S. HRG. 111–120

CATCH ME IF YOU CAN: SOLUTIONS TO STOP MEDICARE AND MEDICAID FRAUD FROM HURTING SENIORS AND TAXPAYERS

HEARING

BEFORE THE

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CATCH ME IF YOU CAN: SOLUTIONS TO STOP MEDICARE AND MEDICAID FRAUD FROM HURTING SENIORS AND TAXPAYERS

WEDNESDAY, MAY 6, 2009

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met at 3:12 p.m., in room SD–216, Hart Senate Office Building, Hon. Mel Martinez, presiding.

Present: Senators Kohl, Martinez, and Graham.

OPENING STATEMENT OF SENATOR MEL MARTINEZ, RANKING MEMBER

Senator MARTINEZ. Good afternoon, everyone. I am, at the request of Chairman Kohl, going to begin the hearing since we are already running a little bit late. He will be here very, very shortly, and when he comes, I am sure he will want to make some opening comments.

Let me begin by welcoming all of you here today to a very important hearing, and I want to thank my chairman, Chairman Kohl, for agreeing to hold this very, very important hearing.

This issue of fraud and abuse in our Medicare and Medicaid system is something that has become a national scandal, and as we talk about ways in which we might improve our overall health care system in our country, there is no question that addressing this issue is at the cornerstone of improving the health care system for all Americans.

Americans expect their Government to be good stewards of the dollars that they pay in taxes. Since almost all of us in this room will some day rely on Medicare for our health care, it is something in which all of us have, indeed, a very personal stake if not only a governmental stake.

One of the greatest threats to our Nation's health care safety net programs like Medicare and Medicaid is fraud and abuse, and both programs have seen more than their share of this. Authorities estimate that health care fraud costs taxpayers more than $60 billion a year. This fraud perpetrated against Medicare diverts resources that are supposed to finance health care for 43 million American seniors and disabled. This fact hurts Medicare beneficiaries, the legitimate businesses that serve these patients, and really every taxpayer.

I regret to say that my home State of Florida has a large number of criminals involved in Medicare fraud, and some of the most egre-

gious cases are in south Florida, as I know we will hear from one of our witnesses. Just two weeks ago, the Department of Health and Human Services' Office of the Inspector General issued a report and that report revealed that while 2 percent of the Nation's Medicare beneficiaries reside in south Florida, that region accounts for 17 percent of Medicare expenditures on durable medical equipment and related items such an inhalation drugs: The Inspector General found that two-thirds of south Florida Medicare beneficiaries with Medicare claims for these inhalation drugs had not seen a doctor in over three years. This raises suspicion that durable medical equipment suppliers are fraudulently billing Medicare for inhalation drugs that doctors have not prescribed.

Another Inspector General review revealed that 8 percent of the Nation's AIDS patients live in south Florida. Yet, 72 percent of Federal AIDS medication payments are sent to that area. In that area alone, there is an estimated $2 billion in fraud. These are just a couple of examples of the systemic fraud and abuse perpetrated against Medicare and the taxpayers.

An example that Mr. Acosta, the U.S. Attorney for the Southern District, who is one of our four witnesses, recounted to me is that of a woman who noticed on her Medicare statement a series of $10,000 Medicare payments for artificial knees, ankles, a glass eye, and a wheelchair, among other things. The truth is that she was completely healthy and, in fact, someone was billing Medicare using her stolen Medicare number.

This is why Senator John Cornyn and I introduced the Seniors and Taxpayers Obligation Protection, or STOP, Act. I am pleased to say that Senator Collins has also joined this bill, and I believe there are a few other Senators who have joined with us on that as well.

Our bill safeguards Medicare beneficiaries from those who use it to fraudulently bill Medicare, helps providers assure that Medicare is not billed for items that they did not prescribe, and focuses on real-time fraud prevention and detection. This legislation will help stop Medicare fraud before it starts rather than continue the current practice of pay and chase.

I want to ask other colleagues of mine on the Aging Committee to join in taking some of these common sense steps to prevent Medicare fraud, save taxpayer dollars, and restore peace of mind to physicians, as well as beneficiaries.

Medicaid also has fraud problems. There are often-cited examples of Medicaid paying for hysterectomies or for birth control for a male patient, things as crazy as that. To address this, I recently introduced the Medicaid Accountability Through Transparency Act, or the MATT Act, which sheds a light on Medicaid claims by posting claims information on the Web while maintaining the privacy of the patient. This will help us all to see where and how taxpayer dollars are being spent. This would reveal crime trends that will help us weed out fraudulent spending.

Of course, this does not solve all the problems, but it would be an easy step forward that would reveal information that has not been revealed before. This is modeled on the Coburn-Obama Earmark Transparency Legislation passed by Congress last session. It is, in essence, a taxpayers' right-to-know issue.

With that, I appreciate, Chairman Kohl, you agreeing to this hearing, which I think is terribly important, and I would call on you to make any opening remarks you care to make.

OPENING STATEMENT OF SENATOR HERB KOHL, CHAIRMAN

The CHAIRMAN. Thank you very much, Senator Martinez.

I appreciate serving on this panel with you as the ranking member, and I appreciate your holding today's hearing on the topic of Medicare and Medicaid fraud.

The high cost of health care is rapidly depleting the Medicare trust fund, crushing State Medicare budgets, and bankrupting working families who cannot afford health insurance. Health care fraud robs patients and providers of the precious resources they need.

According to one estimate, Medicare and Medicaid fraud cost the Government $72 billion last year. So clearly, we need to make sure that every dollar spent by a public or private health plan does, indeed, go to quality health care and not to line the pockets of a scam artist or even a criminal.

So we are eager to hear from today's witnesses about how we can best put a stop to these types of fraud, and we are especially interested in innovative ideas that will put us ahead of the curve in terms of detecting fraudulent schemes before they are carried out. We can detect improper claims before they are paid and address weaknesses in our system more effectively. We can save time and money that is currently spent on chasing down bad payments that have already been made.

Senator Martinez and I have been working closely with the Finance and the HELP Committees as part of a bipartisan group on this issue. Specifically, we are drafting proposals to address the problem of health care fraud as an essential component of health care reform, including measures to improve the detection and prevention of waste, fraud, and abuse and to provide law enforcement with sufficient tools to investigate and prosecute criminal schemes. We believe it is our obligation to protect the integrity of Medicare and Medicaid and ensure that our Government's resources are defended against dishonesty and abuse.

Thank you so much, Senator Martinez.

Senator MARTINEZ. Thank you, sir.

Today we have with us five witnesses to speak about the rampant fraud and abuse in Medicare and Medicaid, and we look forward to hearing your thoughts on combating fraud and your recommendations for reducing this fraud while maintaining quality of care for all the beneficiaries of this system.

First, we have with us the Honorable Alexander Acosta. Mr. Acosta is the United States Attorney for the Southern District of Florida. Mr. Acosta has placed special emphasis on health care fraud prosecutions, hosting the first health care fraud strike force in the Nation, and he has also presided over a 30 percent increase in prosecutions during his tenure there in the Southern District of Florida.

Prior to his appointment as United States Attorney, Mr. Acosta served as the Senate-confirmed Assistant Attorney General for the Civil Rights Division of the United States Department of Justice.

Mr. Acosta was the first Hispanic to serve as an Assistant Attorney General at the Department of Justice.

Next is the Honorable Daniel Levinson, Inspector General of the United States Department of Health and Human Services. As Inspector General, Mr. Levinson is the senior official responsible for audits, evaluations, investigations, and law enforcement efforts with one of the largest Departments in the Federal Government.

We have Jim Frogue, who serves as the Center for Health Transformation's chief liaison to State policy projects. His primary areas of focus are on Medicaid and health savings accounts.

Robert Hussar, who is the first Deputy Medicaid Inspector General in the State of New York's Office of the Medicaid Inspector General. He works with the Inspector General to oversee investigations of Medicaid fraud in State agencies and private providers.

Finally, we have with us Stephen Horne, Vice President of Master Data Management and Integration Services for Dow Jones Business and Relationship Intelligence. Mr. Horne has over 30 years' experience in large-scale data integration and data utilization.

Gentlemen, we welcome all of you. We thank you for taking the time to be with us today, and Mr. Acosta, we will begin with you for your opening remarks.

STATEMENT OF R. ALEXANDER ACOSTA, UNITED STATES ATTORNEY, SOUTHERN DISTRICT OF FLORIDA, U.S. DEPARTMENT OF JUSTICE, MIAMI, FL

Mr. ACOSTA. Thank you, Senator. Mr. Chairman, Ranking Member Martinez, members of the committee, thank you very much for holding today's hearing.

As you both mentioned, Americans enjoy one of the world's best health care systems. A challenge to that system is the increasing costs of health care. One reason for this is health care fraud. There are various estimates regarding the size of this fraud. One number that is often repeated is $60 billion. It could be even greater. I am certain you hear many estimates, however. So what I wanted to do in my opening remarks is to present a few facts based on my own experiences in South Florida.

Now, in 2006, I organized a health care fraud prosecution initiative in the Southern District of Florida, and we did this in partnership with the FBI and the Office of Inspector General. The following year, our efforts were substantially energized as the Criminal Division's Fraud Section contributed their attorneys and their resources through the strike force.

The results have been both sad and spectacular. We have charged in South Florida more than 700 individuals responsible for billing Medicare more than $2 billion. Those are actual cases that have now been brought. We have collected more than $350 million that has been returned to the Federal Treasury, both civilly and criminally. We have prevented an estimated, at least—or contributed to the prevention of $1.75 billion in additional expenditures and billings to DMEs. We have done this with a local budget of $2.5 million annually spent by the United States Attorney's Office, and we could do more. Resources are our primary limitation.

Senators, that billions are being wasted each year should come as absolutely no surprise. The problems are well known. Allow me to describe, if I could, an operation that we call Operation Whac-a-Mole, the old video game. In this operation Federal agents visited 1,581 durable medical equipment suppliers. They visited them and inspected them for basic criteria. Were the businesses there? Were they open? Did they have regular business hours? Four hundred ninety-one of the durable medical equipment companies failed that inspection, one out of three. Instead of a durable medical equipment company, Federal agents found flower shops, a real estate company, locations with mail stacked outside the door, pharmacy closed signs, for rent signs. In less than one year, those 491 nonexistent companies had billed Medicare $237 million and Medicare had actually paid them $97 million, $97 million wasted. That is just one example.

I should add that many of the civil matters that we do are an important part of our effort and account for a large part of our collections.

I began this health care fraud effort in 2006 because I was absolutely disgusted by the levels of health care fraud that I found in South Florida, and we will continue to prosecute these cases and will continue these efforts. But I want to make some important points.

First, this is not just a South Florida problem. Senator Martinez pointed to some numbers regarding South Florida, but in part, because we are doing so much, the problems have been identified in South Florida. The strike forces are being set up based on the South Florida model in other cities around the Nation. Two cities are or will be hosting strike forces. So whatever changes should be made should be systemic and go beyond South Florida.

Secondly, as a prosecutor, I want to put emphasis on a point that is, to some extent, contrary to my interests as a prosecutor but is important to the Nation. Prosecutions are not the solution. Let me explain what I mean.

If one wants to prevent traffic accidents, one puts up red lights. One puts up stop signs. One has good rules of the road that prevent accidents in the first place. Tickets given after an accident occurs rarely prevent accidents in the first place, not to mention we do not have enough law enforcement to watch every intersection. So what we do is we have good rules of the road.

The same applies for health care fraud. With additional resources, my office could easily double and triple the prosecutions. We could go from $2 billion to $3 billion to $4 billion in fraud prosecuting, but the best way by far to prevent fraud in the first place is to improve the rules of the road, in other words, to implement systemic changes at CMS that are designed to ensure rapid payment as is appropriate, yet at the same time identify and deny fraudulent bills.

One final point and an important one. Our prosecutions did not second guess medical judgment, and this is important to both physicians and to industry. We do not look over physicians' shoulders. The frauds that I speak about are blatant, people billing for services that have never been provided, an individual billing for the same wheelchair time after time after time after time when not a

single patient receives that wheelchair. This is not second guessing medical judgment, and that is important to understand.

We will continue to do our part, but it is important that we address systemic changes in the system in my opinion. To put this in perspective, it is easy to throw around numbers like $60 billion in fraud, $2 billion in fraud prosecuted. So far, in our district in South Florida, if you look at and assume approximately 500,000 beneficiaries, we have prosecuted $4,000 in fraud per capita. So my question is this. What could be done with the savings of $4,000 per Medicare beneficiary? That is money that is currently going to line the pockets of criminals. Those are precious health care dollars that could, instead, be used where they need to be used to help those in need. That is why I thank you for holding this hearing.

[The prepared statement of Mr. Acosta follows:]

Department of Justice

STATEMENT OF

R. ALEXANDER ACOSTA
UNITED STATES ATTORNEY
SOUTHERN DISTRICT OF FLORIDA
UNITED STATES DEPARTMENT OF JUSTICE

BEFORE THE

UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING

HEARING ENTITLED

"FRAUD IN THE MEDICARE AND MEDICAID PROGRAMS"

PRESENTED

MAY 6, 2009

Mr. Chairman and distinguished Members of the Committee. I appreciate the opportunity to appear before you to discuss fraud in the Medicare and Medicaid programs. We are grateful for the leadership of your Committee on this important topic and to you, Mr. Chairman, for inviting us to discuss the Department of Justice's enforcement efforts. As United States Attorney for the Southern District of Florida, I have been committed for some time to the vigorous investigation and prosecution of health care fraud cases in South Florida.

I have been asked to provide testimony concerning the efforts of the Department of Justice (the Department) to combat fraud and abuse in the Medicare and Medicaid programs. This is a critical issue; Medicare and Medicaid are critical programs that provide an essential role in our health system. They serve vulnerable populations of seniors, people with disabilities, and various low-income Americans. Last year, my District in South Florida, prosecuted 245 individuals responsible for $793 million of fraudulent Medicare billings. Those cases represent money that could be used to help individuals actually in need of medical care, but is instead being stolen by criminals seeking personal profit.

The Department's prosecutions have a broader impact as well: the deterrent effect of well-coordinated inter-agency investigative, administrative, civil and prosecutorial resources, laser-beam focused on widespread, but regionally targeted, health care fraud schemes. Our inter-agency Departments of Justice and Health and Human Services prosecutions, spearheaded by the Department's Criminal Division and U.S. Attorneys Offices and the Strike Force in Miami, Los Angeles, and Houston, and other HHS administrative enforcement actions targeting durable medical equipment (DME) fraud, have led, for example, to estimated reductions of $1.75 billion in DME claim submissions and $334 million in DME claims paid by Medicare over the 12 months following the Strike Force's inception, compared to the preceding 12-month period.

Our criminal and civil enforcement have taught us some important lessons about Medicare fraud. First, in the criminal arena, we have learned that the most aggressive criminals targeting our system are not inventing new schemes, but are copying the most successful and profitable schemes in their communities. Because these frauds are learned, we know that the schemes are both regional and viral in nature. The very claims data has proven to be some of the most compelling evidence we use in our criminal prosecutions. It allows the Department to focus its efforts. Finally, we have learned to identify criminal claim trends and track systemic weaknesses so that we can make every effort to attempt to stop false claims before they occur. We cannot prosecute our way out of this problem, we must work to eliminate fraud before money is wrongfully paid and to better prevent bad actors from gaining access to participation in the Medicare program.

Medicare and Medicaid are extremely large programs, Federal and state spending on both programs collectively exceeds $800 billion per year. Therefore, while we must do all that we can to fight fraud and eliminate waste, it is not reasonable to have zero fraud, unless we were to restrict the programs to such an extent that access to vital services for beneficiaries would be threatened.

In my written testimony, I will describe the role the Department plays in Medicare and Medicaid program integrity, including the role of the Department's Criminal, Civil and Civil Rights Divisions, the Federal Bureau of Investigation (FBI), and the 94 U.S. Attorneys' Offices across the country. I will also address our sources of funding, our cooperative relationship with the Department of Health and Human Services, and our substantial accomplishments. I will conclude by emphasizing that a renewed and fortified program, which

continues and expands our capacity to combat health care fraud, is a critical element of this administration's health care reform agenda.

MORE THAN $12 BILLION IN RECOVERIES RETURNED TO THE MEDICARE AND MEDICAID PROGRAMS SINCE 1997

As you know, national health care spending in the United States exceeded $2.2 trillion and represented 16 percent of the Nation's Gross Domestic Product (GDP) in 2007. The Federal Government financed more than one-third of the Nation's health care that year; federal and state governments collectively financed 46 percent of U.S. health care costs. The National Health Care Anti-Fraud Association estimates that 3 percent of the nation's health care spending—or more than $60 billion each year—is lost to fraud. Over the next ten years, U.S. health care spending is projected to double to $4.4 trillion and to comprise more than 20 percent of national GDP. We must prepare for this growth today, not attempt to play catch-up in the future.

The Department is committed to rooting out and punishing individuals and corporations who commit health care fraud, including providers and practitioners, equipment suppliers, corporate wrongdoers, and other common criminals. The Department is not alone in the fight to combat fraud and preserve the integrity of the country's health care system. Within the framework of the Health Care Fraud and Abuse Control Program (HCFAC) established in 1997, we work closely with the Inspector General of the Department of Health and Human Services, as well as our colleagues at the Centers for Medicare and Medicaid Services (CMS). We also work closely with the Food and Drug Administration, including its Office of Criminal Investigations (FDAOCI), the Federal Employees Health Benefits Program (FEHBP) at the Office of Personnel Management and its Office of Inspector General, and our State law enforcement partners in their Offices of Attorneys General and Medicaid Fraud Control Units.

Because health care fraud schemes frequently impact private health insurance plans, we also work with private sector health care insurance providers.

Working with our colleagues, since the inception of the HCFAC program in 1997, the Department has obtained, according to our preliminary estimates, more than $14.3 billion in total recoveries, which include criminal fines and Federal and State civil settlements in health care fraud matters, predominantly involving losses to the Medicare program. Of this total, $12.5 billion has been transferred or deposited back into the Medicare Trust Fund and $1.2 billion, representing the federal share of Medicaid fraud recoveries, has been transferred to the Treasury. The monetary recoveries we achieve go right back into the Medicare and Medicaid programs to help fund the health care costs of the Americans who are enrolled in these programs.

These recoveries were made possible by the dedicated funding stream provided by the HCFAC Program, which was established by the Health Insurance Portability and Accountability Act of 1996, and the supplemental appropriations enacted by Congress, most recently earlier this year. The HCFAC program is the principal source of annual funding for Department of Justice efforts to combat Medicare and Medicaid fraud.

DEPARTMENT STRIKE FORCES SUCCESS AGAINST MEDICARE FRAUD

I would like to start by detailing a recently developed successful strategy in combating Medicare and Medicaid fraud involving durable medical equipment (DME) and Human-Immunodeficiency Virus (HIV) infusion therapy services. In 2006, I implemented a health care fraud prosecution initiative in the Southern District of Florida. Through this initiative, our prosecutors worked in partnership with the FBI and the Department of Health and Human Services (HHS), to implement a targeted criminal, civil and administrative effort against

individuals and companies that fraudulently bill the Medicare program in Miami, Florida. This effort was substantially energized in March 2007, when the Department's Criminal Division brought its expertise and resources, resulting in what is now the South Florida Medicare Fraud Strike Force. This Medicare Fraud Strike Force was structured in five teams with criminal prosecutors, a licensed nurse, federal HHS and FBI agents, and state and local police investigators. In March 2008, the Department's Criminal Division expanded the Strike Force to a second site, partnering with the United States Attorney's Office for the Central District of California, and involving four teams of prosecutors and federal and state agents to combat DME fraud in the Los Angeles metropolitan area. The Strike Force model for criminal health care fraud prosecutions has since become a permanent component of both United States Attorneys' Offices.

As I will outline for you, the Strike Force model is based on focusing the training of agents and prosecutors on how to identify and fight those highly repetitive fraud schemes, those I have described as viral, and then focusing enforcement resources and efforts in those regions that have the greatest rates of crime in a concentrated effort to deter fraudulent claims.

In March 2009, the Department's Criminal Division initiated a third Strike Force phase, in partnership with the United States Attorney's Office for the Southern District of Texas, forming three teams of prosecutors and federal and state agents targeting fraudulent DME and billing agencies in the Houston area. The Department's Criminal Division is currently planning to launch a fourth Strike Force phase in the near future using its allocation of the supplemental funding Congress provided in the Omnibus Appropriations Act of 2009.

Since its inception two years ago, the Strike Force, with a limited number of investigators and prosecutors, has:

- filed 108 cases charging 196 defendants who collectively billed the Medicare program more than half a billion dollars;
- taken 127 guilty pleas;
- handled 14 jury trials resulting in convictions of 18 others on all counts charged; and
- obtained 109 sentences of imprisonment, ranging from 30 years to 4 months of home confinement, with an average term of imprisonment of 48 months.

Here are several examples of the Strike Force successes:

- Two owners of a billing company and an employee were sentenced for conspiracy to commit health care fraud. The two owners were each sentenced to 14 years' incarceration and the employee was sentenced to 11 years. The three conspired to bill Medicare nearly $420 million for DME purported to have been provided to Medicare beneficiaries by 85 DME companies. These claims for were for equipment that not been ordered by physicians or delivered to the beneficiaries as claimed.
- A physician's assistant pleaded guilty and was sentenced to 14 years' imprisonment for his part in a $119 million HIV infusion fraud conspiracy; three other co-defendants remain fugitives. The physician's assistant admitted to training physicians at eleven fraudulent HIV infusion clinics to prepare and submit medically unnecessary HIV infusion services that were allegedly administered to Medicare patients. He also admitted to overseeing the documentation of fraudulent services to make it appear that the clinics provided legitimate services, and to knowing that the infusion treatments billed at the clinics were medically unnecessary and/or were never provided.
- DME company owners were sentenced for conspiring to defraud the Medicare program by submitting false claims for medically unnecessary DME items and supplies, including

aerosol medications and oxygen concentrators. The companies paid kickbacks to a physician previously investigated by OIG, and to several Medicare beneficiaries in order to use their Medicare numbers to submit the fraudulent claims. The 13 convicted DME company owners involved in the scheme were ordered to pay a total of more than $6.4 million in restitution. The 13 subjects were also sentenced to various terms of imprisonment, probation, and/or home detention, the longest prison sentence for the case being 6 years and 6 months.

- After a five-week trial, a Federal jury in Miami convicted three owners of two DME companies, a home health agency and an assisted living facility which conspired to defraud Medicare of more than $14 million for unnecessary medicine, DME, and home health care services. Two defendants were sentenced to 51-month terms of imprisonment, and the third was sentenced to a 31-month prison term. Patients testified at trial that they took kickbacks, were falsely diagnosed with chronic obstructive pulmonary disease and prescribed unnecessary aerosol medications, including commercially unavailable compounds. A fourth co-defendant who was a dermatologist, was also convicted in a separate jury trial and was sentenced to prison for 41 months.

As proud as we are of our Strike Force initiative, it is but one element of our comprehensive health care fraud efforts.

STATUTORY BACKGROUND AND FUNDING

Social Security Act Section 1128C(a), as established by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA or the Act), created the HCFAC Program, a comprehensive program to combat fraud and abuse in health care, including both

public and private health plans. Under the joint direction of the Attorney General and the HHS Secretary, the HCFAC Program's goals are to:

(1) coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse with respect to health plans;

(2) conduct investigations, audits, inspections, and evaluations relating to the delivery of and payment for health care in the United States;

(3) facilitate enforcement of all applicable remedies for such fraud;

(4) provide guidance to the health care industry regarding fraudulent practices; and

(5) establish a national data bank to receive and report final adverse actions against health care providers, and suppliers.

The Act requires the Attorney General and the HHS Secretary to submit a joint annual report to the Congress which identifies both:

(1) the amounts appropriated to the Trust Fund for the previous fiscal year under various categories and the source of such amounts; and

(2) the amounts appropriated from the Trust Fund for such year for use by the Attorney General and the HHS Secretary and the justification for the expenditure of such amounts.

The Act requires that an amount equaling recoveries from health care investigations – including criminal fines, forfeitures, civil settlements and judgments, and administrative penalties, but excluding restitution, compensation to the victim agency, and relators' shares – be deposited in the Medicare Trust Fund, also known as the Hospital Insurance (HI) Trust Fund.

All funds deposited in the Medicare Trust Fund as a result of the Act are available for the operations of the Medicare programs funded by the Medicare Trust Fund. The Act appropriates monies from the Medicare Trust Fund to an expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and the Attorney General jointly certify annually as necessary to finance anti-fraud activities. The maximum amounts available for certification are specified in the Act. Congress established the dedicated HCFAC resources to supplement the direct appropriations that HHS and the Department otherwise devoted to health care fraud investigation and prosecution. The Act specifies the total annual maximum amount collectively available to HHS (including the HHS Office of Inspector General (OIG)) and the Department for their health care fraud enforcement work, assigns specific authorities to the HHS OIG, and, beginning with fiscal year 2007, specifies the minimum amount of funding OIG must receive each year.

In Fiscal Year (FY) 1997, HIPAA authorized HHS and the Department to appropriate from the Account up to $104 million collectively, and allowed the Departments to increase that appropriated amount by up to 15 percent annually until FY 2003. HIPAA also provided $47 million in dedicated funding for the FBI's health care fraud investigations beginning in 1997 and increasing annually until 2003.

In FY 2003, the maximum available for HHS and the Department collectively was "capped" by statute at $240.558 million annually. Of this total, the Office of the Inspector General (OIG) received the statutory maximum amount of $160 million annually. The Department's litigating components and other (non-OIG) HHS components split the remaining balance amounting to $80.558 million, which we refer to as the "wedge." The Department's litigating components received $49.415 million annually from the wedge in FY 2003 through FY

2006. HIPAA separately appropriated $114 million annually in dedicated funding to the FBI over this same time period to support the FBI's health care fraud investigative activities.

Section 303 of Division B of the "Tax Relief and Health Care Act of 2006" modified the FY 2003 funding cap beginning in FY 2007 to provide for annual inflation adjustments to the maximum amounts available from the HCFAC Account and to the FBI allocation, through FY 2010. In FY 2010, a fixed funding level or "cap" will be reinstated, set at the 2010 level for subsequent fiscal years, unless Congress acts to extend annual inflationary adjustments for the program.

Earlier this year, the Omnibus Appropriations Act of 2009 provided a one-time additional $198 million for joint HHS and Department health care antifraud programs through an allocation adjustment for new program integrity work, predominantly for the Part D, Medicaid and Children's Health Insurance (CHIP), and Medicare Advantage programs. Nearly $19 million of this new amount is designated for the Department. The Administration's FY 2010 budget seeks an additional $311 million in two-year funding to continue and enhance this new program integrity and antifraud enforcement work.

In addition to our partners in the HHS Office of Inspector General, and Centers for Medicare and Medicaid Services, the Department combats the Nation's health care fraud with a total of fewer than 400 full-time equivalent (FTE) positions, and roughly 750 FBI agents and support staff. With $12.5 billion returned to the Medicare Trust Fund since the inception of the HCFAC program, the average "return on investment" for funding provided by HIPAA to all "law enforcement agencies," the figures are as follows: total transfers to Medicare Trust Fund ($3.82 to $1) and all victims ($4.41 to $1). Further, we believe that the deterrent effects from our

efforts may produce far greater "returns on investment" through dramatic reductions in fraudulent billings to and payments from Medicare.

As successful as our Strike Force and other anti-fraud efforts have been, our prosecutors believe that we may be only scratching the surface. The Administration has requested additional resources for FY 2010 to support the Department's efforts to bolster its health care fraud enforcement activities and protection of the Medicare Trust Fund. In this way, the Department can ensure that we can recruit, hire, and fully train the best and brightest attorneys and investigators to conduct and enhance this very important work, especially as the Administration and Congress seek to make health care coverage available to the millions of citizens who currently lack health insurance.

HCFAC PROGRAM ACCOMPLISHMENTS IN FISCAL YEAR 2008

During Fiscal Year 2008, the Department's health care fraud litigation resulted in deposits of $1.48 billion with U.S. Treasury, which was reimbursed to the Centers for Medicare and Medicaid Services, other Federal agencies administering health care programs, or paid to private "whistleblowers" who filed health care fraud litigation completed by the Department. The Medicare Trust Fund received transfers of nearly $1.28 billion during this period as a result of these efforts, as well as those of preceding years, in addition to $344 million representing the federal share of Medicaid money similarly transferred to CMS as a result of these efforts.

In criminal enforcement actions during 2008, prosecutors for the Department and U.S. Attorneys' Offices:

- Opened 957 new criminal health care fraud investigations involving 1,641 potential defendants, and had 1,600 criminal health care fraud investigations involving 2,580 potential defendants pending at the end of the fiscal year; and
- Filed criminal charges in 502 health care fraud cases involving charges against 797 defendants and obtained 588 convictions for the year. Each of these figures represents an "all time high" count of federal criminal cases, defendants, and convictions.

Another 773 criminal health care fraud cases were pending trial or resolution involving 1,335 defendants charged with health care fraud violations at the end of FY 2008. The Department's volume of pending criminal health care fraud cases has increased more than 40 percent since HCFAC program funding was fixed by statute in FY 2003.

In civil enforcement actions during 2008, attorneys for the Department and U.S. Attorneys' Offices opened 843 new civil health care fraud investigations, and filed complaints or intervened in 226 civil health care cases.

INTER-AGENCY DOJ-HHS COOPERATION

Because HHS directly administers the Medicare Program and maintains all the payment records and data submitted by providers, and oversees the Medicaid program in partnership with the states, successful prosecution of criminal cases and litigation of civil cases requires close cooperation between the Departments. Examples of this close cooperation include the following:

- Our Strike Force model is an example of the successful focus of interagency resources on those regions with the highest levels of Medicare program fraud.
- Under the auspices of the HCFAC Program, the Department and HHS hold senior staff-level meetings on a quarterly basis that include representatives from the Office of the

Deputy Attorney General, Office of the Associate Attorney General, the Executive Office for the U.S. Attorneys, HHS Counsel to the Inspector General and Office of General Counsel, and CMS Program Integrity Director.

- Our agencies also hold quarterly CMS-law enforcement agency coordinating meetings among mid- and lower-level staff who work on specific collaborative initiatives, cases, and investigations.
- We hold monthly CMS-Department conference calls involving CMS Program Integrity and other staff with our U.S. Attorneys' Offices and FBI personnel nationwide.
- Interagency health care fraud task forces and working groups exist in a majority of federal judicial districts that consist of Assistant U.S. Attorneys, HHS and FBI investigative agents, CMS program agency personnel and Medicare Program Safeguard Contractors, Medicaid Fraud Control Units, state Attorney General staff, and some private insurer investigators.
- The OIG shares summarized information about all Medicare contractor referrals for investigation with the Department and the Department's FBI, and the FBI exchanges copies of its health care fraud case opening memoranda with OIG.
- The Criminal and Civil Divisions routinely coordinate with the OIG in the review process for issuing industry advisory opinions concerning the application of the anti-kickback statute to specific fact situations.

DEPARTMENT OF JUSTICE COMPONENTS INVOLVED IN MEDICARE AND MEDICAID ANTI-FRAUD ENFORCEMENT

Health care fraud enforcement involves the work of several different components of the Department, each of which receives funding from the HCFAC Program. I will briefly

summarize the roles that different parts of the Department play in pursuing health care fraud matters.

Civil Division

The Department's Civil Division attorneys pursue civil remedies in health care fraud matters, using the False Claims Act, 31 U.S.C. §§ 3729-3733, as the primary statutory tool. The False Claims Act (FCA) prohibits knowingly submitting false or fraudulent claims for payment from the government, and knowingly making false records or statements to conceal or decrease an obligation to pay money to the government. The penalties under the FCA can be quite large because the law provides for treble damages plus additional penalties for each false claim filed.

In addition, lawsuits are often brought by private plaintiffs, known as "relators" or "whistleblowers," under the *qui tam* provisions of the FCA, and the government will intervene in appropriate cases to pursue the litigation and recovery against the provider or company. Under the False Claims Act, a relator must file his or her complaint under seal in a United States District Court, and serve a copy of the complaint upon the USAO for that judicial district, as well as the Attorney General. The Government must then decide whether the case warrants an intervention by the government to litigate the complaint.

Since the False Claims Act was substantially amended in 1986, the Civil Division, working with United States Attorney's Offices, has recovered $21.6 billion on behalf of the various victim federal agencies. Of that amount, $14.3 billion was the result of fraud against federal health care programs - primarily the Medicare program. Cases involving fraud committed by pharmaceutical and device manufacturers have resulted in total criminal and civil recoveries of more than $9.2 billion since 1999.

The Civil Division also pursues many of these cases as criminal violations of the Federal Food, Drug, and Cosmetic Act (FDCA). The Civil Division's Office of Consumer Litigation (OCL) is responsible for criminal and civil litigation and related matters arising under the FDCA and, together with the Food and Drug Administration's Office of Criminal Investigations and other agencies, is actively involved in investigating and prosecuting drug and device manufacturers and responsible individuals believed to be illegally promoting and distributing misbranded and adulterated drugs or devices. OCL works with many of the United States Attorney's Offices on these prosecutions.

For example, in January of this year, OCL and the U.S. Attorney's Office in the Eastern District of Pennsylvania prosecuted Eli Lilly and Co., which pled guilty to violating the FDCA for its illegal marketing of the anti-psychotic drug Zyprexa. Zyprexa was approved by the FDA for use in treating schizophrenia and certain aspects of bipolar disorder. Eli Lilly promoted Zyprexa for unapproved uses, including the treatment of, among other conditions, dementia, Alzheimer's dementia, agitation, and aggression, and specifically directed this effort through its long-term care sales force. That sales force targeted nursing homes and assisted living facilities, even though schizophrenia rarely occurs in the elderly. Eli Lilly sought to convince doctors to use Zyprexa to treat older patients for disorders which are prevalent in this population, despite the fact that the FDA had not approved Zyprexa for those conditions. Because the unapproved uses promoted by Eli Lilly were not medically accepted indications and, therefore, were not covered by State Medicaid programs, the company's conduct caused false claims to be submitted to Medicaid. The global settlement with Eli Lilly totaled $1.415 billion, which included a $515 million criminal fine, $100 million in forfeiture, and $800 million in civil recoveries under the False Claims Act.

In addition to these accomplishments, the Department's Elder Justice and Nursing Home Initiative, coordinated by the Civil Division, supports enhanced prosecution and coordination at federal, state, and local levels to fight abuse, neglect, and financial exploitation of the Nation's senior and infirm population. Through this Initiative, the Department also makes grants to promote prevention, detection, intervention, investigation, and prosecution of elder abuse and neglect, and to improve the scarce forensic knowledge in the field. The Department additionally pursues cases under the False Claims Act against skilled nursing homes and other long term care providers that provide services so substandard as to constitute worthless services and constitute a complete "failures of care."

The Civil Division also remains active in providing training and guidance in connection with pharmaceutical and device fraud matters. Given the nationwide scope of the defendants= conduct, as well as the complex legal and factual issues raised in these cases, the Civil Division plays a critical role in coordinating both investigative efforts and the legal positions taken by the Department and has coordinated extensive training for representatives of various federal and state enforcement and regulatory agencies..

United States Attorney's Offices

The 94 United States Attorney's Offices (USAOs) are the Nation's principal prosecutors of federal crimes, including health care fraud. The efforts of the USAOs are essential to preserving the financial integrity of our Nation's healthcare system and deterring fraud schemes that put our citizens in jeopardy. The USAOs pursue both civil and criminal cases and dedicate substantial resources to combating health care fraud. Each of the districts has a designated Criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator. Many

USAOs supplement the HCFAC program funding they receive by providing additional attorneys, paralegals, auditors, and investigators, as well as funds for litigation expenses for these resource-intensive cases.

In FY 2008, USAOs with the Department litigating components received 957 new criminal matters involving 1,641 defendants, and had 1,600 health care fraud criminal matters pending, involving 2,580 defendants. USAOs filed criminal charges in 502 cases involving 797 defendants, and obtained 588 federal health care related convictions. The USAOs also opened 849 new civil health care fraud matters and had 729 civil health care fraud matters and cases pending.[1] Let me highlight for you just two tremendous successes our USAOs had in FY 2008 in combating health care fraud. In the Eastern District of Pennsylvania, a settlement agreement was reached with the pharmaceutical manufacturer, Merck & Co., Inc. Under the agreement, Merck agreed to pay $399 million, and interest, to resolve civil liabilities for the Medicaid rebates that the company allegedly underpaid to the federal government, 49 states, and the District of Columbia for Zocor and Vioxx. The settlement resolved allegations that Merck paid certain inducements to doctors and other healthcare professionals through 2001 in connection with its various sales programs. In the Western District of Wisconsin, Thomas Arthur Lutz (Lutz), the former President and CEO of Health Visions Corporation (Health Visions) pleaded guilty to conspiracy to defraud TRICARE, the Department of Defense's worldwide health care program for active duty and retired uniformed services members and their families, and was sentenced to 5 years in prison. On behalf of Health Visions, Lutz entered into a kickback agreement with a medical provider in the Philippines, in which the provider paid 50 percent of

[1] These statistical data include cases that are shared with or handled by attorneys in other litigating components of the Department.

the amount of the bills for medical services rendered to TRICARE patients referred by Health Visions, back to Health Visions. The court ordered Lutz and the corporation to pay $99,915,131 in restitution. The court further ordered the corporation to liquidate its assets, pay a $500,000 fine and forfeit $910,910.60. USAOs receive referrals of health care fraud cases from a wide variety of sources, including the FBI, the HHS/OIG, state Medicaid Fraud Control Units, other federal, state, and local law enforcement agencies, and private insurers of medical services. The health care fraud coordinators often work with these partners in fighting health care fraud in local and regional task forces and working groups, and these also can be the basis of case referrals. Cases are also obtained by USAOs by means of *qui tam* complaints.

The Executive Office for United States Attorneys (EOUSA), through the Office of Legal Education (OLE), provides training for AUSAs and other Department attorneys, as well as paralegals, investigators, and auditors in the investigation and prosecution of health care fraud. OLE also sponsored the Health Care Fraud Coordinator's Conference for Civil and Criminal AUSAs, and Health Care Fraud for new AUSAs and Affirmative Civil Enforcement for Auditors, Investigators and Paralegals at the National Advocacy Center. Most recently, it sponsored a Health Care Fraud Trial Practice Seminar for more than 120 Department lawyers.

Criminal Division

The Criminal Division's Fraud Section develops and implements white collar crime policy, and supports the federal white collar crime enforcement community through litigation, coordination, policy, and legislative work. The Fraud Section is responsible for handling and coordinating complex health care fraud litigation nationwide. The Fraud Section also supports the USAOs with legal and investigative guidance and training, and, in certain instances, provides

trial attorneys to prosecute criminal health care fraud cases.

During FY 2008, the Fraud Section opened or filed 30 new health care fraud cases involving charges against 67 defendants; obtained 69 guilty pleas; and litigated seven jury trials, winning guilty verdicts against eight defendants on all counts charged. Prison sentences imposed in the Section's health care fraud cases during the year averaged more than 40 months, including two sentences that met or exceeded 120 months' imprisonment; and court-ordered restitution, forfeiture and fines that exceeded $240 million. Fraud Section attorneys staffed and coordinated most of the Division's health care fraud litigation through the Medicare Fraud Strike Force prosecution teams in the Southern District of Florida (Phase One) and in Central District of California (Phase Two).

In Phase Two of the Strike Force, Fraud Section attorneys, working with federal prosecutors from the U.S. Attorney's Office for the Central District of California, and FBI and HHS-OIG agents, executed six search warrants and charged eleven defendants in nine indictments involving more than $13 million in fraudulent claims to Medicare that were unsealed in May 2008, and arrested another 18 defendants who were charged with submitting more than $33 million in fraudulent claims to Medicare in eight indictments during a second coordinated arrest round up during September 2008.

Fraud Section attorneys also obtained a guilty plea in the Northern District of Ohio from a physician who defrauded Medicare, Medicaid, and other health care benefit programs by causing medically unnecessary cardiology tests to be administered to patients over an eight-year period, 1998-2006. According to the plea agreement, the physician forfeited approximately $1.9 million, surrendered his medical license, and was permanently excluded from participation in all federal health care programs. In another case, in the Southern District of California, an operator

of an unlawful Internet pharmacy pleaded guilty to conspiracy to distribute Schedule II controlled substances, including Oxycontin, Percocet, Endocet, and other prescription drugs, to customers without a prescription or a legitimate medical use. The defendant was not registered with the Drug Enforcement Administration to handle, import, distribute, or dispense controlled substances, and shipped the drugs from Southern California to customers throughout the United States. The defendant is awaiting sentencing.

In addition to health care fraud litigation, the Fraud Section also provided legal guidance to FBI and HHS agents, health program agency staff, AUSAs, and other Criminal Division attorneys on criminal, civil, and administrative tools to combat health care fraud; provided advice and written materials on patient medical record confidentiality and disclosure issues, and coordinated referrals of possible criminal HIPAA privacy violations from the HHS Office for Civil Rights; monitored and coordinated the Department responses to legislative proposals, major regulatory initiatives, and enforcement policy matters; reviewed and commented on health care provider requests to the HHS/OIG for advisory opinions, and consulted with the HHS/OIG on draft advisory opinions; worked with CMS to improve Medicare contractors' fraud detection, referrals to law enforcement for investigation, and case development work; and prepared and distributed to all USAOs and FBI field offices, state law enforcement, and private health plan fraud units, periodic summaries of recent and significant health care fraud cases

The Criminal Division's Organized Crime and Racketeering Section (OCRS) supports investigations and prosecutions of fraud and abuse targeting the 2.5 million private sector health plans sponsored by employers and/or unions, including schemes by corrupt unauthorized insurers that fraudulently entice sponsoring employers and/or unions to purchase what appears to be valid group health coverage only to discover much later that the payment of health claims will not be

made as promised. Such private sector group health plans are the leading source of health care coverage for individuals not covered by Medicare or Medicaid. OCRS also provides strategic coordination in the identification and prosecution of domestic and international organized crime groups engaged in sophisticated frauds posing a threat to the health care industry.

OCRS provides litigation support and guidance to AUSAs and criminal investigative agencies to combat corruption and abuse of employment based group health plans covered by the Employee Retirement Income Security Act [ERISA]. OCRS attorneys also provide health care fraud and abuse training and legal guidance to AUSAs and to criminal investigators and agents of the Department of Labor's Employee Benefits Security Administration and Office of Inspector General. The Section drafts and coordinates criminal legislative initiatives affecting employee health benefit plans and reviews and comments on legislative proposals affecting employee benefit plans.

One OCRS attorney is investigating and prosecuting health care frauds perpetrated by organized criminal groups and is working with the Los Angeles Medicare Fraud Strike Force. In addition, OCRS supports health care fraud prosecutions by Organized Crime Strike Force Units located within various United States Attorney's Offices. Under the International Organized Crime Initiative commenced in 2008, OCRS monitors trends in the targeting of health care by international organized criminal groups.

Civil Rights Division

The Civil Rights Division plays a critical role in the HCFAC Program. The Special Litigation Section of the Civil Rights Division is the sole Department component responsible for the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA). CRIPA authorizes

the investigation of conditions of confinement at state and local residential institutions (including facilities for persons with developmental disabilities or mental illness, and nursing homes) and initiation of civil action for injunctive relief to remedy a pattern or practice of violations of the Constitution or federal statutory rights. The review of conditions in facilities for persons who have mental illness, facilities for persons with developmental disabilities, and nursing homes comprises a significant portion of the program. The Special Litigation Section works collaboratively with the USAOs and HHS.

The Americans with Disabilities Act (ADA) provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court construed Title II of the ADA to require States to place individuals with disabilities in community settings, rather than institutions, wherever appropriate. Further, Executive Order 13217, "Community-Based Alternatives for Individuals with Disabilities," issued June 18, 2001, calls upon the federal government to assist states and localities to swiftly implement the decision of the United States Supreme Court in *Olmstead.* This Order emphasized that:

- unjustified isolation or segregation of institutionalized persons with disabilities is a form of prohibited discrimination,
- the United States is committed to community-based alternatives for individuals with disabilities, and

- the United States seeks to ensure that America's community-based programs for Americans with disabilities effectively foster independence and participation in the community.

In the context of persons residing in health care institutions operated by or on behalf of a government, the Division evaluates residential placements in each of its investigations under CRIPA, in light of the ADA's requirement that services be provided to residents in the most integrated setting appropriate to their needs. Through its CRIPA work, the Division seeks to eliminate the unjustified institutional isolation of persons with disabilities. The Division recognizes that unnecessary institutionalization is discrimination that diminishes individuals' ability to lead full and independent lives. By targeting Olmstead violations in its CRIPA program, the Civil Rights Division's CRIPA enforcement activities have enabled thousands of unnecessarily institutionalized individuals to live safely in the community with adequate supports and services.

For FY 08, the most recent full fiscal year, the Civil Rights Division commenced 19 investigations addressing compliance with the ADA, found that conditions and practices in 12 state facilities violated the ADA, entered into settlement agreements to correct identified ADA violations in two state facilities, continued investigations addressing compliance with the ADA in 12 state or city facilities, monitored compliance with agreements correcting identified ADA violations in 25 state or city facilities, and monitored the implementation of agreements regarding community placement in three jurisdictions following the closure of facilities.

As part of Department's Institutional Health Care Abuse and Neglect Initiative, and as an enhancement to ongoing CRIPA enforcement efforts, the Special Litigation Section staff conducted preliminary reviews of conditions and services at 48 health care facilities in 25 states,

the District of Columbia, and the Commonwealth of Puerto Rico during Fiscal Year 2008. The task in preliminary inquiries is to determine whether there is sufficient information supporting allegations of unlawful conditions to warrant formal investigation under CRIPA. The section reviews information pertaining to areas such as abuse and neglect, medical and mental health care, use of restraints, fire and environmental safety, and placement in the most integrated setting appropriate to individual needs. Separately, in Fiscal Year 2008, the Section opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 67 health care facilities in 23 states, the District of Columbia, the Territory of Guam, and the Commonwealth of Puerto Rico.

In Fiscal Year 2008, the Section commenced investigations of three state-operated facilities for persons with mental illness, 14 state facilities for persons with intellectual and developmental disabilities, and two state veterans nursing homes. The facilities are: Delaware State Psychiatric Hospital, in Newcastle, Delaware; Kings County Hospital Center, in Brooklyn, New York; Ancora Psychiatric Hospital, in Winslow, New Jersey; Denton State School, in Denton, Texas; Abilene State School, in Abilene, Texas; Austin State School in Austin, Texas; Brenham State School, in Brenham, Texas; Corpus Christi State School, in Corpus Christi, Texas; El Paso State Center, in El Paso, Texas; Lufkin State School, in Lufkin, Texas; Mexia State School, in Mexia, Texas; Richmond State School, in Richmond, Texas; Rio Grande State Center, in Harlingen, Texas; San Angelo State School, in Carlsbad, Texas; San Antonio State School, in San Antonio, Texas; Rosewood Center, in Owings Mills, Maryland; Central Virginia Training Center, in Lynchburg, Virginia; William F. Green State Veterans Home, in Bay Minette, Alabama; and Minnesota Veterans Home, in Minneapolis, Minnesota.

The Section found that conditions and practices at eight state facilities for persons with mental illness, two state facilities for persons with intellectual and developmental disabilities, and three nursing homes violate the residents' federal constitutional and statutory rights. Those facilities are: Georgia Regional Hospital, in Atlanta, Georgia; Georgia Regional Hospital, in Savannah, Georgia; Northwest Georgia Regional Hospital, in Rome, Georgia; Central State Hospital, in Milledgeville, Georgia; Southwest State Hospital, in Thomasville, Georgia; West Central Georgia Regional Hospital, in Columbus, Georgia; East Central Georgia Regional Hospital, in Augusta, Georgia; Oregon State Hospital, in Salem, Oregon; Beatrice State Developmental Center, in Beatrice, Nebraska; Northwest Habilitation Center, in St. Louis, Missouri; Tennessee State Veterans Homes, in Murfreesboro and Humboldt, Tennessee; and C.M. Tucker Nursing Care Facility, in Columbia, South Carolina.

The Section entered settlement agreements to resolve its investigations of one state-operated facility for persons with intellectual and developmental disabilities, and one state-operated nursing home. Those facilities are: Beatrice State Developmental Center, in Beatrice, Nebraska, and Laguna Honda Hospital and Rehabilitation Center, in San Francisco, California.

The Section continued its investigations of residential facilities for persons with developmental disabilities: Agnews Developmental Center, in San Jose, California; Sonoma Developmental Center, in Eldridge, California; Lanterman Developmental Center, in Pomona, California; Rainier Residential Rehabilitation Center, in Buckley, Washington; Frances Haddon Morgan Center, in Bremerton, Washington; Conway Human Development Center, in Conway, Arkansas; Lubbock State School, in Lubbock, Texas; Bellefontaine Developmental Center, in St. Louis, Missouri; Clyde L. Choate Developmental Center, in Anna, Illinois; and Howe Developmental Center, in Tinley Park, Illinois. The Division also continued its investigation of

Oregon State Hospital, in Salem, Oregon, a facility for persons with mental illness. In addition, the Section continued its investigations of three publicly-operated nursing homes: Charlotte Hall State Veterans Home, in Charlotte Hall, Maryland; the Laguna Honda Hospital and Rehabilitation Center, in San Francisco, California; and C.M. Tucker Nursing Care Center, in Columbia, South Carolina. In some of these matters, the Section is reviewing voluntary compliance to improve conditions.

The Section monitored the implementation of remedial agreements for 11 facilities for persons with developmental disabilities: Fort Wayne State Developmental Center, in Fort Wayne, Indiana; Clover Bottom Developmental Center, in Nashville, Tennessee; Greene Valley Developmental Center, in Greeneville, Tennessee; Harold Jordan Center, in Nashville, Tennessee; Arlington Developmental Center, in Arlington, Tennessee; New Lisbon Developmental Center, in New Lisbon, New Jersey; Southbury Training School, in Southbury, Connecticut; Woodward Resource Center, in Woodward, Iowa; Glenwood Resource Center, in Glenwood, Iowa; Woodbridge Developmental Center in Woodbridge, New Jersey; and Oakwood Community Center in Somerset, Kentucky. It also monitored the implementation of remedial agreements regarding community placements from facilities for persons with developmental disabilities in Indiana, Puerto Rico, and Washington, D.C.

The Section monitored the implementation of remedial agreements for four nursing homes: Reginald P. White Nursing Facility, in Meridian, Mississippi; Mercer County Geriatric Center, in Trenton, New Jersey; A. Holly Patterson Extended Care Facility in Uniondale, New York; and Ft. Bayard Medical Center and Nursing Home, in Ft. Bayard, New Mexico. The Section also monitored the implementation of remedial agreements regarding 11 state-operated residential facilities for persons with mental illness: Guam Mental Health Unit in the Territory

of Guam; Vermont State Hospital, in Waterbury, Vermont; Dorothea Dix Hospital, in Raleigh, North Carolina; Broughton Hospital, in Morganton, North Carolina; Cherry Hospital, in Goldsboro, North Carolina; John Umstead Hospital, in Butler, North Carolina; Metropolitan State Hospital, in Norwalk, California; Napa State Hospital in Napa, California; Atascadero State Hospital, in Atascadero, California; Patton State Hospital, in Patton, California; and St. Elizabeths Hospital, Washington, D.C.

Finally, the Section monitored the implementation of a remedial agreement regarding one residential facility for children with visual disabilities: New Mexico School for the Visually Handicapped, in Alamogordo, New Mexico.

CONCLUSION

I hope my testimony has given you a comprehensive view of the Department's essential role in prosecuting and deterring fraud on the Medicare and Medicaid programs, restoring funds illegally stolen from the trust funds, and protecting our citizens from those health care fraud schemes which have caused physical harm and loss of life. The Department is committed to the ongoing success of the HCFAC program and will continue to marshal its resources, including those provided by the HCFAC program and its own discretionary funds, to ensure that federal health care dollars are properly expended. To that end, we will prosecute fraud and abuse in the Medicare and Medicaid programs and restore the recovered proceeds to these programs. The HCFAC program pays for itself many times over and helps ensure the safety and availability of medical services to all beneficiaries. With additional resources we could do even more.

Senator MARTINEZ. Thank you very much, sir. I appreciate that very clear testimony.

Mr. Levinson.

STATEMENT OF DANIEL R. LEVINSON, INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. LEVINSON. Mr. Chairman Kohl, Ranking Member Martinez, and Senator Graham, thank you and good afternoon.

This is a great opportunity for us to discuss the Office of Inspector General's experience in fighting fraud, waste, and abuse in the Medicare and Medicaid programs and OIG's strategy and recommendations for ensuring the integrity of these vital health care programs.

The Office of Inspector General is committed to promoting the efficiency and effectiveness of the Medicare and Medicaid programs and protecting these programs and their beneficiaries from fraud and abuse. Our work demonstrates that for Medicare and Medicaid to serve the needs of beneficiaries and remain solvent for future generations, the Government must pursue a comprehensive strategy to combat waste, fraud, and abuse. Based on our audit, evaluation, investigative, enforcement, and compliance work, we have identified the following five principles of an effective health care integrity strategy.

First, scrutinize those who want to participate as providers and suppliers prior to their enrollment in the Federal health care programs. A lack of effective enrollment screening gives dishonest and unethical individuals access to a system that they can easily exploit. As my written testimony describes in more detail, criminals too easily enroll in Medicare and steal millions before detection. Medicare and Medicaid provider enrollment standards and screening should be strengthened. Heightened screening measures for high-risk items and services could include requiring providers to meet accreditation standards, requiring proof of business integrity or surety bonds, periodic recertification and on-site verification that conditions of participation have been met, and full disclosure of ownership and control interests.

Second, establish payment methodologies that are reasonable and responsive to changes in the marketplace. Our office has conducted extensive reviews of payment and pricing methodologies and has determined that the programs pay too much for certain items and services. When pricing policies are not aligned with the marketplace, the programs and their beneficiaries bear the additional costs. In addition to wasting health care dollars, these excessive payments are a lucrative target for unethical and dishonest individuals. These criminals can reinvest some of their profit in kickbacks, thus using the programs' funds to perpetuate fraud schemes. Medicare and Medicaid payments should be sufficient to ensure access to care without wasteful overspending. Payment methodologies should also be responsive to changes in the marketplace, medical practice, and technologies. Although CMS has the authority to make certain adjustments to fee schedules and other payment methodologies, some changes require congressional action.

Third, assist health care providers in adopting practices that promote compliance with program requirements. Health care providers can be our partners in ensuring the integrity of our health care programs by adopting measures that promote compliance with program requirements. Although compliance programs alone will not solve the problem, they are an important component of a comprehensive strategy to curb waste, fraud, and abuse in the health care system. The importance of health care compliance programs is well recognized. Over 90 percent of hospitals have integrated compliance measures into their systems. New York requires providers and suppliers to implement an effective compliance program as defined by our office as a condition of participation in its Medicaid program. Medicare Part D prescription drug plan sponsors are also required to have compliance plans. Accordingly, we recommend that providers and suppliers should be required to adopt compliance programs as a condition of participating in the Medicare and Medicaid programs.

Fourth, vigilantly monitor the programs for evidence of fraud, waste, and abuse. The health care system compiles an enormous amount of data on patients, providers, and the delivery of health care items and services. However, Federal health care programs often fail to use claims-processing edits and other information technology effectively to identify improper claims before they are paid and to uncover fraud schemes. For example, Medicare should not pay a clinic for HIV infusion when the beneficiary has not been diagnosed with the illness, pay twice for the same service, or routinely process claims that rely on the provider identifiers of deceased physicians. Better collection, monitoring, and coordination of data would allow Medicare and Medicaid to detect these problems earlier and avoid making improper payments. Moreover, this would enhance the Government's ability to detect fraud schemes more quickly.

In addition to improving the programs' data systems, it is critical that law enforcement have real-time access to all relevant data. Currently, we receive data weeks or months after claims have been filed, making it far more difficult to detect and thwart new scams.

We also recommend the consolidation and expansion of the various adverse action databases. Providing a centralized, comprehensive public database of sanctions taken against individuals and entities would strengthen program integrity.

Last, respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities. Health care fraud attracts criminals because the penalties are lower than those for other criminal offenses. There are low barriers to entry. Schemes are easily replicated. There is a perception of a low risk of detection. We need to alter the criminal's cost-benefit analysis by increasing the risk of swift detection and the certainty of punishment.

As part of this strategy, law enforcement must accelerate the response to fraud schemes. Although resource-intensive the anti-strike force, as detailed by Mr. Acosta, it is a powerful tool and represents a tremendous return on the investment.

In conclusion, our office and its law enforcement partners are implementing a comprehensive strategy to combat waste, fraud, and

abuse in Federal health care programs. But sophisticated fraud schemes increasingly rely on falsified records, elaborate business structures, and the participation of health care providers, suppliers, and even beneficiaries to create the false impression that the Government is paying for legitimate health care services. In addition, improper payments and misaligned reimbursement rates waste scarce health care resources. The principles that I have described provide the framework to identify new ways to protect the integrity of the programs, meet the needs of the beneficiaries, and keep Federal health care programs solvent for future generations.

Thank you and I will welcome your questions later.

[The prepared statement of Mr. Levinson follows:]

Testimony of:
Daniel R. Levinson
Inspector General
Office of Inspector General, U.S. Department of Health and Human Services

COMBATING FRAUD, WASTE, AND ABUSE IN MEDICARE AND MEDICAID

Good afternoon Chairman Kohl, Ranking Member Martinez, and distinguished Members of the Senate Special Committee on Aging. I am Daniel Levinson, Inspector General of the U.S. Department of Health and Human Services (HHS). I thank you for the opportunity to discuss the Office of Inspector General's (OIG) experience in fighting fraud, waste, and abuse in the Medicare and Medicaid programs and OIG's strategy and recommendations for ensuring the integrity of these vital health care programs.

OIG's Role and Partners in Protecting the Integrity of Medicare and Medicaid

OIG is an independent, nonpartisan agency committed to protecting the integrity of the more than 300 programs administered by HHS. Approximately 80 percent of OIG's resources are dedicated to promoting the efficiency and effectiveness of the Medicare and Medicaid programs and protecting these programs and their beneficiaries from fraud and abuse. Thanks to the hard work of our 1,500 employees and our law enforcement partners, from FY 2006 through FY 2008, OIG's investigative receivables averaged $2.04 billion and its audit disallowances resulting from Medicare and Medicaid oversight averaged $1.22 billion per year. The result was a Medicare- and Medicaid-specific return on investment for OIG oversight of $17 to $1. In addition, in FY 2008, implemented OIG recommendations resulted in $16.72 billion in savings and funds put to better use.

OIG is not alone in the fight to combat fraud and preserve the integrity of Federal health care programs. We work closely with the Department of Justice (DOJ) and our State law enforcement partners, as well as with our colleagues in the Centers for Medicare & Medicaid Services (CMS) and the Food and Drug Administration. The Government's enforcement efforts in FY 2008 resulted in 455 criminal actions against individuals or entities that engaged in crimes against departmental programs and 337 civil and administrative actions, which included False Claims Act and unjust enrichment lawsuits filed in Federal district court, Civil Monetary Penalties Law settlements, and administrative recoveries related to provider self-disclosure matters. Also in FY 2008, OIG excluded 3,129 individuals and entities for fraud or abuse that affected Federal health care programs and/or our beneficiaries. Common reasons for exclusion included convictions for crimes concerning Medicare or Medicaid, patient abuse or neglect, and license revocation.

The collaborative antifraud efforts of HHS and DOJ are rooted in the Health Insurance Portability and Accountability Act of 1996, P. L. 104-191 (HIPAA), which directed the Secretary of HHS, acting through OIG and the Attorney General, to promulgate a joint Health Care Fraud and Abuse Control (HCFAC) Program. The HCFAC Program and Guidelines went into effect on January 1, 1997. HIPAA requires HHS and DOJ to report annually to Congress on

HCFAC Program results and accomplishments. HCFAC Program activities are supported by a dedicated funding stream within the Hospital Insurance Trust Fund.

In its 11th year of operation, the HCFAC Program's continued success confirms the soundness of a collaborative approach to identify and prosecute health care fraud, to prevent future fraud and abuse, and to protect Medicare and Medicaid beneficiaries. Since its inception, HCFAC Program activities have returned over $11.2 billion to the Medicare Trust Fund. As I will discuss, the Government's efforts to address durable medical equipment (DME) and infusion fraud in South Florida exemplify the benefits of a collaborative approach. Although I will highlight efforts focused on DME and infusion fraud in a particular geographic "hot spot," fraud, waste, and abuse occur among all types of health care providers and suppliers and can affect all types of services covered by Medicare and Medicaid in all geographic areas. Although the vast majority of health care providers and suppliers are well-intended, even a small percentage of providers and suppliers intent on defrauding the programs can have significant detrimental effects.

Fraud, Waste, and Abuse Vulnerabilities

The United States spends more than $2 trillion on health care every year. The National Health Care Anti-Fraud Association estimates conservatively that at least 3 percent—or more than $60 billion each year—is lost to fraud. Although it is not possible to measure precisely the extent of fraud in Medicare and Medicaid, everywhere it looks OIG continues to find fraud against these programs. In addition to the enforcement actions cited above, OIG opened 1,750 new health care fraud investigations in FY 2008.

OIG also identifies vulnerabilities that put the programs or beneficiaries at risk of fraud and abuse. For example, in a series of reviews, OIG identified strategies that DME suppliers had used to circumvent billing controls and potentially defraud the program. Medicare regulations require DME suppliers to provide the Medicare provider identifier of the physician who ordered the equipment on the supplier's claim. Previously, Medicare used unique physician identification numbers (UPIN), and as of May 2008, transitioned to using national provider identifiers (NPI) to identify providers enrolled in Medicare. Requiring the ordering physician's UPIN (or NPI) on medical equipment claims is intended to indicate that a physician has verified the need for the DME and to enable CMS to determine who prescribed the DME during any post-payment reviews. OIG studies have uncovered: (1) the use of invalid or inactive UPINs, (2) the use of UPINs that belonged to deceased physicians, (3) the improper use of surrogate UPINs, and (4) the use of legitimate UPINs that were associated with an unusually large number of claims. The vulnerabilities that affected UPINs, as well as other challenges, may affect the integrity of the new NPI system. OIG has planned additional work to examine the accuracy and completeness of NPIs.

OIG has identified certain types of DME that are particularly vulnerable to billing abuses. For example, an investigation of a large wheelchair supplier found that the company had submitted false claims to Medicare and Medicaid, including claims for power wheelchairs that beneficiaries did not want, did not need, or could not use. In 2007, the company agreed to pay $4 million and relinquish its right to approximately $13 million in claims initially denied for payment by CMS.

Nationally, in 2004, OIG estimated that Medicare and its beneficiaries paid $96 million for claims that did not meet Medicare's coverage criteria for any type of wheelchair or scooter and that they overspent an additional $82 million for claims that could have been billed using a code for a less expensive mobility device.

Funds improperly paid and excessive reimbursements for certain items and services deplete needed resources from the health care system. CMS has made progress in addressing improper payments; however, billions of dollars are still paid for services that were not properly documented or medically necessary. CMS reports that the improper payments rate for Medicare fee-for-service payments was 3.6 percent, or $10.4 billion in 2008.

OIG reviews have identified Medicare payments for unallowable services, improper coding, and other types of improper payments for various inpatient and outpatient services. Improper payments range from reimbursement for services not adequately documented and inadvertent mistakes to payments that result from outright fraud and abuse. Expenditures for inpatient services, including those provided by inpatient hospitals and skilled nursing facilities, account for one-third of all Medicare expenditures. OIG work has uncovered problems with hospitals taking advantage of enhanced payments by manipulating billing; hospitals reporting inaccurate wage data, which affects future Medicare payments; and inpatient facilities that may be gaming prospective payment reimbursement systems by discharging or transferring patients to other facilities for financial rather than clinical reasons.

OIG also continues to identify vulnerabilities related to certain types of services provided by physicians and other health professionals, including services related to advanced imaging, pain management, and mental health. For example, OIG found that from 1995 to 2005, expenditures for advanced imaging paid under the Medicare Physician Fee Schedule grew more than fourfold, from $1.4 million to $6.2 million. Services provided by independent diagnostic testing facilities (IDTF) accounted for nearly 30 percent of this growth. OIG work has found problems with IDTFs, including noncompliance with Medicare requirements and billing for services that were not reasonable and necessary.

Medicaid services that OIG has found to be particularly vulnerable to inappropriate payments include school-based health services and case management services. For example, in 2006, OIG found that a State Medicaid agency claimed Federal Medicaid funding totaling $86 million for unallowable targeted case management services. In a series of reviews in several States, OIG consistently found that schools had not adequately supported their Medicaid claims for school-based health services and identified almost a billion dollars in improper Medicaid payments.

In addition, OIG has identified reimbursement rates for certain items and services that are too high, resulting in waste and opportunities for fraud and abuse. For example, in 2006, OIG reported that Medicare had allowed, on average, $7,215 for the rental of an oxygen concentrator that costs about $600 to purchase new. Additionally, beneficiaries incurred, on average, $1,443 in coinsurance charges. We determined that if home oxygen payments were limited to 13 months rather than the current 36 months, Medicare and its beneficiaries would save $3.2 billion over 5 years.

In March 2009, OIG reported that Medicare reimbursed suppliers for negative pressure wound therapy pumps based on a purchase price of more than $17,000, but that suppliers paid, on average, approximately $3,600 for new models of these pumps. Negative pressure wound therapy pumps are a type of DME used to treat ulcers and other serious wounds. When Medicare first started covering wound pumps in 2001, it covered only one model, which was manufactured and supplied by one company. Medicare paid for this pump based on the purchase price as identified by that company. In 2005, Medicare expanded its coverage to include several new pump models manufactured by other companies. However, Medicare reimburses suppliers for these new pumps based on the original pump's purchase price, which is more than four times the average price paid by suppliers.

Reimbursement issues are not limited to payments for DME. For example, OIG estimated that in 2005, Medicare paid $97.6 million for evaluation and management (E&M) services that were included in global fees for eye surgery but not provided during the global surgery periods. Medicare pays global surgery fees that cover the surgical service and the related pre- and post-operative E&M services. These global fees are based in part on CMS's estimates of the number of pre- and post-operative E&M services typically provided. The global surgery fees did not reflect the number of E&M services provided to beneficiaries because CMS had not recently adjusted its estimates for most of the surgeries included in our review. For some of these global surgery codes, CMS has not updated its estimates of the resources involved with furnishing the service in more than 15 years.

Medicare Fraud and Abuse in South Florida

OIG and our law enforcement partners are focusing antifraud efforts in geographic areas at high risk for Medicare fraud, including South Florida. In 2007, the Government launched in South Florida a Medicare Fraud Strike Force (Strike Force) made up of staff from OIG, the U.S. Attorney's Office for the Southern District of Florida, the Federal Bureau of Investigation, and DOJ. The Strike Force's mission is to identify, investigate, and prosecute DME suppliers and infusion clinics suspected of Medicare fraud. As of April 17, 2009, the Strike Force has convicted 146 of its targets and secured $186 million in criminal fines and civil recoveries.

The recent investigation and prosecution of Medcore Group LLC (Medcore) and M&P Group of South Florida (M&P) illustrate some of the Medicare program's vulnerabilities. Medcore and M&P operated as Miami-based HIV clinics from approximately 2004 through 2006, billed approximately $5.3 million to the Medicare program, and received payments of more $2.5 million. From their inception, Medcore and M&P were set up as criminal enterprises designed to defraud Medicare. The scheme was to submit claims for medically unnecessary HIV infusion and injection treatments. The three owners of Medcore and M&P included a former gas station attendant, a trained cosmetologist, and an individual currently incarcerated for Medicare fraud involving a separate DME company he operated from 2001 to 2003. None had a medical background.

At trial, one of Medcore's owners, Tony Marrero, testified that the scheme was so profitable so quickly that he became concerned about getting caught and decided to set up a second fraudulent clinic, M&P, in the name of his wife. M&P was located in the same building as Medcore, had

the same employees, submitted claims under the Medicare provider number of the same physician, and submitted claims on behalf of six of the same patients. In fact, the same physician was associated with other Miami-area infusion clinics, which billed Medicare for more than $60 million between 2004 and the end of 2005.

Mr. Marerro also testified at trial that he had an arrangement with a pharmaceutical wholesale company to buy invoices that showed the purchase of large amounts of medications, when only small amounts were actually purchased. One of the medical assistants testified that she manipulated the patients' blood samples to ensure that lab results would appear to support the Medicare claims.

Like many infusion fraud schemes, Medcore and M&P gained the cooperation of patients by giving them kickbacks of up to $200 per visit. Four patients testified that they took kickbacks and never received any medication at the clinics. One patient testified that he used his payments from the clinics to support his cocaine addiction. Another patient testified that he did not have HIV, even though the clinics' documents showed he was being infused with medication to treat HIV. By the patients' own admission, they had been receiving kickbacks from numerous Miami clinics for many years.

On March 17, 2009, a Federal jury in Miami convicted two physicians and two medical assistants who worked for Medcore and M&P in connection with the fraud scheme. The Government obtained 6 pleas before trial, resulting in 10 convictions in total.

OIG's fraud-fighting efforts in South Florida also draw on the expertise of our auditors and evaluators. For example, OIG identified weaknesses in Medicare's supplier enrollment process and its supplier oversight activities. In 2006, OIG conducted unannounced site visits to 1,581 DME suppliers in South Florida and found that 31 percent did not maintain physical facilities or were not open and staffed during business hours, contrary to Medicare requirements.

OIG's analysis of Medicare billing patterns in South Florida for inhalation drugs used with DME has uncovered evidence of abusive billing. Despite CMS's efforts to address inappropriate payments, problems persist. For example, Medicare paid almost $143 million for inhalation drugs in Miami-Dade County alone—an amount 20 times greater than the amount paid in Cook County, Illinois, the county (outside South Florida) with the next highest total payments. However, according to Medicare enrollment data, Cook County is home to almost twice as many Medicare beneficiaries as Miami-Dade County. Medicare's average per-beneficiary spending on inhalation drugs was five times higher in South Florida than in the rest of the country. Further, 75 percent of South Florida beneficiaries who received a particular inhalation drug, budesonide, had Medicare-paid claims that exceeded Medicare utilization guidelines, compared to 14 percent of beneficiaries in the rest of the country. For 62 percent of South Florida inhalation drug claims, the beneficiaries on these claims did not have a Medicare-billed office visit or other service in the past 3 years with the physician who reportedly prescribed the drug. Finally, 10 South Florida physicians were each listed as the ordering physician on more than $3.3 million in submitted inhalation drug claims in 2007, or an average of $12,000 per day. We have shared with our Office of Investigations and CMS information on providers with aberrant billing patterns for further review and followup.

Similarly, OIG found that CMS has had limited success controlling aberrant billing by infusion clinics. In the second half of 2006, claims originating in three South Florida counties accounted for 79 percent of the amount submitted to Medicare nationally for drug claims involving HIV/AIDS patients and constituted 37 percent of the total amount Medicare paid for services for beneficiaries with HIV/AIDS. However, only 10 percent of Medicare beneficiaries with HIV/AIDS lived in these three counties.

OIG's Five-Principle Strategy to Combat Health Care Fraud, Waste, and Abuse

For Federal health care programs to serve the medical needs of beneficiaries and remain solvent for future generations, the Government must pursue an effective and comprehensive strategy to combat fraud, waste, and abuse. Based on OIG's audit, evaluation, investigative, enforcement, and compliance work and experience, we have identified the following five principles of an effective health care integrity strategy.

1. Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.

2. Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

3. Assist health care providers and suppliers in adopting practices that promote compliance with program requirements, including quality and safety standards.

4. Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

5. Respond swiftly to detected frauds, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

These principles provide a useful framework for designing and implementing program benefits and integrity safeguards. When OIG provides CMS with the results of its audits, evaluations, and investigations, these principles are reflected in OIG's programmatic recommendations and suggested corrective actions. Based on these principles, we offer the following recommendations to strengthen the integrity of Federal health care programs.

1. Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in health care programs.

As the Medcore and M&P case demonstrates, a lack of effective screening measures gives dishonest and unethical individuals access to a system they can easily exploit. Even after Medcore had billed Medicare for $4 million in fraudulent claims, it was easy for the clinic's owner to obtain a provider number in his wife's name for a second clinic, M&P, operating in the same building as Medcore, with the same medical director, employees, and patients. When one of the owners, Mr. Marrero, ultimately sold M&P for $100,000 in cash, he testified that he went to a lawyer's office so the lawyer could fill out paperwork to put ownership of the clinic in the

name of two nominee owners. The sale was structured as a stock sale so that the new "owners" would have 90 days to notify Medicare of the change in ownership, allowing a window of time for the fraud to continue under new "ownership." In our experience, it is too easy for unscrupulous individuals to recruit nominee owners of fraudulent companies.

Medicare and Medicaid provider enrollment standards and screening should be strengthened, making participation in Federal health care programs as a provider or supplier a privilege, not a right. It is more efficient and effective to protect the programs and beneficiaries from unqualified, fraudulent, or abusive providers and suppliers upfront than to try to recover payments or redress fraud or abuse after it occurs. Greater transparency in the enrollment process will help the Government know with whom it is doing business. Providers and suppliers applying for enrollment in Medicare or Medicaid should be screened before they are granted billing privileges. Heightened screening measures for high-risk items and services could include requiring providers to meet accreditation standards, requiring proof of business integrity or surety bonds, periodic recertification and onsite verification that conditions of participation have been met, and full disclosure of ownership and control interests. The cost of this screening could be covered by charging application fees. New providers and suppliers should also be subject to a provisional period during which they are subject to enhanced oversight, such as prepayment review and payment caps.

2. Establish payment methodologies that are reasonable and responsive to changes in the marketplace.

OIG has conducted extensive reviews of Medicare and Medicaid payment methodologies and has determined that the programs pay too much for certain items and services. As OIG's reviews of home oxygen equipment and wound therapy pump payments demonstrated, when reimbursement methodologies do not respond effectively to changes in the marketplace, the program and its beneficiaries bear the cost. As the experience of South Florida illustrates, excessive payments are also a lucrative target for criminals. These criminals can reinvest some of their profit in kickbacks for additional referrals, thus using the program's funds to perpetuate the fraud scheme.

We support efforts to pay appropriately for the items and services covered by Federal health care programs. Medicare and Medicaid payments should be sufficient to ensure access to care without wasteful overspending. Payment methodologies should also be responsive to changes in the marketplace, medical practice, and technology. Although CMS has the authority to make certain adjustments to fee schedules and other payment methodologies, for some changes, congressional action is needed.

3. Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.

Health care providers and suppliers must be our partners in ensuring the integrity of Federal health care programs and should adopt internal controls and other measures that promote compliance and help prevent, detect, and respond to health care fraud, waste, and abuse. To this end, OIG has published on its webpage extensive resources to assist industry stakeholders in

understanding the fraud and abuse laws and designing and implementing effective compliance programs. These resources include sector-specific Compliance Program Guidance that describes the elements of an effective compliance program and identifies risk areas; advisory opinions; and fraud alerts and bulletins.

In many sectors of the health care industry, such as hospitals, compliance programs are widespread and often very sophisticated; other sectors have been slower to adopt internal compliance practices. Compliance programs not only benefit the Federal health care programs; they also benefit industry stakeholders by improving their business practices, by fostering early detection and correction of emerging problems, and by reducing the risk that they will become the subject of a whistleblower complaint or fraud prosecution.

States also have begun to recognize the value of compliance systems. For example, New York now requires providers and suppliers to implement an effective compliance program as a condition of participation in its Medicaid program. Medicare Part D also requires that prescription drug plan sponsors have compliance plans that address eight required elements.

Although compliance programs do not guarantee reduced fraud and abuse, they are an important component of a comprehensive government-industry partnership to promote program integrity. We recommend that providers and suppliers should be required to adopt compliance programs as a condition of participating in the Medicare and Medicaid programs. OIG has gained extensive experience with compliance programs through its industry guidance initiatives described above and through the negotiation and monitoring of corporate integrity agreements with providers and suppliers that have entered into settlements to resolve civil and administrative Federal health care program investigations. CMS should consult with OIG on the standards for mandatory compliance programs.

4. Vigilantly monitor the programs for evidence of fraud, waste, and abuse.

The health care system compiles an enormous amount of data on patients, providers, and the delivery of health care items and services. However, Federal health care programs often fail to use claims-processing edits and other information technology effectively to identify improper claims before they are paid and to uncover fraud schemes. For example, Medicare should not pay a clinic for HIV infusion when the beneficiary has not been diagnosed with the illness, pay twice for the same service, or routinely process claims that rely on the provider identifiers of deceased physicians. Better collection, monitoring, and coordination of data would allow Medicare and Medicaid to detect these problems earlier and avoid making improper payments. Moreover, more effective use of data would enhance the government's ability to detect fraud schemes – such as the South Florida DME and inhalation drug schemes – more quickly.

CMS is taking significant steps to enhance the data available to monitor payment accuracy and internal controls. For example, CMS is working to develop a centralized data repository as part of its One Program Integrity System Integrator (One PI), which would warehouse data on Medicare Parts A, B, and D and on Medicaid. However, the target implementation date for One PI has been delayed, and it is not clear when the system will be complete and operable. In addition, national Medicaid claims data are limited in their capacity to support program integrity

and oversight activities. Limitations include the following: some essential data elements, such as provider identification information, are not captured; data are updated quarterly, limiting the ability to analyze national data in real time; and CMS's process for collecting and validating the States' Medicaid data files can take as long as 2 years, making the final data outdated for certain program integrity activities. CMS is working to expand the Medicaid data elements that it captures.

In addition to structural improvements to the data systems, real-time access to all relevant Medicare and Medicaid data by law enforcement is critical to the success of the antifraud effort. Currently, law enforcement receives data weeks or months after claims have been filed, making it more difficult to detect and thwart new scams. It is essential that law enforcement have real-time access to Medicare and Medicaid program data. In addition, we recommend that Congress authorize OIG to streamline the process for matching Medicare data to other relevant databases, such as Medicaid data obtained from States and data from the Social Security Administration. We also recommend the consolidation and expansion of the various provider databases, including the Health Care Integrity and Protection Data Bank, the National Practitioner Data Bank, and OIG's List of Excluded Individuals/Entities. Providing a centralized, comprehensive, and public database of adverse actions and other sanctions imposed on individuals and entities would be an effective means of preventing providers and suppliers with problem backgrounds from moving from State to State unnoticed by licensing, government, and health plan officials.

5. Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

Our investigations have found evidence of an increase in organized crime in health care. Health care fraud is attractive to organized crime because the penalties are lower than those for other organized-crime-related offenses (e.g., offenses related to illegal drugs); there are low barriers to entry (e.g., a criminal can easily obtain a supplier number, gather some beneficiary numbers, and bill the program); schemes are easily replicated; and there is a perception of a low risk of detection. We need to alter the cost-benefit analysis by increasing the risk of swift detection and the certainty of punishment.

As part of this strategy, law enforcement must accelerate the Government's response to fraud schemes. The Government's Strike Force model has proved highly successful. In addition to prosecuting criminals and recovering funds for the Medicare Trust Fund, the South Florida Strike Force has had a powerful sentinel effect. Medicare claims data show that during the first 12 months of the Strike Force (March 1, 2007, to February 29, 2008), claim amounts submitted for DME decreased by 63 percent to just over $1 billion from nearly $2.76 billion during the preceding 12 months.

Although resource intensive, the strike force is a powerful antifraud tool and represents a tremendous return on the investment. Building on the success of the South Florida Strike Force, in March 2008, DOJ and OIG created a second Strike Force in Los Angeles. Since operations began, the Strike Force has opened 46 cases and is targeting individuals and organizations that collectively have submitted more than $33 million in fraudulent claims to the Medicare program.

The schemes include false claims for wheelchairs, orthotics, and other DME that was medically unnecessary and/or was not provided to the beneficiaries identified in claims.

OIG uses a range of administrative sanctions, including civil money penalties (CMP) and program exclusions, as an adjunct to criminal and civil enforcement. OIG has identified a number of enhancements to these administrative authorities that, if mandated by Congress, would increase our ability to address emerging schemes, such as authorizing CMPs for the intentional submission of erroneous data used to set Medicare payment and a CMP for the ordering or prescribing of items or services by an excluded person.

Conclusion

OIG and its law enforcement partners are implementing a comprehensive strategy to combat fraud, waste, and abuse in Federal health care programs. However, sophisticated health care fraud schemes increasingly rely on falsified records, elaborate business structures, and the participation of health care providers, suppliers, and even beneficiaries to create the false impression that the Government is paying for legitimate health care services. In addition, improper payments and misaligned reimbursement rates waste scarce health care resources. The principles described above provide the framework to identify new ways to protect the integrity of the programs, meet needs of beneficiaries, and keep Federal health care programs solvent for future generations.

Senator MARTINEZ. Thank you, Mr. Levinson.
Mr. Frogue.

STATEMENT OF JAMES FROGUE, STATE PROJECT DIRECTOR, CENTER FOR HEALTH TRANSFORMATION, WASHINGTON, DC

Mr. FROGUE. Chairman Kohl, Senator Martinez, and Senator Graham, thank you very much for the opportunity to share some thoughts with you today.

Think for a moment how other large businesses operate. Federal Express and UPS have 23 million packages a day that they ship. You can go online and track in real time for free with your $12 fee.

Large, sophisticated retailers in the supermarket, clothing, or auto parts industry can tell you every night how many cans of soup, pairs of pants, or spark plugs they sold anywhere in the world.

The American credit card industry involves over $2 trillion in transactions a year, almost the size of health care. There are over 700 million credit cards in existence, millions of vendors, and countless items that can be purchased. Yet, total credit card fraud is less than 1 percent.

Now look at health care. A GAO study in January 2009 estimated that a full 10 percent of Medicaid claims paid in 2007 were improper. It is a total of $32.7 billion. These GAO reports are consistent with OIG and State-level investigations too. I will not go through a list of examples of fraud. The other witnesses have done a good job and there are many to go through.

But Miami-Dade County, for example, presently has 897 licensed home health agencies which is more than the entire State of California.

I spoke with Jim Sheehan, the Medicaid Inspector General of New York, and he corrected something that is in my written testimony. There are actually only 55 men who received maternity benefits in New York State Medicaid over a 2-year period.

The Medicare and Medicaid systems we have in place today, in particular fee-for-service, which account for the majority of enrollees and dollars, simply beg for waste, fraud, and abuse. They cheat taxpayers, honest doctors, and hospitals, but most importantly, 100 million Americans who are elderly or low-income who depend on these vital programs.

My purpose today, however, is not to dwell on examples of fraud but, instead, to give some specific solutions. I want to agree with something Mr. Acosta pointed out. Law enforcement is only a very small part of the answer here. Even successful prosecutions tend to be expensive, take years, and end up only capturing a small amount of money lost, not to mention their deterrent effect appears to be negligible.

The No. 1 most important thing that the Congress or States can do is put all Medicare and Medicaid claims and patient encounter data online for public access. This is similar to the idea, Senator Martinez, that you have in your piece of legislation.

Selected academics have had access to Medicare claims data, for example, for years. The Dartmouth Health Atlas, which comes out annually, is a fantastic publication. More importantly than where the dollars go, it tracks health outcomes. For example, one of the

key findings of the Dartmouth Health Atlas is that per capita Medicare spending by locality is inversely correlated with the likelihood of receiving recommended care. A look at another State's Medicaid claims data last year found out, for example, that only 17 percent of women over age 50 were getting annual mammograms who were on Medicaid. These records are appalling, but nobody knew this because nobody has access to the data. It is like taking a test and you have the answers right here, but you are not allowed to look at them.

Simply put, patients and taxpayers have the right to know the quality produced and where the dollars are going.

Among the couple ideas I would like to walk through, one of them is—this would cost Congress absolutely not a penny—allow seniors on Medicare the option, just the option, of traveling to another city to receive major, nonemergency surgeries if it is something they chose to do. If a particular set of procedures was thousands of dollars less in Des Moines than it was in Chicago, and if patients opted for it, why not split the difference with them?

The commercial insurer Wellpoint just launched a demonstration project that allows customers the option of traveling to India, as in India next to China, for services that are less expensive but the quality is equally as good. Surely taking advantage of arbitrage opportunities in our own Medicare system is not too radical.

Another is enhanced discovery of third party liability in Medicaid. There is a GAO study a couple years back that showed 13 percent of people on Medicaid actually had third party coverage. There was another private study recently that found that. One to two percent of every State's Medicaid spending is on people who are already covered by another. That is simply reported coverage. If you add unreported to that, the numbers go up dramatically.

Use unique ID numbers for Medicare beneficiaries instead of their Social Security numbers. A Social Security number makes people particularly vulnerable to fraud.

Consider moving to or biometric ID for Medicare and Medicaid beneficiaries, which is much harder to be stolen, copied, or forged.

Recognize the recommendations of MedPAC, which is the shortcomings of fee-for-service, uncoordinated care, and fraud is much higher in fee-for-service than it is in managed care options. Move rapidly toward a medical home model which has shown a lot of success in many places.

Encourage better data analytics across programs. This is much like law enforcement. Sex offenders, for example—if they move to a different State, they have a couple days to register, and if they do not, they are tracked instantly using public documents. If you are a bad doctor or a bad DME provider in Miami and you move to a different State, no one may ever know. So this technology is not crazy or nonexistent. It exists in law enforcement right now.

Durable medical equipment. The fraud in DME is almost laughable. Instead of trying to have CMS fix their forms and their culture, you might as well just outsource the whole thing to Visa or Mastercard. They have 700 million cards in existence right now and could do a much better job. They certainly could not do worse than CMS and studies prove it.

Medi-Cal, the Medicaid program in California, has done a very good job of rooting out DME fraud. They are one of the best and do a much better job than Medicare fee-for-service and others state Medicaid programs.

One other is allow Medicare and Medicaid to auto-enroll patients with outlier behaviors into managed care. This is a very tiny percent. It is just 1 to 2 percent. Individuals who are excessively billing at, say, emergency rooms or DME providers, are probably getting poor, uncoordinated care. It may not even necessarily be them. It might be fraudulent providers doing it without the knowledge of the patient.

But there are several other recommendations, and I look forward to your questions, Chairman Kohl. Thank you and, Senator Martinez, thank you.

[The prepared statement of Mr. Frogue follows:]

Testimony to United States Senate Special Committee on Aging

"Catch Me If You Can: Solutions to STOP Medicare and Medicaid Fraud"

Chairman Herb Kohl (D-WI)
Ranking Member Mel Martinez (R-FL)

By
James Frogue
State Project Director
Center for Health Transformation

Wednesday, May 6, 2009

Chairman Kohl, Ranking Member Martinez, and Members of the Committee, thank you for the opportunity to share a few thoughts with you today. I commend you highly for holding this hearing and hope we will continue to share ideas well into the future. My oral and written remarks are my responsibility alone. They do not necessarily reflect the views of my employer, the Center for Health Transformation, any of its staff or members.

Think for a moment about how other large businesses operate in the modern world. FedEx and UPS track a combined 23 million packages each day in real time. You can go online, for free, and track the movement of your item from pickup to delivery. Exceedingly rare are stories of FedEx or UPS losing packages or about how those companies are rife with fraud.

Large, sophisticated retailers in the supermarket, clothing or auto parts industries can tell you every night how many cans of soup, pairs of pants, or spark plugs they sold that day in every one of their facilities all over the world.

The American credit card industry involves over $2 trillion in transactions per year which is nearly the size of the healthcare sector. There are over 700 million credit cards in circulation, millions of vendors, and countless items that can be purchased with a credit card. Yet total credit card fraud is a fraction of 1 percent. If you have ever made a large purchase in a city you do not typically frequent, you've probably been asked to show ID by the clerk.

Now look at healthcare. A Government Accountability Office study in January of 2009 estimated that a full 10 percent of paid Medicaid claims in 2007 were improper. That is a total of $32.7 billion. Several GAO studies have documented fraud and abuse in the durable medical equipment area that is several steps beyond laughable. Those GAO reports are consistent with OIG and state-level investigations too. Medicare and Medicaid lose billions of dollars annually to DME fraud, an industry that has attracted organized crime because the windfalls are so great and the risk is so low. There are shopping malls in Miami with over a dozen DME providers within 200 yards of each other.

(Appendix A is a partial list of just GAO studies of Medicare and Medicaid fraud for the past 15 years).

Examples of fraud are endless. Here is a tiny smattering:

- Miami-Dade County presently has 897 licensed home health agencies which is more than the entire state of California
- In 2005, there was $2.2 billion worth of claims submitted to Medicare for HIV drug infusion therapy. That was 22 times the amount submitted by the rest of the country combined, a trend that "continues to this day" according to the *Miami Herald* in August, 2008
- South Florida has 2 percent of the nation's Medicare beneficiaries, but 17 percent of the nation's inhalation drugs
- A dentist in Brooklyn had 991 claims in one day
- 150 *men* who received maternity benefits from New York Medicaid
- New York Medicaid may have well over $10 billion annual fraud and abuse *annually*. "40 percent of all claims are questionable." – former IG James Mehmet.
- The Vice President of the City of Angels medical center in Los Angeles was recently convicted of soliciting homeless people to his facility in order to provide them with unnecessary medical services
- HIV case managers allegedly double-dipping in Ryan White and Medicaid funds

Anyone with even a passing interest in this issue should take a few seconds and simply sign up for Google News Alerts on Medicare and Medicaid fraud. On any given day you will get up to a dozen stories from all over America. The biggest challenge is not gathering the tales, but is instead not becoming desensitized to the breathtaking scope, magnitude and pervasiveness of fraudulent behavior.

The Medicare and Medicaid systems we have in place today, in particular the fee-for-service portions which account for the majority of enrollees and dollars, simply beg for fraud, waste and abuse. They cheat taxpayers, honest doctors and hospitals, and most

importantly tens of millions of poor and elderly Americans who depend on these vital programs as their only lifelines to medical care. Fee-for-service the nickname "pay and chase" because fiscal intermediaries are judged primarily on how fast they crank out checks with relatively little regard to coordination of care and fraud.

My purpose here today however is not to dwell on articulating the amounts of fraud but instead to lay out 16 specific actions Congress could take that would save at least tens of billions of dollars annually.

Before getting to the solutions, it is important to emphasize that better law enforcement is only a small part of the solution. Even successful prosecutions tend to be expensive, take years, and end up capturing only a small fraction of the money lost, not to mention their deterrent effect appears to be negligible. It is much better to prevent the dollars from getting into the hands of criminals and fraudsters in the first place by employing technology and tactics that are common in advanced, non-health industries.

Recommendations:

1). Put all Medicare and Medicaid claims and patient encounter data online for public access. This data is the mother lode of everything you would ever want to know about both programs. It contains every key detail about health outcome data by facility, by fee-for-service vs managed care, by any comparison you want. The total amount of billing should match up with reported outlays from federal and state coffers.

Selected academics have access to Medicare data, for example, and produce excellent report such as the Dartmouth Health Atlas. Among their many key finding is that per capita Medicare spending by locality is *inversely* correlated with the likelihood of receiving recommended care.

As good as the Dartmouth team is, they are not better than the collective wisdom of everyone who would look at the data and come up with studies, patterns, and various findings heretofore not even considered.

Put simply, patients and taxpayers have the right-to-know the quality produced by every facility that receives taxpayer money and how and where scarce taxpayer dollars are spent. This data should only be released however after being vigorously patient de-identified, as is done in the academic world.

2). Change Medicaid from the open-ended federal match system to one in which the federal financial contribution is fully transparent upfront and based on the number of people in poverty in that state. The current system has a lengthy history of state-level accounting gimmicks to amplify the receipt of federal monies beyond the agreed percentage (Please see Appendix B). Taxpayers and program integrity would be better served by a federal partnership based on a clearly defined federal dollar amount which would free up state officials to focus exclusively on measuring and improving health outcomes for people on Medicaid.

Most people accept the inherent problem of a third party payer system. When Person A receives a service from Person B paid for by Person C, Person A is far more likely to spend with less discretion. Medicaid under the 40 year old federal match

arrangement is actually a *fourth* party payer system, making Persons A and C even less concerned about spending, especially considering that Person D (the federal government) is not particularly assertive about clamping down on abuses.

3). Allow seniors on Medicare the option of traveling to another city to receive major non-emergency surgeries. If a particular set of procedures is thousands of dollars less expensive in the next state over and the quality outcomes are as good or better, it makes sense to allow people the choice of facilities especially if the individual receiving care and taxpayers can split the savings.

The commercial insurer Wellpoint just launched a demonstration project that allows customers the option of traveling to *India* for non-emergent elective procedures like plastic surgery. Surely it is not too radical to take advantage of arbitrage opportunities here in America within our own Medicare system.

4). Enhance discovery of third party liability in Medicaid. Simply maximizing *self-reported* third party coverage by patients could save state Medicaid programs 1-2 percent per year. An attached GAO report shows up to 13% of people on Medicaid with other coverage.

5). Continue to move to a system of 100 percent electronic remittances. Paper and postage are unnecessarily costly and time consuming.

6). Use unique ID numbers for Medicare beneficiaries instead of their social security numbers. A stolen social security leaves a person much more vulnerable.

7). Require more timely updates from states on Medicaid enrollment data. Even senior Congressional staff as of April 2009 can only get state-by-state Medicaid enrollment data up to 2006. The latest available for Maine was 2004. Compare that to Fed Ex and UPS that track 23 million packages a day in real time.

8). Consider moving to biometric ID for Medicare and Medicaid beneficiaries. Cards are easily lost, stolen, copied and forged which contributes to uncoordinated care and fraud.

9). Recognize the shortcomings of fee-for-service arrangements and follow two of MedPAC's key recommendations: Expand the use of risk-adjusted plans in Medicare and expand the medical home model particularly for people with one or more chronic conditions. Enhanced use of medical homes would be particularly helpful in a Medicare system where specialists are overpaid relative to primary care. The standard fee-for-service model rewards volume first and foremost with coordination of care, improvement of patient health, and fraud as secondary considerations at best. The same recommendations are appropriate for Medicaid as well.

10). Encouraging better data analytics across programs and jurisdictions is a must. State Medicaid programs and medical licensing boards could benefit tremendously from the same level of inter-agency data sharing that is becoming increasingly common in law enforcement. When sex offenders move between states they are required to register

immediately with local law enforcement. If they miss their deadline, they are flagged instantly by sophisticated systems pulling information from public sources. Doctors, hospital administrators, DME salesman, criminal beneficiaries, etc are much freer to set up shop in a new state – or to send a new "unknown" member of a fraud ring into the system - without being targeted. The Medicare and Medicaid programs could benefit from enhanced data sharing for the dual eligibles as well.

11). Dramatically improve the authentication required of prospective Medicare Durable Medical Equipment providers. Currently the CMS-855S form that prospective DME providers must fill out lacks even a simple, "under penalty of perjury" line by the signature. That extremely minor tweak alone would be helpful to prosecutors and perhaps even have some deterrent effect. As would making the submission of bogus claims a clear reason for revocation of the supplier's billing number.

Otherwise, follow the example set by Medi-Cal which has done a good job of reigning in DME supplier abuses in the last five years. Medi-Cal is much more rigorous than Medicare and most other Medicaid programs in requiring thorough background checks of applicants. Or simply look to the anti-fraud efforts of commercial insurers.

In extreme problem areas like Miami, a flat out moratorium on new DME and home health providers may be appropriate.

12). Allow Medicare (Medicaid too) to auto-enroll patients with outlier behavior into managed care. Individuals who are excessively billing at, say, emergency rooms are probably getting poor, uncoordinated, inefficient care, or their Medicare/Medicaid cards are being billed by fraudulent providers with our without the knowledge of the patient. In either case, both the individual in question and taxpayers would be better served by auto-enrollment in managed care of the tiny number of people with highly unusual patterns of billing.

13). Dramatically expand the scope, use, and distribution of the HHS OIG exclusion list. Consider direct financial penalties to facilities receiving Medicare or Medicaid dollars that choose to employ any physician, executive, or administrator convicted of Medicare or Medicaid fraud in any state or responsible for a settlement with the government.

14). Require hospital cost reports for Ambulatory Surgical Centers. These facilities are growing by leaps and bounds but are not even required to submit cost reports.

15). Move Medicare and Medicaid beneficiaries into account-based plans where each individual has direct and immediate financial incentives to engage in behaviors that improve health status. There are myriad ways to structure these, the least controversial being zero-balance accounts where beneficiaries are literally paid money for taking steps to improve health status. The vast majority of health care spending in the decades to come will be on people with chronic conditions. This means personal choices around care regimens will have a major, long-term impact on quality outcomes and cost. We must continue developing and deploying models of health care financing that maximize patient behavior change. Ultimately that is the only way to save American health care. Account-based plans are the most effective way to create incentives that will accomplish this.

16). Take Medicare and Medicaid fraud seriously. I certainly intend that with all due respect and do not mean it to be taken as any form of sarcasm. To say there are many tens of billions of dollars of waste, fraud, and abuse in Medicare and Medicaid annually is being conservative. Fortunately, there are a number of steps Congress can take that would dramatically upgrade fraud-fighting efforts while also improving patient care.

Thank you Chairman Kohl and Ranking Member Martinez for holding this hearing. I very much look forward to working with Senators and staff on both side of the aisle to come up with pro-active, creative, and effective ways to eliminate waste, fraud and abuse from Medicare and Medicaid. Taxpayers, and far more importantly poor and elderly Americans who depend on these programs, deserve our full attention.

Appendix A
Medicare and Medicaid Fraud and Abuse – GAO Reports and Testimony

March 2009 – Medicare – Improvements Needed to Address Improper Payments in Home Health
For a 12-month period ending September 30, 2007, the Comprehensive Error Rate Testing program estimated that more than $209 million in improper payments. GAO targeted several states that were identified as experiencing the highest growth in Medicare home health spending or utilization from 2002 through 2006. Inadequate administration of the Medicare home health benefit leaves Medicare vulnerable to improper payments, particularly upcoding. GAO recommends that CMS more effectively screen HHA's, more effectively partner with physicians to identify potentially fraudulent and abusive activities, and more effectively sanction providers engaging in improper billing practices.

January 2009 – Report to Congress – High-Risk Series: An Update
In FY2007, CMS estimates that the states made $32.7 billion in improper Medicaid payments. Although CMS has taken some steps to improve oversight of Medicaid, several oversight weaknesses identified by GAO have not yet been addressed. These include: Congress limiting Medicaid payments to government facilities to the costs of providing service; CMS identifying needed systems projects/taking certain recommended steps to improve payment oversight; and HHS developing methods to better ensure budget neutrality of Medicaid demonstrations.

July 2008 – Medicare Party D – Some plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited
GAO states that, given the size, nature, and complexity of the Part D program, it is a particular risk for fraud, waste, and abuse. GAO selected five Part D sponsors, and found that all had not completely implemented all of CMS's seven required compliance plan elements and selected recommended measures for Part D fraud and abuse programs. GAO recommends that CMS conduct timely audits of Part D sponsors' fraud and abuse program implementation.

July 2008 – Medicare – Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process
GAO was easily able to set up two fictitious DME companies using undercover names and bank accounts, which were then approved for Medicare billing privileges despite having no clients and no inventory. CMS estimated that from April 2006 – March 2007, Medicare improperly paid $1 billion for DME supplies. More prevention controls must be implemented.

May 2008 – Medicaid – CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments

GAO examined the information states reported about supplemental payments, as well as how much of total Medicaid expenditures were distributed as supplemental, to what providers and for what purposes. GAO recommended that CMS expedite the final rule, implementing additional DSH reporting requirements and develop a strategy to identify all supplemental payment programs established in Medicaid plans.

April 2008 – Medicaid Financing – Long-standing Concerns about Inappropriate State Arrangements Support Need for Improved Federal Oversight
In 2003, CMS began an oversight initiative that by August 2006 resulted in 29 states ending one or more inappropriate financing arrangements. GAO reported in 2007 that although CMS's initiative was consistent with Medicaid payment principles, it was not transparent in implementation. In May 2007, CMS issued a final rule that would limit payments to government providers' costs. GAO has not yet reviewed that rule.

January 2008 – Medicaid Demonstration Waivers – Recent HHS Approvals Continue to Raise Cost and Oversight Concerns
GAO examined whether Medicaid demonstrations were budget neutral to the federal government and maintained Medicaid's fiscal integrity. GAO recommends that Congress require HHS to improve demonstration review and approval process and address HHS's authority to approve demonstrations, such as Vermont's. GAO recommends HHS reexamine FL's spending limit.

February 2007 – Prescription Drugs – Oversight of Drug Pricing in Federal Programs
There is a lack of CMS oversight of the prices manufacturers report to CMS to determine the statutorily required rebates owed to states. Oversight inadequacies, inaccurate prices, lack of transparency and the potential for abuse are all areas that the GAO encourages an increase in emphasis.

January 2007 – Medicare – Improvements Needed to Address Improper Payments for Medical Equipment and Supplies
GAO found that three shortfalls in reviewing Medicare claims: no automated prepayment controls to identify questionable claims part of an atypically rapid increase in billing; no controls in place to identify claims for items unlikely to be prescribed in the course of routine quality medical care; and no requirement of contractors to share information on the most effective automated prepayment controls with other contractors or consider adopting them.

September 2006 – Medicaid Third-Party Liability – Federal Guidance Needed to Help States Address Continuing Problems
Using Census Bureau statistics, an average of 13 percent of respondents who reported having Medicaid coverage for the entire year also reported having private health coverage at some time during the same year. GAO recommends that CMS provide guidance to states on when states must have law in place to implement the Deficit Reduction Act's requirements related to third party liability, and which entities are required to provide states with coverage and other data.

March 2006 – Medicaid Integrity – Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud, Waste, and Abuse

Table 1: CMS Activities to Support and Oversee States' Fraud and Abuse Control Efforts, Fiscal Year 2004

CMS Initiatives	Description
PAM/ Payment Error Rate Measurement (PERM)	CMS conducted a 3-year pilot called PAM to develop estimates of states' accuracy in paying Medicaid claims. During fiscal year 2006, PAM will become a permanent program—to be known as the PERM initiative—in order to measure improper payments in Medicaid, to fulfill a requirement of the Improper Payments Information Act of 2002.* Under PERM, states will be expected to ultimately reduce their payment error rates over time by better targeting program integrity activities in their Medicaid and SCHIP programs.
Medi-Medi	Under this pilot program, CMS facilitates the sharing of health benefit and claims information between the Medicaid and Medicare programs. Medi-Medi is a data match pilot designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries to reduce fraudulent schemes that cross program boundaries.
TAG	Through telephone conferencing, CMS provides a forum for states to discuss issues, solutions, resources, and experiences on fraud and abuse issues. Any state may participate; roughly one-third do so regularly. States have also used the TAG to propose policy changes to CMS.
Compliance reviews	CMS conducts on-site reviews to assess whether state Medicaid fraud and abuse control efforts comply with federal requirements, such as those governing provider enrollment, claims review, utilization control, and coordination with each state's Medicaid Fraud Control Unit. If reviewers find a state that is significantly out of compliance, they may encourage it to develop a corrective action plan and revisit the state to verify actions taken.

September 2005 – Medicare – More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers

In 2004, CMS reported that Medicare improperly paid $900 million for DME; they hired the National Supplier Clearinghouse to verify that suppliers meet 21 standards before billing. GAO found that NCS was weak in 1) checking state licensure and 2) conducting on-site inspections, thereby leaving Medicare open to fraud and abuse. This oversight must be strengthened.

June 2005 – Medicaid Fraud and Abuse – CMS's Commitment to Helping States Safeguard Program Dollars is Limited

GAO contends that the resources CMS expends to support and oversee states' Medicaid fraud and abuse control activities remain out of balance (in terms of dollar and staff resources allocated) with the amount of federal dollars spent annually to provide Medicaid benefits.

June 2005 – Medicaid Financing – States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight
GAO recommends that CMS improve oversight of contingency-fee projects and states' reimbursement-maximizing methods. An increasing number of states are using consultants on a contingency-fee basis to maximize their federal Medicaid reimbursements. GAO reviewed 2 states (GA & MA) and identified concerns in each of the 5 categories of claims, including *targeted case management, rehabilitation services, supplemental payment arrangements, school-based services, and administrative costs,* generating more than $2B from 2000-2004.

June 2005 – Medicaid Drug Rebate Program – Inadequate Oversight Raises Concerns about Rebates Paid to States
To help control Medicaid spending, states receive rebates from pharmaceutical manufacturers through a drug rebate program. GAO recommended that CMS issue clear, updated guidance on manufacturer price determination methods and price definitions. It also recommended that CMS implement systematic oversight of manufacturer methods and a plan to ensure accuracy of reported prices and rebates to states.

June 2005 – Medicaid – States' Efforts to Maximize Federal Reimbursements Highlight Need for Improved Federal Oversight
This is testimony before the Senate Committee on Finance. The testimony addresses how some states have inappropriately increased federal reimbursements; ways states have increased federal reimbursements for school-based Medicaid services and administrative costs; and how states are using contingency-fee consultants to maximize federal Medicaid reimbursements. GAO recommends that CMS improve oversight of contingency-fee projects and states' reimbursement-maximizing methods.

July 2004 – Medicaid Program Integrity – State and Federal Efforts to Prevent and Detect Improper Payments
According the GAO, 15 clinical laboratories in one state billed Medicaid $20M for services that had not been ordered, an optical store falsely claimed $3M for eyeglass replacements, and a medical supply company agreed to repay states nearly $50M because of fraudulent marketing practices. Thirty-four of 47 states that completed a GAO inventory reported using one or more measures to control enrollment of high-risk providers (such as on-site inspections, background checks, etc.) CMS has initiatives designed to support states' "program integrity" efforts, but its oversight is limited.

March 2004 – Medicaid – Intergovernmental Transfers Have Facilitated State Financing Schemes
IGTs are used to create the illusion of a valid state Medicaid expenditure to a health care provider. This report summarizes the various schemes, as well as what has been done about them. Some states, for example, receive federal matching funds on the basis of large Medicaid payments to certain providers, such as nursing homes operated by local governments, which greatly exceed established Medicaid rates. In reality, large payments

are often temporary, since states can require the local-government providers to return all or most of the money to the states, which states then use at their own discretion.

February 2004 – Medicaid – Improved Federal Oversight of State Financing Schemes Is Needed
GAO was asked to examine CMS's oversight of nursing home UPL arrangements. Although efforts by Congress and CMS have narrowed the UPL loophole, it has not been eliminated. In phasing out UPL schemes, CMS has granted provisional transition periods to states. GAO estimates that the 10 states with 5- or 8-year transition periods could receive about $9 B in excessive federal matching funds. GAO suggests that Congress consider a recommendation to prohibit Medicaid payments to government-owned facilities that exceed costs. It also recommends expediting financial reviews, establishing uniform guidance for states, and improving state reporting.

June 2002 – Medicaid Financial Management – Better Oversight of State Claims for Federal Reimbursement Needed
This is House testimony. GAO found that CMS has financial oversight weaknesses that leave Medicaid vulnerable to improper payments. While it is trying to improve financial oversight, the increasing size and complexity of Medicaid, coupled with diminishing oversight resources, requires a new approach. GAO encourages CMS to develop baseline information on Medicaid issues at greatest risk for improper payments, and then measure improvements in program management.

October 2001 – Medicaid – HCFA Reversed Its Position and Approved Additional State Financing Schemes
This report addresses how the Health Care Financing Administration's actions to implement UPL regulation permitted additional states to establish the same type of financing schemes that it was attempting to curtail, and the estimated additional costs to the federal government of the largest two of these newly established schemes.

Table 2: Overview of Process for Exploiting Upper Payment Limit

Step	Activity
1	State calculates difference in upper payment limit amount (what Medicare would have paid for comparable services) and what the state actually pays nursing homes for Medicaid services.
2	County government takes out a bank loan that is based on calculation in step 1. The loan covers the full amount, both the state and the federal share, of the excessive Medicaid payment.
3	County wires the loaned money from its bank account directly to the state.
4	State creates an official "Medicaid payment" by immediately wiring the loaned funds back to the county bank account.
5	County uses money returned by the state to pay off the loan.
6	State can then claim the federal share of the payment that it made to the county.

GAO found that HCFA's actions to revise UPL regulations were troubling, as it allowed additional states to engage in the very schemes it was trying to shut down, at a substantial additional cost to the federal government.

October 2001 – Strategies to Manage Improper Payments – Learning from Public and Private Sector Organizations
This report details specific practices to manage improper payments: data sharing, data mining, neural networking, recovery auditing, contract audits, and prepayment investigations. The control activities (listed above) are highlighted with different case studies.

June 2001 – Medicaid – State Efforts to Control Improper Payments Vary
GAO states that the exact amount lost in improper Medicaid payments is unknown because few states actually measure the overall accuracy of their payments. Lax administration increases the risk, and efforts by state Medicaid programs to address improper payments are modestly and unevenly funded.

September 2000 – Medicaid – State Financing Schemes Again Drive Up Federal Payments
This testimony describes funding schemes and how these compromise the agreement for federal/state sharing of Medicaid. Current schemes inappropriately increase federal Medicaid payments by paying certain providers more than they would normally receive and then having providers return the bulk of the extra monies to the state (excess payments). As of July 2000, 17 states have plans that could allow them to use this practice, and 11 other states have drafted plans for doing so. GAO says this "violates the integrity of Medicaid's federal/state partnership."

July 2000 – Health Care Fraud – Schemes to Defraud Medicare, Medicaid, and Private Health Care Insurers
In the *rent-a-patient scheme*, organizations pay for individuals to go to clinics for unnecessary diagnostic tests and cursory exams. Physicians then bill insurers for those services and often for other services or medical equipment never provided. Or, physicians buy individual health care insurance identification numbers for cash.

In the *pill mill scheme*, separate health care individuals and entities, usually including a pharmacy, collude to generate a flood of fraudulent claims that Medicaid pays. After a prescription is filled, the beneficiary sells the medication to pill buyers on the street who then sell the drugs back to the pharmacy.

The *drop box scheme* uses a private mailbox facility as the fraudulent health care entity's address, with the entity's "suite' number actually being its mailbox number. The fraudulent health care entity then uses the address to submit fraudulent claims and to receive insurance checks.

The *third-party billing scheme* revolves around a third-party biller who prepares and remits claims to Medicaid for health care providers. This person can add claims without the providers' knowledge and keep remittances.

July 2000 – Medicaid – HCFA and State Could Work Together to Better Ensure the Integrity of Providers
It is critical to protect program funds by making efforts to ensure that only legitimate providers bill Medicare and Medicaid. Different state agencies report differing practices to ensure provider integrity, and only nine states report that they perform comprehensive provider enrollment activities. At the time of the report, HCFA was redesigning its Medicare provider enrollment process, and it was suggested that developing a joint Medicare/Medicaid provider enrollment process would be beneficial.

April 2000 – Medicaid in Schools – Improper Payments Demand Improvements in HCFA Oversight
Some methods used by school districts and states to claim reimbursement for school-based services do not ensure that health services are provided, or that administrative activities are properly identified and reimbursed. Bundled rate methods used by school districts to claim reimbursement have frilled in some cases to take into account variations in service needs among children and have often lacked assurances that services paid for were provided. These poor controls have resulted in improper payments.

November 1999 – Medicaid – Federal and State Leadership Needed to Control Fraud and Abuse
Common fraud and abuse schemes include improper billing practices (upcoding, ghost billing, and delivering more treatment than is necessary/appropriate), misrepresenting qualifications (submitting false credentials to get provider number and performing treatments outside the bounds of what is permitted by one's license) and improper business practices (kickbacks for referring patients to a particular provider or product).

March 1997 – Medicaid Fraud and Abuse – Stronger Action Needed to Remove Excluded Providers From Federal Health Programs
Over the years, thousands of providers have been excluded from participating in federal health care programs b/c of health care fraud or abuse. However, there are several weaknesses: (1) lack of control at OIG field offices to ensure that all state referrals received are reviewed and acted on promptly; (2) inconsistencies among OIG field offices as to the criteria for excluding providers; (3) lack of oversight to ensure that states make appropriate exclusion referrals to the OIG; and (4) problems states experience in attempting to identify and remove from their programs providers that appear on the OIG's exclusion list.

March 1996 – Fraud and Abuse – Providers Excluded From Medicaid Continue to Participate in Federal Health Programs
OIG has worked to exclude thousands of providers; GAO finds several weaknesses that leave them on the rolls for federal programs. There are (1) lengthy delays in the OIG's decision process, even in cases where a provider has been convicted of fraud or patient abuse or neglect; (2) inconsistencies among OIG field offices regarding which providers will be considered for nationwide exclusion; (3) states not informing OIG about providers who agree to stop participating in Medicaid even though reason for agreeing to withdraw

is sometimes egregious patient care or abusive billing; and (4) how states use information from the OIG to remove excluded providers from state programs.

March 1995 – Medicare and Medicaid – Opportunities to Save Program Dollars by Reducing Fraud and Abuse

Medicaid participants face strong incentives to over-provide services, weak fraud/abuse controls to detect questionable billing practices, few limits on those who can bill, and little chance of being prosecuted or having to repay fraudulently obtained money. Solving these problems will require exploring options to make greater use of managed care strategies, such as PPOs or HMOS, greater investment in the people and technology needed to ensure that federal dollars are spent appropriately, more demanding standards for gaining authority to bill the federal programs, and exploring administrative reform options proposed in various bills introduced in Congress.

August 1993 – Medicaid Drug Fraud – Federal Leadership Needed to Reduce Program Vulnerabilities

Medicaid prescription drug fraud is widespread; a common scheme is the "pill mill" in which physicians, clinic owners, and pharmacists collude to defraud Medicaid by prescribing and distributing drugs for the primary purpose of obtaining reimbursement. States have instituted both up-front controls and measures to facilitate pursuit, punishment, and financial recovery. However, state officials told GAO that most leads are not pursued, cases take too long to resolve, and penalties are light even for those convicted. HCFA should display more leadership in developing an overall strategy to address prescription drug diversion and heighten states' sensitivity to the financial benefits of effective preventive measures.

Appendix B
State Schemes to Game the Federal Match – GAO Reports and Testimony

May 2008 – Medicaid – CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments
GAO examined the information states reported about supplemental payments, as well as how much of total Medicaid expenditures were distributed as supplemental, to what providers and for what purposes. GAO recommended that CMS expedite the final rule, implementing additional DSH reporting requirements and develop a strategy to identify all supplemental payment programs established in Medicaid plans.

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In 2003, CMS began an oversight initiative that by August 2006 resulted in 29 states ending one or more inappropriate financing arrangements. GAO reported in 2007 that although CMS's initiative was consistent with Medicaid payment principles, it was not transparent in implementation. In May 2007, CMS issued a final rule that would limit payments to government providers' costs. GAO has not yet reviewed that rule.

March 2007 – Medicaid Financing – Federal Oversight Initiative is Consistent with Medicaid Payment Principles but Needs Greater Transparency
GAO examined the number and fiscal effects of states ending financing arrangements; the extent to which CMS's initiative (to end inappropriate arrangements) represents a change in agency approach or policy; and transparency and consistency of the initiative. GAO found that CMS had not implemented its initiative transparency, contributing to concerns about consistency of reviews of state financing arrangements. GAO says CMS should issue written guidance to clarify.

June 2006 – Medicaid Financial Management – Steps Taken to Improve Federal Oversight but Other Actions Needed to Sustain Efforts
In this report, GAO examined (1) the extent to which CMS has improved its ability to identify and address emerging issues that put federal Medicaid dollars at risk, and (2) how CMS used fund for Medicaid from the HCFAC fund. GAO recommends CMS creates permanent funding specialist positions and determine what systems projects are needed to further enhance data analysis capabilities. (What CMS had done was hired, in 2004, 100 new funding specialists to perform in-depth reviews of high-risk issues.)

June 2005 – Medicaid Financing – States' Use of Contingency-Fee Consultants to Maximize Federal Reimbursements Highlights Need for Improved Federal Oversight
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Appendix C

Medicaid Financing Schemes Used to Inappropriately Generate Federal Payments and Federal Actions to Address Them, 1987-2005

Financing arrangement	Description	Action taken
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by states.
Provider taxes and donations	Revenues from provider-specific taxes on hospitals and other providers and from provider "donations" were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially barred certain provider donations, placed a series of restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments	DSH payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the state and federal funds to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped both the amount of DSH payments states could make and the amount individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to the state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state's DSH payments that can be paid to state psychiatric hospitals.
Upper payment limit (UPL) for local government health facilities	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate payment limit for each of several classes of local government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.
Restocking and double billing of prescription drugs	Unused prescriptions were returned by hospitals or nursing homes to pharmaceutical companies or pharmacies. Unopened and meeting other standards, these drugs were then resold and build again to Medicaid.	The Deficit Reduction Act of 2005 prohibited federal matching payments for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than a reasonable re-stocking fee).
Managed Care Organization provider tax	States were able to tax health care providers as a way to raise their share of the Medicaid matching payment. These funds, used to draw down Federal Medicaid dollars, were then returned to the provider, in effect, holding them harmless for the tax they originally paid. This loophole permitted states to shift the cost of their Medicaid programs directly to the Federal government.	DRA of 2005 demanded that MCOs are treated the same as other classes of healthcare providers with respect to provider tax uniformity requirements. Specifically, states would be required to tax all managed care organizations, not just those with Medicaid contracts, in order to meet the uniformity requirements. States are prevented from guaranteeing that tax revenues paid to states by MCOs be returned.

Senator MARTINEZ. Thank you.
Mr. Hussar.

STATEMENT OF ROBERT A. HUSSAR, FIRST DEPUTY MEDICAID INSPECTOR GENERAL, OFFICE OF THE MEDICAID INSPECTOR GENERAL, STATE OF NEW YORK, ALBANY, NY

Mr. HUSSAR. Thank you, Chairman Kohl and Ranking Member Martinez and all committee members present. On behalf of New York's Medicaid Inspector General, James Sheehan, and the New York State Office of the Medicaid Inspector General, known as OMIG, I thank you for the opportunity to describe our efforts at preventing and detecting Medicaid fraud, waste, and abuse in New York's program.

The OMIG was created to coordinate and improve the State's process of combating Medicaid fraud, waste, and abuse. We do this by collaborating with our fellow State and Federal partners and with providers and their representatives to prevent or detect and recoup overpayments in the Medicaid program. We pursue this mission in the framework of Governor Patterson's commitment to ensuring a patient-centered approach to health care, and we carefully consider the effect that each and every enforcement action has on the quality and availability of care in the community.

Measured by fraud and abuse recoveries reported to CMS, New York was the most successful State in the Nation in Medicaid program integrity over the past year, identifying recoveries of more than $551 million. This success results from the commitment of State elected officials and State agencies, as well as the support of Federal agencies. While recovering overpayments is an essential part of our efforts and although we have been successful in identifying significant recoveries, New York's long-term program integrity goal is to prevent or minimize improper payments. This is a daunting task, given the approximately $48 billion we spend on Medicaid, which covers approximately 60,000 providers and over 4 million enrollees.

Even at a time of enacting our enabling legislation, the New York State legislature fully appreciated that a pay-and-chase approach is neither effective nor efficient and that providers have a responsibility and are in a prime position to identify instances of noncompliance and to correct billing and payment mistakes. Through bipartisan legislation, New York now requires Medicaid providers to implement effective compliance programs. As a former in-house compliance officer for a comprehensive health care system, I have seen firsthand what works and what does not in terms of provider efforts to assure program integrity.

With this in mind, in developing our compliance guidance documents, in addition to addressing the typical billing and coding issues, we have raised the bar for accountability of board members, senior executives, and front-line staff related to governance and oversight of ethical business conduct and the expectation that all providers will ensure access to high-quality care.

To complement our compliance initiatives, we also support the use of administrative tools related to provider enrollment review, payment suspension, prepayment review, audits, and individual and entity exclusions when improper payments are discovered.

These remedies should not be deterred pending the outcome of an extended criminal investigation with the result of keeping those providers in the program who are most likely to be collecting the improper payments.

Recognizing that we will never eliminate all overpayments, we have and continue to develop ways to integrate technology into our audit and investigatory practices. Every OMIG auditor, investigator, clinical staff, and data analyst has access to our claims data that consists of over $200 billion in claims data covering the past 5 years, and they incorporate data mining into their daily activities.

Examples of recent findings resulting from the use of one and sometimes multiple applications in our data mining toolbox include: fees paid to managed care companies after a Medicaid recipient has been admitted to an assisted living or a nursing home; multiple client identification numbers used for the same recipient; the pharmacies which reportedly provided home-delivered prescriptions to patients who died weeks or months before; managed care plans and hospitals that bill Medicaid for prenatal services, as Jim already mentioned; the transportation company that bills Medicaid for patients who are dead, hospitalized, or incarcerated at the time the outpatient services were allegedly provided; and finally, those providers who do refund money when an agency review identifies an overpayment, but then rebills for those same claims 6 months or a year down the road.

We need to move to a system which makes program integrity a major goal of oversight, investigative, and prosecutive efforts through the following principles.

First, require and support effective corporate compliance programs and professional compliance officers. This can be done, in part, by holding senior executive board members accountable for failing to have systems in place to prevent improper billing. The Office of the Inspector General has done a great job of articulating its expectations for board members of hospitals and nursing homes. We need now to expand that effort.

Literature has shown that frequent and predictable communication and interventions with providers are more effective than occasional severe sanctions.

Next, as I mentioned earlier, we need to evaluate, support, and use administrative tools of payment suspension, prepayment review, audit, sanctions, and exclusions when appropriate.

We also need to have regular discussions with providers, and we are regularly engaged in outreach with the provider community.

We are finding fraud, waste, and abuse in recovering overpayments, but our ultimate goal, as I said, is to prevent those payments from being made in the first place. Toward that end, we are committed to educating the provider communities on ways to incorporate compliance into their day-to-day activities and to build integrity in on the front end of the program. Our efforts have contributed significantly to the integrity of the Medicaid program in New York and beyond, and we hope that our ideas will be replicated in other States as we as a Nation seek to improve the quality of health care for all citizens.

Again, on behalf of the OMIG and New York, I thank you again for the opportunity to share these thoughts.

[The prepared statement of Mr. Hussar follows:]

Statement of

ROBERT A. HUSSAR

FIRST DEPUTY
MEDICAID INSPECTOR GENERAL

NEW YORK STATE
OFFICE OF THE MEDICAID INSPECTOR GENERAL

Before

SPECIAL COMMITTEE ON AGING

on

Catch Me If You Can:
STOP Medicare and Medicaid Fraud
From Hurting Seniors and Taxpayers

May 6, 2009

Office of the Medicaid Inspector General

Ranking Member Martinez and all Committee Members present,

On behalf of New York's Medicaid Inspector General James G. Sheehan, and the New York State Office of the Medicaid Inspector General, known as OMIG, I thank you for the opportunity to describe our efforts at preventing and detecting Medicaid fraud, waste and abuse.

The New York State Office of the Medicaid Inspector General (OMIG) was created to coordinate and improve the state's process of combating Medicaid fraud, waste and abuse. We do this by collaborating with our fellow state and federal partners and with providers, their representatives, consultants and counsel, to prevent or detect fraud, waste and abuse in the Medicaid Program. While we do not have prosecutorial authority, when we find possible criminal intent, we assist federal, state and local law enforcement agencies to ensure that criminal activities relating to Medicaid answer to the full extent of the law.

We pursue our mission in the framework of our Governor's commitment to ensuring a "patient-centered" approach to health care. We carefully consider the effect each enforcement action has on the quality and availability of medical care, services and supplies in the community and always base our actions on the best interest of both the Medicaid program and Medicaid enrollees.

Measured by fraud and abuse recoveries reported to CMS, New York was the most successful state in the nation in Medicaid program integrity over the past year, identifying recoveries of more than $551 million. This success results from the commitment of state elected officials and state agencies and the support of federal agencies. It is also the result of congressional, media and legislative attention in 2005 and 2006 to the significant failures of New York's Medicaid oversight. While recovering overpayments is a necessary part of our efforts, and although we have been successful in identifying significant recoveries, New York's long-term program integrity goal is to prevent or

minimize improper payments. This is a daunting task given the $46 billion spent on Medicaid covering 60,000 providers and over 4 million enrollees.

Even at the time of enacting our enabling legislation, the New York Legislature fully appreciated that a "pay and chase" approach is neither effective nor efficient and that New York State Medicaid Providers have a responsibility and are in a prime position to identify instances of non-compliance and to correct billing and payment mistakes. With this in mind, our State Legislature, on a bi-partisan effort, passed §363-d of the Social Services Law that mandates that providers of Medicaid care services or supplies adopt an effective compliance program. As a former in-house Compliance Officer for a comprehensive healthcare system, I have seen first-hand what works, and what doesn't in terms of provider efforts to adopt and implement systems and tools to assure program integrity.

In developing our compliance guidance documents, in addition to addressing the typical billing and coding issues, we have placed additional accountability on Board members, senior executives and font-line staff related to governance and oversight of ethical business conduct and the expectation that all providers will provide access to high quality care.

We also support and use the administrative tools related to provider enrollment review, payment suspension, pre-payment review, audit, sanction, and individual and entity exclusion when improper payments are discovered. All too often, these remedies are deferred pending the outcome of the extended criminal investigation-this means that we keep providers in the program who are most likely to be collecting improper payments and continue to pay those providers. In New York, we have significantly expanded the use of pre-payment reviews, payment suspensions and individual and entity exclusions.

Recognizing that we will never eliminate all overpayments, we have and continue to develop ways to integrate technology into our audit and investigatory practices. Individuals throughout the OMIG use data mining as a resource during the course of day-

to-day activities. Every OMIG auditor, investigator, clinical staff (including physicians, dentists, pharmacists and nurses) and data analyst has unlimited and immediate access to our "data-warehouse", our claims data system that holds $200 billion in claims data covering claims submitted by 60,000 providers for services for over 5 million Medicaid enrollees over the past 5 years.

Some of these individuals operate within our audit or investigative units, while others are dedicated to targeting, provider analysis, support of targeting tools, creation of data match algorithms and the provision of pre-audit analysis & audit samples, but everyone involved with data mining collaborates with program units to get new ideas and fresh perspective from the field

We utilize several tools – one that presents ease-of-use through a graphical user interface, yet allows the user to make complex queries and effortlessly drill down into increasing levels of detail. Another specializes in resolving entity relationships (e.g. link analysis) from disparate data sources. Examples of recent findings include:

- Managed care fees paid to managed care companies after a Medicaid recipient has been admitted to an assisted living center or nursing home
- Multiple client identification numbers used for the same recipient
- The pharmacies which provide "home-delivered" prescriptions to patients who died weeks or months before;
- The managed care plans and hospitals that bill Medicaid for prenatal services for males;
- The transportation company that bills Medicaid for patients who are dead, or hospitalized, or in a nursing home, or incarcerated at the time the outpatient services were allegedly rendered:
- The providers who credit a refund when an agency review identifies an overpayment, and then rebill the State for the same services six months later.

Through data mining, and technology we are able to identify issues that enable our investigators to dig deeper into a situation and determine whether we have found an isolated incident or a trend that indicates potential fraud, waste or abuse.

We need to move to a system which makes program integrity a major goal of oversight, investigative, and prosecutive efforts through the following principles:

- First, require and support effective corporate compliance programs and professional compliance officers. New York requires by law that larger providers have an effective compliance program, with eight elements. The Medicare program suggests model compliance programs. We want health care providers to identify and resolve issues themselves; the best already do.

- Second, hold senior executives and board members accountable for failing to have systems to prevent improper billing. Corporate and non-profit law requires boards to have systems in place "reasonably likely to detect and prevent" violations of law. The Office of Inspector General (HHS) has done a great job of articulating its expectations for board members of hospitals and nursing homes. We need to assure that the focus of program integrity efforts is on systems control failures by management and the board as well as wrongful intent.

- Third, elevate, support and use the administrative tools of payment suspension, prepayment review, audit, sanction, and individual and entity exclusion when improper payments are discovered. All too often, these remedies are deferred pending the outcome of the extended criminal investigation-this means that we keep providers in the program who are most likely to be collecting improper payments and continue to pay those providers. In New York, we have significantly expanded the use of pre-payment reviews, payment suspensions and individual and entity exclusions.

- Fourth, recognize that the most effective deterrence requires regulator communication to and persuasion of those whose behavior we are trying to influence. Most health care providers are risk-averse and the literature has shown frequent and predictable interventions for providers are more effective than occasional severe sanctions.

- Fifth, develop and communicate consistent measures of effectiveness of program integrity which capture cost reduction and avoidance as well as recoveries, and minimize costs imposed by reviews and investigations. Measuring program integrity by recoveries alone, or by prosecutions alone, or by the cost of auditors divided by their recoveries does not give a clear picture of what is expected or of what is being accomplished.

- Sixth, recognize incentives which cut against effective program integrity. CMS currently requires states to repay the federal share of identified Medicaid recoveries as soon as they are identified (Section 1903 (d)(2)(A) of the Social Security Act, 42 U.S.C. 1396b (d)(2)(A). This discourages states from investing in program integrity efforts against program providers who are in financial difficulty and will be unable to repay identified overpayments. Let the state and federal governments face the same risk of non-payment from providers who have obtained improper payments, or provide an enhanced percentage to states for identified overpayments.

Conclusion

We are finding fraud, waste and abuse in New York's Medicaid program, and we are also intensifying our efforts to stop these problems. We expect providers to review themselves and correct incidents of non-compliance. Our recently released self-disclosure protocols and annual work plan are posted on our Web site to inform providers of areas of focus. We are recovering improper payments, but our ultimate goal is to prevent those payments from being made in the first place. Toward that end, we are committed to educating the provider community on ways to incorporate compliance and integrity into their day-to-day activities..

Our efforts have contributed significantly to the integrity of Medicaid in New York and beyond. We believe that the time for other states to take on these issues is long overdue, and hope that our ideas will be replicated in other states as we seek--as a nation--to improve the quality of health care for all citizens.

On behalf of OMIG and New York, I want to thank you for the opportunity to present this testimony today.

Senator MARTINEZ. Thank you, sir, very much.
Mr. Horne.

STATEMENT OF STEPHEN C. HORNE, VICE PRESIDENT, MASTER DATA MANAGEMENT AND INTEGRATION SERVICES, DOW JONES ENTERPRISE MEDIA GROUP, EDGEWATER, NJ

Mr. HORNE. Good afternoon, Chairman Kohl, Ranking Member Martinez, Senator Graham.

I have spent about 30 years working on building very complex databases, and as I am listening to the people here on the panel, it sounds like we have got an information problem.

It has been well documented that there is a tremendous amount of waste, fraud, and abuse within the Medicare system. According to the recent Government Accountability Office report, the Centers for Medicare and Medicaid Services is now estimating there are about $10.4 billion improper payments made for just fee-for-service providers alone. That is out of the over $70 billion I understand is part of the overall waste, fraud, and abuse number.

The Medicare system is made up of hundreds of processors, hundreds of thousands of providers, millions of recipients, all of whom can independently contribute to abuse. In the past, it was thought to be prohibitively expensive to rebuild the infrastructure to provide the information necessary to assert the proper controls over the Medicare system.

The original computer systems that were designed to process Medicare claims were mostly based on older mainframe-based technology that were designed to efficiently process data at the lowest cost possible at the time of implementation. These systems are not very effective at creating useful analysis that could lead to a reduction in abuse.

Today, it is cost-effective to extract the data from the current computer systems in near real time. Using specialized methods, data can be transformed into actionable information that can be analyzed by applying potentially hundreds of thousands of "rule" combinations to create true transparency and oversight of the Medicare system, capture those parts of the process that are susceptible, and provide the appropriate analysis to correct the problem.

For example, you heard in the IG's report for inhalation therapy drugs in South Florida where 2 percent of the Medicare beneficiaries live. I believe, Senator Martinez, you also brought this up. The area accounted for 17 percent of the Medicare spending in 2007. Medicare paid almost $143 million, about 20 times greater than any other county except for Cook, which was the next largest county in total payments. Cook County is home to almost twice as many Medicare beneficiaries as in Miami-Dade.

With today's technology, data mining, and analysis tools, the data that was found by the IG's audit would set off a series of alarms as soon of the thresholds of reasonable volumes were breached. This would create two possible opportunities for managing waste, fraud, and abuse.

The first was we would be able to deny claims that were outside the bounds of reasonable norms as soon as they were identified and

allow HHS and the IG to recover those claims paid that fell into the categories identified in near real time.

Second, it would enable the IG's office to identify and act on problems as they occur rather than having to react to problems after the fact. Technology would not only reduce the amount of funds lost through waste, fraud, and abuse, but it would serve as a traffic cop for the Medicare system to deter misuse.

The processes an individual claim may go through from submission through final disposition can sometimes be called a Rube Goldberg combination of procedures that no one can easily figure out, particularly when Medicare and Medicaid transactions intersect with each other.

Databases, when programmed correctly, are much better at figuring out what we call "tree logic" that these claims follow and may branch off into multiple directions. We try to capture the information between the various rules and jurisdictions of each claim of the agencies and processes indicated on an individual claim. Although these claims my represent a fraction of the total claims processed by the system, they probably take up the majority of the expense of the processing cost because the amount of human interaction required to get them right. This is where there probably is the highest significant potential for pure waste.

There is also a substantial what we call "Pareto Factor" in the system. Pareto's Law, also known as the 80-20 rule, applies in the case where 80 percent of instances of waste, fraud, and abuse occur in 20 percent of the total cases. I believe that further analysis will find that the numbers are more likely 90–10. Reducing the percentage of instances of problems and segmenting these problems into manageable groups will allow the system to manage the problems on a more cost-effective basis. The present system is not capable of achieving comparable results because it cannot identify the 10 percent of the specific possibilities for waste, fraud, and abuse. I believe if you look at the CERT program, you will see that that is a 120,000-record sample out of millions of transactions. You cannot figure it out that way.

According to the IG's office, the Government paid more than $1 billion in questionable Medicare claims for medical supplies just in 2007 that showed little relation to a patient's condition, including blood glucose strips for sexual impotence, special diabetic shoes for leg amputees, wheelchairs or wheelchair accessories for patients listed as having a deformed nose and sprained wrist. In cases such as these, the line between waste, fraud, and abuse are blurred because these errors, regardless of intent, would have been prevented if a codification validation system were in place.

We can extend the life of the existing Medicare computer systems if they are used for the purposes that they were originally intended for, which is to process claims. Do not force them to do anything else. Outliers can be identified by a separate but connected computer system that incorporates technology-based data mining and analysis tools to enable CMS and the IG's office to effectively act in cases of fraud and abuse, and process management techniques can be initiated to counteract waste.

Thank you, Mr. Chairman, Ranking Member Martinez, Senator Graham for your time and your attention.

[The prepared statement of Mr. Horne follows:]

United States Senate
Special Committee on Aging
Hearing on Solutions to STOP Medicare and Medicaid Fraud

Testimony of Steve Horne, Vice President
Master Data Management
Dow Jones Enterprise Media Group

May 6, 2009

Good afternoon Chairman Kohl, Ranking Member Martinez and Members of the Special Committee on Aging. Thank you for inviting me here today to testify about how leveraging the right data and data systems can allow the government to monitor potential waste, fraud and abuse of federal funds.

My name is Steve Horne and I am the Vice President of Master Data Management for the Dow Jones's Enterprise Media Group. I have spent over 30 years building sophisticated databases and transforming very complex data into usable information. Dow Jones has provided transparency to the marketplace in the form of indexes, publicly and privately held corporate information, news and analysis for over 100 years.

It has been well documented that there is a tremendous amount of waste, fraud and abuse within the Medicare system. According to a recent Government Accountability Office (GAO) report, the Centers for Medicare & Medicaid Services (CMS) is now estimating that $10.4 billion in improper payments were made to fee-for-service providers in 2008 alone.

CMS currently oversees several initiatives to help identify waste, fraud and abuse within the Medicare system. These initiatives include Comprehensive Error Rate Testing, Recovery Audit

Contractors, and the Disclosure Financial Relationships Report. One problem with reports generated by these types of initiatives is that they are based upon "samples of data" that do not bring to the surface the key areas within the Medicare system that comprise the largest volume of waste, fraud and abuse.

The Medicare system is made up of hundreds of processors, hundreds of thousands of providers and millions of recipients, all of whom can independently contribute to waste, fraud and abuse. In the past, it was thought to be prohibitively expensive to rebuild the infrastructure to provide the information necessary to assert proper controls over the Medicare system. Today, at a fractional cost of funds lost to waste, fraud and abuse, it is possible to improve the current Medicare computer system to enable it to systematically track transactions between the various parties in an individual Medicare claim. An improved computer system could also track transactions from the original submission of a claim to the final disposition, and all of the processes in between, without rebuilding the infrastructure upon which Medicare has been based. By extracting the data from all of the various systems, normalizing it into a single, comprehensive format, applying the rules -- or what is known as "meta data" -- to the data collected and then transforming it into information, one can accurately track those processors, providers or recipients who are not following the rules by either acts of omission or intentional acts of fraud, and more effectively address any problems in near real time.

The original computer systems designed to process Medicare claims are based on older, "mainframe" based technology that were designed to efficiently process data at the lowest cost possible. These computer systems have not been very effective at creating useful analysis that could lead to a reduction in waste, fraud and abuse.

Today, it is cost effective to extract the data from the current computer systems in near real time. Using specialized processes, data can be transformed into actionable information that can be analyzed by applying potentially hundreds of thousands of "rule" combinations to create true transparency and oversight of the Medicare system, capture those parts of the process that are

susceptible to waste, fraud, and abuse, and provide the appropriate analysis to correct the problem.

For example, in a recent Health and Human Services (HHS) Inspector General's (IG) Report[1] for Inhalation Therapy drugs dispensed through durable medical equipment (DME), or more commonly known as inhalation therapy devices, there was an audit performed that showed that aberrant claim activity (more than 20 times the volume for similar treatments in other geographies) was happening in certain parts of South Florida. The process the IG went through is a traditional and admirable audit:

- They used the Medicare National Claims History file to identify all inhalation drug claims in 2007.

- They compared the average number of paid claims and the dollar amount paid for inhalation drug claims for beneficiaries in South Florida (Miami-Dade, Broward, and Palm Beach Counties) to beneficiaries in the rest of the country.

- They compared the average amount submitted and paid per supplier for beneficiaries in South Florida to the average amount submitted and paid per supplier for beneficiaries in the rest of the country.

- They compared the average Medicare spending per beneficiary for inhalation drugs in South Florida and the rest of the country to the amounts associated with the maximum milligrams listed in the local coverage determination (LCD).

- Finally, they determined the percentage of paid South Florida inhalation drug claims in 2007 for which the beneficiary did not have any Medicare Part B service claims (e.g., a Medicare-billed office visit) occurring in 2005, 2006, or 2007 with the physician who reportedly prescribed the drug.

Although only 2 percent of Medicare beneficiaries live in South Florida, this area accounted for 17 percent of Medicare spending on inhalation drugs in 2007. Medicare paid almost $143 million for

inhalation drugs in Miami-Dade County alone—an amount 20 times greater than the amount paid in Cook County, Illinois, the county (outside South Florida) with the next highest total payments. However, according to Medicare enrollment data, Cook County is home to almost twice as many Medicare beneficiaries as Miami-Dade County.

With today's technology-based data mining and analysis tools, the data that was found by the IG's audit would set off system alarms as soon as the thresholds for reasonable volumes were breached. This would create two possible opportunities for managing waste, fraud and abuse.

First, it would deny claims that were outside the bounds of reasonable norms as soon as they were identified and allow the HHS to recover those claims paid that fell into the category identified.

Second, it would enable the IG's office to identify and act on problems as they occur, rather than having to react to problems after the fact. This technology would not only reduce the amount of funds lost through waste, fraud and abuse, it would serve as a "traffic cop" for the Medicare system to deter misuse.

In addition to the obvious opportunity to identify fraudulent claims, the new database technology will get at the potentially larger problem of waste and abuse of the Medicare system.

The processes an individual claim may go through from submission to final disposition can sometimes be called a "Rube Goldberg" combination of procedures that no one can figure out, particularly when Medicare and Medicaid transactions intersect with each other.

Databases, when programmed correctly, are much better at figuring out the "tree logic" that these claims follow which may branch off into dozens of directions based upon the interaction between the various rules and jurisdictions of each of the agencies and processes indicated by an individual claim. Although these claims may represent a fraction of the total claims processed by the system, they probably take up the majority of the expense of processing because

of the amount of human interaction required to get them right. This is where there is the greatest potential for waste.

There is also a substantial "Pareto Factor" in the system. Pareto's Law, also known as the 80-20 rule, applies in a case where 80 percent of the instances of waste, fraud and abuse occur in 20 percent of the total cases. I believe that after further analysis we will find that the numbers are more like 90 percent – 10 percent. Reducing the percentage of instances of problems and segmenting these problems into manageable groups will allow the system to manage the problems on a more cost-effective basis. The present system is not capable of achieving such results because it cannot identify the 10 percent of specific possibilities for waste, fraud and abuse.

According to the IG's[2] office, the government paid more than $1 billion in questionable Medicare claims for medical supplies just in 2007 that showed little relation to a patient's condition, including blood glucose strips for sexual impotence and special diabetic shoes for leg amputees. Other questionable claims included wheelchairs or wheelchair accessories for patients listed as having a deformed nose or sprained wrist; shoe inserts for those with leg amputation or "precocious sexual development"; and, walkers for people diagnosed with paraplegia. In cases such as these, the lines between waste, fraud and abuse are blurred. It has been shown that mis-codification of a specific condition may have led to these types of errors. In other cases it is a result of sloppy and undisciplined processing by the providers or processors. These errors, regardless of intent, would have likely been prevented if a codification validation system were in place. The facially-absurd examples set forth above would fall into an outlier category and would have been rejected because of the edits and validation in the system that would block the combinations of services that fall outside of the permissible combinations. This type of tool would help CMS and the IG's office reduce the amount of waste, fraud and abuse in the Medicare system simply by eliminating those situations that can be managed by data driven processes.

Cost effective technology to help prevent waste, fraud and abuse is available today. We can extend the life of the existing Medicare computer systems if they are used for the purposes for which they

were originally designed; namely, to process claims. Outliers can be identified by a computer system that incorporates technology-based data mining and analysis tools to enable CMS and the IG's office to efficiently act on cases of fraud and abuse and process management optimization techniques can be initiated to counteract waste.

Thank you Mr. Chairman, Ranking Member Martinez, and Members of the Committee for your time and attention.

Footnotes

[1] ABERRANT CLAIM PATTERNS FOR INHALATION DRUGS IN SOUTH FLORIDA Daniel R. Levinson, Inspector General, April 2009 OEI-03-08-00290

[2] Office of the Inspector General Report on CMS COMPREHENSIVE ERROR RATE TESTING Daniel R. Levinson, Inspector General August 2008 OEI-05-07-00202

Senator MARTINEZ. Thank you very much. Chairman Kohl had to be excused.

Senator Graham has a couple of questions, and then I have some myself. So we will call on Senator Graham.

Senator GRAHAM. Well, thank you, Senator Martinez. To you and the chairman, I really appreciate having this hearing, and I know people are busy, but I cannot think of a more important topic than waste, fraud, and abuse when it comes to Medicare and Medicaid. If you are serious about health care reform, you have to be serious about this topic. If you asked any audience in America how many people in this room believe that waste, fraud, and abuse is a problem with Medicare and Medicaid, and you have experienced some of it, everybody raises their hands. The numbers are staggering.

But one observation, Mr. Frogue—is that how you pronounce your name? Mr. Horne. You have given some examples of a lot of abuse that really was not caught in the example of a wheelchair. You talked about American Express and credit card companies and FedEx being able to do a better job tracking the flow of inventory and finding out where the dollars are.

To me the big difference is that in a private sector enterprise, if you allow people to rip you off, you go out of business. When it is my money, I am a lot more concerned about being ripped off if I got to pay my credit card bill fraudulently or somebody ripped my credit card bill off or they did something that affects my pocket. The problem here is that we are not stealing money from individual pockets, and there is no bottom-line effect. We just print more money.

Do you not think that is a basic problem, Mr. Frogue? A big difference?

Mr. FROGUE. I think you hit the nail right on the head, Senator Graham. That is exactly right. We also recognize the problem of a third party payor system where if a third person is paying the bill and you are in a transaction, the purchasers does not spend money as wisely. Medicaid is actually a fourth party payor system where there is yet another entity, which is the Federal Government, paying the bill. So people care even less.

Senator GRAHAM. We have got to fix that somehow. We have got to make people care. Senator Martinez mentioned that an insurance adjustor in a worker's comp—you have people following around false claims all the time because it puts the insurance company out of business if I pay too many false claims.

So we have got to somehow get people caring more because it is bankrupting future generations. The amount of money we are spending on Medicare and Medicaid alone in 20 years is going to equal the entire discretionary budget. So this may not be coming directly out of a pocket and it does not affect the bottom line of a business. It affects your kids and your grandkids.

So I would like, if you could, to me or the committee—you have all given a lot of input. Could you in one or two pages put down a consensus among yourselves, talk among yourselves, as to the things that this committee and this Congress could do to deal with fraud? Because you have given a lot of information, but if you sat down in a room, I bet you could find the top four or five things we need to do.

Second, as to caring, I know that prosecution alone is not going to work. It is like the horse is out of the barn deal. You want to prevent it. But I have found, being a military officer, that when the military got very serious about DUIs—if you had a DUI as a senior NCO or an officer, your career was over. The culture in the military was to drink every Friday and people got home the best they could. When we got serious about cracking down on driving under the influence, it really did change because people realized that if I get caught with a DUI, my career is over.

So I would urge you—is it Mr. Acosta?

Mr. ACOSTA. Yes.

Senator GRAHAM. To not discount so much—I want to work with Senator Martinez and Senator Kohl to increase penalties dramatically. I really do want to send a signal that if you are robbing the system, you are cheating the system, you are hurting the country. We are going to look at dramatically increasing the penalties.

Senator MARTINEZ. Would you comment on that, Mr. Acosta, because I think you probably have some ideas of how we could do that?

Mr. ACOSTA. Well, certainly, Senator. Let me emphasize when I say that prosecution is not the solution, in no way, shape, or form—

Senator GRAHAM. I totally agree with that.

Mr. ACOSTA [continuing]. Am I discounting the value of prosecution. Since beginning the initiative in 2006, we went from prosecuting $186 million in fraud a year to nearly $800 million in fraud a year. My only point is with the limited prosecutorial resources, there is a limit to how many cases can be brought.

One thing that I think is worth noting is we are seeing—and some patterns that we see are, I think, quite interesting. We see individuals that used to engage in drug dealing, for example, that will say quite openly—and these are individuals that have now been convicted.

Senator GRAHAM. The cost of doing business is lower.

Mr. ACOSTA. The cost of doing business is safer to engage in Medicare fraud and it is more profitable to engage in Medicare fraud, and so we are now engaging in Medicare fraud.

Senator GRAHAM. I have to go here. With your help, give us some idea, not now but later on, about how we could increase the penalty scheme to make the cost of doing business here unacceptable for a large percentage. There will always be people trying to cheat. But you go where it is easiest to cheat and where the penalties are the least. I think Senator Martinez and myself are convinced that if we increase penalties, the cost of doing business would be harder and it might, at least on the margins, affect the people involved.

So thank you all for what you are doing for our country.

Senator Martinez, this is a great hearing. Let us stay on this topic because I think this is one place for bipartisanship.

Senator MARTINEZ. Thank you, Senator Graham. I appreciate it.

I wanted to follow up with a few questions of my own. Mr. Acosta, I wanted to ask you because it is so embarrassing that the State of Florida seems to be absolutely in the lead here, even beyond Cook County, which I find astounding. Why do you think Florida has such a problem with this fraud?

Mr. ACOSTA. Well, Senator, it is difficult to say with specificity. South Florida is, unfortunately, a leader in many types of fraud from Medicare fraud to mortgage fraud. So South Florida has one of the largest U.S. Attorney's offices because we have one of the largest law enforcement challenges.

All that said, because we are focusing so much on health care fraud and because we are working so closely with the Inspector General's Office, we are the subject of heightened scrutiny. I think that is great, but that does focus the eye on South Florida. In the same way that in South Florida, whether it is HIV infusion or inhalers or now where we are putting our focus is home health care, we see those particular types of fraud in other parts of the country. I am certain that other types of fraud are sort of the fraud du jour.

Different regions have different payor systems, and as a result there are different frauds that we see in different parts of the country. I say that because a solution to this would not simply be to begin demonstration programs in South Florida. That does not address the issue. It really has to be a nationwide set of solutions.

Senator MARTINEZ. Well, I can also imagine if prosecutions continue like you have done them in south Florida, the problem will only move elsewhere because it will be easier to do it someplace else.

Mr. ACOSTA. I have spoken with my colleague in the Central District of Florida, in the Tampa-Orlando region, that has noticed an increase in frauds, and I have also been told that Atlanta is now seeing an increase in frauds as people leave South Florida and set up shop, unfortunately, elsewhere.

Senator MARTINEZ. Mr. Levinson, one of the durable medical equipment issues that I have noticed is how can we look at that problem, which seems to be so flagrant, and create some safeguards that might prevent some of that from occurring as we go forward? Do you have any suggestions there?

Mr. LEVINSON. Mr. Martinez, I think it would be especially valuable to focus on enrollment, on who gets into the program. Historically Medicare has been very, very concerned with access, understandably so especially in the early years of the program. But as the program has matured over the years and as the population affected has truly exploded in growth, the paperwork, the filtering, the need to focus on who should be in the program has not kept pace. Rather than have enrollment in Medicare as a privilege, in effect a special opportunity, it is simply treated too much as "fill out the form". If you have the form right, you get the number and you are in the Medicare program. We need to do a much better job of controlling enrollment because it is a whole lot easier, if possible, to keep the fraudster out of the program in the first instance than to try to catch up later to do what often is a pay-and-chase.

Senator MARTINEZ. What about the fraudulent billing part of the business, if you will? Do you have any recommendations?

Mr. LEVINSON. Well, we in the course of our studies, certainly have identified excessive reimbursement for a variety of DME equipment. We think that getting prices better aligned with the market would make DME fraud a less attractive target over time. So it is important to make sure that as CMS looks at its reim-

bursement policies, that we get a better alignment with real marketplace pricing.

Senator MARTINEZ. Mr. Frogue, have any States begun to place Medicaid data online while, at the same time, protecting the identity of patients?

Mr. FROGUE. Senator Martinez, that is a great question. Governor Sanford in South Carolina has a version of this where you can search any provider in the State and get the amount of money they receive and the number of patients they treat. It is a good first step. I think the next step after that is more along the lines of where you are trying to go, which is to get all the claims online in a usable fashion so not only can you track all the dollars, but track the health outcomes of every provider because there are very, very wide discrepancies in which hospital is most likely to kill you. That is good information to have. It does not matter where you are in the political spectrum. You want to know which hospital is more likely to kill you. The data—it is all there and we just have to access it.

As Mr. Horne said, it is just an information problem. If we use better tools—and again, these tools are all in the private sector, FedEx, UPS, any large retailer. Everywhere else it exists. This is not theory. We just need to apply the best practices to health care.

Senator MARTINEZ. Explain to me, if you could, the difference in the Medicare and Medicaid fraud?

Mr. FROGUE. I think it is substantial in both. Again, the data explains it better than anything. There are a lot of examples of fraud all over the country and not only in South Florida but in every region of the entire United States. It is different but it is substantial in every program and in every State, but it is difficult to track because the information technology is so poor and the incentives, as Senator Graham pointed out, are not there to actually not have it occur in the first place.

Senator MARTINEZ. Mr. Hussar, what has the State of New York done to focus more on the investigation of Medicaid fraud?

Mr. HUSSAR. We have taken essentially three approaches. No. 1, as some of the other witnesses have testified to, we have put in mandatory compliance programs. So we put some of the onus on providers to adopt effective compliance programs to really build integrity in on the front end of the program and self identify and report internet problems.

No. 2, we have engaged in effective measurement of program integrity. We believe that that measurement has to go beyond just the amount of—I am sorry—rather, the amount of recoveries or the number of prosecutions. We need to look also at cost avoidance to make sure that we have a consistent, well-publicized process to evaluate our effectiveness. I think there is a common saying that we manage what we measure, and we need to make sure that we are measuring the right thing.

Third, we publicize and utilize, to a great extent, our exclusion and other administrative tools. We want to make sure that we get people out of the program who do not deserve to be in there, people who are billing the program inappropriately, people who are unable on who fail to come into compliance with established professional standards.

Again, a lot of this is done through data mining. We have data mining that goes on throughout our organization. We have virtually real-time access to our claims data, and that ensures that all of our individuals, whether they be clinicians, auditors, or investigators, can look at what the latest trends are and address concerns as they arise.

If I may, Senator Martinez—

Senator MARTINEZ. Yes, please.

Mr. HUSSAR [continuing]. Just to follow up on Inspector General Levinson's remarks on DME. I think there are three areas that New York has engaged in that have been effective, that do relate to the pre-enrollment process.

First, we have a density analysis that we perform by geographical location to make sure that we do not have an oversupply of providers within a particular community. Obviously, if there are too many providers, it may lead to inappropriate billing.

Second, we ensure that the entities need to be viable beyond just the Medicaid reimbursement, that they can survive on Medicare and other third party insurance, lest they be forced to focus on inappropriate alternatives.

Finally, we conduct pre-enrollment site visits to make sure that they actually stock the appropriate items, that they are not just a storefront—

Senator MARTINEZ. It seems pretty basic. I mean, you go see if they really are in business before you start sending them checks.

Mr. HUSSAR. Right, and we do see a number of times where they do have a storefront setup where the mail is piled up outside and clearly no one has been there.

Senator MARTINEZ. Mr. Acosta showed me a picture of a closet with some half-used cans of paint that acted as the storefront or the supposed place of business for one of these entities.

Mr. Frogue.

Mr. FROGUE. Senator, if I might—

Senator MARTINEZ. It would be really funny if it was not so sad and if it was not our taxpayer dollars and the future of our children.

Mr. HUSSAR. Well, and if they were not trying to pass Reeboks off as medical shoes.

Senator MARTINEZ. Yes.

Mr. FROGUE. To add to either a sad or funny quotient, there is a State representative who I spoke to in preparation for this, Julio Robaino, in Miami who said right next to his district office he watches busloads of people pull up, walk into a fake DME provider, and walk out counting their cash. This is literally right underneath his nose. So this is so obvious and so apparent.

Again, there are tools in the private that are very common which are not applied to health care.

Senator MARTINEZ. We did this Whack-a-Mole operation. How many of these 491 durable medical equipment companies were expelled from billing Medicare after Operation Whack-a-Mole, Mr. Acosta, Mr. Levinson?

Mr. ACOSTA. Well, I believe the majority were recommended that they be de-licensed, but that then went into the CMS administra-

tive process, and I believe Mr. Levinson might be in a better position to—

Senator MARTINEZ. It went into the CMS administrative process. I do not think I like where this is going.

Mr. LEVINSON. It, nevertheless, has a reasonably happy ending in terms of enforcement because many of those who had appealed were ultimately denied readmission to the program. This was an exercise that I think is worth reminding everyone concerned that this involved is a very small number of the basic requirements for enrollment in the program. Investigators and inspectors were only looking at some of the bare minimum requirements, you know such as, do you have an office? Do you have office hours? Are you open during office hours—not even getting to the admittedly more complicated requirements of running a business. So this was really a threshold effort that unexpectedly resulted in scores of DME providers being thrown out of the program and who remain out of the program.

Mr. ACOSTA. Senator, if I may. I was just provided some numbers. Of the 491, 243 appealed and received hearings before CMS. Those hearings traditionally are one-sided in that the provider has the hearing before the CMS administrative agent, but the Government is not necessarily there. Of those, 222 were reinstated. We subsequently prosecuted several of those. Upon conviction, they then were finally brought out of the Medicare system. So I can provide further details.

Senator MARTINEZ. It would be nice if you would provide those details for the record.

Mr. ACOSTA. But certainly the way it proceeds, the CMS administrative process reinstated their numbers until they were not just charged but then subsequently convicted.

Senator MARTINEZ. Mr. Horne, a computer system, it would seem to me—and I am not a computer person, but I can just see how it would be so easy to have a system that would analyze the data to provide minimal sorts of checks. We are talking about a $60 billion fraud bill. I would bet it is higher. What do you think could be done in terms of providing a system that would be effective and also at what cost?

Mr. HORNE. Well, I think you have to look at it in a couple of different ways.

First, I want to sort of congratulate you, Senator, on the fact that you and your staff, you being an original sponsor of the TARP transparency bill, and your staff looked at me and said, if you could do TARP transparency, could you also do Medicare transparency? Data is data. So the reality is that yes, not that it is simple because nothing from this is simple. It takes grunt work, but from a logic standpoint, it is very straightforward. It is take the data, put it into a structured, normalized format, examine it, analyze where the anomalies are, process the claims through that should be processed through, flag the ones that should not, and put actions in place to stop those behaviors. It is straightforward.

You heard members of this panel say over and over again part of issue was in terms of prosecution and the actual CMS review process. These are all processes. Processes can be fixed. Processes can be changed. But if you do not identify where the issues are in

the first place—and what is happening now is in most cases, the IG's Office, the special prosecutor's office have to go and find the problem. Systems will bring those problems to the surface.

Senator MARTINEZ. Well, maybe it would prevent them from ever becoming a problem in the first place.

Mr. HORNE. Prevent them from ever happening in the first place because you would know that somebody is actually in violation at the point of violation, not at the point 6 months down the road where you show up at the doorstep and there is paint in the closet, if you get my drift. That is kind of the way that this happens.

What happens is that these people do migrate. They will become sort of like a migratory bird flying around the country going from place to place where they can set up new shops. They can be identified. They can be identified and thwarted before they ever get to the point of setting up shop.

Senator MARTINEZ. Right.

Mr. ACOSTA. If I may comment on the systems, as well, with a specific example. One of the things that we did through our initiative—I do not know if it is still the case, but we were the first U.S. Attorney's Office in the Nation to interface with and collocate with the Office of Inspector General so that we now have agents with the Bureau and OIG and prosecutors working side by side. What that has also done is give us access to data which is very important.

One of the ways that we have identified many of our cases is I have directed our prosecutors and Federal agents to look for suppliers that are billing for providing medical services to a substantial number of patients that live more than X miles from where that provider is located on the theory that most people do not travel a few hundred miles to receive their inhaler or to get their wheelchair. These companies are getting individuals' numbers from around the Nation and they are billing Medicare for providing those services.

Senator MARTINEZ. It is common sense stuff.

Mr. ACOSTA. Very, very common sense, and what is so painful about this is that there are very common sense algorithms that can be used that we run on a manual basis because we have to do it that way. But there are a number of common sense solutions that credit card companies do all the time that could be applied to that data. That is how we identify so many of those cases.

Mr. HORNE. Senator Martinez, just as a comment on what the prosecutor was saying, I have built or been involved with building systems such as the UPS tracking system, such as the American Express system. I was involved in some of the original on their business cards, working with IBM in terms of their global customer management system.

These are processes that are exactly the same from company to company. It does not change. Your staff saw so clearly that the TARP process and this process—it is data. What inhibits the people who are responsible for tracking these things from getting the job done as easily as they could is because they have to go find the data. If you just gave them information, which is the transformation of data into usable knowledge that they can act upon, then we can limit this process, a lot of the exercise up front dra-

matically, and put them in the position where they can go after the worst offenders in order and literally get them out of the way, categorize them, and then build all the flags and alarms into the system that set off as soon as a problem has occurred.

Senator MARTINEZ. Understood.

Well, thank you all very, very much for participating on the panel. To those of you who are fighting this every day, I appreciate what you are doing and thank you. We look forward to perhaps having you put together some of the answers that Senator Graham requested because I think it would help us to have some of your specific recommendations on how we can help alleviate the problem. It is obvious that there is need for legislation. There is a need for more resources and a common sense approach.

As we look at the future of health care in America—and we are about to have a big debate in the Congress about perhaps enlarging the role of Government in health care. It is frightening to think that what is being done today with the money that is being spent on Medicare and Medicaid would apply tenfold, and the fraud that is happening in this program would be no different than any other. If we are talking about 10 percent of the money being wasted basically by criminality and waste and fraud, imagine 17 percent of GDP being treated the same way. It would bankrupt our Nation. So this is important. It is timely.

I thank you for being with us. I thank you for your work.

At this point, I will declare the hearing adjourned.

[Whereupon, at 4:20 p.m., the hearing was adjourned.]

APPENDIX

DANIEL LEVINSON RESPONSE TO SENATOR MARTINEZ QUESTION

Question. You testified that of the 1,581 durable medical equipment suppliers that DOJ, HHS–OIG, and CMS visited in 2007 in South Florida, 491 failed to maintain a physical facility or were not open for business and staffed. How many of the 491 durable medical equipment suppliers were referred for revocation of billing privileges? How many suppliers' billing privileges were actually revoked? How many appealed the revocation? How many were reinstated after appeal? Of those that were reinstated, how many were ultimately convicted or agreed to settle?

Answer. As set forth in our report entitled "South Florida Durable Medical Equipment Suppliers: Results of Appeals (October 2008)," OIG and CMS staff conducted unannounced site visits to 1,581 suppliers located in Miami-Dade, Broward, and Palm Beach Counties. OIG found that 491 of these suppliers failed to maintain physical facilities or were not open and staffed during the unannounced site visits as required.

All the 491 suppliers were referred to CMS so that CMS could consider revoking their billing privileges. CMS subsequently revoked these suppliers' billing privileges. Nearly half of the suppliers appealed and received hearings; hearing officers conducted hearings for 243 of the 491 revoked suppliers. Billing privileges were reinstated for 222 of the 243 suppliers. As of March 2008, the billing privileges of half of the suppliers (111 of 222) that were reinstated by hearing officers have subsequently been revoked as a result of National Supplier Clearinghouse's follow-up project and its continuing efforts to identify suppliers that do not meet Medicare standards. In addition, 17 percent of the suppliers (37 of 222) have had their billing privileges inactivated. As a result, two-thirds of suppliers whose billing privileges were reinstated by hearing officers (148 of 222) had their privileges revoked again or inactivated by CMS.

Between April and September 2007, the U.S. Attorney's Office indicted 18 individuals connected to 15 of the 222 reinstated suppliers. As of April 2008, 10 of the 18 individuals had been convicted, sentenced to jail terms, and ordered to pay restitution. Six of the eight remaining individuals have since been sentenced to jail terms and ordered to pay restitution. Two of the eight individuals are currently fugitives.

Statement of S3 Matching Technologies
For the Senate Special Committee on Aging
Hearing on Medicare and Medicaid Fraud
May 6, 2009

Chairman Kohl, Ranking Member Martinez, and Distinguished Committee Members:

On behalf of S3 Matching Technologies, we appreciate the opportunity to share our views on the critical topic of Medicare and Medicaid waste, fraud and abuse. We applaud your leadership in highlighting this important problem, which threatens to sap the Medicare and Medicaid programs of limited resources and thereby jeopardize health care services for beneficiaries in greatest need.

I. Introduction

S3 Matching Technologies is an Austin, Texas based company focused on providing data quality management software for the IT, telecom, financial services, and health care industries. S3 invented TeraMatch®, the first ever hybrid algorithmic and rules-based matching engine. The company provides mission critical data services to numerous Fortune 50 enterprises and has partnered successfully with a large State Medicaid Agency to use its advanced information technology to prevent fraud and abuse in the Medicaid program.

Conservative estimates by the National Health Care Anti-Fraud Association indicate that more than $68 billion is lost each year to fraud, seriously threatening the Medicare and Medicaid programs. While some controls exist to reduce this risk, they are applied inconsistently, are easily bypassed, and focus on recovering improper payments rather than preventing them – essentially relying on a "pay-and-chase" model focused on audits and recovery efforts.

Clearly, a more cost-effective approach would be to prevent fraudulent or improper payments in the first place, and advanced information technology can accomplish that objective. Specifically, available tools can prevent excluded providers from enrolling or reenrolling in Medicaid and Medicare and give honest providers the ability to conduct meaningful self-audits in real time.

II. Advanced Information Technologies Can Prevent Fraud and Improper Payments

A. Ensuring Accurate Verification Prior to Provider Enrollment

Many factors currently inhibit meaningful fraud prevention efforts. One significant problem is the inability to track providers who have already been excluded for fraudulent, wasteful, or abusive practices. Currently, provider names are not added to the Department of Health and Human Services Office of Inspector General (OIG) list of excluded providers and the General Services Administration (GSA) debarment list in a timely manner. Further, fraud schemes often cross state lines, and excluded providers frequently simply move from one state to another and continue their fraudulent practices.

While States are required to perform a check of the federal exclusion list before enrolling providers in Medicaid, there are no minimum standards. This enables excluded health care providers to make simple changes to distinguishing information and thereby re-enter the Medicaid provider network. States' failure to consistently share information on excluded providers allows providers to simply cross state lines and continue to defraud the Medicaid program.

This situation also impacts Medicare by reducing the visibility of providers demonstrating patterns of fraud at the state level. The combination of insufficient controls and the lack of interstate information-sharing thus contribute to the "pay-and-chase" approach to fraud, create unnecessary costs and administrative burdens, and divert scarce resources from the delivery of health care services.

Innovative information technology solutions, such as advanced matching technology, can enable the states and the Federal government to detect and prevent fraud. Accurate, real-time technologies can actually stop improper payments before they occur and identify signs of fraud earlier than current auditing techniques.

Advanced technology systems can recognize subtle distinctions in data to identify providers with multiple identification numbers, to recognize duplicate entries, or to distinguish inadvertent errors from intentional fraud. These real-time, interactive capabilities can match an individual to all of the excluded provider lists at once, through a single point of service.

These technologies interface with centralized reporting centers to consolidate exclusion data and digitally fingerprint each transaction to identify internal fraud and ensure program compliance. Automation improves the quality and completeness of accreditation lists to speed the enrollment process for valid providers, thereby expanding available provider coverage for beneficiaries. These advanced technology systems can also prevent fraud by improving the recognition of improper claims prior to payment through enhanced analysis and sophisticated matching of claims patterns.

The number of providers on the federal exclusion list and the quality of self-reported data make it impractical to perform this validation without the use of advanced information technology that can recognize both exact and similar matches across any number of databases. Such technology has been used in the private sector and on a limited basis in the Medicaid program to identify both new and currently enrolled providers who should be excluded.

In fact, we estimate that advanced data verification systems could save the Medicaid and Medicare programs more than $500 million dollars each year (based on internal analysis by S3 Matching Technologies) by preventing thousands of ineligible providers from fraudulently billing the programs.

B. Facilitating Provider Self-Audits

Advanced information technologies can also prevent improper payments by giving providers the tools they need to conduct self-audits to detect "bad actors" in their systems and to identify inadvertent overpayments. A more effective self-auditing system could greatly increase program compliance, while lessening the burden of third-party audits and reducing the potential for liability.

Self-disclosing overpayments, in most circumstances, would produce a better outcome for providers than independent discovery by third-party auditors. Allowing providers the opportunity to reliably self-audit will encourage them to work in partnership with state and federal agencies to help capture overpayments without the threat of costly lawsuits.

Today, however, many providers may be hesitant to utilize available tools without clear guidance from federal and state regulators. By facilitating providers' selection and use of available information technologies, the federal government could vastly improve the integrity of the Medicaid and Medicare programs and help dollars flow back to state and federal coffers.

III. Policy Recommendations for Congress:

To achieve these important objectives, we respectfully submit the following policy recommendations for the Committee's consideration:

- Congress should strengthen the provider enrollment process by integrating Medicare and Medicaid exclusion lists in a standardized, real-time manner utilizing advanced information technologies.
- Congress should also establish more stringent screening procedures to prevent excluded Medicaid or Medicare providers from enrolling or reenrolling, including a review of other relevant records such as delinquent taxes, licensing verification, death registries, business registrations and sex offender registries.
- States play a key role in fraud prevention, and they should be required to remove providers from the Medicaid and Medicare network if they become excluded providers; and timely report excluded providers to the federal List of Excluded Individuals/Entities (LEIE).
- Congress should also provide financial incentives and technical assistance to assist states in adopting best-practice information technology solutions to detect fraudulent providers and to identify improper claims before they are paid.
- To ensure that states take these crucial fraud prevention steps, Congress should establish meaningful penalties for state noncompliance with federal requirements.
- Congress should also direct the Secretary of Health and Human Services to establish a process for certifying advanced information technologies for provider self-auditing purposes under Medicare and Medicaid.

IV. Conclusion

On behalf of S3 Matching Technologies, thank you for considering our views. We are grateful for the Committee's efforts to eradicate waste, fraud, and abuse in the Medicare and Medicaid programs, and we believe that advanced information technologies hold enormous potential to help solve those vexing problems. We look forward to working with Members on these important issues and would be glad to provide any additional information or assistance you may require..

Respectfully submitted,

Jack Holt, CEO / COO
S3 Matching Technologies

Statement of the
American Association for Homecare

to the

Senate Committee on Homeland Security and Governmental Affairs
Subcommittee on Federal Financial Management, Government Information,
Federal Services, and International Security

on

Elimination of Waste and Fraud in Medicare and Medicaid

April 22, 2009

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American Association for Homecare 13-Point Anti-Fraud Program

Statement by the American Association for Homecare

Mr. Chairman and Ranking Member, on behalf of the American Association for Homecare's more than 4,000 member locations serving Medicare beneficiaries in every state in the nation, we appreciate the opportunity to submit this statement to the Senate Committee on Homeland Security and Governmental Affairs Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security regarding the elimination of waste and fraud in Medicare and Medicaid.

The American Association for Homecare (AAHomecare) represents durable medical equipment providers, manufacturers, and other organizations in the homecare community. Members serve the medical needs of the millions of Americans who require oxygen equipment and therapy, power wheelchairs and other mobility assistive technologies, oxygen and inhalation drug therapy, home infusion, hospital beds, diabetic supplies, and other medical equipment, supplies, and services in the comfort of their homes. Receiving these services and equipment in the home reduces the need for lengthy, expensive institutional stays, and allows patients to receive the best treatment of all: the company of loving family and friends.

AAHomecare and its members applaud the recent statement by President Obama that his administration would "root out the waste, fraud, and abuse in our Medicare program that doesn't make our seniors any healthier."

The Association has zero tolerance for fraud and remains committed to eliminating fraud and abuse in the Medicare program. We are eager to work with Congress, the White House, the Centers for Medicare and Medicaid Services (CMS), and federal law enforcement agencies in efforts to ensure the integrity of the Medicare program. To that end, we continue to offer suggestions for additional fraud and abuse prevention strategies.

This past February, AAHomecare presented its Medicare Anti-Fraud Legislative Action Plan to Members of Congress. This 13-point legislative action plan lays out tough, effective measures to stop waste, fraud and abuse in Medicare's home medical equipment (HME) sector.

Our legislative action plan is designed to protect these patients and their families—as well as the American taxpayers—by stopping fraud and abuse in the Medicare system before it can start. The plan targets fraud and abuse at the source through proposed policies that will ensure that providers who participate in Medicare are responsible, legitimate businesses, and that disreputable actors are locked out of the system and prevented from abusing the public trust.

Among the provisions detailed in the legislative proposal are more rigorous quality standards, increased penalties for fraud, mandated site inspections for new providers, and real-time claims analysis.

The Association and its members want to work with Congress, the Administration, and CMS to enact these new steps to prevent criminals from abusing Medicare.

While HME fraud only constitutes a small fraction of overall Medicare fraud, we firmly believe that any abuse of the Medicare system is a disgraceful waste of taxpayers' dollars and represents theft of resources needed by patients, seniors, and individuals with disabilities.

It is important to note that the American Association for Homecare welcomes a full and thorough review of reimbursement policies for durable medical equipment to ensure that Medicare payments reflect the true costs of providing home medical care to beneficiaries. We would welcome an opportunity to meet with congressional committee staff and with the Office of Inspector General staff to discuss the cost of services needed to provide proper care for seniors who require medical oxygen therapy, complex rehabilitative equipment, and other forms of home-based care.

It's also worth noting that the most recent National Health Expenditures data show that spending in the durable medical equipment sector grew by a rate of just 0.75 percent between 2006 and 2007, and that rate of growth is probably negative now. Spending in our sector of Medicare represents 1.6 percent of total Medicare spending.

In the Medicare Anti-Fraud Legislative Plan, the American Association for Homecare proposes the following 13 specific recommendations to stop fraud and abuse in the homecare sector. These steps would eliminate most of the Medicare fraud attributed to the home medical equipment sector by attacking the problem at the front of the process rather than relying on the "pay-and-chase" approach to stopping fraud.

1) **Mandate Site Inspections for All New Home Medical Equipment Providers**
   A July 2008 GAO report underscored the need for CMS to ensure that its contractors are conducting effective site inspections for all new applicants for a Medicare provider number.
2) **Require Site Inspections for All HME Provider Renewals**
   All renewal applications should require an in-person visit by the National Supplier Clearinghouse (NSC), the contractor that CMS uses to ensure integrity in the Medicare program.
3) **Improve Validation of New Homecare Providers**
   Additional validation of new providers should be included in a comprehensive and effective application process for obtaining a Medicare provider number.
4) **Require Two Additional Random, Unannounced Site Visits for All New Providers**
   Two unannounced site visits should be conducted by NSC during the first year of operation for new HME providers.
5) **Require a Six-Month Trial Period for New Providers**

The NSC should issue a provisional, non-permanent supplier number to new suppliers for a six-month trial period. After six months of demonstrated compliance, the provider would receive a "regular" supplier number.

6) **Establish an Anti-Fraud Office at Medicare**
CMS should establish an office with the sole mandate of coordinating detection and deterrence of fraud and improper payments across the Medicare and Medicaid programs.

7) **Ensure Proper Federal Funding for Fraud Prevention**
Increase federal funding to ensure that NSC completes site inspection and other anti-fraud measures.

8) **Require Post-Payment Audit Reviews for All New Providers**
Medicare's program safeguard contractors should conduct post-payment sample reviews for six months worth of claims submitted to Medicare by new providers.

9) **Conduct Real-Time Claims Analysis and a Refocus on Audit Resources**
Medicare must analyze billings of new and existing providers in real time to identify aberrant billing patterns more quickly.

10) **Ensure All Providers Are Qualified to Offer the Services They Bill**
A cross-check system within Medicare databases should ensure that homecare providers are qualified and accredited for the specific equipment and services for which they are billing.

11) **Establish Due Process Procedures for Providers**
CMS should develop written due process procedures for the Medicare provider number process, including issuance, denial and revocation of the Medicare supplier number. The procedures must include, for example, an administrative appeals process and timelines.

12) **Increase Penalties and Fines for Fraud**
Congress should establish more severe penalties for instances of buying or stealing beneficiaries' Medicare numbers or physicians' provider numbers that may be used to defraud the government.

13) **Establish More Rigorous Quality Standards**
Ensure that all accrediting bodies are applying the same set of rigorous standards and degree of inspection to their clients.

This action plan is a tangible demonstration of the home medical equipment sector's commitment to stopping fraud and abuse in the homecare sector. More importantly, the plan will ensure that bad actors will no longer manage to enter the system, and those that are unfortunately already in are quickly discovered, removed and harshly punished.

For more information about the Medicare Anti-Fraud Legislative Action Plan, please contact Walter Gorski at 703-535-1894 and visit www.aahomecare.org/stopfraud.

American Association For Homecare: 13-Point Legislative Action Plan

AAHomecare 13-Point Legislative Action Plan

1. **Mandate Site Inspections for All New Home Medical Equipment Provider**
   A July 2008 GAO report underscored the need for CMS to ensure that its contractors are conducting effective site inspections for all new applicants for a Medicare supplier number.

2. **Require Site Inspections for All HME Provider Renewals**
   All renewal applications should require an in-person visit by the National Supplier Clearinghouse (NSC), the contractor that CMS uses to ensure integrity in the Medicare program.

3. **Improve Validation of New Homecare Providers**
   Additional validation of new providers should be included in a comprehensive and effective application process for obtaining a Medicare supplier number.

4. **Require Two Additional Random, Unannounced Site Visits for All New Providers**
   Two unannounced site visits should be conducted by NSC during the first year of operation for new HME providers.

5. **Require a Six-Month Trial Period for New Providers**
   The NSC should issue a provisional, non-permanent supplier number to new suppliers for a six-month trial period. After six months of demonstrated compliance, the provider would receive a "regular" supplier number.

6. **Establish an Anti-Fraud Office at Medicare**
   CMS should establish an office with the sole mandate of coordinating detection and deterrence of fraud and improper payments across the Medicare and Medicaid programs.

7. **Ensure Proper Federal Funding for Fraud Prevention**
   Increase federal funding to ensure that NSC completes site inspection and other anti-fraud measures.

8. **Require Post-Payment Audit Reviews for All New Providers**
   Medicare's program safeguard contractors should conduct post-payment sample reviews for six months worth of claims submitted to Medicare by new providers.

9. **Conduct Real-Time Claims Analysis and a Refocus on Audit Resources**
   Medicare must analyze billings of new and existing providers in real time to identify aberrant billing patterns more quickly.

10. **Ensure All Providers Are Qualified to Offer the Services They Bill**
    A cross-check system within Medicare databases should ensure that homecare providers are qualified and accredited for the specific equipment and services for which they are billing.

11. **Establish Due Process Procedures for Suppliers**
    CMS should develop written due process procedures for the Medicare supplier number process, including issuance, denial and revocation of the Medicare supplier number. The procedures must include, for example, an administrative appeals process and timelines.

12. **Increase Penalties and Fines for Fraud**
    Congress should establish more severe penalties for instances of buying or stealing beneficiaries' Medicare numbers or physicians' provider numbers that may be used to defraud the government.

13. **Establish More Rigorous Quality Standards**
    Ensure that all accrediting bodies are applying the same set of rigorous standards and degree of inspection to their clients.

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FOR THE RECORD

STATEMENT OF WILLIAM A. DOMBI, VICE PRESIDENT FOR LAW

THE NATIONAL ASSOCIATION FOR HOME CARE & HOSPICE

TO THE SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

May 19, 2009

Thank you for the opportunity to provide written testimony in follow-up to the recent hearing regarding fraud, waste, and abuse in the Medicare program held by the Special Committee on Aging of the U.S. Senate. We applaud the work of the Committee on this important topic and looking forward to working with the Committee and its staff in developing better protections for the Medicare program and the elderly and disabled citizens that the program serves.

The National Association for Home Care & Hospice, Inc. (NAHC) is the largest trade association in the country representing the nation's home health agencies, hospices and the patients in their care. While isolated in the scope and number of offenders, home health care and hospice is unfortunately afflicted with fraud, waste, and abuse. Any Medicare spending that is not fully appropriate victimizes those who need the help the most—the ill and infirm individuals entitled to Medicare coverage.

Recognizing the need to establish stronger protections from these abuses within Medicare, the Board of Directors of NAHC developed a 10 point Action Plan that recommends a number of steps that must be taken to preserve the integrity of the Medicare home health and hospice benefits. As part of this submission, we include the Action Plan for the record.

On May 13, 2009, NAHC held an Ethics and Compliance Summit at which leaders from home care came together to develop the implementation of the Action Plan in greater detail. We will forward the report that will be issued from that Summit upon its completion.

The home care and hospice community is committed to achieve 100% compliance. We look forward to working towards that goal with the Committee.

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Ethics and Compliance Action Plan
January 29, 2009

Abuses in home health services uncovered to date necessitate a stepped-up effort to eliminate or curtail the risks posed to Medicare and the patients it is intended to serve. Several instances of concern are of note. First, Medicare has initiated an antifraud effort through the use of the provider enrollment process targeted at the Los Angeles and Houston areas as a result of the exponential growth in the number of home health agencies participating in Medicare. In the Houston area alone, there are currently nearly 700 Medicare participating home health agencies, over seven percent of the agencies nationwide. Spending for home health services has grown by over 200 percent in the state of Texas. With its special effort, Medicare has required that home health agencies in these locales re-enroll in the Medicare program, thereby allowing for Medicare to examine the ownership and management of these companies.

In the Miami-Dade area of Florida, Medicare has targeted home health agencies that have extraordinarily high incidence of claims involving outlier payments. It is reported that over 250 of the 350-plus agencies in Miami-Dade have more than 50 percent of their claims as outliers in comparison to approximately three percent of claims for all agencies otherwise. The high incidence of outlier claims has led to a surge in outlier payments in excess of $300 million paid in Miami-Dade. Medicare's response has been to suspend payment to the ten highest outlier home health agencies and to institute pre-payment review on any agency with more than five percent of its claims as outliers.

Recently, in Michigan, five home health agency owners were indicted with allegations of over-utilization and the submission of false claims for Medicare payment. These indictments followed the initiation of a focused effort on Medicare home health services by Michigan law enforcement authorities following numerous tips from whistleblowers and complaints from competing home health agencies.

A heightened level of attention to home health is warranted by various other factors. With Medicare home health services, the spending has risen from under $9 billion in 1999-2000 to over $15 billion in 2007 with the number of home health agencies increasing from 6800 to over 9400. As a result of these growth trends, the Office of Inspector General at the U.S. Department of Health & Human Services has included a number of hospice and home health audits and studies in its 2009 Work Plan. At the same time, Government Accountability Office (GAO) recently evaluated compliance issues in Medicare home health services payment and raised concerns about the growth in home health spending, the increase in the numbers of home health agencies, and incidences of fraud and abuse. That study was requested by the ranking member of the Senate Finance Committee, Senator Charles Grassley.

Medicare home health services has been down this path before in the mid-1990s. In response, Congress and Medicare regulators established anti-fraud measures including Operation Restore Trust and the surety bond requirement for existing and new providers. Further, Congress replaced the reimbursement model for home health services with the infamous Interim Payment System. In other words, the response to spending growth and isolated incidences of noncompliance were directed to the home health care community at large rather than targeted to specific offenders. Based on these past experiences and the current environmental factors, the National Association for Home Care & Hospice, Inc. offers the following proposed **Plan of Action**.

1. **NAHC should convene an Ethics and Compliance Summit**

   One way to address concerns and to firmly establish that home health care and hospice intends to help police itself is to take on the issues in an open and transparent way. The proposed Summit would include representatives from home health care and hospice, the Office of Inspector General, the Centers for Medicare & Medicaid Services, and State Medicaid Directors. This summit would explore the risk areas in Medicare and Medicaid payment for home health services and hospice care and design a series of actions that would take place to address these risks. Working in concert with the oversight and enforcement bodies would give the industry the opportunity to prove that it is a capable partner in helping to keep home health care and hospice compliant.

2. **Revise and strengthen the NAHC Code of Conduct.**

   The current code of conduct for NAHC members should be refocused on today's ethical and compliance areas of concern. Further, the code should offer more detailed standards of conduct regarding specific risk areas such as financial relationships with physicians and referral sources. Other healthcare sectors, including the pharmaceutical and technology sectors, have instituted such detailed codes of conduct that have been well received by federal and state oversight bodies.

3. **Expand NAHC educational efforts regarding ethics and compliance.**

While NAHC has done much to present the standards for appropriate compliance in home health and hospice, those efforts must be further expanded to reach all participants in delivery of that care. Of growing concern as areas in need of educational efforts are coverage and service documentation standards. With the increase in the utilization of home health services and hospice, comes the risk that oversight bodies will claim that the services provided are not within Medicare coverage standards or that the documentation fails to establish such. In the 1995-97 era, Operation Restore Trust was triggered by similar misguided accusations. NAHC staff has noted that the quality of service documentation has deteriorated in terms of the effectiveness of that documentation to establish Medicare coverage.

4. **Establish a federal requirement that administrators of home health agencies and hospices are credentialed under NAHC's Certified Home Care Executive (CHCE) standards or other comparable standards.**

The ethics and compliance performance of an organization starts with the top. The CHCE program establishes a high level of professional credentials for executives and serves to achieve a comprehensive understanding of performance measures, including ethics and compliance.

5. **Establish a certification program for financial managers**

If there is one part of a home health agency or hospice that is best equipped to prevent compliance lapses or spot them before they are out of control, it is the financial division of the organization. Through NAHC's Home Care & Hospice Financial Managers Association (HHFMA), a certification program can be established utilizing credits earned through appropriate educational programming. Further, the certification program can be strengthened through a financial manager's certification of adherence to principals of compliance that would be developed by HHFMA.

6. **Institute a system for reporting the failure of oversight bodies to act upon provider complaints of noncompliance**

A common concern expressed by personnel from home health agencies and hospices is that complaints to various enforcement authorities such as the Office of Inspector General go unaddressed. For example, one home care executive indicates that a representative from the OIG responded to a complaint by stating that they address only matters that are worth $3 million or more. With such inadequate response to the self-policing efforts of home care and hospice, the industry has a thin chance of success. There must be

timely and forceful action by enforcement authorities to these complaints. By maintaining a registry of reports of inadequate response, the industry positions itself to deflect complaints from Congress, regulatory agencies, and the media about the source of any compliance problems.

7. **Enact a targeted moratorium on new home health agencies and hospices**

NAHC believes that the risks of ethical lapses and noncompliance, along with more serious issues of fraud and abuse, are heightened as a market is oversaturated with providers of services. For example, the standards for service coverage may be stretched beyond a breaking point as providers attempt to gain sufficient patient census to achieve a financially viable business. Further, providers may be tempted to cross the line in terms of incentives to referral sources in order to secure sufficient patients. Currently, there are several locations across the country where market saturation may already have occurred. A moratorium could be targeted to those areas where the ratio of providers to Medicare beneficiaries exceeds a threshold level.

8. **Issue "compliance alerts" highlighting risk areas**

One way to prevent noncompliance is to provide clear, succinct guidelines on what is acceptable and not acceptable action. With this proposal, NAHC's Center for Health Care Law (CHCL) would issue periodic compliance alerts that focus only on actions that are not acceptable. CHCL would not focus its compliance alerts in a manner that approves of any particular conduct because of the risk of disagreement between CHCL and government enforcement authorities. For those circumstances, CHCL would refer providers to the OIG Advisory Opinion Process and the CMS Stark Rule Advisory Process. CHCL could offer legal assistance to those parties looking to gain protection through those processes.

9. **Issue a "how to complete a Medicare cost report" DVD and manual**

NAHC has noted widespread errors and omissions on home health agency and hospice cost reporting. These deficiencies lead to an inaccurate analysis of financial status by the Medicare Payment Advisory Commission (MedPAC) and others. Further, improper cost reporting poisons the database that is used to rebase payment rates and establish reforms to reimbursement models. As proposed, NAHC's HHFMA would develop and distribute a DVD and manual to all home health agencies and hospices whether they are members of NAHC or not.

10. **Conduct a study that evaluates Medicare financial margins and any correlation with quality of care and service utilization**

Medicare margins for home health agencies continue to range widely in result. Over 30 percent of all home health agencies currently have negative Medicare margins while over 25 percent of agencies have margins in excess of 25 percent. NAHC should conduct a detailed study to determine whether there is any correlation between financial performance and quality of care or service utilization. The purpose of the study would include determining whether home health agencies with high Medicare margins achieve those results at the expense of their patients' care or through overutilization of services. A serious risk area is that there would be an accusation that home health agencies are stinting on care or cherry-picking patients in order to achieve profit.

Implementation

The proposed plan of action requires in-depth implementation to be effective. Among the recommended implementation steps would be:

A. A national public relations campaign to unveil the industry's effort.
B. The use of web-based media for communications and dissemination of information
C. The issuance of a "seal of compliance" to NAHC member agencies willing to sign the code of ethics
D. The development of an alliance with the Health Care Compliance Association and the American Health Lawyers Association
E. A briefing of members of Congress and staff regarding the plan of action

Conclusion

NAHC recommends expedited consideration and approval of this plan of action with any necessary amendments thereto.

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