HHS NEWS

#107

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE

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 (including hospices), and durable medical equipment suppliers.

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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 of targeting 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 and focus groups 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 judgements 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 prevent more than $1 billion a year in fraud, waste and abuse. The recommended 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 heading 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 the nation's elderly are particularly vulnerable to unscrupulous providers: "Seniors who are receiving care under Medicare and Medicaid deserve to get the highest quality of care from providers who obey the law."

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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Zero tolerance for health care fraud

Donna E. Shalala is secretary of the U.S. Department of Health and Human Services.

AS WE WORK to balance the federal budget, we must be sure that every federal dollar spent on health care goes to meet the needs of the elderly, poor, and disabled — and *not* into the pockets of fraud artists. We must do all that we can to eliminate fraud and abuse in the Medicare and Medicaid programs. We take that obligation seriously.

DONNA E. SHALALA

Across the government, law enforcement agencies have worked to separate the few bad apples who seek to spoil our high-quality health care system from the caring, professional majority. As a result, more than $15 billion has been saved in three years.

Working together, the departments of Health and Human Services and Justice have aggressively confronted cheaters and frauds. In May 1995 HHS initiated Operation Restore Trust, a five-state demonstration program aimed at rooting out waste, identifying fraud, and eliminating abuse in Medicare and Medicaid programs. President Clinton announced the program at the 1995 White House Conference on Aging calling it "a win-win situation for everybody except the perpetrators of fraud. And it's about time they lost one."

We focused first on three areas where expenditures were growing fastest — home health care, nursing home care (including hospice care), and medical equipment and supplies. And we concentrated on the five states — New York, Florida, Illinois, Texas, and California — which account for nearly 40 percent of Medicare beneficiaries and 34 percent of those on Medicaid. We combined the resources in HHS of the Health Care Financing Administration, the Office of the Inspector General, and the Administration on Aging, and we enlisted help from U.S. attorneys' offices, state and local government officials, private businesses, and consumers.

The results are impressive: In 12 months, with an expenditure of $4 million, we have gained $42.3 million in restitutions, fines, settlements, and overpayment recoveries. That's a return of more than $10 for every dollar spent.

Since March 1, 1995, we have obtained 35 criminal convictions and 18 civil judgments in cases involving health care fraud. A total of 93 health care providers have been excluded from participation in Medicare and Medicaid because of their fraud. Nearly 300 cases of potential health care fraud are being pursued.

Achieving such results involved cooperation with local communities and consumers. The Health Care Financing Administration opened a satellite office in Miami to help alert the public and local businesses to health-care fraud schemes.

Inspector General June Gibbs Brown has established a toll-free hotline (1-800-HHS-TIPS) to receive tips on fraud. In addition, Assistant Secretary for Aging Fernando M. Torres-Gil began an aggressive effort to increase public awareness.

Now it's time to take the next step: We must expand Operation Restore Trust from a five-state demonstration program to a 50-state national effort. The president proposes to do that in his budget. By spending a relatively small amount of additional money — $158 million in fiscal year 1997 — I am confident that we can save the American taxpayers at least another $3.5 billion.

When we were 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.

MIAMI HERALD 6/6/96

MEDICARE FRAUD

Anti-cheating pilot project deserves kudos

For all the caterwauling 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 heath care fraud schemes.
- Promote voluntary disclosure of evidence of fraud.

Operation Restore Trust has recovered $423 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 spend $597 million for a nationwide anti-fraud initiative for Medicare and Medicaid, a $158 million increase over current funding levels. The payoff in savings is estimated to be $3.5 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 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 fail to monitor excesses would be deeply wrong. Indifference in this area is not only affront to taxpayers, but a certifiable health threat to the lawful and needful users of Medicare and Medicaid.

Thursday, May 16, 1996 [illegible] 19 A

Operation Restore Trust
ORT info

May 13, 1996

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

HCFA Press Office
690-6145

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

$4,704,957 in civil settlements and judgements

8.160873

ACCOMPLISHMENT HIGHLIGHTS--EXAMPLES

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4.704

- 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.

- 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

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.

Your Strongest Weapon to Fight Health Care Fraud . . .

1-800-HHS-TIPS

(1-800-447-8477)

- Every year, millions of dollars are lost to health care fraud. Everyone can play a role in putting an end to this by calling the Health and Human Services Confidential Tip Line: 1-800-HHS-TIPS.

- Please call Monday through Friday, 9 a.m. to 8 p.m., anytime you believe you have information about fraud. You do not have to give your name to make a real difference.

To report fraud, write to:

Office of Inspector General
U.S. Department of Health and Human Services
HHS-TIPS Hot Line
P.O. Box 23489
Washington, DC 20026

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary
Administration on Aging

Washington, D.C. 20201

Operation Restore Trust

Operation Restore Trust (ORT) is a federal-state partnership to combat fraud and abuse in the Medicare and Medicaid programs. It targets provider fraud in nursing homes and home health care services, including hospice care, and in the durable medical equipment (DME) industry in the five states where forty percent of Medicare and Medicaid dollars are expended — New York, Florida, Texas, Illinois, and California.

The United States General Accounting Office (GAO) has estimated that ten percent of every Medicare and Medicaid dollar spent is lost to fraud. This translates into fewer resources to serve those who depend on these programs for health care and places severe strains on federal and state budgets. Vigorous action is required to ensure that public health care dollars are spent for essential goods and services, not for the enrichment of a few at the expense of the many.

ORT combines the efforts of three agencies within the U.S. Department of Health and Human Services — the Office of the Inspector General (OIG); the Health Care Financing Administration (HCFA); and the Administration on Aging (AoA) — and the following state programs and agencies: long-term care ombudsmen, state units on aging, Medicaid fraud control units, attorney general offices, and health departments. Teams of representatives from these programs in each target state are working to:

- increase public awareness of fraudulent practices;
- reduce and prevent the incidence of such practices;
- detect and punish wrong-doing; and
- encourage self-monitoring and reporting of fraud by provider companies.

It is expected that millions, and possibly billions, of dollars in savings will be achieved through court awards in fraud cases, decreased up-front billings for fraudulent and wasteful practices, and other savings generated through Operation Restore Trust.

Because of their work in nursing homes, state long term care ombudsmen in the five target states are part of the core federal/state interdisciplinary team for their state. Their involvement has opened a gateway for the involvement of both statewide ombudsman staff and volunteer networks and others serving the elderly through programs under the Older Americans Act. Those working in the ombudsman and aging networks are in daily contact with older people and can educate thousands of elders and their families about how to recognize Medicare and Medicaid fraud and what to do when it is detected. In this way, aging network staff, volunteers and older people themselves can become both effective agents and partners with law enforcement personnel in reducing and preventin Medicare and Medicaid fraud and abuse.

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

FOR IMMEDIATE RELEASE
Wednesday, May 3, 1995

CONTACT: HHS Press Office
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PRESIDENT ANNOUNCES HEALTH CARE ANTI-FRAUD PROJECT: "OPERATION RESTORE TRUST"

President Clinton today announced a partnership of federal and state agencies to crack down on Medicare and Medicaid fraud, waste, and abuse associated with home health agencies, nursing homes, and durable medical equipment suppliers.

The targeted anti-fraud project, known as "Operation Restore Trust," will initially focus on five states -- New York, Florida, Illinois, Texas, and California -- that have nearly 40 percent of all Medicare and Medicaid beneficiaries.

The President made the announcement to delegates at the White House Conference on Aging.

"One area where we can all agree is the importance of maintaining the nation's health safety net, Medicare and Medicaid, and that means taking strong measures to ensure that these programs are as efficient as possible," said HHS Secretary Donna E. Shalala.

Savings will include court awards in fraud cases and decreased up-front billings for fraudulent and wasteful practices.

"'Operation Restore Trust' will be a win-win for everybody except those who try to cheat the system," Secretary Shalala said. "For every dollar we spend on this program, the Medicare and Medicaid programs will save six to eight dollars in reduced spending on wasteful practices and court awards from fraud cases."

In addition to identifying and penalizing those who willingly defraud the government, the project is designed to alert the public and industry to the fraud schemes. The project will also help identify and correct the vulnerabilities in the Medicare and Medicaid programs.

A voluntary disclosure program included in the project will allow companies to come forward with evidence of fraud or errors within their own organizations, in consideration for possible reduced penalties.

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The HHS Office of Inspector General (OIG), the Health Care Financing Administration (HCFA) and the Administration on Aging will be partners in "Operation Restore Trust." The project will also involve an intergovernmental team comprised of federal and state personnel.

Shalala said participation by the public, including Medicare and Medicaid beneficiaries, as well as the medical providers in the private sector will be crucial to the project. Later this month, HHS will establish a special hot-line for fraud and waste reports by the public.

"We need to weave fraud control deeper into the fabric of our programs, and we need our beneficiaries and our private sector partners to help us," Shalala said.

Recent reports and investigations by the OIG and special program initiatives by HCFA have shown that home health care and nursing facilities are particularly susceptible to fraud and abuse.

In the home health industry, this fraud has included billing for excessive services or for services not rendered, the use of unlicensed or untrained staff, falsified plans of care, forged physician signatures, and kickbacks.

"We have found significant evidence of inappropriate payments and overuse of services in nursing homes, which means not only the loss of money to the Medicare program, but also a financial burden on beneficiaries," said HHS Inspector General June Gibbs Brown.

Suppliers of durable medical equipment (DME) are also implicated in many of the abuses identified.

"In a time of fiscal austerity, this project is a mechanism that increases our capacity to combat health care fraud and abuse," said HCFA Administrator Bruce C. Vladeck. "It's a smart investment that will save money for the government and the taxpayer, and can mean lower health care costs for beneficiaries as well."

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HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

May 3, 1995

Contact: HHS Press Office
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OPERATION RESTORE TRUST

Overview: "Operation Restore Trust" is a new effort to combat health care fraud, waste, and abuse in the five states with the highest Medicare expenditures.

In "Operation Restore Trust," HHS is designing an interdisciplinary project team of federal and state government and private sector representatives to target Medicare abuse and misuse in California, Florida, New York, Texas, and Illinois. Together, these states account for 40 percent of the nation's Medicare and Medicaid beneficiaries.

The team will focus on home health care, nursing home care, and durable medical equipment, 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.

HHS plans to reinvest monies generated from health care anti-fraud activities to fund expanded enforcement, by placing the monies into a Health Care Fraud Control Reinvestment Fund. The fund would be sustained by money awarded by the courts in Medicare fraud cases.

Background

Recent reports and investigations by the HHS Inspector General and special program initiatives by HCFA have shown home health care and nursing facilities to be particularly susceptible to fraud and abuse.

In the home health industry, this fraud has included billing for excessive services or for services not rendered, the use of unlicensed or untrained staff, falsified plans of care, forged physician signatures, and kickbacks.

Examples: One audit showed that more than 75 percent of claims submitted by a home health agency in a target state did not meet Medicare reimbursement requirements. The review disclosed that 21.5 percent of the claims were for visits that were not provided; 29 percent were for visits to beneficiaries who were not homebound; and 23.5 percent were for visits that were not properly authorized by a physician.

In nursing homes, the Inspector General has found significant evidence of inappropriate payments and overuse of services, which increases the financial burden on beneficiaries and the Medicare and Medicaid programs.

Examples: One supplier provided simple low-cost restraining devices, but submitted claims for more expensive, custom-made orthotic body jackets. In another case, a psychotherapist conducted limited group-therapy sessions, but billed the program for multiple individual sessions.

Suppliers of durable medical equipment (DME) are also implicated in many of the abuses identified.

Health Care Programs Affected

The two health care programs covered by this demonstration project 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 1994 was 37.7 million persons nationally.
- In 1994, there were 33.1 million aged persons enrolled in Medicare.
- 1994 Medicare outlays were $158.2 billion.

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

- Total recipients for 1994 estimated at 34.6 million persons nationally.
- Medicaid outlays for 1994 totaled $145.9 billion.
- Medicaid recipients make up 13 percent of U.S. civilian population.
- In 1993, 31 percent of Medicaid dollars were spent on services provided to Medicaid recipients aged 65 or older.

Targeted Providers in "Operation Restore Trust"

The initiative will target two sets of health care providers--long-term care providers (skilled nursing facilities), and home health agencies.

Skilled nursing facilities -- In 1994 there were 11,000 long-term care facilities nationwide, including skilled nursing facilities reimbursed under Medicare and nursing facilities reimbursed under state-administered Medicaid programs.

- In 1993, Medicaid spent $25 billion for services to 1.6 million Medicaid recipients residing in nursing facilities.
- Between 1993 and 1994, the number of persons receiving care in skilled nursing facilities increased by 12 percent.

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

- This year, Medicare payments will total about $16 billion, up from $7.1 billion in 1992.
- In 1994, Medicare made payments to 7,000 home health agencies.
- In 1993, Medicaid spent $5.5 billion for home health services provided to 1 million Medicaid recipients.

Activities in "Operation Restore Trust"

Activities that will be part of the project include:

- Financial audits by OIG and HCFA
- Criminal investigations and referrals by OIG to appropriate law enforcement officials
- 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.
- Voluntary disclosure program.
- Fraud and Waste Report Hotline

HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

May 3, 1995

Contact: HHS Press Office
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*see below

OPERATION RESTORE TRUST: TARGET STATES

Overview: Five states are involved in the "Operation Restore Trust" project: New York, Florida, Illinois, Texas, California.

- These states account for 40 percent of the nation's Medicare and Medicaid beneficiaries.
- 35.4 percent of all money paid by Medicare in 1993 to HHAs went to providers in these states.
- 39 percent of all money paid by Medicare in 1993 went to skilled nursing facilities in the targeted states;
- DME providers and suppliers in these states accounted for more than 38 percent of the total amount of Medicare dollars paid for DME items and services.

Following is more detailed information concerning each of the targeted states:

New York

- 2.7 million Medicare enrollees (1994 data)
- 2.6 million Medicaid recipients (14.1 percent of population) (1992 data)
- 1993 Medicaid payments: $18 billion
- 1994 Medicare payments: $12.5 billion
- Medicare reimbursement for skilled nursing care:
  1993: $205 million (62,300 beneficiaries)
  1992: $166.6 million (59,400 beneficiaries)
- Medicare reimbursement for home health services
  1993: $545.8 million (166,300 beneficiaries)
  1992: $418.4 million (151,000 beneficiaries)

Florida

- 2.6 million Medicare enrollees (1994 data)
- 1.5 million Medicaid recipients (11.4 percent of population) (1992 data)
- 1993 Medicaid payments: $4.9 billion
- 1994 Medicare payments: $13.7 billion
- Medicare reimbursement for skilled nursing care:
  1993: $348 million (65,400 beneficiaries)
  1992: $243.6 million (53,200 beneficiaries)
- Medicare reimbursement for home health services
  1993: $934.8 million (245,100 beneficiaries)
  1992: $818.8 million (235,700 beneficiaries)

Illinois

- 1.6 million Medicare enrollees (1994 data)
- 1.3 million Medicaid recipients (11.3 percent of population) (1992 data)
- 1993 Medicaid payments: $4.9 billion
- 1994 Medicare payments: $6.6 billion
- Medicare reimbursement for skilled nursing care:
  1993: $194 million (50,400 beneficiaries)
  1992: $143 million (41,500 beneficiaries)
- Medicare reimbursement for home health services
  1993: $350.8 million (126,700 beneficiaries)
  1992: $280.6 million (111,700 beneficiaries)

Texas

- 2.1 million Medicare enrollees (1994 data)
- 2.0 million Medicaid enrollees (11.4 percent of population)
- 1993 Medicaid payments: $7.0 billion
- 1993 Medicare payments: $8.0 billion

- Medicare reimbursement for skilled nursing care:
  1993: $279.5 million (53,500 beneficiaries)
  1992: $174.7 million (40,400 beneficiaries)

- Medicare reimbursement for home health services
  1993: $729.9 million (174,800 beneficiaries)
  1992: $534.0 million (142,200 beneficiaries)

California

- 3.6 million Medicare enrollees (1994 data)

- 4.9 million Medicaid recipients (14.5 percent of population) (1992 data)

- 1993 Medicaid payments: $14 billion

- 1994 Medicare payments: $18.9 billion

- Medicare reimbursement for skilled nursing care:
  1993: $650 million (109,800 beneficiaries)
  1992: $569 million (100,300 beneficiaries)

- Medicare reimbursement for home health services
  1993: $791.8 million (228,700 beneficiaries)
  1992: $566.5 million (212,700 beneficiaries)

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HHS FACT SHEET

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

May 3, 1995

Contact: HHS Press Office
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"OPERATION RESTORE TRUST"
VOLUNTARY DISCLOSURE PROGRAM

The voluntary disclosure program will be initiated on a pilot basis under the auspices of Operation Restore Trust, a major anti-fraud project sponsored by the Secretary of the Department of Health and Human Services (HHS) and the HHS Inspector General, and endorsed by the Attorney General. Through this pilot program, the Office of Inspector General (OIG), in conjunction with the Department of Justice (DOJ), will establish procedures by which health care corporate providers in the home health and nursing home industries may come forward with full disclosure of potential fraud and abuse which may give rise to corporate liability. The voluntary disclosure program will be available to home health and nursing home providers whose activities affect Medicare and Medicaid beneficiaries in the five target States. The voluntary disclosure pilot will last for the duration of the demonstration project, at which time it will be fully evaluated. Appropriate modifications and/or expansions may be made after that time.

The primary purpose of the pilot program is to facilitate increased industry participation in the detection and prevention of Medicare and Medicaid fraud and abuse. Promoting self-disclosure will assist the OIG in its efforts to identify developing patterns and practices of fraudulent activity in the designated industry segments.

Voluntary disclosure offers self-disclosing entities the opportunity to minimize the potential cost and disruption of a full scale audit and investigation; to negotiate monetary settlements to the Medicare and Medicaid programs based upon the matter disclosed; and to reduce or avoid an OIG permissive exclusion under 42 U.S.C. § 1320a-7(b), as appropriate.

In consultation with DOJ, the Office of Investigations, OIG, has established procedures for responding to voluntary disclosures, including phases of application, verification and resolution. For example, an entity requests admission into the pilot program by submitting a written application that fully describes the facts and circumstances of the matter being disclosed, presents a preliminary estimate of the cost to Medicare, and Medicaid where applicable, and contains a pledge to continue to cooperate and disclose fully all relevant matters throughout the program.

The OIG will admit an entity as a "volunteer" upon determination that the following basic criteria are met:

1. The disclosure is made on behalf of a corporate entity. The program is not available to an individual person, officer or employee.

2. The disclosure is "voluntary," i.e., at the time of the disclosure, there is no investigation by a Federal or State law enforcement agency relating to the matter disclosed, and the entity is not the subject of any audit or criminal, civil or administrative proceeding with respect to the matter disclosed.

3. The entity discloses specific information about the nature of the wrongdoing and potential harm to the Medicare and Medicaid programs or their beneficiaries. To ensure that the disclosure is not in response to an ongoing Government investigation, the entity must fully disclose the origin of its information.

Once admitted, the volunteer, the OIG and DOJ execute an agreement that defines the parties' participation in the program. Among the provisions of the agreement are the volunteer's commitment to cooperate fully with the OIG in its verification of the disclosure. In addition to executing the agreement, the volunteer agrees to take corrective action, including appropriate disciplinary actions and payment of restitution to the affected programs. The OIG will agree to stay any administrative sanction within its authority relating to the disclosure during the pendency of the verification process.

After signing the voluntary disclosure agreement, the volunteer may elect to perform an internal investigation of the matter disclosed, and to submit a report of that internal investigation. The OIG cannot and will not make any assurances concerning the Government's use of the internal investigative report in any subsequent investigation or prosecution of the entity. Typically, the OIG will expect any internal investigation to be completed and reported within 90 days of executing the disclosure agreement. The volunteer is also strongly encouraged to conduct any audit necessary to determine and document the financial impact of the fraud on the Medicare and Medicaid programs.

In all cases, the OIG will conduct a verification of the matter disclosed. The extent of the Government's work will depend upon such factors as the completeness of the disclosure; the potential amount of Medicare and Medicaid dollars involved; and the nature of the matter disclosed.

Upon completion of the verification process, the OIG will determine if civil or criminal referrals to State authorities are appropriate, using existing guidelines for case referrals. Such referrals will include a statement by the OIG indicating that the matter has been voluntarily disclosed, and describing the level and degree of the entity's cooperation with the OIG. The federal civil and criminal merits of the case will be determined by DOJ according to DOJ guidelines.

Where criminal or civil action is not deemed appropriate, the OIG and the entity will enter into negotiations to resolve administrative liabilities, including restitution and exclusion from the Medicare and Medicaid programs. Where applicable, the State Medicaid Fraud Control Unit may participate in negotiating the resolution of the entity's liabilities with the State.

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