MEDICARE AND MEDICAID FRAUD

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

JULY 22, 1980

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MEDICARE AND MEDICAID FRAUD

TUESDAY, JULY 22, 1980

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON FINANCE,
Washington, D.C.

The committee met, pursuant to notice, at 10 a.m. in room 2221, Dirksen Senate Office Building, the Honorable Herman Talmadge (chairman of the subcommittee) presiding.

Members present: Senators Talmadge, Nelson, Baucus, Dole, Packwood, and Heinz.

[The press release announcing this hearing follows:]

SENATE COMMITTEE ON FINANCE,
SUBCOMMITTEE ON HEALTH,
July 10, 1980.

SUBCOMMITTEE ON HEALTH SCHEDULES BRIEFING AND HEARING WITH FBI ON MEDICARE-MEDICAID FRAUD

The Honorable Herman E. Talmadge (D., Ga.), Chairman of the Subcommittee on Health of the Committee on Finance, announced today that the Subcommittee will hold a public hearing on July 22, 1980, to receive testimony from top officials and undercover agents of the Federal Bureau of Investigation on fraud running into billions of dollars in the Medicare and Medicaid programs.

Senator Talmadge stated that the hearing, scheduled to begin at 10 a.m. on July 22 in Room 2221 of the Dirksen Senate Office Building, would be preceded at 9 a.m. by a confidential and off-the-record briefing for Committee Members by Assistant FBI Director Oliver B. Revell, Chief of the Bureau's Criminal Investigative Division. Revell is expected to review the status of current and prospective FBI investigations into Medicare and Medicaid fraud.

"To avoid jeopardizing any FBI personnel or informants or potential prosecution, attendance at the closed hearing will be strictly controlled," Talmadge said.

The Georgia Democrat pointed out that Medicare and Medicaid cost Federal and State taxpayers $66 billion a year. Talmadge noted that estimates of fraud range in the billions.

"The rampant and pervasive fraud, which the FBI says they have found, cheats everyone except the cheaters." said Talmadge. "Fraud robs the poor, the elderly and the taxpayers, as well as honest practitioners and providers of health care.

"I am extremely pleased that the FBI says that it has found the Medicare anti-fraud statute, which I sponsored, and which was enacted into law in 1977, to be the key legal authority for investigation and prosecution.

"We want to make law enforcement against fraud abuse in the Medicare and Medicaid programs so tight and so tough," Talmadge said, "that would-be cheaters would worry themselves to death before they would take a chance on vigorous prosecution that would send them to prison for a long time."

Senator TALMADGE. This hearing will please come to order.

As you know, we have just finished a closed session of the committee with this morning's witnesses for the purpose of current discussion with the FBI of these ongoing investigations and other matters without jeopardizing any of the substance or personnel involved in investigations. Some of us have been involved with

monitoring the medicare and medicaid fraud and abuse in those programs.

Those two programs now cost Federal and State taxpayers a total of $66 billion a year.

We have repeatedly inquired into and been shocked at the magnitude of fraud and abuse in those programs. We have repeatedly done everything we could as legislators to provide the necessary statutory authority for detection, investigation, prosecution, and punishment of fraud under these public programs.

This committee initiated the legislation to establish an Inspector General for what was the Department of Health, Education, and Welfare, and which is now the Department Health and Human Services.

In 1977 Senator Dole and I were principal sponsors of the medicare and medicaid antifraud and abuse amendments, enacted by the Congress as Public Law 95-142.

I know that Senator Dole is as pleased as I am that the FBI cites sections of that statute which we sponsored as their principal legal support in the investigation of medicare and medicaid fraud.

Congress can pass laws, but it cannot implement them. The most clear and comprehensive statute to fight criminal fraud is completely meaningless unless those charged with carrying out the law do so.

Clearly—as will be developed in testimony this morning—we are a long, long way from bringing fraud under medicare and medicaid to a stop—let alone getting it to an even tolerable limit.

We are extremely pleased that the FBI has, during the last several years, expanded its efforts intended to detect and punish medicare and medicaid fraud.

While the scope of fraudulent activity appears almost limitless, the FBI's efforts appear to be limited by competing priorities for their available manpower and resources.

It is my hope, as a result of this hearing, we will be able to develop a basis for providing the FBI with additional funding for more personnel and related needs—perhaps through direct appropriation from the medicare trust fund—for the express purpose of setting up medicare and medicaid antifraud strike forces. This is the same approach that the Department of Justice and the FBI have taken with respect to organized crime.

Additionally, we may want to consider authorizing a unit within the Department of Justice which would consist of assistant U.S. attorneys expert in health care fraud, who would serve to back up the regular U.S. attorney's staffs throughout the country.

The purpose of this is to avoid any fraud cases which should be pursued from going unprosecuted for lack of prosecutors.

Finally, under the Talmadge-Dole antifraud statute, fraud under medicare and medicaid is a felony punishable by up to 5 years imprisonment and a fine of up to $25,000. It is my understanding that in all too many cases suspended sentences are being meted out upon conviction. If sentences are suspended relatively indiscriminately and generally, a lot of deterrent effect is lost.

Perhaps it might be worthwhile to consider changing the law to require that the first 30 days of a sentence upon conviction may not be suspended but must be served in jail. Under unusual and

exceptional circumstances the first 30 days might also be suspended where the sentencing judge so recommended and where the Attorney General concurred.

It is also time to give credit where credit is due.

The FBI has stated that much of the pioneering work which led to their expanded interest and activity in the medicare and medicaid fraud areas was stimulated by investigative work and efforts of Senate investigators.

In this regard, the work of Mr. Val Halamandaris, former counsel to the Senate Special Committee on Aging, and now counsel with the House Committee on Aging, is noteworthy both for his innovative investigative techniques and his reports highlighting fraudulent activity.

He is to be commended for these services to the Congress and to the citizens of this country.

And now we will pleased to hear from Mr. Oliver B. Revell, Assistant Director of the FBI and Chief of the Bureau's Criminal Investigative Division.

Mr. Revell, we certainly are pleased to have you with us and look forward to your testimony.

Do any of the other Senators want to make a statement?

Senator DOLE. Mr. Chairman, may I make a brief statement?

Senator TALMADGE. Senator Dole.

Senator DOLE. Mr. Chairman, I would just ask that my statement be made a part of the record.

I don't think that we should start this hearing—I say this in all sincerity, Mr. Chairman—without thanking you for your commitment, concern, and continued hard work in fighting medicare and medicaid fraud and abuse. As you have indicated, we have worked together in the past developing legislation designed to strengthen our efforts to ferret out program abuse, and I think that some of the suggestions you have just made are excellent, and I hope we can continue to work together.

Medicare and medicaid fraud and abuse are diseases, and are potentially fatal processes that may serve to destroy these programs. Those who are adversely affected by these abuses are the recipients, those poor and elderly in our communities that depend on these programs for survival. These individuals suffer because fraud and abuse takes the money needed for service to these people, and puts it in the hands of the unscrupulous whose sole purpose is an increase in their own wealth.

I believe that all those providers, be they physicians, or hospital administrators, or laboratories, or whoever, have an obligation, following these hearings, to start investigations of their own associations and their own organizations to make certain that they can ferret out some fraud and abuse before it reaches a criminal investigation stage.

Legitimate health care providers also suffer because the names of many good practitioners are needlessly blackened, and their professionalism is in question because of those who are unethical.

Finally, the taxpayers suffer because they expect that the money they have put into the system will be used for the purpose that is intended, but instead the money is abused, and the taxpayers cheated.

As was indicated in the closed session, and as I believe the witnesses will tell us in the public session, fraud and abuse are rampant, and kickback and rebates are a way of life. They believe that no phase of the medicare and medicaid industry is free from fraud. I just suggest that that is a rather sweeping indictment of the program, but it is a statement made, and a conclusion reached by those who have been working on fraud and abuse for some time.

Finally, Mr. Chairman, I think we need to raise some questions about the effectiveness of the Inspector General. This committee created the Office of the Inspector General to try to stop some of the fraud and abuse, and we should ask whether they have been effective, whether they have been diligent in their efforts, and if so, what is their record of success?

I think that we all have to address the question of how we can best augment their efforts. Should we specifically support some new FBI activity, as the chairman suggested, or should we strengthen the hand of the Inspector General directly.

I would also point out a memorandum dated February 8, 1980, and I quote.

In a recent meeting, Secretary Harris informed us that in the future, rather than using the phrase "fraud, abuse, and waste," she would prefer "program misuse and management inefficiency." I agree that the Secretary's terminology more accurately reflects what we are measuring and working to eliminate. The change is effective immediately. Please see that this is effected in your areas of responsibility.

Of course, we no longer speak about fraud and abuse. We have made it more polite. I just suggest that this is an area that we must begin to address, and I hope again that we pursue the chairman's efforts to make all the inroads possible.

Thank you.

STATEMENT OF SENATOR DOLE ON MEDICAID/MEDICARE FRAUD AND ABUSE

I would like to begin by commending the distinguished Chairman of this Subcommittee, Senator Talmadge, for his commitment, concern and continued hard work in fighting medicare and medicaid fraud and abuse. We have worked together in the past in developing legislation designed to strengthen our efforts to ferret out program abuse and I look forward to working with you again Mr. Chairman, in this our current effort.

Medicare and Medicaid fraud and abuse are diseases, and are potentially fatal processes that may serve to destroy these programs.

Those who are adversely affected by these abuses are the recipients; those poor and elderly in our communities who depend on these programs for survival.

These individuals suffer because fraud and abuse takes the money needed for services to these people and puts it into the hands of the unscrupulous whose sole purpose is an increase in their own wealth.

Legitimate health care providers also suffer because the names of many good practitioners are needlessly blackened, and their professionalism questioned because of those who are unethical.

And finally, the taxpayers suffer because they expect that the money they have put into the system will be used for the purpose it was intended; but instead, the money is abused and the taxpayers cheated.

The witnesses before us today will tell us that fraud and abuse are rampant—that, and I quote, "Kickbacks and rebates are a way of life." They believe that no phase of the Medicare and Medicaid industry is free from fraud. Well the time to stop the fraud is now.

We cannot mask it, ignore its existence and hope it will go away by merely deleting those terms from our vocabulary, as some have suggested. We must fight it with all the tools at our disposal.

In 1976, during the Presidential campaign, then candidate Jimmy Carter, frequently criticized the Ford Administration for failing to correct abuses in the Medicaid program.

Today, four years after these claims were made and four years after the election of Jimmy Carter, the FBI is here to tell us that rampant waste and illegality still exists—in fact they are worse.

Some years ago this Committee was instrumental in the creation of the Office of the Inspector General.

The Inspector General was given the responsibility of fraud detection and control in HHS programs and I am anxious to hear from him as soon as possible regarding the activities of his office. However, it is clear to me, after an opportunity to talk with the FBI this morning, that the efforts of the IG are insufficient to stem the tide of this onslaught of crimes.

The question would seem to be how we can best augment their efforts—Should we specifically support some new FBI activities, as the Chairman has suggested? Or should we strengthen the hand of the IG directly?

CONCLUSION

Medicare and Medicaid are taking an increasing amount of the Federal budget. Health care costs are rising. The need for reforms in the system grows. But until we gain a greater control over our existing program our efforts are hampered.

Certainly it is not our intention with these hearings to cast dispersions on those members of the health profession or on those health facilities who have provided responsible, qualified care. We are concerned about the percentage that have taken advantage of their position.

The control of fraud and abuse is a responsibility that cannot be borne solely by the Federal Government. It must be shared by all. Our efforts today are to identify areas of particular problems—and devise ways to rectify these problems.

I look forward to hearing from out witnesses—and to working with the Committee in addressing these serious issues.

Senator TALMADGE. Thank you.

Any other comments?

Senator PACKWOOD. Could I make just one comment?

Senator TALMADGE. Senator Packwood.

Senator PACKWOOD. Could I comment upon what these gentlemen have told us in the session.

I think what we have come down to is a situation where the Department of Health, Education, and Welfare, or the Department of Health and Human Services as we now call it, is not seriously interested in prosecuting fraud, waste, and abuse.

They have access to the preliminary information, and yet we discovered in talking to these gentlemen before this hearing that almost every lead they had, almost everything they discovered about fraud, waste, and abuse, they either instigated themselves, or got from informants. They got almost nothing from the Department that is in charge of giving out the money.

The Department is not concerned particularly with the fraud, waste, and abuse. That is way down their list of priorities. If it was way up on top of their list of priorities, we would not have these gentlemen testifying today because what they have discovered would have been discovered by the Department of Health and Human Services long before the FBI ever had to get into it.

Senator TALMADGE. Senator Heinz.

Senator HEINZ. Thank you.

First, I am pleased that you are holding these hearings, and I want to commend you for holding them. I think that they are extremely important. The question of fraud and abuse in our medicare and medicaid programs is a subject that I find deeply disturbing.

We have had hearings both in the Aging Committee, on which I serve, and this committee over the years has had hearings to try

and get to the bottom of many of the fraudulent and abusive practices in the medicare and medicaid programs.

What we are finding is that at the same time that our trust fund is being very tightly squeezed, that we are losing millions upon millions of dollars; as I think we will hear, upward of 10 percent of all medicare and medicaid expenditures may be being siphoned off by corrupt practices within the health care industry. That is a staggering amount of the $66 billion that Chairman Talmadge mentioned a moment ago.

I believe that the time has come for this committee to address the problem even more directly, and I mean legislatively. For example, it might substantially eliminate much of the opportunity for fraud and abuse if, instead of the Federal Government paying on a fee-for-service basis as we do now for ancillary services, we would require that the provision of such services be bid for competitively. This is what I mean by addressing the issue competitively.

I might also add that in my own State of Pennsylvania there have been some very commendable efforts made to halt the corrupt medicaid practices. What they have done is to create, in one instance, a model pharmacy lock-in program. They have clamped down on the acquisition of commonly abused supplies, and services, and they have eliminated thereby a number of corrupt providers.

These are the kinds of efforts, Mr. Chairman, I hope we will be able to make nationwide. I hope that out of this hearing we develop a format for legislative action. It has to bother every member of the committee, and indeed I know it does that our limited resources are being denied to many needy elderly, that the American taxpayer is indeed being ripped off by fraud, that public confidence is being undermined by our inability to insure the efficient delivery of services; and that our Nation's confidence in our health care industry which is, in spite of the fraud and abuse, one of the very great deliverers of excellent health care in the world, is being undercut.

I appreciate, Mr. Chairman, the public service you are providing in helping this committee and the Congress to get to the bottom of these critical issues.

Thank you.

Senator TALMADGE. Thank you very much.

You may proceed, Mr. Revell.

STATEMENT OF OLIVER B. REVELL, ASSISTANT DIRECTOR, FEDERAL BUREAU OF INVESTIGATION CHIEF OF CRIMINAL INVESTIGATIVE DIVISION

Mr. REVELL. Mr. Chairman, and members of the committee. I appreciate the opportunity to appear here with my colleagues to testify before this committee which has, indeed, done a great deal to provide those of us with the responsibility of investigation the tools to conduct the investigations.

By way of introduction, I have accompanying me this morning, to my far left, Assistant U.S. Attorney Robert Ramsey, Jr., of Los Angeles, Calif., who is handling the prosecution of these type cases in the Los Angeles area, and Special Agents Ralph Lumpkin, to my right, and Jonathan Hersley, to my left, who were the agents

actually involved in the undercover operation we conducted in the medicare and medicaid fraud area in Los Angeles.

During 1976 and 1977, there was considerable publicity surrounding frauds in the Government funded health care industry. A number of our offices began conducting preliminary investigations into this area. Our Los Angeles Office determined through preliminary investigation that there was apparent extensive fraud and kickbacks in that geographic area.

After considerable study of the various investigative avenues available, it was decided that an undercover approach would have a high probability of success and would be the most effective way to not only determine the depth of the problem but, with minimal use of manpower, would enable the investigator to obtain direct evidence of the crimes being committed.

The statutes available for use were title 18, United States Code, section 286, Conspiracy to Submit a False Claim; Section 287, Submission of a False Claim; Section 1001, Submission of a False Statement; Section 371, Conspiracy; Section 1341, Mail Fraud; and title 42, United States Code, section 1395nn and 1396h, which prohibit false statements in applications for payments or benefits; and the solicitation, receipt, offering, or payment of any remuneration for referral or the procurement of goods or services under the medicare and medicaid programs.

From our analysis of the programs, available statutes, and information from knowledgeable sources in the industry, it was determined that the title 42, United States Code, citations would be the most viable for the purposes of the investigation.

A decision was then made to begin the undercover operation with our agents representing themselves to be representatives of a large company who was interested in entering the health care industry, specifically nursing homes. These undercover agents, sitting here with me this morning, began contacting the providers of various services.

It became immediately apparent that kickbacks and rebates were a way of life. Virtually every provider of ancillary services that they contacted made offers of rebates and kickbacks in an effort to provide the business services which would be needed to maintain a nursing home. These offers were made by clinical laboratories, therapists, X-ray services, providers of oxygen, et cetera. However, by far the most offers were made by clinical laboratories—this included nine direct offers. In the first 3 months of operation, 22 cases were opened and set aside for future investigation. In addition to the offers of kickbacks, information was developed that indicated kickbacks were being paid to specific hospitals, nursing homes, clinics, and doctors.

In summary, the initial undercover activity had obtained information which would lead one to believe that no phase of the medicare and medicaid industry was free from fraud.

During December 1978, and January 1979, several individuals were arrested as a direct result of the undercover operation. The ensuing publicity in the Los Angeles area led certain individuals to directly contact our Los Angeles Office. Among these individuals was the owner of a clinical laboratory. This individual indicated

that he was very pleased with our efforts and offered his services to assist in the investigation in any way possible.

With this individual's cooperation, our undercover agents were placed into his business as salesmen. The undercover agents and the laboratory owner, working in concert, were able to identify a large number of doctors, hospitals, and clinics who would directly solicit kickbacks as a precondition to any business being given to the laboratory.

While this phase of the operation was underway, an owner of a clinic agreed to assist in the investigation by both making contacts with suspect providers and by permitting undercover agents to portray themselves as representatives of his clinic for the same type of contacts.

The operation was expanded various times throughout its duration as legitimate individuals involved in the industry would come forth and voluntarily cooperate in the investigation. One individual indicated he was losing $800,000 to $1 million per year in business due to his reluctance to participate in the kickback activity.

The operation was closed in March 1980, due to public awareness of the operation and due to the backlog of cases that had been generated which could not be investigated overtly without exposing the existence of our undercover activities.

We learned many things from the investigation, the most evident of which is that corruption has permeated virtually every area of the medicare and medicaid health care industry. Also, of equal importance, we have learned that there are many honest, reliable businessmen and professional people who will do whatever is necessary to assist in removing the corruption from the industry.

Based on our experience, the methods to commit fraud in the medicare and medicaid programs are virtually unlimited. The most widely used method of paying kickbacks in this program is by cash. Generally, the payment is based on the percentage of dollar volume of the medicare medicaid business generated by a particular client. For instance, a laboratory may receive $10,000 per month in medicare and medicaid business from a particular doctor client.

The laboratory will agree to the kickback based on a percentage of the $10,000 of medicare and medicaid work referred to the laboratory. Generally, the percentage agreed upon is 10 to 20 percent, but has been as high as 33 percent. This arrangement naturally provides an incentive for the doctor or client to order medicare and medicaid business that is not necessary.

We have found a number of different methods of paying kickbacks. One method is for a laboratory to provide free services to a doctor's or clinic's non-medicare/medicaid patients. Other methods of paying kickbacks to clients of the providers are: The provision of free supplies ranging from business equipment to pharmaceutical items; payment of rental for office space; free trips; and salaries of employees. Yet another method is for the provider and the client to combine and form a shell corporation which is used to wash the kickbacks.

Our agents were advised by one doctor that he was receiving $5,000 per month as a kickback from one laboratory. This doctor stated that the laboratory had asked him to order certain tests

because they could be reimbursed at a higher rate. The doctor stated that he did order these tests and did receive the results. However, he did not know what the purpose of the tests or the meaning of the results, but he did know the tests were not necessary.

We have conducted investigations of these types of frauds in several areas of the country with the same general findings. In Detroit, Mich., our investigation to date has resulted in 42 convictions, of which 22 were related to laboratories, 10 were doctors, 7 were nursing home related, and three were pharmacy-related cases.

In Tampa, Fla., we have completed a number of investigations. However, we are still awaiting completion of prosecutive action. In Tampa, Fla., to date the only significant accomplishment has been a reported sizable reduction in claims amounting to hundreds of thousands of dollars.

The Los Angeles operation has resulted in the conviction of 14 individuals to date. Ten of these individuals were the owners or operators of laboratories. Two individuals, one of whom was a State of California Department of Justice investigator, and the other an owner of a laboratory, were convicted of a violation of the Hobbs Act as a result of their activities in attempting to influence State medical fraud investigations involving various physicians in the Los Angeles area.

Currently in Los Angeles, there are indictments pending involving 11 individuals and 3 laboratories, all involving either the paying or soliciting of kickbacks. Four of these individuals are doctors. To date, over 200 cases have been developed and an additional 30 to 50 indictments are expected before the investigation is concluded.

We believe the people committing these frauds have absolutely no fear of being caught. For example, during December 1978 and January 1979, considerable publicity was generated as a result of arrests which were openly identified as stemming from an undercover operation. This exposure had no effect whatsoever and the same undercover agent continued an expanded operation until it was closed during March of this year.

Since that time, the only effect of the publicity has been discussions during which the undercover agent and the subject accused each other of fronting for the FBI and, afterwards, our undercover agent was able to continue dealing with this individual who accepted that he was not an FBI agent.

Furthermore, one of our offices has advised us that the people who commit these frauds are aware of their illegal activity, however, have decided to take the risk because they believe that if they are caught, the worst that can happen to them is that they will have to repay the money they obtained fraudulently.

Our experience has shown that fraud in this area is at best extremely difficult to detect. For example, at the time one individual was arrested, a search warrant was served for all records of his laboratory. This individual subsequently pled guilty and admitted committing fraud. A detailed examination of his records, however, failed to reveal how the fraud was being perpetrated and the

individual refused to discuss the bookkeeping procedures he utilized.

I have focused on the area of kickbacks as this is the primary area where we have had success. We have uncovered other areas involving fraud which are aggravated. In one instance, a doctor had been paid $2 million in a 2-year period as a result of his medicare and medicaid activities. The doctor was performing abortions on women who were not pregnant.

He had instructed his laboratory staff that they were not to tell the patients the results of the tests that were conducted if they were not pregnant. If the patient somehow became aware of the results, he would conduct a physical examination, state that the test was wrong, and immediately perform an abortion.

This doctor billed for an abortion performed on a woman who previously had a hysterectomy. Another abortion was allegedly performed on a woman who previously had a tubal ligation. In 48 separate instances, this doctor billed for performing 2 abortions within 1 month on the same patients.

While conducting this investigation, we learned that the doctor had obtained a Comprehensive Employment and Training Act (CETA) contract for the purpose of hiring and training unemployed individuals in medical procedures. The investigation discovered that the doctor had directed his employees to furnish false information in order to qualify for the CETA program.

The doctor was subsequently indicted and convicted of mail fraud and making a false statement to the U.S. Government. He was sentenced to 2 years imprisonment and fined $6,000.

In another case in which two dentists were convicted, it was determined that they had submitted 16 bills on behalf of one public aid patient for work that included 51 fillings in 10 of the patient's teeth, 14 in 1 single tooth. One of these dentists had billed for extracting 4 wisdom teeth each from 23 separate patients in 1 day. During the investigation, 16 of these patients were determined to have from 1 to 4 wisdom teeth in their mouth. These dentists were sentenced to 18 months imprisonment and fined $29,000 each.

We had another instance in which we were conducting a surveillance of a doctor who was involved in the home care program. The doctor, while making his rounds, was observed on many occasions to be lost and was constantly checking a map. We had difficulty believing he could possibly get lost in view of the fact that he had been submitting billings for seeing most of the patients for at least 2 years.

In a Western State, while conducting an investigation involving nursing homes, we determined that a nursing home was inflating the number of staff members, which is part of the basis for reimbursement, and they were taking patients funds that were to be used to purchase personal incidentals and pharmaceutical items.

The owners of the home were inflating the cost reports by charging personal expenses, phony expenses, and other items which had the effect of raising the reimbursement rate. The investigation also developed allegations that the owners were soliciting kickbacks from providers of ancillary services.

These investigations are not limited to any specific area of the medicare and medicaid programs. We have cases in which pharma-

cists are submitting totally false billings. We have cases that involve hospitals soliciting kickbacks and engaging in other illegal activities.

We have cases that involve massive overutilization. An example of this is one doctor, while treating a patient for a fractured thumb, ordered over $300 worth of blood workups. We have another instance in which a doctor is alleged to have submitted bills which would have required the doctor to treat a patient every 12 to 15 seconds during the billing period.

These examples are not even representative of all the circumstances under which fraud has been discovered. However, I believe they will help you in your endeavors to determine the seriousness of the problems in this area that the FBI has encountered.

We have had problems in conducting traditional investigations in these types of cases. These fraud investigations are extremely involved, time consuming, and at their conclusion prosecution is extremely difficult due to the complexity of the crimes.

One specific problem area is overutilization. It is extremely difficult to ascertain when prescribed treatment can be considered reasonable and prudent and when overutilization of tests and laboratory examinations occurs to the point where it becomes fraud.

Fraud in the medicare and medicaid programs is undoubtedly costing the American taxpayer substantial sums of money. Far worse is the fact that the money being lost through fraud could be used to provide much needed medical help or diverted to other areas which have curtailed operations due to lack of funding.

The area of my concern is that with the amount of overutilization in the laboratories alone, are all the tests or even the required tests being conducted? Our investigations to date are not conclusive on this point.

The FBI believes fraud against the medicare and medicaid programs is nationwide in scope and we further believe that the investigations to date have had only limited effect. From our experience, we do not believe any area of this program is free from fraud.

The FBI does believe that the problems can be substantially corrected. This will require extensive mutual effort and cooperation on the part of the FBI, the Inspector General of the Department of Health and Human Services, the Department of Justice, the State program enforcement officials, as well as various components of the medical profession, private citizens, and Congress.

In conjunction with the Department of Justice's new Economic Crime Units, the FBI and the Office of the Inspector General of the Department of Health and Human Services are currently establishing a joint task force on a major Eastern city to address medicare and medicaid frauds. An expansion of this concept is being drawn up for other geographic areas to address this problem on a national scale.

It is believed that the knowledge gained from these operations will be very beneficial to the Inspector General in identifying any necessary restructuring of these programs that can be implemented to minimize the vulnerability to fraud.

In your request you asked for our comments as to how widespread this problem is. The examples cited today, while not drawn

from every area of the country, are truly indicative of problems we are finding nationwide. In March 1980, 52 of our 59 field offices had cases pending involving fraud against the Department of Health and Human Services. We do anticipate that all of our offices will be developing cases in this area in line with the Department of Justice white-collar crime national priorities.

You further asked if, in the FBI's judgment, there are indications that this problem extends beyond nursing homes and clinical laboratories. The answer to this is an unqualified yes. We have found these problems in virtually every facet of the medicare and medicaid area. The problems we are finding in rural, as opposed to urban areas, are not of the same magnitude. However, the same problems do exist.

I hope our testimony here today will be beneficial to you in your current efforts. I want you to know that Director Webster has placed a high priority on our efforts in this important area.

Gentlemen, this concludes my formal statement. I believe that Mr. Ramsey, at this point, also has a statement to enter.

Senator TALMADGE. We will proceed to interrogating you first, Mr. Revell.

Any objection to following the 5-minute rule this morning on the order of arrival?

[No response.]

Senator TALMADGE. Without objection, it is so ordered.

Mr. Revell, I want to compliment you on your statement. It is clear, concise, detailed, and goes to the heart of the problem.

How many active medicare and medicaid cases do you have under consideration now?

Mr. REVELL. At the present time, between 650 and 700 throughout the country.

Senator TALMADGE. Were you surprised at the amount of fraud and abuse uncovered in your investigation?

Mr. REVELL. I think that all of us were surprised in the undercover investigation in Los Angeles with the pervasiveness that appeared to exist in the program. Yes, sir.

Senator TALMADGE. Given the investment in manpower and resources with respect to medicare and medicaid fraud, has the FBI found that the payoff in terms of arrests, indictments, convictions, and recovered funds has been worthwhile?

Mr. REVELL. That is difficult to quantify, Senator, but I believe we are getting tangible results today. I believe that we are seeing a more serious attitude taken by prosecutors, and by judges. I think that a heightening of awareness is occurring, but certainly it is spotty, it is not consistent throughout the country, and much more needs to be done in this regard.

Senator TALMADGE. If we were able to establish specific units within the Bureau being known as the medicare and medicaid antifraud strike forces, do you believe that the visibility and knowledge of those units would help as a deterrent?

Mr. REVELL. Senator, I believe that the FBI needs the flexibility to address priority problems across the United States. I do think that we need to have specific units that are dedicated to problems in medicare and medicaid, as we have done in Los Angeles.

We are at the present time considering this in certain other major metropolitan areas, and I think that in conjunction with the Department of Justice's Economic Crime Units, and with the Inspector General of the Department of Health and Human Services, we do need to dedicate more resources in this area.

Senator TALMADGE. We are spending $66 billion now on medicare and medicaid. If fraud and abuse is as prevalent as your statement seems to indicate, there must be billions and billions wasted, and taken by crooks. Would that be a fair statement?

Mr. REVELL. Senator, our information is based on the cases that we investigate. I think that you can draw certain inferences from these cases. I don't think that you can make a flat statement as to the percentage of the program that is fraudulent. Our indications are that it is substantial.

Senator TALMADGE. What do the cases in Tampa involve?

Mr. REVELL. Our cases there involve, I believe, the provision of unrequired services, the inflation of prices, and a substantial amount of unnecessary work being done by laboratories and other ancillary services. These cases I cannot discuss in detail because they are still in a pending prosecutive status.

Senator TALMADGE. If the FBI, and I am not saying that you have not done so, were to set up similar operations in New York, Chicago, Miami, Philadelphia, or Denver, do you believe that you would find activities in those cities similar to what you have already discovered?

Mr. REVELL. Based on our experience throughout the country, and with the success that we have had in Detroit, and Los Angeles, I believe that we could probably detect, using these types of investigative techniques, fraud and abuse throughout the country.

Senator TALMADGE. All of the cases referred to you, or which have been developed by you, or the leads which you developed, in fact followed up in a timely fashion?

Mr. REVELL. To the best of our resources and ability. Yes, sir. We obviously have to prioritize our investigative efforts, and an item of information that might indicate a rather minor fraud may not receive as timely a consideration due to other more important pending cases. But ultimately, within the availability of our resources, they will all be addressed and investigated.

Senator TALMADGE. Do you have adequate personnel to do the job?

Mr. REVELL. Well, sir, we do the job to the best of our ability with what we have. It is dependent upon what the administration and the Department believe is necessary.

Senator TALMADGE. Senator Packwood.

Senator PACKWOOD. You indicated that you have 42 convictions in Detroit?

Mr. REVELL. Yes, sir.

Senator PACKWOOD. How many of those 42 were sentenced?

Mr. REVELL. It is my understanding that nine of them were sentenced to imprisonment, but that the imprisonment was suspended in most of these instances to community type facilities. Of the nine that were sentenced, I believe the average sentence was about 11 months.

Senator PACKWOOD. Let me rephrase it. Of the nine that were sentenced, none of them served any time in prison?

Mr. REVELL. In a traditional prison, I believe that is correct.

Senator PACKWOOD. The other 33 that were convicted served no time, or received no sentence to serve time.

Mr. REVELL. Probation and fines.

Senator PACKWOOD. You have obtained 42 convictions, all felonies, and nobody is serving time.

Mr. REVELL. I believe that is correct, sir.

Senator PACKWOOD. You indicate in your statement that this corruption continues because, first, most people are not even afraid that they are going to get caught; second, if they do get caught, all they think they will have to do is pay back the money.

Mr. REVELL. That is correct, sir.

Senator PACKWOOD. Before you started your investigation, how effective was the Department of Health, Education and Welfare, now the Department of Health and Human Services, in ferreting out and finding, and calling to the U.S. attorney's attention the same kind of facts and information that you have discovered with the FBI?

Mr. REVELL. Senator, I think that it would be fairer to let Mr. Ramsey, who prosecutes these cases and would be familiar with what the Office of Investigations of HHS was doing and is doing, to answer that question.

Senator PACKWOOD. Fine.

Mr. RAMSEY. With respect to that question, Senator, as we discussed earlier, the HHS, or the Department of Health, Education, and Welfare as it was known at the time this investigation began, were not concerning themselves with the kickback and bribe section of the statute.

Senator PACKWOOD. Say that again. At the time you started this investigation, the Department of Health, Education and Welfare was not concerned with what?

Mr. RAMSEY. They were not concerning themselves with title 42, section 1395nn, which is the kickback and bribe statute.

Senator PACKWOOD. Why not?

Mr. RAMSEY. I don't know why, Senator. I think at that time, which would have been in early 1978, the Office of Investigation was just getting started at that time, and I don't think they have any investigative efforts into the kickback and bribe area. However, they were looking at false statements, and false bills at that time.

But with respect to your specific question regarding kickback and bribes, which is the area that the FBI was looking at, I would venture to say that none of the information was brought to the FBI by HEW, which is now the Department of Health and Human Services.

Senator PACKWOOD. None of the information brought to the FBI came from the Department of Health and Human Services.

Mr. RAMSEY. I would say that, Senator, with respect to the kickback and bribes.

Now the agents could be more specific as to whether any information was given to them by HEW.

Senator PACKWOOD. I will limit myself to the kickbacks and bribes.

What you were saying, your principal sources of information are informants, or your undercover operation.

Mr. RAMSEY. That is correct.

Senator PACKWOOD. To the best of your knowledge, as far as kickbacks and bribes are concerned, you have gotton nothing from the principal Government department whose principal responsibility it is to supervise the programs.

Mr. RAMSEY. Again, I would qualify this because the agents will talk to it.

However, I would say that that would be true, Senator, because usually the kickbacks and bribes that are given, or the rebates or discounts, are not disclosed through any records. Consequently, it would be impossible to detect whether or not bribes and kickbacks are being given unless you would have one in a 1-on-1 position with the individual that is either offering or receiving the kickback or bribe. That is why the sting operation was so successful which HEW did not concern themselves with.

Senator PACKWOOD. What you have is a situation where the Department of Health and Human Services has an Inspector General, whose function is to attempt to ferret out this kind of information, and call it to the attention of the U.S. attorney, and they have been unable to ferret out the information.

Finally, when the U.S. attorney and the FBI get into it, and you get to Detroit, you have 42 felony convictions, and only 9 people are sentenced, and none of them serve any time in prison. Is it any wonder that people think, "Why not go ahead with this fraud? Why not go ahead with this deception? We are not likely to get caught because the Department of Health and Human Services can't even find us, and if we do get caught, we will never have to go to prison because all we will have to do is pay back the money at the most."

With that kind of a system, how on Earth are you going to stop this fraud and corruption?

Mr. RAMSEY. Senator, that is a good question. I think that everything the Senator has said is true. I also think there are other things that we have to look at to determine why this type of activity and this conduct continue to exist.

I think the first thing we have to look at is the type of individuals that commit this type of fraud. I believe that they consider this a normal business practice to be able to get the type of business, and to make the type of money that they are making off of the program.

Senator PACKWOOD. You mean to say that we have reached the stage where they regard this kind of fraud and corruption as a normal business practice?

Mr. RAMSEY. I think that is correct, Senator. I think to a large extent that is absolutely correct.

Senator PACKWOOD. No wonder they don't think that they are going to go to prison. You mean they don't think they are doing anything wrong anymore?

Mr. RAMSEY. That is correct.

Senator PACKWOOD. And the Department of Health and Human Services may or may not think that they are doing anything, but they can't find it.

Mr. RAMSEY. That may be true also, Senator.

I think that for a long period of time the Department of Health and Human Services, or HEW as it was before, concerned themselves mainly with the administrative process. They did not have those types of investigators that were qualified to go out and conduct criminal investigations.

I think that it has only been recently that they have engaged in this type of activity, once the Office of Investigations was established, or the Inspector General, as it were.

Senator PACKWOOD. I think what happened was this: When you fellows got into it, and started finding what you were finding, the Department of Health and Human Services was absolutely embarrassed, with egg on their face.

I frankly don't think that they care much about fraud or corruption. Their job is not to find out who is guilty of fraud or corruption. Their job is to shovel out as much money as they can. If there is some fraud or corruption that is part of the normal business overhead apparently.

My time is up.

Mr. REVELL. Mr. Chairman, one point that Mr. Ramsey made, the two undercover operatives believe, based on face-to-face contact with the vendors and providers, that they know what they are doing is illegal. However, it is an accepted way of doing business.

Senator PACKWOOD. Say that again?

Mr. REVELL. They know that it is illegal, but it is an accepted way of doing business.

Senator PACKWOOD. HEW or HHS know that it is illegal.

Mr. REVELL. I am talking about these two undercover agents in their contacts with the providers of ancillary services, and the vendors, and the doctors involved, and so forth, there is a substantial indication that they know what they are doing is illegal.

Senator PACKWOOD. And it is an accepted way of doing business.

Mr. REVELL. Yes, it is an accepted way of doing business.

Senator PACKWOOD. With the U.S. Government.

Mr. REVELL. I think that you might want to ask them how they came up with these types of determinations because they were in face-to-face contact, and had these types of conversations.

Senator PACKWOOD. Mr. Chairman, my time is up. I don't know whether the two agents want to answer that type of question.

Senator DOLE. I think the way HEW handled it, they said, "We don't use the words 'fraud and abuse' anymore." That is the memo that I read earlier dated February 8 in answer to Senator Packwood's inquiry.

They say that they are not going to use the words "fraud and abuse and waste." They will just use program misuse and management inefficiency. That is one way to solve the problem. There is not going to be any more fraud and abuse, because we are not going to use the words "fraud and abuse."

I go back to 1976 occasionally—I don't want to get the FBI involved in politics. I know you are totally non-partisan, and so are the rest of us—but in 1976 Candidate Carter had big headlines

criticizing President Ford for not doing anything about fraud and abuse which was running between $4 and $7 billion a year. He made quite an issue of that. I am not sure how effective it was, but it was effective enough. [Laughter.]

The point is, in March of 1977—I am going to ask a question about this in a minute—on March 21 the Washington Post carried a story that alleged, and there is an affidavit on file in this committee by Mr. Walsh, who was the HEW Chief Investigator, that he had been hindered by Mr. Califano from investigating an alleged fraud involving a San Jose, Calif., firm that uses medicare and medicaid money to provide health care to the poor and the aged.

Califano denied that, and I am not suggesting what happened, but there is an affidavit on file, which we will make a part of the record here, where Mr. Walsh made these allegations that he was not permitted to make an investigation involving fraud. If that is the case, if that is the policy, then I understand Senator Packwood's frustration.

In the affidavit that was filed with the Senate Finance Committee, he said that he quit his job after being told by Califano that he had to clear every investigation with HEW's general counsel.

So with that background, it is probably easy to understand why there has been less than effective enforcement by HEW. First of all, there is an allegation that they did not want to investigate; second, they just stopped using the words.

Having said that, the cases you mentioned are probably the worst. You probably picked out the worst cases. You don't normally find people putting 14 fillings in one tooth. Would that be accurate?

Mr. REVELL. I think they are rather graphic demonstrations. I would not say that they are atypical.

Senator DOLE. You mean that what you told us is a cross section of what you found out there?

Mr. REVELL. They were types of fraudulent activities that these would typify. I don't think that they would be necessarily more aggravated than others that could have been used.

Senator DOLE. How did you actually get into the LA investigation?

Mr. REVELL. I will let one of the undercover agents, Mr. Lumpkin, tell us about that.

Mr. LUMPKIN. After receiving the information from our headquarters that we were to direct our attention to these program frauds, we initially contacted various individuals in the health industry regarding the information that there was potential fraud in these areas. The indicators that we received were, in fact, that there was a lot of misuse and fraud in the program. Based on that, we did decide to take this action.

Senator DOLE. Who was it that asked you to get into it? Was it HEW?

Mr. LUMPKIN. No, sir. It was our Bureau headquarters.

Senator Dole. They had had a complaint; I guess some of this you can't divulge. I guess someone had made a complaint.

Mr. REVELL. No, sir. It was an attempt to put more emphasis on program fraud across the board in the Federal activities, and we went out to our field offices and instructed them that the agents in

charge were to attempt to determine if there was substantial program fraud in any area, CETA, medicare and medicaid, whatever, and to apply whatever resources they had available to these program fraud activities.

Based on that, a survey was conducted in Los Angeles, as well as in other places. We found that there was an indication to predicate investigations, and they went from that point.

Senator DOLE. Is there any evidence of any organized crime involvement in any of the cases you are currently, or have in the past, become involved with?

Mr. REVELL. We have some indications of organized crime involvement in certain laboratories and clinics. It is not definitive as yet. There are indicators and not proven facts. At this point, I would say that it is an area that we are looking into.

Senator DOLE. With reference to providers, because we are talking about a lot of people involved, whether they be physicians, or whether they be technicians, or whether they be hospital administrators—you could probably name me 50 providers. There are a lot of honest people who are not involved in these activities. Is that a correct statement?

Mr. REVELL. They are very chagrined at the activities. Several of them came to us and asked us to be allowed to help us.

Senator DOLE. At the same time, you are suggesting that what you have found is rather pervasive. It is widespread.

Do you have any percentage figures of all the numbers that you have talked, what percent were involved, and what percent were not involved?

Mr. HERSLEY. Senator, I would estimate that 90 percent of the people that we talked to, if they were not involved in some type of fraudulent activity, it was at least questionable as to the activity that they were involved in. Where in some instances the evidence would not necessarily result in an indictment, it was certainly an irregularity that should be followed up by us and referred over to the appropriate authorities.

Senator DOLE. If I could just pursue that, even though my time has expired.

In other words, all the people that you talked to, who were investigated which would include, I assume, administrators, laboratories, physicians—I am not certain how many of each, but I don't want to broadbrush anyone—90 percent of all those people there were some irregularities, or they were somehow involved.

Mr. HERSLEY. That is a fair estimate; yes.

Senator DOLE. It does not leave very many.

Mr. REVELL. Senator, there is another thing to be considered. We did not just go out indiscriminately and contact people. We had to have a lead in, an indication from someone else involved, that so-and-so might be interested in doing business. Our contacts were not indiscriminate, and therefore you could not say that 90 percent of all doctors in the health care industry are involved.

Senator DOLE. I understand that, but it is still a rather substantial percentage.

Mr. REVELL. Yes, sir.

Senator TALMADGE. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

One question I have, do you have any evidence that those who engage in criminal fraud are also providing poor and inappropriate care? Is there any correlation there?

Mr. REVELL. Senator, we have had certain indications in the past that some of the laboratories were not conducting tests, were maintaining very poor quality control on their tests, and so forth. I have no specific case example on this point, all I can state is that we have indications that this may be the case.

Senator BAUCUS. You are saying that it is a reasonable probability, then.

Mr. REVELL. I would say, in my personal opinion, from what I have seen, yes.

Senator BAUCUS. How did the FBI get involved in these investigations? Were you called by HHS; or did you go on your own initiative?

Mr. REVELL. We went in on our own initiative. It is part of our jurisdictional responsibility to investigate fraud against the Government. There are substantial sums of money as Senator Talmadge indicated, some $66 billion, in this program. We had informants and confidential sources, and members of the public coming to us saying that there were problem areas.

Based on our mandated priorities of organized crime, and white-collar crime investigations, we tried to initiate certain investigative techniques that would enable us to find out if there was fraud ongoing in this particular industry. Obviously, the results speak for themselves.

Senator BAUCUS. Do you think the FBI could accomplish more in exposing this waste if you had more funds and manpower to affirmatively go out, rather than waiting for referrals?

Mr. REVELL. The end result of any investigative endeavor is the amount of resources you have to put into it, taken into consideration with all the other priorities. For example, we are only expending 60-agent man-years on the medicare and medicaid programs at the present time.

Senator BAUCUS. Sixty agent man-years?

Mr. REVELL. Yes, sir.

Senator BAUCUS. What would you think would be a reasonable effort, how many more agent man-years?

Mr. REVELL. I just have no idea. Our program today is generating more information and data than we have had in the past. Obviously, we are going to have to commit more resources, and we are going to evaluate between this priority and others. I believe that we will have to certainly put additional resources in this area. It will be a determination of what we can take them from.

I cannot give you an answer of any definitive number of agents that we need in this program. We need more, and we will certainly have to put more into it.

Senator BAUCUS. Can you give me some idea as to whether 60 agent man-years, assuming you had a reasonable increase in your resources, amounts to a tenth of the problem, or a quarter, or a half. I am trying to get some feel here, some sense of how many additional personnel could reasonably be devoted by and large before you get a point of diminishing returns, in exposing the substance and the balance of most of the fraud and abuse.

Mr. REVELL. If anyone could tell us the extent to which the fraud exists throughout the country, then we could make an estimation based on our case generated information of how long it takes to investigate a case on the average and so forth.

Senator, we just don't know how extensive it is. Therefore, it would be impossible for us to say how much of our resources it would require to detect, investigate and prosecute.

Senator BAUCUS. Still, you have to have some sense of how extensive it is, based upon your feel and your experience. I am not trying to hold you to hard figures here. I am just trying to get a very rough estimate here.

Mr. REVELL. Where we have had the information come to light, either through sources or public complaints, or through referrals, we have found a very substantial incidence of fraud. Based on that, the best we can say is, we believe that it is fairly substantial throughout the United States, and that obviously the Justice Department, the FBI, and HHS have to use more resources if we are to have any impact on the problem at all.

Senator BAUCUS. Let's look a little more broadly here.

If you could delegate where additional funds are spent, that is, HHS, FBI, and other law enforcement agencies, would you give us some rough sense of what your priorities would be? Where would you spend the money in order to significantly reduce the incidence?

Mr. REVELL. Sir, we spend at the present time 23 percent of our total investigative resources on white-collar crime. We spend about 21 percent of our resources on organized crime. It is difficult to say that medicare and medicaid deserves more resources than CETA fraud, or other areas of government program fraud. It is difficult to say that a particular type of white-collar crime deserves more priority, for instance, than major embezzlements.

Certainly, a big problem today are international con-man schemes, we are always in a situation of trying to prioritize the basis of what the Justice Department and what we, as the investigative arm, determine to be the highest priorities existing at that time.

I think as we find more substantial indications as we have found today in medicare and medicaid, we have to be willing to reallocate these resources because we do have finite resources to operate with.

Senator BAUCUS. Thank you, Mr. Chairman. I see my time has expired.

Senator TALMADGE. Any more questions of Mr. Revell?

Senator PACKWOOD. I have got some more.

Senator TALMADGE. Senator Packwood.

Senator PACKWOOD. In your estimation, if you had more money for agents and for undercover work, either through recovery of outright fraud that has to be repaid, or the stopping of other fraud, would you be able to more than cover the cost of what the additional investigation would be?

Mr. REVELL. Sir, there is a very interesting case that I personally directed recently when I was an Agent in charge of a field office that has resulted in the forfeiture of nursing homes and laboratories to the Government.

I think the Government, the Justice Department, HSS, and the FBI's investigations have to be directed toward recovering the ill-gotten gain. I think that we need to look at the forfeiture and confiscation, and substantial fine possibilities in order to take the incentive out of this, as well as stricter penalties, or the enforcement of stricter penalties for those that are convicted.

Senator PACKWOOD. Let me carry it a bit further. We have already talked about the Detroit situation where nobody went to prison even though there were 42 convictions.

Mr. REVELL. I have updated information. There were nine individuals who were sentenced to short jail terms, two were on work release, and the rest were fines and probations. The average term there was 11 months.

Senator PACKWOOD. But nobody went to prison. Nobody served any time at all. You had some on work release, you said. Some others were fined, and some others on alternative work, but none of them went to prison.

Mr. REVELL. Nine were sentenced to jail time. They may have served it locally, but they served time in jail.

Senator PACKWOOD. In your estimation, if you had additional funds, and if there were reasonably stiff jail sentences, do you think there would be a significant deterring effect on other people involving themselves in this fraud and corruption?

Mr. REVELL. I think that if there is a significant potential for detection and prosecution, and if there is a signficant potential for stiff penalties and forfeiture, there is obviously a deterrent effect.

Senator PACKWOOD. One last question.

The Inspector General's Office of the Department of Health and Human Services said that in 1978 they had discovered between $6.4 and $7.3 billion that were lost through fraud, waste and abuse. Of that, roughly $3.9 to $4.2 was in the health care program alone. This is an investigation finished for the year 1978. You did not start into this business in Los Angeles until about mid-1978, as I recall.

Why with that kind of information and knowledge was the Department of Health, Education and Welfare seemingly unable to stop it?

Mr. REVELL. Senator, I think that you would have to direct that to HHS. We have made known to all the Inspector Generals, and to Mr. Lowe of HHS our availability to cooperate and assist in investigations, to undertake sophisticated investigations including the use of surveillance techniques, undercover operations, and where warranted the use of court-authorized wire-intercepts and all of the sophisticated techniques available to us in the development of informants.

We have made known to the IG's that we are committed to this program. We are receiving cooperation. I think that it is a very difficult area for the IG's to come to grips with. I believe that they have problems in educating program people as to indications of fraud, I believe that their screening techniques are not adequate to the task.

The IG's themselves are not receiving the referrals from the program managers that would allow them to really move into the

detection and investigation as deeply and as forthrightly as they might.

Senator PACKWOOD. Let me ask the question this way.

There is no question, if the Inspector General's report of HEW is to be believed, but that they knew the fraud was there. Their own report says that.

Until you got into it, they were either unable or unwilling to stop it themselves. Is that an accurate statement?

Mr. REVELL. Obviously, they have not been successful in stopping it.

Senator PACKWOOD. Thank you.

I have no other questions, Mr. Chairman.

Senator BAUCUS. Mr. Chairman.

Senator TALMADGE. Senator Baucus.

Senator BAUCUS. In your investigations, have you found fraud and activities in other areas, that is, in Blue Cross, or other private health insurance? Or, do you have any kind of feeling as to whether the same kind of activity occurs in the private sector?

Mr. REVELL. We found it in other Government funded programs, such as CHAMPUS. I believe the agents who actually dealt with the vendors, and so forth, might actually have a better insight into that than me because we would essentially have no jurisdiction. But they would know from their contacts.

Jonathan, do you have any information on that?

Mr. HERSLEY. In connection with the other programs, we did not involve ourselves too much because we were dealing primarily with the ancillary service providers in the medical industry.

Senator BAUCUS. So you did not have an opportunity to look into Blue Cross, or the private health insurance companies to see whether there is any similar fraud with respect to ancillary services.

Mr. LUMPKIN. Senator, if I might, the only analogy you could get from our investigation with respect to whether or not fraud was occurring within the private sector, that would be for instance whenever a doctor gets free service for his private patients from a laboratory owner. Then he may bill the private insurance company any amount that he wishes to bill that insurance company as the amount that he paid for it, when in fact he did not pay anything for it.

This is the only knowledge that we could give with respect to whether or not private insurance companies were also being defrauded as a result of the conduct of providers.

Senator BAUCUS. Thank you, Mr. Chairman.

Senator PACKWOOD. Mr. Chairman, let me just read one thing.

Senator TALMADGE. Senator Packwood.

Senator PACKWOOD. This puts the problem in perspective. This is the annual report of the Office of the Inspector General of the Department of Health, Education, and Welfare for 1979 talking about fraud.

"Initially, some 47,000 cases were identified. However, in order to make this 'a learning experience,' only about 50 of the most blatant cases in each state were selected." Of those 50 from each state, they have had 40 convictions out of 47,000 identified cases of fraud.

It is no wonder that they have got to call on you for help. They are incapable, unwilling, and it is beyond their comprehension of taking care of this situation that they know exists.

I have no other questions, Mr. Chairman.

Senator TALMADGE. Thank you very much.

[The prepared statement of Mr. Revell follows:]

STATEMENT OF OLIVER B. REVELL, ASSISTANT DIRECTOR, CRIMINAL INVESTIGATIVE DIVISION, FEDERAL BUREAU OF INVESTIGATION

Mr. Chairman and Distinguished Members of this Committee, Executive Assistant Director Mullen has asked me to express his regrets in not being able to testify here today. He requested that I appear before you in his absence to discuss our experience in investigations involving Medicare and Medicaid fraud.

I would like to state at the outset that we, at the FBI, appreciate this opportunity to convey to the Committee and the public the results of our investigations.

By way of introduction, I have accompanying me this morning Assistant United States Attorney Robert Ramsey, Jr., of Los Angeles, California, who is handling the prosecution of these type cases in the Los Angeles area, and Special Agents Ralph Lumpkin and Jonathan Hersley, who were the Agents in our undercover operation conducted in Los Angeles.

During 1976 and 1977, there was considerable publicity surrounding frauds in the Government funded health care industry. A number of our offices began conducting preliminary investigations into this area. Our Los Angeles Office determined through this preliminary investigation that there was apparent, extensive fraud and kickbacks in that geographic area.

After considerable study of the various investigative avenues available, it was decided that an undercover approach would have a high probability of success and would be the most effective way to not only determine the depth of the problem, but, with minimal use of manpower, would enable the investigator to obtain direct evidence of the crimes being committed.

The statutes available for use were Title 18, U.S. Code, Section 286, Conspiracy to Submit a False Claim; Section 287, Submission of a False Claim; Section 1001, Submission of a False Statement; Section 371, Conspiracy; Section 1341, Mail Fraud; and Title 42, U.S. Code, Sections 1395nn and 1396h, which prohibit false statements in applications for payments or benefits; and the solicitation, receipt, offering, or payment of any remuneration for referral or the procurement of goods or services under the Medicare/Medicaid Programs. From analysis of the programs, the available statutes, and information from knowledgeable sources in the industry, it was determined that Title 42, U.S. Code, Sections 1395 and 1396, would be the most viable for the purposes of the investigation.

A decision was then made to begin the undercover operation with our Agents representing themselves to be representatives of a large company who were interested in entering the health care industry, specifically nursing homes. These undercover Agents, sitting here with me this morning, began contacting the providers of various services. It became immediately apparent that kickbacks and rebates were a way of life. Virtually every provider of ancillary services that they contacted made offers of rebates and kickbacks in an effort to provide the business services which would be needed to maintain a nursing home. These offers were made by clinical laboratories, therapists, X-ray services, providers of oxygen, etc.; however, by far, the most offers were made by clinical laboratories (nine direct offers). In the first three months of operation, 22 cases were opened and set aside for future investigation. In addition to the offers of kickbacks, information was developed that indicated kickbacks were being paid to specific hospitals, nursing homes, clinics, and doctors. In summary, the initial undercover activity had obtained information which would lead one to believe that no phase of the Medicare/Medicaid industry was free from fraud.

During December of 1978 and January of 1979, several individuals were arrested as a direct result of the undercover operation. The ensuing publicity in the Los Angeles area led certain individuals to directly contact our Los Angeles Office. Among these individuals was the owner of a clinical laboratory. This individual indicated that he was very pleased with our efforts and offered his services to assist the investigation in any way possible.

With this individual's cooperation, our undercover Agents were placed into his business as salesmen. The undercover Agents and the laboratory owner, working in concert, were able to identify a large number of doctors, hospitals, and clinics who

would directly solicit kickbacks as a precondition to any business being given to the laboratory.

While this phase of the operation was underway, an owner of a clinic agreed to assist in the investigation by both making contacts with suspect providers and by permitting undercover Agents to portray themselves as representatives of his clinic for the same type contacts.

The operation was expanded various times throughout its duration as legitimate individuals involved in the industry would come forth and voluntarily cooperate in the investigation. One individual indicated he was losing $800,000 to $1,000,000 per year in business due to his reluctance to participate in the kickback activity.

The operation was closed in March, 1980, due to public awareness of the operation and due to the backlog of cases that had been generated which could not be investigated overtly without exposing the existence of our undercover activities.

We learned many things from the investigation, the most evident of which is that corruption has permeated virtually every area of the Medicare/Medicaid health care industry. Also, of equal importance, we have learned that there are many honest, reliable businessmen and professional people who will do whatever is necessary to assist in removing the corruption from the industry.

Based on our experience, the methods to commit fraud in the Medicare/Medicaid Programs are virtually unlimited. The most widely used method of paying kickbacks in this program is by cash. Generally, the payment is based on the percentage of the dollar volume of the Medicare/Medicaid business generated by a particular client. For instance, a laboratory may receive $10,000 per month in Medicare/Medicaid business from a particular doctor client. The laboratory will agree to the kickback based on a percentage of the $10,000 of Medicare/Medicaid work referred to the laboratory. Generally, the percentage agreed upon is 10 to 20 percent but has been as high as 33 percent This arrangement naturally provides an incentive for the doctor or client to order Medicare/Medicaid business that is not necessary.

We have found a number of different methods of paying kickbacks. One method is for a laboratory to provide free service to a doctor's or clinic's non-Medicare/Medicaid patients. Other methods of paying kickbacks to clients of the providers are: the providing of free supplies ranging from business equipment to pharmaceutical items; payment of rental for office space; free trips; and salaries of employees. Yet another method is for the provider and the client to combine and form a shell corporation, which is used to wash the kickbacks.

Our Agents were advised by one doctor that he was receiving $5,000 per month as a kickback from one laboratory. This doctor stated that the laboratory had asked him to order certain tests because they could be reimbursed at a higher rate. The doctor stated he did order these tests and did receive the results; however, he did not know the purpose of the tests or the meaning of the results, but he did know the tests were not necessary.

We have conducted investigations of these types of frauds in several areas of the country with the same general findings. In Detroit, Michigan, our investigation to date has resulted in 42 convictions, of which 22 were related to laboratories, ten were doctors, seven were nursing home related, and three were pharmacy-related cases. In Tampa, Florida, we have completed a number of investigations, however, we are still awaiting completion of prosecutive action. In Tampa, Florida, to date, the only significant accomplishment has been a reported sizable reduction in claims amounting to hundreds of thousands of dollars.

The Los Angeles operation has resulted in the conviction of 14 individuals to date. Ten of these individuals were the owners or operators of laboratories. Two individuals, one of whom was a State of California Department of Justice investigator, and the other an owner of a laboratory, were convicted of a violation of the Hobbs Act as a result of their activities in attempting to influence state medical fraud investigations involving various physicians in the Los Angeles area. Currently, in Los Angeles, there are indictments pending involving eleven individuals and three laboratories all involving either the paying or soliciting of kickbacks. Four of these individuals are doctors. To date, over 200 cases have been developed and an additional 30 to 50 indictments are expected before the investigation is concluded.

We believe the people committing these frauds have absolutely no fear of being caught. For example, during December of 1978 and January of 1979, considerable publicity was generated as a result of arrests which were openly identified as stemming from an undercover operation. This exposure had no effect whatsoever and the same undercover Agents continued an expanded operation until it was closed during March of this year. Since that time, the only effect of the publicity has been discussions during which the undercover Agent and the subject accuse each other of fronting for the FBI and, afterwards, our undercover Agent was able to continue dealing with this individual who accepted he was not an FBI Agent.

Furthermore, one of our offices has advised us that the people who commit these frauds are aware of their illegal activity, however, have decided to take the risk because they believe that if they are caught, the worst that will happen to them is that they will have to repay the money they obtained fraudulently.

Our experience has shown that fraud in this area is at best extremely difficult to detect. For example, at the time one individual was arrested, a search warrant was served for all records of his laboratory. This individual subsequently pled guilty and admitted committing fraud. A detailed examination of his records, however, failed to reveal how the fraud was being perpetrated and the individual refused to discuss the bookkeeping procedures he utilized.

I have focused on the area of kickbacks as this is the primary area where we have had success. We have uncovered other areas involving fraud which are aggravated. In one instance, a doctor had been paid two million dollars in a two-year period as a result of his Medicare/Medicaid activities. The doctor was performing abortions on women who were not pregnant. He had instructed his laboratory staff that they were not to tell the patients the results of the tests that were conducted if they were not pregnant. If the patient somehow became aware of the results, he would conduct a physical examination, state that the test was wrong, and immediately perform an abortion.

This doctor billed for an abortion performed on a woman who previously had a hysterectomy. Another abortion was allegedly performed on a woman who previously had a tubal ligation. In 48 separate instances, this doctor had billed for performing two abortions within one month on the same patients.

While conducting this investigation, we learned that the doctor had obtained a Comprehensive Employment and Training Act (CETA) contract for the purpose of hiring and training unemployed individuals in medical procedures. The investigation discovered the doctor had directed his employees to furnish false information in order to qualify for the CETA Program. The doctor was subsequently indicted and convicted of Mail Fraud and Making False Statements to the U.S. Govenment. He was sentenced to two years imprisonment and fined $6,000.

In another case in which two dentists were convicted, it was determined that they had submitted 16 bills, on behalf of one public aid patient, for work that included 51 fillngs in ten of the patient's teeth, 14 in a single tooth. One of these dentists had billed for extracting four wisdon teeth, each from 23 separate patients on one day. During the investigation, 16 of these patients were determined to have from one to four wisdom teeth remaining in their mouths. These dentists were sentenced to 18 months imprisonment and fined $29,000 each.

We had another instance in which we were conducting a surveillance of a doctor who was involved in the Home Care Program. The doctor, while making his rounds, was observed on many occasions to be lost and was constantly checking a map. We had difficulty believing he could possibly get lost in view of the fact he had been submitting billings for seeing most of the patients for at least two years.

In a western state, while conducting an investigation involving nursing homes, we determined that a nursing home was inflating the number of staff members, which is part of the basis for reimbursement, and they were taking patient funds that were to be used to purchase personal incidentals and pharmaceutical items. The owners of the home were inflating the cost reports by charging personal expenses, phoney expenses, and other items which has the effect of raising the reimbursement rate. The investigation also developed allegations that the owners were soliciting kickbacks from providers of ancillary services.

These investigations are not limited to any specific area of the Medicare/Medicaid Programs. We have cases in which pharmacists are submitting totally false billings. We have cases that involve hospitals soliciting kickbacks and engaging in other illegal activities.

We have cases that involve massive overutilization. An example of this one doctor, while treating a patient for a fractured thumb, ordered over $300 worth of blood workups. We have another instance in which a doctor is alleged to have submitted bills which would have required the doctor to treat a patient every 12 to 15 seconds during the billing period.

These examples are not even representative of all the circumstances under which fraud has been discovered, however, I believe they will help you in your endeavors to determine the seriousness of the problems in this area that the FBI has encountered.

We have had problems in conducting traditional investigations in these types of cases. These fraud investigations are extremely involved, time consuming, and, at their conclusion, prosecution is extremely difficult due to the complexity of the crimes.

One specific problem area is overutilization. It is extremely difficult to ascertain when prescribed treatment can be considered reasonable and prudent and when overutilization of tests and laboratory examinations occur to the point where it becomes fraud.

Fraud in the Medicare/Medicaid Programs is undoubtedly costing the American taxpayer substantial sums of money. Far worse is the fact that the money being lost through fraud could be used to provide much needed medical help or diverted to other areas which have curtailed operations due to lack of funding. The area of my concern is that with the amount of overutilization in the laboratories alone, are all the tests or even the required tests being conducted? Our investigations to date are not conclusive on this point.

The FBI believes fraud against the Medicare/Medicaid Programs is nationwide in scope and we further believe that the investigations to date have had only limited effect. From our experience, we do not believe any area of this program is free from fraud.

The FBI does believe that the problems can be substantially corrected. This will require extensive mutual effort and coordination on the part of the FBI, the Inspector General of the Department of Health and Human Services (HHS), the HHS Program administrators, the Department of Justice, the State Program enforcement officials, as well as the various components of the medical profession, private citizens, and Congress.

In conjunction with the Department of Justice's new Economic Crime Units, the FBI and the Office of the Inspector General of the Department of Health and Human Services are currently establishing a joint task force in a major eastern city to address Medicare/Medicaid frauds. An expansion of this concept is being drawn up for other geographic areas to address this problem on a national scale. It is believed that the knowledge gained from these operations will be very beneficial to the Inspector General in identifying any necessary restructuring of these programs that can be implemented to minimize the vulnerability to fraud.

In your request you asked for our comments as to how widespread this problem is. The examples cited today, while not drawn from every area of the country, are truly indicative of problems we are finding nationwide. In March, 1980, 52 of our 59 field offices had cases pending involving fraud against the Department of Health and Human Services Programs. We do anticipate that all of our offices will be developing cases in this area in line with the Department of Justice White-Collar Crime national priorities. You further asked if, in the FBI's judgment, there are indications that this problem extends beyond nursing homes and clinical laboratories. The answer to this is an unqualified yes. We have found these problems in virtually every facet of the Medicare/Medicaid area. The problems we are finding in rural, as opposed to urban areas, are not of the same magnitude. However, the same problems do exist.

I hope our testimony here today will be beneficial to you in your current efforts. I want you to know that Director Webster has placed a high priority on our efforts in this important area.

This concludes my formal statement; and if you or the members of the Committee have any questions, we will be happy to answer them.

Senator TALMADGE. The next witness is Mr. Robert Ramsey, assistant U.S. attorney, Los Angeles, Calif.

You may proceed, sir.

STATEMENT OF ROBERT RAMSEY, ASSISTANT U.S. ATTORNEY, LOS ANGELES, CALIF.

Mr. RAMSEY. Mr. Chairman, and distinguished members of this committee. I have filed with this committee a prepared statement. I have attached to that statement an addendum that should follow the first full paragraph on page 8. I would like to give that statement at this time.

By way of background, I am Robert Ramsey, Jr. I have served as an assistant U.S. attorney for the Central District of California in Los Angeles for more than 6 years. Our district includes Los Angeles and six neighboring counties, and is the most populous Federal judicial district in the country. I am presently an Assistant Chief of the Criminal Division assigned to prosecute major crimes. For the

past 2 years, I have been involved almost exclusively in the investigation and prosecution of cases concerning medicare and medicaid program fraud.

I am here today to discuss the experiences of our office and of the agencies with whom we work in investigating and prosecuting individuals and corporations who defraud the medicare and medicaid programs. As this committee knows, the past few years have seen a tremendous growth in the Government's awareness of and attention to fraud against and abuse of Federal human service programs, including medicare and medicaid.

As investigators and prosecutors, our first step in addressing such problems must be to look at the law. The basic statutes that are employed in attacking Government program fraud are found in the following sections of title 18, United States Code:

Section 287, which is false claim to a Government agency.

Section 371, which is conspiracy to defraud the Government.

Section 1001, which is false statement to a Government agency.

With specific reference to medical program fraud, these statutes are supplemented by the Social Security Act at title 42, United States Code, sections 1395nn and 1396h, which prohibit the solicitation, receipt, offering, or payment of any remuneration for referral of patients or the procurement of goods or services under the medicare and medicaid programs.

This act, in its present form, includes two significant changes made by the Congress in 1977. First, the conduct probihited by the statute was clarified. The pre-1977 statute did not use the words "any remuneration," but instead prohibited any "kickback" or "bribe" in return for inducing a person to refer medicare and medicaid patients.

Courts differed over what constituted a "kickback," or "bribe," and some cases were lost. This weakness in the statute was eliminated by the 1977 amendment proscribing "any remuneration."

Second, the penalty was increased from a misdemeanor to a felony. These changes have been extremely beneficial to us in prosecuting laboratory owners and doctors who engage in illegal activity.

The Social Security Act includes another feature that is conducive to enforcement. It allows for the immediate expulsion from program participation of anyone convicted under the statute. Moreover, since the conviction is now a felony, most convicted providers are also subject to loss of their professional licenses.

During the hearings on this legislation, the Attorney General made a commitment to Congress actively to pursue investigations and prosecutions in this area. In furtherance of the Department's commitment, the U.S. attorney for the Central District of California and the Los Angeles District Office of the FBI shortly thereafter established a program to investigate and prosecute medicare and medicaid—medicaid is medi-Cal in California—fraud.

In early 1978, I was assigned to monitor and coordinate all cases involving fraudulent activities affecting the medicare and medicaid programs. The assignment required me to work closely with representatives of four agencies. The Federal Bureau of Investigation, the Office of Investigations of the Department of Health, Education, and Welfare, now known as the Department of Health and

Human Services, the California State Department of Health, and the California State attorney general's medi-Cal fraud unit. At the very outset, we established a critical element of our program: close agent-attorney teamwork.

We collectively analyzed the powers and responsibilities of each agency and examined what we knew of pertinent criminal activity in the Los Angeles area. The FBI had determined that there appeared to be a significant amount of fraud related to laboratories kickbacks and bribes.

We, therefore, decided that the Buerau would place primary emphasis on investigating violations of sections 1395nn and 1396h of the title 42, with the goal of capitalizing upon the aforementioned amendments provided by the Congress in 1977.

Considerable study was given to the method of investigation. Since bribes and kickbacks involve collaborating offenders and an unknowing victim, it was decided that a proactive undercover investigation would be most effective. The operation, code name "medi-fraud," was conceived and implemented by the FBI, with six special agents assigned. I helped draft and edit the proposal for medi-fraud, and assumed the responsibility of advising the agents on a day-to-day basis in their investigations.

The medi-fraud operation presented many problems that may not occur in other proactive investigations and sting operations. We recognized that providers of medicare and medicaid services were abusing and defrauding the program in a manner such that only an insider could provide reliable information.

Problems in designing the program included operating in the medical service arena without violating the rights of legitimate and honest medical providers, avoiding situations that would raise entrapment issues, and monitoring independent administrative investigations so that the integrity of the medi-fraud program was not jeopardized.

In many undercover operations, the FBI may have an idea of who the target is going to be, and this information is generally provided by an informant. In medi-fraud, the FBI did not have any informants or operative within the medical profession when the investigation began.

I advised the undercover agents concerning their day-to-day meetings with prospective defendants in order to avoid successful claims of entrapment or other due process violations. I spent many hours working with the agents and was always available to answer their questions and advise them as to proposed investigative conduct.

The medi-fraud operation began in about July 1978, and ended in about January 1980. The operation to date has resulted in the conviction of 26 individuals and 5 corporations. I personally handled the majority of these cases after indictment, but several have been prosecuted by other lawyers in our office, notably assistant U.S. attorneys Deanne H. Smith, Katherine M. Quadros, and Robert A. Pallemon. We have approximately 50 more cases under consideration for prosecution.

An especially noteworthy and somewhat unique case saw a combination of medicaid fraud and public corruption. In *United States* v. *Caldwell and Johnson,* CR 79-1001-IH, defendant Caldwell was

a special investigator for the State attorney general's medi-Cal fraud unit and defendant Johnson was a laboratory owner.

Caldwell told Johnson that for a fee he could help Johnson with a State investigation of Johnson's laboratory. Johnson agreed to pay a sum of money to Caldwell, and to contact other medi-Cal providers on behalf of Caldwell.

Caldwell pleaded guilty to two counts of extortion under the color of official right. Johnson was convicted after a jury trial of aiding and abetting Caldwell. Johnson was also convicted of medicare and medi-Cal fraud in a separate indictment. Caldwell was sentenced to 2 years in prison. Johnson was sentenced to 9 months on both indictments.

In the other cases arising from the medi-fraud investigation, the individual and corporate defendants convicted were all charged with conspiracy to defraud the Government and offering or receiving a remuneration to induce a person to refer medicare and medi-Cal business.

As of this date, we have met several pretrial legal challenges to the statute, but none has been successful. Most current attacks on the statute focus on the word "offer." For example, one defense attorney whose client was charged with making an offer of a prohibited remuneration sought to call as a witness a contracts professor from UCLA.

The witness offered to testify that the words exchanged between the defendant and the undercover agent did not constitute an offer. We urged and the court agreed that whether an "offer" was made by the defendant was a factual determination for the jury, and not a question for a legal expert.

We have also experienced some difficulty with that portion of the statute that excepts certain conduct. The prohibition in the statute does not apply to discounts that are disclosed to the Government. We have seen cases where a laboratory owner has offered to give the referring provider "free privates"—free service for the provider's private, non-medicare/medicaid patients—or a discount on their "privates" in return for their medicare/medicaid business. The laboratory owner will argue at trial that he was giving the doctor a volume discount and that there is no place to disclose it in the claim form that is submitted for payment.

Sentences in these cases—other than the Caldwell case—have ranged from probation to 9 months in custody. The average fine has been approximately $5,000. Since the penalties imposed are in the misdemeanor range, it might not appear that the amendments enacted in 1977 have had much impact. However, we think that the new legislation has been effective notwithstanding the sentences.

We find that providers of health services to medicare and medi-Cal patients are very much aware of our efforts in the central district to detect and prosecute fraud. The proactive FBI approach to investigations has had a definite impact upon the health care community.

The press in the Los Angeles area has given considerable attention to these prosecutions. Because of the publicity, individual providers have come forward and offered their facilities and services to the FBI in connection with such investigations. Indeed, perhaps

as a consequence, it appears that some individuals and corporations are seeking new and innovative ways to find loopholes in the law.

Often, with the help of attorneys, providers will set up corporations, partnerships, consulting services, and other sophisticated mechanisms for giving or receiving remuneration.

Moreover, while we have experienced success in cases involving bribes and kickbacks, we have not seen as many prosecutions involving overbilling, billing for services not rendered, and false statements. These matters are handled by the Office of Investigation of the Department of Health and Human Services, and we are working with that agency to see how the limited resources of both our offices can be best addressed to this area.

In addition to criminal medicare and medicaid prosecutions in the Central District of California, cases are referred to our Civil Division for recovery of overpayments to providers or for civil action against providers pursuant to the False Claims Act. The act entitles the Government to recover double the amount of loss it has actually sustained and a penalty of $2,000 for each false claim submitted by the provider.

Cases filed under the False Claims Act have included actions against doctors for billing services not rendered or misrepresenting the nature of the services provided, against convalescent hospitals for receiving kickbacks from laundries and pharmacists, and against hospitals for falsifying cost reports and underlying books and records to maximize reimbursement.

We think that medicare and medicaid fraud prosecutions are important in the Federal effort to control such activity. While it is hard to measure the deterrent value or the financial impact of such prosecutions, it is clear that the entire medical community is becoming aware of our crackdown on providers who defraud the programs.

I, therefore, believe that these prosecutions will have a significant effect in deterring providers from committing fraud. This is especially likely since, under the statute, a provider convicted of fraud is now immediately suspended from participation in the medicare program.

Investigations and prosecutions in this area should also result in significant savings to the taxpayers and the Government. If we deter the kickbacks and bribes, we reduce the incentive to overutilize the program.

In conclusion, I would like to say that we are gratified with our success to date in the Central District of California in the cooperative investigation and prosecution of medicare and medicaid fraud. We also recognize that there is much to be done, and we applaud the interest of this committee in the problem.

This concludes my prepared statement. I would be happy to answer any questions you may have at this time.

Senator TALMADGE. Thank you very much for a fine statement, Mr. Ramsey.

Is the law that this committee initiated, and Congress adopted adequate for you to do your job?

Mr. RAMSEY. Senator, I think I can definitely say that it is adequate for us to do our job.

Senator TALMADGE. Does it need any changes, any modifications to it in any way?

Mr. RAMSEY. Your Honor, I think in some cases, some clarification might be appropriate in the statute. As I brought out in my reading of the statement, we have had some problem with what constitutes an offer. We have also had some problem with the so-called volume discounts.

Senator TALMADGE. If you will work with the Department, and submit technical corrections, we will be happy to consider your suggestions.

Mr. RAMSEY. Thank you.

Senator TALMADGE. What kind of crimes other than bribes and kickbacks have you encountered?

Mr. RAMSEY. Mr. Senator, we have encountered crimes concerning overbilling, billing for services that were not rendered, and just generally making false statements on the claim forms to the intermediary for medicare and medi-Cal.

Senator TALMADGE. If medicaid fraud is found, is there usually also fraud against medicare as well?

Mr. RAMSEY. As a general rule, we have found, Mr. Senator, that whenever there is a significant fraud found in either programs, specifically in the medicaid area, there is also fraud in the Medicare area. Yes, we have found that to be true.

Senator TALMADGE. Do you believe that some sort of minimum sentence, say, 30 days of actual jail time upon conviction would aid in deterring, or in the prosecution of medicare fraud?

Mr. RAMSEY. Let me say this, Mr. Senator. I don't know whether or not jail time would deter fraud. I think perhaps it would. I would not like to take a position on any minimum mandatory sentence.

I would say this to the committee. If the committee is thinking of going that way, I would say that a reasonable time would be a minimum of a 30-day period.

Senator TALMADGE. Thank you very much.

Senator Packwood.

Senator PACKWOOD. I have no other questions.

Senator TALMADGE. Senator Dole.

Senator DOLE. I would ask you, do you have any evidence in California of any organized crime involvement in the cases that currently or in the past have become involved with?

Mr. RAMSEY. Senator, I think that this is more properly a question for the agents because what constitutes organized crime. I think, in a legal manner as far as our statutes are concerned may be different than what constitutes organized crime in the investigations area.

Senator DOLE. It is my understanding that in your prosecutions, those involved have been individuals, corporations, and providers.

Mr. RAMSEY. That is correct. In our investigations, the ones that we have had so far in the southern California area, we have not found any evidence of organized crime in the sense that the money is being used for other purposes, other than ones of self-gratification.

Senator DOLE. Do any of the agents have anything to add there?

Mr. HERSLEY. Generally that is accurate. The only thing that I can add is that we have received indicators that organized crime could be involved. We have no concrete information that we followed out on that.

Senator DOLE. You are going to make some suggestions as far as the statutes are concerned.

Are you still in the process of looking for new cases, or did you close down shop earlier this year?

Mr. RAMSEY. Let me answer this like this. No, we have not closed down shop, Senator. The undercover investigation, to the extent that it was not public at the time, has been closed down. I say that because the agents are no longer in the field working. However, it is my understanding that, of course, we still get referrals even though the undercover operation has surfaced at this time.

What we are doing, we are looking at those cases now that we had investigated during the time the agents were under, and we are prosecuting those cases now. So we have not closed shop, and we are still, as the agents will tell you, getting referrals from the providers out there who want to engage in illegal activity.

Senator DOLE. There has not been any letup as far as the intensity of the investigations, the number of agents involved? Everything is still moving?

Mr. REVELL. No, sir. In fact, since we have gone from the covert to the overt stage, we have actually added resources in order to get the cases into court. You can only do so much with so many people in an undercover capacity, so when we went to the overt stage we have added additional resources in these investigations.

Senator DOLE. The Anti-Fraud and Abuse Act passed in 1977, I think, has four principal parts. One, as indicated, was to increase the penalty and raise the penalty to $25,000 and 5 years imprisonment. I noted from Mr. Ramsey's comments that it has not been that severe, but there has been some improvement.

We also authorized funding for State fraud units. I understand that there are about 30 units now in operation. We required the Secretary of HEW to suspend from the programs doctors or other practitioners convicted of criminal offenses related to the program. I don't know how effective this has been.

We required medicare and medicaid providers to disclose data on ownership and financial relationships among providers and suppliers for obvious reason, to see what connection there might be. I understand that that is a requirement.

I have reviewed these provisions because you will be making other recommendations of a technical nature on how we still might improve that act, and make it easier, but still proper, for those of you who are charged with the responsibility of investigation and prosecution to do your job.

Mr. RAMSEY. Yes, sir. I will look at those areas also, and I have a couple of comments that I would like to make.

With respect to the Secretary of HEW, or the Secretary of HHS as it known now, and requiring them to remove from the program these individuals convicted under the statute, just Friday, before coming out here, I did have a discussion with the special agent in charge of the Office of Investigations in San Francisco, and we are going to set up a program with him whereby after a conviction is

had, we will forward to HEW, or the Department of Health and Human Services a certified copy of the indictment and the order of conviction, and that way they will be able to implement a program of carrying out the mandate of the statute.

Senator DOLE. If I could follow on that same line.

Those that have been convicted, are they back in the program now, or are they back to work? A $5,000 is not much of a penalty if this is as lucrative as has been indicated by the testimony. Are they still eligible for participation in the medicare and medicaid programs?

Mr. RAMSEY. I am not sure that they are, but I am not sure that they have had administrative action taken against them at this time.

Senator DOLE. That is beyond your jurisdiction, or your responsibility.

I would hope that there is somebody here from Department of Health and Human Services who might provide that information.

Senator TALMADGE. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman.

Mr. Ramsey, as I listen to you and Mr. Revell, to a considerable degree it sounds like for a lot of these people who are involved in these kinds of activities, it is kind of a way of life. That is, it is so pervasive, and I suppose it is based partly on overutilization of services that the people who participate in these programs no longer distinguish between what is wrong and what is right.

My question really is, to what degree, as a practical matter, are your law enforcement efforts having any impact? Are they significantly deterring, or are these people adopting more sophisticated techniques, and we are no further along than when we started.

I ask this question because it seems like it is so pervasive, and because a lot of these people have probably rationalized on some basis that probably the extra test might produce one scintilla of some evidence that might somehow be significant sometime, so they just keep going at it.

Mr. RAMSEY. Senator, I would like to respond to that in two ways.

No. 1, with respect to your first question, how effective do I think our efforts have been. I think in light of the whole situation, our efforts have been fairly effective.

I said, and I will say again as I did in my prepared statement, I think that it is hard at this time to determine the effect of the prosecutions that we have had because we have only just begun. We have not been at it long enough to see any impact.

My conversations with the agents, and my conversations with other attorneys who are in the field, and attorneys who represent these health care providers—For instance, I will get calls from the attorney for the California Laboratory Association, and he wants to know from me what type of conduct is illegal under the statute. Of course, being a prosecutor for the Government, I cannot give legal advice to a private individual. However, I do suggest to him what type of conduct that I would think would be illegal. He will suggest other conduct to me, and as to whether or not that would constitute illegal conduct.

Now, not only that attorney, but other attorneys have called me, and we have found, the investigators have when they are undercover, these same types of conversations will come back to them. He will ask, if we have a legitimate employment relationship that would not be illegal, not knowing that the agents, are agents, of course. They are sitting down talking to them in a lengthy conversation, and they are saying, "If you are the FBI, then I know a particular way we can do this, and it will not be illegal, and you can never prosecute me in court."

I say that it is effective, that is our investigation, because they are aware of it, and they are taking precautions. They can't find a legal way to hide the illegality.

So just the fact that they are aware of it makes me feel that we have been effective to some extent. The prosecutions have been effective.

Senator BAUCUS. Is this an area, though, that perhaps deters investigations and prosecutions because it is too complicated? This Medicare and Medicaid fraud is too complicated, or too specialized?

In other words, do you need a lot more experts here, or is there anything that is different about this that makes it difficult to investigate and prosecute?

Mr. RAMSEY. We have not found that it is too sophisticated to be prosecuted, or that we need particular experts. One becomes an expert in the field by doing the work, or some work along with the statute. As you probably know this is a fairly new statute. It has not been used that much in the past because it only became effective in October 1977.

Senator BAUCUS. I am referring more to the near infinite types of practices that are pursued here.

Mr. RAMSEY. I think that in order to prosecute those types of cases, we will need that type of information from an insider. I think that that is the only way we will ever be able to prosecute those types of cases. Of course, sometimes it is possible to trace the paper in the books and the records, if in fact they keep records.

Senator BAUCUS. Let me ask you another question.

If you could wave a magic wand and accomplish one reform or one effort that would substantially solve this problem, what would it be?

Think broadly. Would you change this from a service industry to one where the ancillary services are out for bid, and the contract is bid, or would you rather spend millions of dollars in enforcement? Would you fire half of HHS and replace them with some competent people?

Mr. RAMSEY. Senator, that is a hard question to answer.

Senator BAUCUS. You have looked at it for a while, if you could put your finger on it.

Mr. RAMSEY. I will think about it for a few years.

Senator TALMADGE. Senator Heinz.

Senator BAUCUS. Excuse me, Mr. Chairman, but I would like him to attempt to answer that, if he could.

Mr. RAMSEY. I don't think that I can answer it, Senator. I have sat down for many hours with the agents, and I have tried to figure out what we could do, how we could stop this type of activity. Believe me, I don't think that it is any one solution.

If you say, how are we going to stop it——

Senator BAUCUS. Look at it as a series of issues. What is number one at the top?

Mr. RAMSEY. No. 1, I think we would have to start with the medicare and medicaid program itself. I think that we would have to start there. I don't know how we could start all over again.

You ask me about the magic wand, and of course it would be to get rid of the entire program, and start all over again. I don't think that that is feasible at this time.

Senator BAUCUS. I don't want to take too much time, but do any of the other three gentlemen have any ideas there?

Mr. REVELL. I think that we need to have a more substantial interest and direction in programs, controls, and standards. I think there needs to be determinations made of reasonable limits of service. I think the referrals mechanisms need to be very firmly established and closely followed.

These are not in any way going to resolve the problem, but I think they will facilitate a more expeditious and capable investigative effort on part of both the Office of Investigations and the FBI, and certainly prosecutions. I think that very reasonably prosecutions, particularly where a significant penalty is given where the public trust is violated will serve as a deterrent.

Senator BAUCUS. Thank you, Mr. Chairman.

Senator TALMADGE. Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you.

Mr. Revell, I detected an implication in your statement that you could probably open an investigation in any city, or for that matter, if you had the resources, in every city in the United States, and find the kind of widespread fraud, notwithstanding Secretary Harris's admonition that they don't use the term "fraud and abuse" at HHS anymore, in virtually every city. Is that a reasonable implication?

Mr. REVELL. I think there are substantial indicators that this is a nationwide problem.

Senator HEINZ. You appear, therefore, to have uncovered very effectively, and I commend you and those people working with you for doing an excellent job, on uncovering the tip of an iceberg. This morning in the private briefing, and here again in the public hearing today since, you described a health care industry that is sick.

You have described an almost unimaginable number and instances and types of unethical and illegal conduct. You have described a pestilence of cheating of both the elderly and the taxpayers. You have described a growing epidemic of payoffs and kickbacks. You have proved, in sum, that fraud is endemic among the providers that you have investigated.

One is forced to conclude that either a majority of the health service providers, and people running laboratories are dishonest—much more dishonest than the population as a whole—and that these dishonest people are going into health care, instead of jail. Or, that there is something else wrong. Something else, like the way in which we pay for health care: fee for service, which is the basic method, is just fundamentally unsound, and just invites fraud

and abuse. It is inherently a weak system for bringing out the best, and instead brings out the worst in the American people.

In answer to the first possibility that somehow this industry just attracts the dregs of the American people, all the cheats and thieves, and pickpockets in the world, there are a couple of possible explanations. One is that organized crime has just simply decided to target the health care industry.

Earlier you indicated that you did not think that this was the case. If you are correct in that, it seems a little farfetched to me that there would be any logical explanation why this industry would particularly attract all the unethical people in the United States. It is possible, but not reasonable.

This tends to lead me to the last conclusion, the other alternative, that there is something wrong with the way we pay for health care, the system of fee for service which is essentially cost plus whatever cost or kickback you care to build into the system. It is inherently unsound. It is inherently anticompetitive. It inherently goes against all the principles of most other industries.

My question to you is twofold. One, would you agree with this analysis; two, more specifically, would you agree that there should be changes in the system, with the general goal of introducing competition. Specifically, requiring that laboratories and the kinds of services we have talked about, be competitively bid so that we would get away from this money tree that providers and consumers feel they can cut a branch off of, and just take it home and do whatever they want with it.

I address that question to you, and to all your associates, Mr. Revell.

Mr. REVELL. Sir, it is obvious that when there is a program that is funded at $66 billion that there is a lot of money out there. It is obvious that that attracts a lot of sharp operators. It is also obvious that the motives of the program are to provide needed services to the public which is not able to afford them.

I think these things come together to establish, perhaps, a situation in which some unscrupulous operators see a pot at the end of the rainbow. So it probably does attract some unscrupulous operators because of the way in which the money is put into the program, not judging the program from its value at all, but from the way the money is put into the program.

I do not think that it is unique. I think there are other State and Federal programs that are also infested with this type of mentality. Very frankly, I don't think that the Federal Government does an adequate job in detecting, deterring and prosecuting. Those are my views based upon what I have seen of the programs.

I do think that we need to insure a more competitive basis, and certainly there needs to be some type of review that determines whether or not repetitive treatment, and a wide panoply of tests and treatments, and the continual institutionalization of patients is necessary. It is a very difficult area. It goes into professional competence. It is certainly not one that we want to get into as investigators, but it is something that needs to be examined.

Senator HEINZ. If I may continue for one more minute, Mr. Chairman.

Senator TALMADGE. Without objection.

Senator HEINZ. I understand you, to be saying that with respect to specific services provided by, if you will, secondary party laboratories, as opposed to physicians, that a competitive approach, such as bidding, would in fact very possibly be helpful.

What I hear you saying with respect to primary providers, doctors, hospitals, clinics, is that there needs to be a better system of review. There is a system of review, in theory, called Professional Standard Review Organizations, PSRO's.

In your experience, is peer group review, which is a group of physicians looking over another physician, an effective mechanism that you would endorse or not?

Mr. REVELL. I don't see how, when you deliver an abortion to a woman who has had a hysterectomy, or when you can deliver two abortions in 1 month to the same person that that is very effective peer review. Those are the examples that I cited in the material.

Senator HEINZ. I remember it from the material quite vividly.

What I would like to establish is, had those cases been reviewed by a Professional Standard Review Organization, do we know that for a fact?

Mr. REVELL. We don't know that, sir.

Senator HEINZ. There are a lot of things that are not reviewed by PSRO's. If that was, in fact, reviewed by a PSRO, I would like you to indict all the members of that group for having aided and abetted fraud, and also having been medically incompetent.

Mr. REVELL. We have not been able to determine whether or not a review was performed by a PSRO. We have determined that the doctor's license was invalidated by a State licensing organization. To date, the license has not been reinstated.

Senator HEINZ. That would be very helpful, yes.

Thank you, Mr. Chairman.

Senator TALMADGE. Are there any other questions of Mr. Ramsey?

Senator PACKWOOD. I have some other questions.

Are the two gentlemen going to testify, Mr. Lumpkin and Hersley, or not?

Mr. REVELL. Yes, they will testify.

Senator PACKWOOD. They have some testimony.

Mr. REVELL. They don't have any statement, sir, but they will answer any questions.

Senator PACKWOOD. I have some questions of them.

Senator TALMADGE. So have I.

Senator PACKWOOD. First, I would like Mr. Lumpkin and Mr. Hersley, just very briefly, to tell us who you are, and what your connection was with this case. As best I can tell from talking to you ahead of time, you were sort of the Starsky and Hutch of this operation. [Laughter.]

STATEMENT OF RALPH E. LUMPKIN AND JONATHAN R. HERSLEY, SPECIAL AGENTS

Mr. HERSLEY. We would not consider ourselves as Starsky and Hutch at all.

My name is Jonathan Hersley, and myself and Ralph Lumpkin were special agents with the Federal Bureau of Investigation in Los Angeles. We were the two agents that were initially assigned

to set ourselves forth as representatives of a group of investors that were interested in purchasing nursing homes for these people that we represented. We were, therefore, putting ourselves in to the position that we could contact various ancillary service providers, and determine whether or not they were, indeed, involved in paying or offering to pay kickbacks in return for services under the medicare and medicaid programs.

Senator PACKWOOD. In the very real sense, the two of you were gathering the information that Mr. Ramsey was going to need for prosecution. Isn't that right?

Mr. HERSLEY. That is accurate.

Senator PACKWOOD. If anybody knows what facts were available, and how the process operated, the two of you were intimately involved at the very bottom level; I don't mean that in a demeaning sense, but at the very base level of how this fraud operates.

Mr. HERSLEY. That is correct.

Senator PACKWOOD. Let me ask you this. Did the Inspector General's office provide any significant help in your investigation?

Mr. HERSLEY. Yes, in the sense that they did make available to us two sources of information who later cooperated with us, or were significantly involved in the prosecution of several individuals.

Senator PACKWOOD. Did any of the people that you talked with initially, any of the people that you were working with in attempting to see whether they were interested in participating in fraud, have any fear of being caught by the IRS or any other agencies?

Mr. HERSLEY. No. As a matter of fact, there were statements made to us during our undercover contacts that that was primarily one of the reasons that they were engaging in this type of activity. They did not fear detection. There had been no efforts along those lines in California up until the time that we began our operation.

Senator PACKWOOD. Based upon your experience, does the Inspector General's office in the Department of Health and Human Services have the experience, or the interest in prosecuting and furthering investigations of these kinds of cases?

Mr. HERSLEY. I would say that their experience today has centered more around determining whether or not there had been false billing, and billing for services that were not rendered. That is what they concentrated on as opposed to the payment of kickbacks.

Senator PACKWOOD. Would you be comfortable being involved with them in a joint investigation into the kind of fraudulent activity you have undercovered?

Mr. HERSLEY. In kickback operations?

Senator PACKWOOD. Yes.

Mr. HERSLEY. To a limited extent.

Senator PACKWOOD. Do you want to elaborate on that?

Mr. HERSLEY. Department of Health and Human Services was capable, and did in fact in Los Angelos after we began our operations, provide us with the names of various ancillary service providers who were involved in questionable activities.

Senator PACKWOOD. After you started your investigation. I love your unbounded enthusiasm and your answer. After you started your investigation, they gave you some names of labs.

Mr. HERSLEY. That is correct.

Senator PACKWOOD. Was that the sum total of their help?

Mr. HERSLEY. In Los Angeles it was.

Senator PACKWOOD. I have no other questions. It is incredible.

Senator TALMADGE. Mr. Lumpkin, and Mr. Hersley, how and when did you get involved in medicare and medicaid fraud?

Mr. LUMPKIN. Senator, we began considering an investigation into this program in approximately October of 1977. This is when we began our initial review. After talking to various individuals, prosecutors, and sources of information, we felt like we had a predication to conduct an investigation.

Senator TALMADGE. Did you work together as a team?

Mr. LUMPKIN. Yes, sir, we did.

Senator TALMADGE. Would you please describe how you set up your operation?

Mr. LUMPKIN. Initially, we rented office space, and prepared ourselves to have a financial background in the purchase of large convalescence chains. Through these preparations, we began to come into contact with certain individuals who would explain to us how the system worked, and who we should seek out to receive our remuneration for referring medi-Cal and medicaid patients. Through these introductions from other individuals, we began contacting providers who would offer us kickbacks for referring our work to them.

Following that period of time, when the several arrests occurred in December of 1978, individuals came forward who desired to cooperate with us because they were tired of the problems that they had seen in the industry for several years, and made themselves available to us. Basically, there were two clinical laboratories and one clinic.

Myself, Agent Hersley, as well as other agents, posed as clinic owners, laboratory salesmen, hospital administrators, nursing home owners, in contacting various individuals who were suspected of violating the law.

Senator TALMADGE. What were some of the most sophisticated methods of paying kickbacks that were determined through your investigations?

Mr. LUMPKIN. Basically, one of the most effective ways of paying kickbacks is cash. Once the cash changes hands, it is almost impossible to determine, unless you have someone talking to you about it.

Second, the payment of consultant fees for marketing sales fees to third parties who are not connected easily with the recipient of the funds is a very effective way, and hard way to detect.

Probably the most sophisticated method that we determined was the setting up of new corporations, or joint venture laboratories wherein either the doctor or the hospital administrator, or the clinic operator shared in a portion of the profits that were generated from that new joint venture laboratory, when in fact they had to do nothing in order to carry out the laboratory's function, except to refer the patient or the blood work to that particular laboratory.

In several instances, the laboratory owners would indicate to the doctors and clinic administrators that they could name their percentage of ownership in the new joint venture laboratory, and

therefore could receive that percentage amount of profits that were being generated from the joint venture laboratory.

Senator TALMADGE. Were you offered any unusual kinds of bribes or kickbacks?

Mr. HERSLEY. Yes.

Senator TALMADGE. Would you describe what they were?

Mr. HERSLEY. A particular instance comes to mind. We were offered—One particular laboratory owner had a condominium in Palm Springs, Calif., that he indicated to us he allowed his key hospital owners and administrators to use at no charge. There was food, and whatever you needed at the condominium. We, in effect, as prospective clients could take a trip up to the condominium at our leisure.

Senator TALMADGE. What shocked you most during the course of your undercover work?

Mr. HERSLEY. I think that what shocked me the most was the blatant manner in which the providers were willing to talk about the payment of kickbacks in return for getting the business, and the fact that it had been going on so long, at least in the California area, with no efforts made to stop it. They continued, and it became in effect a way of life for them.

Senator TALMADGE. In other words, it seemed to be a normal business transaction for them?

Mr. HERSLEY. I can't say that it seemed to be really a normal business transaction because there were a lot of statements made to us in the recordings where the people admitted and told us that they knew it was wrong, and it was a felony to do it. Some of them explicitly stated portions of the statute. However, due to the fact that there had been no efforts to combat it, they were still willing to do it, and they did not fear being detected.

Senator TALMADGE. Senator Dole.

Senator DOLE. I think you have indicated before that it is a $66 billion program, and there are about 47 million people involved—I think that it is 24 million on medicaid and 23 million on medicare. I am not asking you to comment, but I cannot think of a stronger argument against national health insurance, where we might have as many as 100 million people involved, and probably triple or quadruple the fraud and abuse that we have in this program.

It seems to me that before we launch into an effort to have a national health insurance program, maybe we had better try to find out how we can control the one we have.

I am interested in the same line of questioning that Senator Talmadge started. If either of you have any other insights that might be helpful to this committee, I would be happy to hear it now.

Mr. HERSLEY. Senator, I would like to bring to your attention this manner of doing business. They did talk to us repeatedly, when we were working an undercover capacity, about the willingness to pay us money, or the willingness of the other individual to solicit money from us.

Senator Talmadge asked earlier about different methods. One instance that comes to my mind is the price discrimination that occurs between what a doctor is charged a clinical laboratory for

his own private work versus what the program is charged for the same work.

An example that comes to my mind immediately is the laboratory that charges a doctor 97 cents to do a CBC, or a complete blood count, for a patient, when in fact several people have indicated to me that the charge for doing that test is far below what the cost for performing that test should be, and that the Government, on the other hand, is billed as much $6.15 for that test.

So you can see that the program does not receive the benefit of discounts.

Senator DOLE. I think you have indicated in your statement the man with the broken thumb who had $300 worth of blood tests. This has been described as overutilization, but I think more properly it should be described as greed. You don't violate the law, but you just prescribe everything and every test to be taken.

I listened to Senator Talmadge make these comments in our 1977 hearings about how you go into the hospital with a cold, and you get $400 worth of tests in the process. I am not certain how we get a handle on it. You have indicated that in your view—again I am not asking one agency to take on another—you find full cooperation with Department of Health, Education, and Welfare, or Department of Health and Human Services?

Mr. HERSLEY. No.

Senator DOLE. Is it because they don't have the powers that you have? Is it because they don't have subpena powers, or search powers, arrest powers?

Mr. REVELL. They have subpena power, which we do not. Our subpenas have to be requested from the Federal Grand Jury.

I think that the Office of Inspector General of the Department of Health and Human Services is doing an admirable job of trying to become effective in this area. I think that we all have a long way to go. I think that we need a very specific and comprehensive joint venture. I think they need our expertise and sophisticated investigative operations. I think we need their expertise in programs, and requirements of the various activities of the Department.

Senator DOLE. When you go out, I understand that you carry weapons. I understand that they are not allowed to carry weapons. Is that correct?

Mr. REVELL. I believe that is correct. They are not law enforcement officers under the 18.11 series. They have no arrest power, and cannot execute search warrants.

Senator DOLE. They do have some impediments. If they don't have full authority, it is pretty difficult.

Mr. REVELL. Sir, most of the investigative activities here are more of the detection, audit, and so forth, than traditional law enforcement techniques. These gentlemen did not carry weapons either while they were in their undercover capacities, nor did they make arrests at that time.

I would not say that the lack of the traditional law enforcement techniques is a hindrance in this regard, but I do think that we are learning to put together this IG concept with the Department and the FBI. I sit on the Committee to Combat Fraud and Waste in Government. We are working with the IG's, and we are chaired by the Deputy Attorney General.

We are putting together some joint audit standards, investigative referral techniques, and some joint operations. We will have additional results in other programs from these types of techniques, which you will hear about later. We are not standing still.

I guess if I can portray something, the essence is that it is a big problem. We haven't got a handle on it. We are trying to get a handle on it. We really are not there yet. We do think that the proactive technique that we have pioneered at this point has a definite place, and can be of benefit.

Senator DOLE. It just seems to me that it is such a massive program, with millions of people involved—thousands of providers, I assume, involved—we have examples here of 9 cases and 25 convictions, and those all ended in probation with a very small fine. So I think that it is fair to say that you have done a good job, but certainly we don't even have a handle on the problem yet.

I would guess, as Senator Heinz has indicated, if you go into cities in my State, and every other State, and can duplicate just what has been said here this morning. You have just barely touched the surface, or scratched the surface.

Mr. REVELL. I think that that is a fair assessment, Senator.

Senator TALMADGE. Mr. Hersley, and Mr. Lumpkin, was there any evidence of competition where you investigated these matters in Los Angeles?

Mr. HERSLEY. The one thing additional that probably alarmed us more than anything else was the lack of any cost containment procedures built into the program. Any time you have a kickback being paid to the person that orders the service, it is going to increase the amount of services that are ordered.

The doctor obviously benefits directly from the money that he is going to stick in his pocket from the kickback. The laboratory owner is going to benefit from the new business that he is able to obtain, and if he bases the kickback on the basis of the business that he is going to obtain, he is going to encourage the doctor to order even more services because that puts more money into the doctor's pocket.

In a system like that there really is no cost containment. There is no incentive for the doctor to hold down on the number of tests that he orders, and there is no incentive for the laboratory to put emphasis on that.

In the situation that Mr. Lumpkin touched on briefly, if the ancillary services were put out on a contract bid bases, it is our feeling that the Government would receive the benefit of the competitive nature of the bids that were handed out. Once the laboratory in that particular area has the contract, there is no reason, no encouragement for the doctor to order additional service. Then, it becomes a matter of him ordering tests based solely on his professionalism, and what he thinks should be ordered, as opposed to whether or not it is going to put an extra dollar in his pocket.

Senator TALMADGE. Do you know if any of the people you investigated in Los Angeles operated outside that area?

Mr. HERSLEY. Do you mean, any of the ancillary services, did they operate outside of Los Angeles?

Senator TALMADGE. Yes.

Mr. HERSLEY. Yes.

Senator TALMADGE. You contend that medicare and medicaid fraud is widespread and pervasive. What facts or examples lead you to this conclusion?

Mr. HERSLEY. Of the individuals that we contacted, approximately 90 percent of them were either engaged in that particular activity at the current time, or were more than willing to offer us some type of unlawful remuneration in return for our business.

Also, various comments that were made to us when we were acting in our undercover capacity about other areas of the medical field, such as hospitals, the billing of insurance carriers that inflated rates. That is, when the laboratory bills the physician at a particular rate—that rate, I might add, is a low rate in order so that the ancillary service can get that physician's medicare and medicaid work, and he will give him a break on his private patients. The physician, then, jacks up the bill that he is going to charge the insurance company above and beyond 6 to 10 times as much as what the laboratory is charging him.

Senator TALMADGE. Were any of them prosecuted for attempting to bribe a Federal officer?

Mr. HERSLEY. Not to my knowledge, a Federal officer. We had the one statement that Mr. Ramsey mentioned in his statement of a State medi-Cal fraud investigator attempting to solicit bribes.

Senator TALMADGE. You made no cases against any of them for attempting to bribe you? Did you, or not?

Mr. HERSLEY. No.

Senator TALMADGE. Do you have examples of laboratories billing the Government more than the bill for private patient work?

Mr. HERSLEY. Definitely.

Senator TALMADGE. How much more?

Mr. HERSLEY. As I indicated, it varies anywhere from, let us say, 6 to 10 times as much.

Senator TALMADGE. Any further questions, Senator Dole?

Senator DOLE. You touched on this in your statement, and I was just wondering, are there any other techniques that are used to disguise kickbacks that were not mentioned in your statement?

You said that they paid employees. You said that they took cash, which I assume should involve the IRS, but I understand they are reluctant to get involved. Are there some other unusual techniques? These are rather standard techniques.

Mr. REVELL. I would like to correct a misunderstanding. IRS is not reluctant to get into these cases. It is just that these are very cumbersome procedures, and we can't wait for them.

Senator DOLE. I did not suggest that you said they were reluctant. I suggested that I said they were reluctant.

Mr. REVELL. I would think that the widescope of techniques utilized that were detected in this would indicate that any conceivable method of kicking back can and probably has been used in these type of operations. I have seen nothing that would indicate that there is any limitation on what would be done.

Senator DOLE. The same would be true whether it is laboratory, nursing home, and so on?

Mr. Ramsey, do you have a comment?

Mr. RAMSEY. There was one unique way, I think, we found where an individual was able to get a lot of kickbacks. He would pay

money to a charity, the charity of the individual's choice. How it would work, and what the purpose of it was, I presume, was a tax break from Internal Revenue. In fact, the funds, or the percentage of money would be paid over to a charity of the individual's choice, and in turn, I suspect, that that money was deducted from income tax.

I think that the agents can tell you something about that. I think that it just slipped their mind.

Mr. HERSLEY. Basically, it is as Mr. Ramsey describes. A contribution might be made to the particular doctor's, or clinic owner's charity, and he gets the benefit, I think, as much as the benefit from the income tax angle. He gets the benefit of being recognized in his community as having made that contribution, and he reaps all the benefits of that contribution when it was made by somebody else.

Senator DOLE. Then the laboratory would deduct it as a charitable contribution. If they gave money to the blood bank, which would seem to be proper in this case, then the doctor would get recognition as being a big blood bank supporter, and the laboratory would get a deduction?

Mr. RAMSEY. I would suspect so.

Senator DOLE. Did you find that to be the case where payments were made in cash or in some other way? Did you check to see whether these were claimed as deductions?

Mr. REVELL. We cannot do that under the Tax Reform Act. We could ask, but IRS could not tell us.

Senator DOLE. Could they tell us?

Mr. REVELL. I doubt it.

Senator DOLE. They can't tell anybody?

Mr. REVELL. Unless they are taking a case to prosecution, they have to go through a very elaborate procedure to have disclosure. We have had a very difficult time, and have not been able to overcome this to get them involved on a real time basis in our investigations.

Senator DOLE. This gets into confidentiality, which is certainly important. But as Senator Nelson was saying in our closed hearing, in Wisconsin anybody can write and see what somebody paid in income tax. You can't get all the details.

But from your own investigations, do you have any evidence that there were any deductions claimed in any of the cases, certainly in some of the cases that have been mentioned?

Mr. LUMPKIN. Senator, we found that in most cases the individual paying the cash kickback, or whatever, was perfectly willing to eat the income tax on their own returns. We never determined whether the other individual who received the money actually claimed it. I highly doubt that he did.

Senator DOLE. The point being, if this is just normal operating procedure, then it ought to be a normal business expense, which could properly be deducted. Then, that might be another place to look. I understand that you cannot get into the IRS area, and I am not sure that we can either. I think that we probably could.

Mr. RAMSEY. I would suspect, Senator, as Mr. Lumpkin said, with respect to the cash basis, they would be willing to eat that because they could not put it down in their books as anything.

However, with respect to the other types of in-kind payments, such as leasing an automobile for your use, and consultant fees, this type of kickback, or the situation that we just talked about, paying to a charity, I would suspect that there is a real possibility that they are. That is, the person, who is giving the kickback or bribe, is really charging that off as a legitimate business expense.

Senator DOLE. I mean, as bad as it seems, and apparently it is quite bad and pervasive, I think the record ought to indicate that you have just scratched the surface. This is not an indictment of the medical profession all across the country, or of those who operate laboratories, hospital administrators, or nursing homes—If it is, maybe I incorrectly read the statement.

Would that be an accurate statement, or do you think that there is enough evidence to suggest that that is so pervasive that we should operate on the premise that this is standard operating procedure in almost every city in America?

Mr. REVELL. No, sir, I don't think we have enough impirical evidence to make such a broad statement. I certainly would not do so.

I do think that we have an indication of a problem that the medical profession should examine internally, that the Federal Government, and the State governments need to examine, and certainly the investigative agencies need to put more emphasis into.

We would be foolish to think that what we have detected to date is limited to the areas that we have detected it. Our cumulative experience would indicate to us that that simply is not the case. But it would also be unfair to blanket indict an industry on such limited data as we have.

Senator DOLE. Have you had any contact from any of the medical associations, laboratories, hospitals, whatever, any effort to cooperate by the officers in these associations?

Mr. RAMSEY. I have been contacted by—I think I mentioned this earlier—the California Association of Diagnostic Clinics. With respect to them helping, I don't know that I could say that.

Senator DOLE. I don't mean in the sense of joining the investigation, but at least in the sense of providing some information.

Mr. RAMSEY. You mean looking at their organization, a peer group type of review. No.

However, I think they are interested in what is going on, and the fact that they have invited me to speak to their group of individuals, and to talk about this new statute, and maybe to some extent let their people know that, No. 1, that we are prosecuting this type of activity and conduct; and, No. 2, what conduct may be violative or prohibited by the statute.

So in that sense, some of the organizations, professional organizations, are in fact concerned about their individual groups. I don't know whether or not they are asking me to do this by stating that maybe our people don't know that what they are doing is wrong, or just what their problem is, but I think it does point up the fact that these organizations, at least this particular one is interested in what is going on.

Senator DOLE. I think the honest, and I am assuming that the great majority are, are really at a disadvantage from the stand-

point of the competitive advantage or disadvantage if this has become standard operating procedure. There is the evidence of one laboratory operator who cooperated, and pointed out that he was losing $800,000 to $1 million worth of business a year.

Mr. REVELL. That is right, because of his unwillingness to participate in kickback type operations.

Senator DOLE. I think that we will have to continue the efforts, and I am sure that Senator Talmadge will continue the efforts here.

Senator TALMADGE. Thank you very much, Mr. Revell, Mr. Ramsey, Mr. Lumpkin, and Mr. Hersley. The committee expresses its gratitude for your testimony. It has been extremely helpful to our deliberations. Please thank Director Webster for us.

We urge you to continue this investigation. As we have pointed out, and you have stated, $66 billion of the Government's money is being spent in this area, and that always attracts criminals, and fast buck artists. I believe the overwhelming majority of people involved in this area are honest, and doing the best job they know how. But it does attract criminals.

I hope that the testimony that you have given here today will be widely disseminated by the news media, and I hope that those in the Department of Health and Human Services, and prosecuting officers throughout the country, and the judges throughout the country will become cognizant of this problem, and renew their efforts to try to eradicate it.

Every dollar that the fast-buck artists take deprives needy citizens, the poor, the helpless, the crippled, the disabled, and the sick to that much aid that Congress intended through this program to go to them.

Thank you very much.

Mr. REVELL. Thank you, sir.

[The prepared statement of Mr. Ramsey follows:]

STATEMENT OF ROBERT RAMSEY, JR., ASSISTANT U.S. ATTORNEY, CENTRAL DISTRICT OF CALIFORNIA BEFORE THE SUBCOMMITTEE ON HEALTH OF THE SENATE FINANCE COMMITTEE JULY 22, 1980 CONCERNING INVESTIGATION AND PROSECUTION OF MEDICARE AND MEDICAID FRAUD IN THE LOS ANGELES AREA

Mr. Chairman and distinguished members of this Committee, I am Robert Ramsey, Jr. I have served as an Assistant United States Attorney for the Central District of California in Los Angeles for more than six years. Our district includes Los Angeles and six neighboring counties, and is the most populous federal judicial district in the country. I am presently an Assistant Chief of the Criminal Division assigned to prosecute major crimes. For the past two years, I have been involved almost exclusively in the investigation and prosecution of cases concerning medicare and medicaid program fraud.

I am here today to discuss the experiences of our office and of the agencies with whom we work in investigating and prosecuting individuals and corporations who defraud the medicare and medicaid programs. As this Committee knows, the past few years have seen a tremendous growth in the Government's awareness of and attention to fraud against and abuse of federal human service programs, including medicare and medicaid.

As investigators and prosecutors, our first step in addressing such problems must be to look at the law. The basic statutes that are employed in attacking Government program fraud are found in the following sections of Title 18, United States Code: Section 287 (False Claim to a Government Agency); Section 371 (Conspiracy to Defraud the Government); Section 1001 (False Statement to a Government Agency).

With specific reference to medical program fraud, these statutes are supplemented by the Social Security Act at Title 42, United States Code, Sections 1395nn and 1396h, which prohibit the solicitation, receipt, offering, or payment of any

remuneration for referral of patients or the procurement of goods or services under the medicare and medicaid programs.

This Act, in its present form, includes two significant changes made by the Congress in 1977. First, the conduct prohibited by the statute was clarified. The pre-1977 statute did not use the words "any remuneration," but instead prohibited any "kickback" or "bribe" in return for inducing a person to refer medicare or medicaid patients. Courts differed over what constituted a "kickback" or "bribe," and some cases were lost. This weakness in the statute was eliminated by the 1977 amendment proscribing "any remuneration."

Secondly, the penalty was increased from a misdemeanor to a felony. These changes have been extremely beneficial to us in prosecuting laboratory owners and doctors who engage in illegal activity.

The Social Security Act includes another feature that is conducive to enforcement. It allows for the immediate expulsion from program participation of anyone convicted under the statute. Moreover, since the conviction is now a felony, most convicted providers are also subject to loss of their professional licenses.

During the hearings on this legislation, the Attorney General made a commitment to Congress actively to pursue investigations and prosecutions in this area. In furtherance of the Department's commitment, the United States Attorney for the Central District of California and the Los Angeles District Office of the FBI shortly thereafter established a program to investigate and prosecute medicare and medicaid (Medi-Cal) is medicare in California., fraud.

In early 1978, I was assigned to monitor and coordinate all cases involving fraudulent activities affecting the medicare and medicaid programs. The assignment required me to work closely with representatives of four agencies: the Federal Bureau of Investigation; the Office of Investigations of the Department of Health, Education, and Welfare (now Health and Human Services); the California State Department of Health; and the California State Attorney General's Medi-Cal Fraud Unit. At the very outset, we established a critical element of our program: close agent-attorney teamwork.

We collectively analyzed the powers and responsibilities of each agency and examined what we knew of pertinent criminal activity in the Los Angeles area. The FBI had determined that there appeared to be a significant amount of fraud related to kickbacks and bribes. We therefore decided that the Bureau would place primary emphasis on investigating violations of Sections 1395nn and 1396h of Title 42, with the goal of capitalizing upon the aforementioned amendments provided by the Congress in 1977.

Considerable study was given to the method of investigation. Since bribes and kickbacks involve collaborating offenders and an unknowing victim, it was decided that a proactive undercover investigation would be most effective. The operation, code named "Medi-Fraud," was conceived and implemented by the FBI, with six special agents assigned. I helped draft and edit the proposal for Medi-Fraud, and assumed the responsibility of advising the agents on a day-to-day basis in their investigations.

The Medi-Fraud operation presented many problems that may not occur in other proactive investigations and sting operations. We recognized that providers of medicare and Medi-Cal services were abusing and defrauding the program in a manner such that only an insider could provide reliable information. Problems in designing the program included operating in the medical service arena without violating the rights of legitmate and honest medical providers, avoiding situations that would raise entrapment issues, and monitoring independent administrative investigations so that the integrity of the Medi-Fraud program was not jeopardized. In many undercover operations, the FBI may have an idea of who the target is going to be, and this information is generally provided by an informant. In Medi-Fraud, the FBI did not have any informants or operatives within the medical profession when the investigation began.

I advised the undercover agents concerning their day-to-day meetings with prospective defendants in order to avoid successful claims of entrapment or other due process violations. I spent many hours working with the agents and was always available to answer their questions and advise them as to proposed investigative conduct.

The Medi-Fraud operation began in about July 1978 and ended in about January 1980. The operation to date has resulted in the conviction of 26 individuals and five corporations. I personally handled the majority of these cases after indictment, but several have been prosecuted by other lawyers in our office, notably Assistant United States Attorneys Deanne H. Smith, Katherine M. Quadros, and Robert A. Pallemon. We have approximately 50 more cases under consideration for prosecution.

An especially noteworthy and somewhat unique case saw a combination of Medicaid fraud and public corruption. In *United States* v. *Caldwell and Johnson,* CR 79-1001-IH, defendant Caldwell was a special investigator for the State Attorney General's Medi-Cal Fraud Unit and defendant Johnson was a laboratory owner. Caldwell told Johnson that for a fee he could help Johnson with a state investigation of Johnson's laboratory. Johnson agreed to pay a sum of money to Caldwell, and to contact other Medi-Cal providers on behalf of Caldwell. Caldwell pleaded guilty to two counts of extortion under the color of official right. Johnson was convicted after a jury trial of aiding and abetting Caldwell. Johnson was also convicted of Medicare and Medi-Cal fraud in a separate indictment. Caldwell was sentenced to two years in prison. Johnson was sentenced to nine months on both indictments.

In the other cases arising from the Medi-Fraud investigation, the individual and corporate defendants convicted were all charged with conspiracy to defraud the government and offering or receiving a remuneration to induce a person to refer Medicare or Medi-Cal business.

As of this date, we have met several pretrial legal challenges to the statute, but none has been successful. Most current attacks on the statute focus on the word "offer." For example, one defense attorney whose client was charged with making an offer of a prohibited remuneration sought to call as a witness a contracts professor from UCLA. The witness offered to testify that the words exchanged between the defendant and the undercover agent did not constitute an offer. We urged and the Court agreed that whether an "offer" was made by the defendant was a factual determination for the jury, and not a question for a legal expert.

We have also experienced some difficulty with that portion of the statute that excepts certain conduct. The prohibition in the statute does not apply to discounts that are disclosed to the government. We have seen cases where a laboratory owner has offered to give the referring provider "free privates" (free service for the provider's private, non-Medicare/Medicaid patients) or a discount on their "privates" in return for their Medicare/Medicaid business. The laboratory owner will argue at trial that he was giving the doctor a volume discount and that there is no place to disclose it in the claim form that is submitted for payment.

Sentences in these cases (other than the *Caldwell* case) have ranged from probation to nine months in custody. The average fine has been approximately $5,000. Since the penalties imposed are in the misdemeanor range, it might not appear that the amendments enacted in 1977 have had much impact. However, we think that the new legislation has been effective notwithstanding the sentences. We find that providers of health services to Medicare and Medi-Cal patients are very much aware of our efforts in the Central District to detect and prosecute fraud. The proactive FBI approach to investigations has had a definite impact upon the health care community. The press in the Los Angeles area has given considerable attention to these prosecutions. Because of the publicity, individual providers have come forward and offered their facilities and services to the FBI in connection with such investigations. Indeed, perhaps as a consequence, it appears that some individuals and corporations are seeking new and innovative ways to find loopholes in the law. Often with the help of attorneys, providers will set up corporations, partnerships, consulting services, and other sophisticated mechanisms for giving or receiving remunerations.

Moreover, while we have experienced success in cases involving bribes and kickbacks, we have not seen as many prosecutions involving overbilling, billing for services not rendered, and false statements. These matters are handled by the Office of Investigation of the Department of Health and Human Services, and we are working with that agency to see how the limited resources of both our offices can be best addressed to this area.

In addition to criminal medicare and medicaid prosecutions in the Central District of California, cases are referred to our Civil Division for recovery of overpayments to providers or for civil action against providers pursuant to the False Claims Act. That Act entitles the government to recover double the amount of loss it has actually sustained and a penalty of $2,000 for each false claim submitted by the provider. Cases filed under the False Claims Act have included actions against doctors for billing services not rendered or misrepresenting the nature of the services provided, against convalescent hospitals for receiving kickbacks from laundries and pharmacists, and against hospitals for falsifying cost reports and underlying books and records to maximize reimbursement.

We think that Medicare and Medicaid fraud prosecutions are important in the federal effort to control such activity. While it is hard to measure the deterrent value or the financial impact of such prosecutions, it is clear that the entire medical community is becoming aware of our crackdown on providers who defraud the

programs. I therefore believe that these prosecutions will have a significant effect in deterring providers from committing fraud. This is especially likely since, under the statute, a provider convicted of fraud is now immediately suspended from participation in the Medicare program.

Investigations and prosecutions in this area should also result in significant savings to the taxpayers and the government. If we deter the kickbacks and bribes, we reduce the incentive to overutilize the program.

In conclusion, I would like to say that we are gratified with our success to date in the Central District of California in the cooperative investigation and prosecution of Medicare and Medicaid fraud. We also recognize that there is much to be done, and we applaud the interest of this Committee in the problem.

This concludes my prepared statement. I would be happy to answer any questions you may have.

Senator TALMADGE. The committee will stand in recess subject to the call of the Chair.

[Whereupon, at 12:20 p.m., the subcommittee adjourned, subject to call of the Chair.]

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