weapon in the battle to preserve the integrity of the Medicare program," said William R. Horton, Group Vice President of Government Programs at Palmetto Government Benefits Administrators, the Medicare contractor in the region.

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**DEPARTMENT OF HEALTH & HUMAN SERVICES**
**OFFICE OF THE INSPECTOR GENERAL**
**330 INDEPENDENCE AVENUE, SW**
**WASHINGTON, D.C. 20201**

**FACSIMILE TRANSMISSION RECORD**

DATE: May 14, 1996

TOTAL NUMBER OF PAGES (including this cover page): 13

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**Return Fax #:**

REMARKS: Convictions under Operation Restore Trust

U.S. Department of Justice

*United States Attorney*
*Western District of New York*

*Further Inquiries (716) 551-4814*

# PRESS RELEASE

May 14, 1996

**RE: UNITED STATES v. ALTERNATE HEALTH CARE, INC.**

Inspector General June Gibbs-Brown, United States Department of Health and Human Services, Patrick H. NeMoyer, United States Attorney, and Virgil Woolly, Federal Bureau of Investigation announced a global criminal/civil agreement today against Alternate Health Care, Inc. This announcement came after Alternate Health Care appeared before the Honorable William M. Skretny and pled guilty to one-count of mail fraud, in violation of Title 18, United States Code, Section 1341. As a result of this criminal plea, Alternate Health Care Inc. faces a maximum penalty of five years probation, $500,000 in fines and approximately $1.1 million in restitution to the Medicare Trust Fund.

Additionally, Alternate Health Care, Inc. and its sister company, Buffalo Hospital Supply, Inc., both of 130 Pineview Drive, Amherst, New York, entered into a civil settlement agreement under the False Claims Act requiring them to pay $3.6 million to resolve allegations of false Medicare billings. Approximately $1.1 million of the settlement agreement will be directed to the Medicare Trust

Fund as full restitution for the criminal fraud. Furthermore, as the primary corporate entity, Buffalo Hospital Supply, Inc. agreed to implement a Corporate Integrity Plan to insure future honesty and integrity in dealing with Medicare and Medicaid.

According to Assistant United States Attorney Janice Innis-Thompson, who handled the criminal case, Alternate Health Care, Inc., acted as a billing agent for claims submitted to Medicare on behalf of Buffalo Hospital Supply, Inc., which provides durable medical equipment and other medical supplies to nursing homes in the Western New York area. The president of Alternate Health Care, Inc., Michael Burke is also the president of Buffalo Hospital Supply, Inc. Between 1987 and 1991, Alternate health Care Inc. devised a scheme to defraud Medicare by fraudulently submitting Medicare claims to Pennsylvania Blue Shield for services rendered in Western New York in order to receive higher Medicare reimbursements. Had these claims been correctly submitted to Blue Shield of Western New York, Alternate Health Care Inc. would have received approximately $1.1 million less in Medicare reimbursements. "The sole purpose for submitting the claims to Pennsylvania Blue Shield was to defraud the Medicare program," Innis-Thompson said.

"This is the most significant health care fraud case that we have resolved in the Western District of New York since Operation Restore Trust, a law enforcement initiative of President Clinton and the Department of Health and Human Services. This is a fine example of the federal government's coordinated approach in

fighting health care fraud. I would like to thank the Office of Inspector General, Department of Health and Human Services and the FBI, for their joint efforts in leading this investigation," U.S. Attorney McMoyer said. Virgil Woolly, the Assisstant Special Agent in Charge of the Buffalo Office of the Federal Bureau of Investigation, said: "White Collar Crime and more particularly Health Care Fraud is a priority for the Bureau both nationally and locally. We will continue to actively participate in the Health Care Task Force."

While AUSA Innis-Thompson handled the criminal case, Assistant United States Attorney William J. Gillmeister negotiated the civil settlement on behalf of the United States Attorneys Office. Such parallel criminal and civil proceedings are common when a federally funded programs such as Medicare or Medicaid have been defrauded. AUSA Gillmeister negotiated the civil settlement pursuant to the Federal False Claims Act, which allows the government to collect treble damages and penalties. "In addition to restoring the losses suffered by the Medicare Trust Fund, the $3.6 million civil settlement will vindicate the integrity of the Medicare program and deter unlawful conduct by others," Gillmeister said. Pursuant to the civil settlement agreement, Alternate Health Care Inc. has approximately five years to pay its $3.6 million debt. As of April 12, 1996, the government has recovered approximately $1.1 million of this $3.6 million settlement.

The criminal plea and the civil agreement also bar Alternate

Health Care, Inc. from future participation in federally funded health care programs such as Medicare and Medicaid. "This is the death penalty for a corporate Medicare or Medicaid provider," U.S. Attorney McMoyer said.

The investigation was conducted by HHS-OIG Special Agent Cynthia Pangallo and FBI Special Agent Caryl Cid. Sentencing is scheduled before the Hon. William M. Skretny on ----------.

OFFICE OF INVESTIGATION
OFFICE OF INSPECTOR GENERAL-DHHS
CASE INVESTIGATION MANAGEMENT SYSTEM
PROSECUTIVE ACTIONS - ALL CASES
FROM 03/01/95 TO 04/30/96



FOR PROJECT: RESTORE TRUST - HEADQUARTERS

FIELD OFFICE: LOS ANGELES

| CASE NUMBER | SUBJECT NAME | HHS EMP. | GRT./ CONT. | HCFA | SSA | FDA | PHS | ACF | AOA | OS | OTHER | PTD DATE | DATE REPORTED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| L8801168-9 | RUTGARD, JEFFREY | | | 1 | | | | | | | | | 08/29/95 |
| | TOTALS: | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

OFFICE OF INVESTIGATION
OFFICE OF INSPECTOR GENERAL-DHHS
CASE INVESTIGATION MANAGEMENT SYSTEM
PROSECUTIVE ACTIONS - ALL CASES
FROM 03/01/95 TO 04/30/96



FOR PROJECT: RESTORE TRUST - HEADQUARTERS

FIELD OFFICE: NEW YORK

| CASE NUMBER | SUBJECT NAME | HHS EMP. | GRT./ CONT. | HCFA | SSA | FDA | PHS | ACF | AOA | OS | OTHER | PTD DATE | DATE REPORTED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 28700686-9 | ULLRICH, HARRY | | | 1 | | | | | | | | | 05/08/96 |
| | VOLPE, ANGELO | | | 1 | | | | | | | | | 03/14/96 |
| | LOBACHEVSKAYA, RASHIL | | | 1 | | | | | | | | | 01/11/96 |
| | VAINER, RAISA | | | 1 | | | | | | | | | 11/28/95 |
| | PROSKUROUSKAYA, GALINA | | | 1 | | | | | | | | | 01/11/96 |
| | KARASIK, BRONYA | | | 1 | | | | | | | | 08/30/95 | 11/21/95 |
| 29000826-9 | JACKSON, RODNEY | | | 1 | | | | | | | | | 10/31/95 |
| | JACKSON, CAREY | | | 1 | | | | | | | | | 10/31/95 |
| | ROUSE, JOSEPH | | | 1 | | | | | | | | | 03/08/96 |
| 29400409-9 | BROCCOLO, JOSEPH | | | 1 | | | | | | | | | 07/28/95 |
| | BROCCOLO, DENNIS | | | 1 | | | | | | | | | 01/19/96 |
| 29400714-9 | WISE, RALPH | | | 1 | | | | | | | | | 10/13/95 |
| 29500477-9 | JACKSON, RODNEY | | | 1 | | | | | | | | | 01/26/96 |
| | TOTALS: | 0 | 0 | 13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |

OFFICE OF INVESTIGATION
OFFICE OF INSPECTOR GENERAL-DHHS
CASE INVESTIGATION MANAGEMENT SYSTEM
PROSECUTIVE ACTIONS - ALL CASES
FROM 03/01/95 TO 04/30/96



FOR PROJECT: RESTORE TRUST - HEADQUARTERS

FIELD OFFICE: ATLANTA

| CASE NUMBER | SUBJECT NAME | HHS EMP. | GRT./ CONT. | HCFA | SSA | FDA | PHS | ACF | AOA | OS | OTHER | PTD DATE | DATE REPORTED |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 49000448-9 | SAMITIER, RICARDO | | | 1 | | | | | | | | | 05/22/95 |
| 49100351-9 | PEREZ-BATISTA, JUANA | | | 1 | | | | | | | | | 04/10/95 |
| | MOMPO, VICENTE | | | 1 | | | | | | | | | 05/06/95 |
| | RODRIGUEZ-ABREU, GILBERTO | | | 1 | | | | | | | | | 04/10/95 |
| | LASTRES, CARLOS | | | 1 | | | | | | | | | 04/10/95 |
| | MATUTE, JOSE | | | 1 | | | | | | | | | 05/06/95 |
| | SOBERON, GLADYS | | | 1 | | | | | | | | | 04/10/95 |
| | IBARRA, AMANDA | | | 1 | | | | | | | | | 08/30/95 |
| | AGUERO, MARTHA | | | 1 | | | | | | | | | 05/06/95 |
| | FOSTER, NANCY | | | 1 | | | | | | | | | 04/10/95 |
| | PEREZ-MIRANDA, AZUCENA | | | 1 | | | | | | | | | 04/10/95 |
| 49300135-9 | DAHDAH, CHARLES | | | 1 | | | | | | | | | 04/25/96 |
| | TOTALS: | 0 | 0 | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

OFFICE OF INVESTIGATION
OFFICE OF INSPECTOR GENERAL-DHHS
CASE INVESTIGATION MANAGEMENT SYSTEM
PROSECUTIVE ACTIONS - ALL CASES
FROM 03/01/95 TO 04/30/96



FOR PROJECT: RESTORE TRUST - HEADQUARTERS

FIELD OFFICE: CHICAGO

| CASE NUMBER | SUBJECT NAME | HHS EMP. | GRT./ CONT. | HCFA | SSA | FDA | PHS | ACF | AOA | OS | OTHER | PTD DATE | DATE REPORTE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 58900116-9 | DRUMHELLER, WILLIAM | | | 1 | | | | | | | | | 06/22/9 |
| | TOTALS: | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |

OFFICE OF INVESTIGATION
OFFICE OF INSPECTOR GENERAL-DHHS
CASE INVESTIGATION MANAGEMENT SYSTEM
PROSECUTIVE ACTIONS - ALL CASES
FROM 03/01/95 TO 04/30/96



FOR PROJECT: RESTORE TRUST - HEADQUARTERS

FIELD OFFICE: DALLAS

| CASE NUMBER | SUBJECT NAME | HHS EMP. | GRT./ CONT. | HCFA | SSA | FDA | PHS | ACF | AOA | OS | OTHER | PTD DATE | DATE REPORTE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 69000701-9 | PARR, RICHARD | | | 1 | | | | | | | | 12/20/94 | 03/08/9 |
| 69300163-9 | PRUITT, J | | | 1 | | | | | | | | | 01/18/9 |
| | TOTALS: | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |

OFFICE OF INVESTIGATION
OFFICE OF INSPECTOR GENERAL-DHHS
CASE INVESTIGATION MANAGEMENT SYSTEM
PROSECUTIVE ACTIONS - ALL CASES
FROM 03/01/95 TO 04/30/95



FOR PROJECT: RESTORE TRUST - HEADQUARTERS

FIELD OFFICE: SAN FRANCISCO

| CASE NUMBER | SUBJECT NAME | HHS EMP. | GRT./ CONT. | HCFA | SSA | FDA | PHS | ACF | AOA | OS | OTHER | PTD DATE | DATE REPORTE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 99200144-9 | REVILLE, DONALD | | 1 | 1 | | | | | | | | | 03/15/9 |
| 99200423-9 | AIELLO, FRANK | | | 1 | | | | | | | | | 01/25/9 |
| | HARRIS, SHARON | | | 1 | | | | | | | | | 10/19/9 |
| | WESTBROOK, MILDRENE | | | 1 | | | | | | | | | 08/16/9 |
| | HARRISON, WILLIAM | | | 1 | | | | | | | | 10/20/94 | 08/16/9 |
| | SHELGREN, DONNA | | | 1 | | | | | | | | | 08/28/9 |
| | TOTALS: | 0 | 1 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |

OFFICE OF INVESTIGATION
OFFICE OF INSPECTOR GENERAL-DHHS
CASE INVESTIGATION MANAGEMENT SYSTEM
FROM 03/01/95 TO 04/30/96



CONVICTIONS SUMMARY

FOR PROJECT: RESTORE TRUST - HEADQUARTERS

| REGION | HCFA | SSA | FDA | PHS | ACF | AOA | OS | OTHER | TOT |
|---|---|---|---|---|---|---|---|---|---|
| LOS ANGELES | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| NEW YORK | 13 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| ATLANTA | 12 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| CHICAGO | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| DALLAS | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| SAN FRANCISCO | 5 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| TOTALS: | 35 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |

OFFICE OF INVESTIGATION
OFFICE OF INSPECTOR GENERAL-DHHS
CASE INVESTIGATION MANAGEMENT SYSTEM
FROM 03/01/95 TO 04/30/96



CONVICTIONS SUMMARY W/CIVIL JUDGMENTS

FOR PROJECT: RESTORE TRUST - HEADQUARTERS

| REGION | HCFA | SSA | FDA | PHS | ACF | AOA | OS | OTHER | TOT |
|---|---|---|---|---|---|---|---|---|---|
| LOS ANGELES | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| NEW YORK | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| ATLANTA | 20 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| CHICAGO | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| DALLAS | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| SAN FRANCISCO | 9 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | |
| TOTALS: | 53 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 |

TOTAL CIVIL JUDGMENTS: 18

May 13, 1996

# STATE FACT SHEET--Texas

**BACKGROUND**

2.1 million Medicare enrollees, 5.6% of total Medicare enrollees

$533 million in Medicare reimbursement for SNF care (1995)

$1.73 billion in Medicare reimbursement for HHA care (1995)

$356 million in Medicare allowed payments for medical equipment and supplies (1995)

**ACCOMPLISHMENT HIGHLIGHTS--STATISTICS**

65 cases opened since March 1, 1995

2 convictions

$1,075,754 in court ordered criminal restitutions, fines, and recoveries

58 ombudsmen and ombudsman volunteers received fraud and abuse training at two regional sessions

**ACCOMPLISHMENT HIGHLIGHTS--EXAMPLES**

- J. Michael Pruitt, DBA Support Products, Inc., pled guilty to one felony count involving the filing of fraudulent Medicare claims for orthotic body jackets. Support Products Inc., will pay restitution of $450,000 at sentencing September 8 in Houston, TX.

- A Dallas dentist was indicted on five mail fraud counts. He operated a DME company in Texas, and was instrumental in forming four others. Each company sold wheelchair cushions to nursing home residents in five States. They were reimbursed $1.2 million for orthotic body jackets never provided. Medicaid and private insurance carriers also paid a substantial amount.

- On April 4, 1996, Caroline Haggard Flores, former owner of a now defunct home health agency, Communicare Home Health Agency, Inc., was arrested in San Antonio, Texas, by an HHS/OIG investigator and an FBI agent following her indictment the day before for charges related to Medicare fraud. The

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# STATE FACT SHEET--California

**BACKGROUND**

3.7 million Medicare enrollees, 9.8% of total Medicare enrollees

$967 million in Medicare reimbursement for SNF care (1995)

$1.17 billion in Medicare reimbursement for HHA care (1995)

$361 million in Medicare allowed payments for medical equipment and supplies (1995)

**ACCOMPLISHMENT HIGHLIGHTS--STATISTICS**

63 cases opened since March 1, 1995

7 convictions

3 civil judgements

$19,519,762 in court ordered criminal restitutions, and fines

$2,065,224 in civil settlements and civil monetary penalties

35 regional ombudsmen received fraud and abuse training to better enable them to advise the over 1,000 local ombudsmen

6 focus group discussions held to get local views about the extent of Medicare fraud and abuse problems and what should be done about it

**ACCOMPLISHMENT HIGHLIGHTS--EXAMPLES**

- Donald Reville, a Geriatric Specialist in Sacramento, California, pled guilty to all charges of a 38-count indictment, including mail fraud and false claims to Medicare totaling more than $350,000 for a 2-year period. Reville admitted that he routinely billed Medicare for comprehensive examinations and histories of nursing home patients without ever seeing the patients. He also admitted to billing Medicare for follow-up examinations that were not performed

subject had written off over $3.5 million in fraudulent expenses in her 1991-1994 cost reports.

- In 1995, the Health Care Financing Administration implemented a six-month pilot project to exchange data between the Texas and Louisiana Survey Agencies and the Regional Home Health Intermediary. The purpose of the information exchange was to validate Medicare coverage of home health services for a sample of beneficiaries. The pilot found that 39 percent (289 of 740) of the beneficiaries had received services that did not meet Medicare coverage requirements. Of those beneficiaries who had received non-covered services, 70 percent did not meet Medicare "homebound" requirements. Costs for the pilot project were $116,527. The project recovered $790,197.

- The AoA, through its State Long Term Care Ombudsman Program, has initiated a project to educate over 1,000 Texas ombudsman volunteers, health insurance benefits counselors and others who serve older people about health care fraud and abuse as part of their advocacy role. The State Department on Aging fully supported this objective. The training will be at 47 sites through closed circuit television utilizing the down-linking capability of Texas A&M University, which is providing the air time, staff and equipment free as a public service. Each Federal and State partner contributed to the establishment of a training manual and will participate in the training.

on patients. He merely made entries in the patients' charts. This investigation was conducted jointly with the FBI.

- A formerly licensed psychiatrist Thomas Sargeant was sentenced in California, on March 5, 1996, to 18 months in prison and ordered to perform community service in lieu of restitution for defrauding Medicare. Sargeant billed Medicare more than $100,000 for fictitious psychotherapy services to nursing home patients.

- A major California ORT success occurred in June 1995 with the Medicare fraud conviction of Frank Aiello by a Federal trial jury. Based on an OIG investigation, Aiello, who owned a northern California nursing home known as Lincoln Care Center, had been charged in an indictment by the U.S. Attorney in Sacramento for engaging in conspiracy with others to submit over 7,000 false nursing home claims for which Medicare paid almost $4 million. Aiello had submitted claims for non-existent medical supplies. Aiello was sentenced to 11 years in prison in February. A civil fraud case against Aiello and his wife for treble damages has been filed.

- The California ORT demonstration is finding many signs of widespread problems with home health agencies in the State, especially in Southern California. The operators of one agency, United Home Health Agency, pleaded guilty to the submission of false Medicare claims. This case involved the submission of false claims to Medicare totalling $2.5 million during a 17 month period, payment of kickbacks for the referral of Medicare patients, creation of fraudulent medical records to document the home visits, and submission of false Medicare cost reports. A confidential data base has just been completed listing all agencies alleged to be engaging in fraudulent or abusive practices, based on information from Medicare fiscal intermediaries, state and HCFA surveyors, OIG, HCFA, and hotline referrals. Over 75 California home health agencies are listed in this data base. A number of these agencies are under active investigation by the OIG and FBI for consideration of fraud prosecution.

Administrative action is also being aggressively pursued for home health agencies found to be engaging in improper activity. The OIG Office of

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Audit Services has identified a $3.5 million overpayment in one of its ORT audits, and as a result payments have been cut-off to the agency by the Medicare fiscal intermediary. Additional intensive audits of other home health agencies are planned.

Another tool the California ORT team is using for home health agencies suspected of improper activity is conducting more thorough certification surveys to identify significant deficiencies related to the Medicare Conditions of Participation. Thus far ORT has conducted over 16 such surveys, with the cooperation of the California Department of Health Services. Significant quality of care problems and certification deficiencies have been found at nearly every ORT survey conducted. Many of these agencies have had their Medicare provider agreements terminated as a result of the survey findings. Additional ORT surveys are being conducted. Also, improvements are planned to the new home health agency certification process to ensure that only qualified operators can be certified as a Medicare home health agency in the future.

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# STATE FACT SHEET--New York

**BACKGROUND**

2.7 million Medicare enrollees, 7.2% of total Medicare enrollees

$287 million in Medicare reimbursement for skilled nursing facility (SNF) care (1995)

$638 million in Medicare reimbursement for home health agency (HHA) care (1995)

$298 million in Medicare allowed payments for medical equipment and supplies (1995)

**ACCOMPLISHMENT HIGHLIGHTS--STATISTICS**

63 cases opened since March 1, 1995

13 convictions

7 civil judgements

$384,436 in court ordered criminal restitutions, and fines

$6,882,214 in civil settlements and civil monetary penalties

222 ombudsmen and volunteers received fraud and abuse training at six local sessions

**ACCOMPLISHMENT HIGHLIGHTS--EXAMPLES**

- Barry Feldman, a podiatrist and middleman for a durable medical equipment (DME) company in New York, was arrested for Medicare fraud. Feldman provided kickbacks for referral of Medicare beneficiaries and physicians' unique provider identification numbers (UPINs) and sold information to a DME company. The DME company gave each beneficiary a lymphedema pump, regardless of necessity, and billed Medicare $4,800 for each pump.

- A project to identify duplicate (Medicare/Medicaid) payments for hard goods DME for dual eligible SNF residents and HHA patients involves unprecedented coordination and cooperation between the New York State Department of Social Services (NYDSS) and the Region A DMERC.

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To date, NYDSS has supplied 44 overpayment demand referrals involving over $700,000 in Medicare payments. In the next year, as the DMERC verifies the Medicare payments, the OIG will pursue criminal, civil or administrative actions, as appropriate.

- The Administration on Aging (AoA), through its State Long Term Care Ombudsman Program, has initiated a project to educate the nearly 600 New York ombudsman volunteers in the area of health care fraud and abuse as part of their advocacy role. The State Office for the Aging fully supported this objective. Each federal and state partner contributed to the establishment of a training manual and has participated in training programs that will reach all New York ombudsman volunteers before the end of June 1996. As a part of this effort, a protocol for handling complaints has been developed for fraud and abuse referrals. Seven such referrals have been made as a result of this project.

- Overpayments totalling $5 million to 70 portable x-ray suppliers performing services to SNF residents have been identified. One provider, who accounts for $3.3 million of the overpayments is under criminal investigation by OIG. The remainder are involved in overpayment recoupment through NY Medicare carriers.

- An audit of a home health agency in upstate New York revealed that in 53 of 100 cases reviewed, all or some of the services claimed were ineligible for Medicare reimbursement. An estimated $2-$4 million were inappropriately charged to the federal government. A criminal investigation was initiated based on this audit.

- OIG audit and the Regional Home Health Claims Processors have begun an unprecedented partnership in conducting audits at home health agencies. One currently in process appears to present potential disallowances of over $1 million in general and administrative expenses.

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# STATE FACT SHEET--Florida

**BACKGROUND**

2.6 million Medicare enrollees, 6.9% of total Medicare enrollees

$641 million in Medicare reimbursement for SNF care (1995)

$1.25 billion in Medicare reimbursement for HHA care (1995)

$412 million in Medicare allowed payments for medical equipment and supplies (1995)

**ACCOMPLISHMENT HIGHLIGHTS--STATISTICS**

32 cases opened since March 1, 1995

12 convictions

8 civil judgements

$3,455,916 in court ordered criminal restitutions, fines and recoveries

$4,704,957 in civil settlements and judgements

**ACCOMPLISHMENT HIGHLIGHTS--EXAMPLES**

- A physician formerly licensed in Florida was sentenced to 26 months in jail and ordered to make restitution of $441,000 for submitting false Medicare claims for DME and vascular testing at nursing homes. He was forbidden to have anything to do with a medically related concern during 3 years of supervised release following his jail sentence.

- The owner of Absolut Medical Services, a Miami DME supplier, agreed to pay $65,000 and accepted a 5 year exclusion from the Medicare and Medicaid programs to resolve his civil liability under the False Claims Act and the Civil Monetary Penalty Law. The company paid "recruiters" a $25 kickback for each Medicare beneficiary they supplied. The scheme resulted in $58,212 in Medicare payments for unnecessary DME.

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- An audit of Pro-Med Home Health, Inc. (Pro-Med) of Miami, Florida found an overall error rate of 40 percent of a randomly selected sample of 100 claims.

  Auditors randomly selected for review 100 claims submitted by Pro-Med for Medicare reimbursement during the fiscal year (FY) ended December 31, 1993. These claims represent 2,068 home health services. The review showed that 40 claims, or 40 percent of our sample, contained 846 services that did not meet Medicare guidelines, as follows:

  > 25 percent of the claims were for 466 services made to individuals who, in their own opinion, or in the opinion of medical experts were not homebound;
  >
  > 8 percent of the claims were for 200 services which in the opinion of medical experts were not reasonable or necessary;
  >
  > 5 percent of the claims were for 127 services not provided; and
  >
  > 2 percent of the claims were for 53 services which physicians denied authorizing.

  During the FY ended December 31, 1993, Pro-Med claimed $3.6 million on 2,922 claims representing 54,545 services. Based on the review, the OIG estimates that $1.2 million did not meet the reimbursement guidelines. The HCFA is now pursuing recovery of the overpayments and corrective action by Pro-Med.

- Based upon the recommendation of the South Florida Task Force, HCFA opened an office in Miami on September, 1995, to focus exclusively on fraud and abuse scams in this area. The office supports the investigative efforts of the South Florida Law Enforcement Task Force, a partnership of Federal and State agencies, including Office of the Inspector General, the FBI, the U.S. Attorney's office, and contractors, charged with improving anti-fraud efforts in this region.

  The office, with bilingual staff, conducts outreach and educational activities. Staff have conducted an education campaign in the area, with meetings and briefings at town centers, seniors centers and other sites where seniors congregate. Bilingual flyers with the ORT 800-number and

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information about identified fraud scams have been distributed to better inform beneficiaries, their families and various organizations about specific fraud and abuse problems.

The Miami office has assisted the U.S. Attorney's office in seeking an extension of a temporary restraining order, freezing the assets of a medical clinic transporting patients into the Miami area for unauthorized diagnostic testing. On site surveillance identified a second address used by the clinic. State investigations into home health fraud in South Florida have led to the suspension of payments for two home health agencies, others are awaiting a final determination.

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# STATE FACT SHEET--Illinois

**BACKGROUND**

1.6 million Medicare enrollees, 4.2% of total Medicare enrollees

$286 million in Medicare reimbursement for SNF care (1995)

$534 million in Medicare reimbursement for HHA care (1995)

$180 million in Medicare allowed payments for medical equipment and supplies (1995)

**ACCOMPLISHMENT HIGHLIGHTS--STATISTICS**

21 cases opened since March 1, 1995

1 conviction

$59,000 in court ordered criminal restitutions

$450,000 in civil settlements

176 ombudsmen, benefits counselors and other service staff received fraud and abuse training at 4 regional sessions

**ACCOMPLISHMENT HIGHLIGHTS--EXAMPLES**

- The owner of an Illinois DME company was sentenced for billing Medicare for beds and wheelchairs that were not provided to nursing home residents. This case will be referred for civil monetary action.

- The AoA, through its network of service providers, has initiated a project to mobilize resources and staff of the state and local community agencies to educate their personnel, volunteers, beneficiaries and families about health care fraud and abuse. The State Department on Aging, as part of their advocacy role, fully supported this objective. Each Federal and State partner contributed to the establishment of training content and has participated in training programs that reached 176 Illinois ombudsman volunteers, health insurance benefits counselors and others who service older persons. In addition to special training, knowledge of ORT is enhanced by presentations at

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meetings, articles in newspapers and newsletters, and radio appearances.

# HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OPERATION RESTORE TRUST
## BACKGROUND

**Overview:**

Operation Restore Trust is a two-year effort to combat health care fraud, waste and abuse in the five states with the highest Medicare expenditures. The project reached its mid-point and one-year anniversary on May 3, 1996.

In "Operation Restore Trust," HHS designated an interdisciplinary project team of federal and state government representatives to target Medicare abuse and misuse in California, Florida, New York, Texas and Illinois. These states account for 38.5 percent of Medicaid beneficiaries and 34 percent of Medicare beneficiaries.

The team is focusing on home health care, nursing home care, and medical equipment and supplies, three of the fastest growing areas in Medicare. Three agencies within HHS -- the Office of Inspector General, the Health Care Financing Administration, and the Administration on Aging -- are involved, as is the Department of Justice.

**Health Care Programs Affected**

The two health care programs covered by Operation Restore Trust are Medicare and Medicaid.

Medicare is a federally administered program of health benefits for eligible elderly and disabled persons. Some relevant statistics include:

> Total Medicare enrollees for 1995 was 37.7 million persons. 12.7 million persons, or 34 percent of the total Medicare enrollees, reside in the five Operation Restore Trust States.
>
> 1995 Medicare outlays were an estimated $177.8 billion.

Medicaid is a state-administered program for eligible recipients, substantially funded by federal government under title XIX of the Social Security Act. Some relevant statistics include:

> Total recipients for 1994 projected at 35.1 million persons nationally. Medicaid recipients in Operation

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Restore Trust States are 13.5 million, or 38.5 percent of the total.

Medicaid outlays for 1994 totaled $108.3 billion.

**Areas of Focus Under Operation Restore Trust**

**Long-term Care Providers** -- In 1995, there were 17,000 long-term care facilities nationwide, including skilled nursing facilities reimbursed under Medicare and nursing facilities reimbursed under state-administered Medicaid programs.

In 1994, Medicaid spent $27 billion for services to beneficiaries residing in nursing facilities; $9.5 billion in Operation Restore Trust States.

In 1995, Medicare directly reimbursed skilled nursing facilities $7.3 billion for care provided under the Medicare skilled nursing facility benefit. $2.7 billion was paid in Operation Restore Trust States.

Home Health Agencies -- Agencies are reimbursed by Medicare for certain services provided to homebound beneficiaries.

In 1995, Medicare payments totalled about $14.5 billion; compared to $12.5 billion in 1994. $5.3 billion was paid in Operation Restore Trust States.

In 1994, Medicare made payments to 7,800 home health agencies.

**Medical Equipment and Supplies** -- Medicare reimburses suppliers for specified items that are medically necessary for the care and treatment of illnesses of beneficiaries enrolled in Part B. Payments are made by 5 regional carriers under contract with the Health Care Financing Administration. Covered items include: (1) durable medical equipment, e.g., wheelchairs, walkers, oxygen concentrators; (2) prosthetic devices, (e.g., artificial limbs, catheters), and orthotic devices (e.g., braces); (3) supplies used with durable medical equipment or prosthetics, e.g., oxygen, cleaning solutions; and (4) supplies such as wound care dressings.

Medicare allowed about $4.5 billion in payments for medical equipment and supplies in 1995. $1.6 billion was paid in Operation Restore Trust States.

**Ongoing Activities in Operation Restore Trust**

- Financial audits by OIG and HCFA contractors
- Criminal investigations and referrals by OIG to appropriate law enforcement officials

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- Civil and administrative sanction and recovery actions by OIG and other appropriate law enforcement officials

- Surveys and inspections of long-term care facilities by HCFA and state officials

- Studies and recommendations by OIG and HCFA for program adjustments to prevent fraud and reduce waste and abuse

- Issuance of Special Fraud Alerts to notify the public and the health care community about schemes in the provision of home health services, nursing care and medical equipment and supplies

- Fraud and abuse hotline

- Voluntary Disclosure Pilot Program

- Training of individuals within the aging network on how to identify and report suspected fraud and abuse

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