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MEDICARE PROGRAM INTEGRITY

JOINT HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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MEDICARE PROGRAM INTEGRITY

THURSDAY, MARCH 8, 2007

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
SUBCOMMITTEE ON OVERSIGHT,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (Chairman of the Subcommittee), presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
February 28, 2007
HL–4

CONTACT: (202) 225–3943

Chairmen Stark and Lewis Announce a Hearing on Medicare Program Integrity

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) and Oversight Subcommittee Chairman John Lewis (D–GA) announced today that the Subcommittees will hold a joint hearing on Medicare program integrity, specifically focusing on Administration efforts to identify and eliminate fraud, waste and abuse. **The hearing will take place at 10:00 a.m. on Thursday, March 8, 2007, in Room 1100, Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing. A list of invited witnesses will follow.

BACKGROUND:

The Medicare program will spend over $425 billion providing health care services to over 44 million seniors and people with disabilities in 2007. Fraud, waste and abuse in a program of this size can cost beneficiaries and taxpayers billions of dollars. Medicare has faced problems with overpayments, underpayments, unnecessary services and even criminal fraud. Multiple governmental agencies are charged with identifying, investigating and prosecuting incidents of fraud, waste and abuse in Medicare.

In announcing the hearing, Health Subcommittee Chairman Stark said, **"We owe it to beneficiaries and taxpayers to be good stewards of Medicare dollars. The Congress needs a better understanding of how agencies are working to minimize waste, fraud and abuse in the program."**

"When people abuse the Medicare program, they take advantage of senior citizens and people with disabilities who need medical services and care," said Oversight Subcommittee Chairman Lewis. **"We must find ways to detect and eliminate fraud to protect Medicare beneficiaries. Our Subcommittees will continue to work with governmental agencies to preserve the integrity of the Medicare program."**

FOCUS OF THE HEARING:

The hearing will focus on prevention, detection, investigation and prosecution of Medicare fraud, waste and abuse at the Centers for Medicare and Medicaid Services, the Health and Human Services Office of Inspector General, and the Department of Justice.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage,

http://waysandmeans.house.gov, select "*110th Congress*" from the menu entitled, "*Committee Hearings*" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Thursday, March 22, 2007**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. With the consent of the Chairman of the Oversight Committee and the Ranking Member of the Oversight Committee, the joint hearing can proceed. I want to welcome everyone to the first Medicare Oversight hearing. Mr. Lewis and I felt that it was necessary to hold this as a joint meeting and I welcome that opportunity. The topic, of course, is protecting Medicare beneficiaries from abuse and protecting the taxpayers from waste and fraud.

We are dealing with this in a program that is going to spend 400 billion dollars this calendar year and providing services for 44 million people.

We will hear from three agencies, Inspector General Dan Levinson is in charge of the audits, inspections, investigations of fraud, waste and abuse. The Office of the Inspector General (OIG) has provided Centers for Medicare and Medicaid Services (CMS)

and Congress with a lot of valuable information on everything from part B drugs to nursing home quality to the fraud in some durable medical equipment. It is interesting to note that the OIG Red Book which among other savings options suggests that Medicare Advantage Plans are overpaid. He picks the number 2.5 billion. In 2006 CMS reported improper Medicare payments of over 10 billion.

I believe and I will ask General Levinson to correct me if I am wrong, but improper payments in our system do not imply that every improper payment is a fraud or is a violation.

For those of you who balance your own checkbooks or do your own tax statements, if you could imagine something like 80 million transactions, there are bound to be mistakes. I believe it is correct that the mistakes, the unintentional errors, the arithmetic errors, the transpositions show up in that 10 billion and I would despair of ever getting that to zero just because of the human factor in the huge volume of relatively small transactions that must be processed by intermediaries and then surveyed by CMS. I just want to—I think I am correct to tell my colleagues that my guess would be that somewhere around half of the figures that come out from year to year are actually fraudulent or intentional mistakes and the other half is just what engineers would call the entropy in the system.

The final witnesses responsible for investigating and prosecuting Medicare's bad actors and as a U.S. Attorney for the Southern District of Florida, who I gather has been fired, you are still with us so you are not on that list. Nobody has called you right? Okay, we have got a good one here.

Mr. Acosta has identified numerous schemes to defraud Medicare in the durable medical equipment. For those of you who want some trivia, actually, the impetus for what are now called the Stark laws started because of a lot of good work done by the State legislature in Florida, by some investigative reporters from I think "The Sun Journal," and in finding a lot of abuse in providing Medicare systems I think in those days in diagnostic—either diagnostic labs or imaging, but at any rate, several good reforms have come out of the State of Florida.

I look forward to hearing from all the witnesses and I would recognize my colleague and friend, John Lewis, the Chairman of the Oversight Committee.

Chairman LEWIS OF GEORGIA. Thank you, Chairman Stark. My colleague and Ranking Member Ramstad and I would like to thank you and Ranking Member Camp for holding this joint hearing today with the Subcommittee on Oversight.

It is the responsibility of both Subcommittees to guard the integrity of the Medicare Program and protect its beneficiaries who many times are the most vulnerable people in our society. They are our parents and grandparents who have given their youth to this Nation and they deserve our protection and the finest public service.

I want to thank the witnesses, each of the witnesses for being here today and for all their efforts to protect the Medicare Program. Your work has returned over 8.5 billion dollars to the program. You have done an excellent job. You have helped to move us

down the road to reform that we are seeking in this Congress and we thank you.

There is still so much more that we can do. I am very concerned that there has been almost no oversight of the new prescription drug benefit under Part D. This is not responsible leadership. I hope today I will hear each agency plan to reduce fraud in Medicare Part D.

The fraud and abuse in the Medicare system, the shame and a disgrace, a view of the suspicion of people who question Government's social service. We must find a way to eliminate the fraud in the Medicare system so that it works for the people it was intended to serve.

Your offices have uncovered some disturbing almost unreal and unbelievable cases. In some instances Federal money is used to support unethical, immoral and illegal behavior.

In one unbelievable case a hospital performed painful medically unnecessary procedures on elderly resident of assisted living facilities simply because those procedures have a high rate of government reimbursement.

In another case, a physician was providing a large amount of controlled substances to his patients not to treat their medical condition but to get the government reimbursement on those medications. Those patients were either abusing the drugs or selling them to other people. One person died as a result of this improper treatment and others were seriously injured.

This violation of the public trust will not be tolerated by this Congress and we must hold these people accountable and do all we can to prevent this kind of abuse.

This Congress is committed to finding ways to work even closer with our witnesses to ensure that Medicare beneficiaries are offered the best medical care we can deliver. The wrongdoers are held accountable and that the Medicare Program remains strong for the next generation of Americans.

I look forward to learning more about each agency plan to oversee this important and necessary program that will benefit our citizens.

Thank you very much for being here today.

Thank you, Mr. Chairman. Mr. Chairman, it is my pleasure to recognize my friend and we have been friends since we have both been in the Congress, the Ranking Member of the Oversight Committee, Mr. Ramstad.

Mr. RAMSTAD. Thank you very much, Chairman Lewis, and thank you for your kind words. Thank you, Chairman Stark, both of you for holding this important joint hearing on Medicare Program integrity.

I join my colleagues in welcoming our witnesses who play such a key role in rooting out waste, fraud and abuse in the Medicare Program. I also would like to mention for the record that Ranking Member Camp is unable to be here today because he was called home yesterday by a family medical emergency.

Medicare fraud, as we know, not only cheats taxpayers but it cheats millions of seniors and people with disability who rely on Medicare. Improper payments raise the already enormous costs of

the program and they force vulnerable beneficiaries to pay cost sharing they should not have to pay.

With an estimated 10 billion dollars, that is billion with a B, in Medicare overpayments last year alone, that adds up to real money.

With its multiple parts, players, providers and payment systems, it is no surprise the Medicare Program is at high risk for abuse by unscrupulous types out there. It is also ripe for misunderstanding and unintentional mistakes just because of its shear complexity.

In fact, one of my colleagues said not long ago, the Medicare Program makes the Tax Code look simple and straightforward. I think there is a little bit of hyperbole in that statement, but you get the point.

I look forward to hearing about efforts that are underway to identify vulnerable areas as well as the investigation and prosecution of intentional fraud and abuse. I will also be interested to hear whether additional tools are needed in your arsenal, our arsenal to go after waste, fraud and abuse.

Thank you again, Mr. Chairman. I yield back.

Chairman STARK. We will start with the Inspector General Dan Levinson's testimony. You may proceed General Levinson in any manner you are comfortable.

If you are going to proceed, you have got to push that funny button on your mike so we can hear you.

Mr. LEVINSON. I think it is on now; thank you.

Chairman STARK. Thank you.

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

Mr. LEVINSON. Good morning, Chairman Stark, Chairman Lewis, Ranking Member Ramstad and distinguished Members of the Committee.

I appreciate the opportunity to appear before you today to discuss the important oversight role of the Office of Inspector General and the efforts we undertake to protect the integrity of the Department's programs including Medicare.

My testimony today will briefly discuss OIG's statutory role within the Department, how we are organized to accomplish our mission to protect the integrity of the Department's programs and highlight some of the vulnerabilities within the Medicare Program as well as highlight recent and ongoing OIG work in these areas.

I want to emphasize the importance of protecting the integrity of Medicare. It is a vitally important program that serves more than 43 million people and in fiscal year 2006, the program spent $382 billion dollars.

To fulfill our mission, we rely heavily on working closely with, and leveraging the resources, of our law enforcement and Department partners. I am pleased that the Committee will be hearing from two of our colleagues today, the Department of Justice and CMS. Other key partners include the State Medicaid Fraud Control Units.

Since Congress established our office in 1976, we have developed the necessary expertise to accomplish a wide range of oversight activities. We employ a comprehensive approach to our oversight

work by conducting national reviews of programs to identify systemic vulnerabilities and to make recommendations to improve their efficiency and effectiveness; auditing specific payments, providers and programs to identify and recover overpayments; investigating specific instances of fraud or abuse; and pursuing appropriate enforcement actions as well as promoting voluntary compliance by issuing guidance to the healthcare industry and providers.

Our work in this area and the resulting recommendations are described in our semiannual reports as well as a compendium of unimplemented OIG recommendations, all of which are provided to Congress. The OIG has produced a significant body of work.

I will highlight three areas where we have had impact and where we think vulnerabilities in the Medicare Program merit our continued attention. They are (1) the integrity of Medicare payments, (2) the quality of long term care services, and (3) the new Medicare Part D.

With respect to integrity of Medicare payments, OIG is particularly focused on payments for durable medical equipment and supplies, home health agencies, hospital operations, and part B prescription drugs, as described in my written statement.

In the interest of time my oral testimony will focus on part B prescription drugs. The OIG has produced a large body of work recommending actions that would result in savings and payments for prescription drugs under Medicare part B. Consistent with the recommendations in our body of work, the MMA included provisions that instituted a new drug reimbursement methodology for part B.

In addition to our substantial audit and evaluation work on part B drug pricing issues, we have pursued a number of enforcement cases involving pharmaceutical manufacturers. For example, one drug manufacturer paid more than 875 million dollars to resolve criminal and civil liability resulting from the sales and marketing of a prostate cancer drug. The company pleaded guilty to conspiring to violate the Prescription Drug Marketing Act by causing the sale of free samples and entered into a civil settlement and corporate integrity agreement related to the company's pricing, sales and marketing practices for the drug.

Another area of continued focus has been the quality of care in nursing facilities, due to the increasing number of beneficiaries in these settings and the vulnerability of this population. As a result of OIG's work in this area, a number of programmatic and legislative changes have occurred to improve quality of care.

For example, CMS has issued instructions to nursing facilities on the appropriate use of psychotropic drugs, promulgated regulations that required training standards for nurse aides, and required nursing homes to establish processes for handling abuse complaints.

These are improvements, but more work must be done. The OIG's most recent reviews revealed weaknesses in the nursing home survey and certification process. We found that for the majority of cases requiring mandatory termination of nursing homes, CMS did not apply the remedy because case referrals from States were not timely and CMS's staff were reluctant to impose this severe remedy.

In addition, we found that CMS did not investigate some of the most serious nursing home complaints within the required time-

frame and that CMS's oversight of nursing home complaint investigations is limited. Our report made a number of recommendations to CMS to resolve these issues.

Some nursing home care problems are so serious that they constitute failure of care and thereby implicate the Civil False Claims Act. A recent example of an egregious case of a failure of care involved a nursing home that settled its liability with the Government for $750,000 for allegedly providing skilled nursing services that were not rendered in accordance with applicable laws and rules and were so inadequate that they were not reimbursable under Medicare or Medicaid. The Government alleged that poor oversight and management of the facility's operations led to serious deficiencies in beneficiary care.

A third priority for OIG is Medicare Part D. As Chairman Lewis has noted, with a new program, with so much money at stake, especially one as structurally and operationally complex as this is, we believe that oversight is necessary. To address this we are implementing a strategic plan to protect the integrity of Part D and its beneficiaries by focusing on (1) enforcement and compliance, (2) payment accuracy, (3) beneficiary access, (4) drug pricing and reimbursement and (5) the integrity of information systems.

We have ongoing investigations of Medicare Part D cases along with audits and evaluations underway, as outlined in our Fiscal Year 2007 Work Plan, and we will share our findings and recommendations with CMS and Congress as the work is completed.

In addition to enforcement efforts, we also promote voluntary industry compliance. Our approach in promoting industry compliance is twofold. First, we issue a variety of guidance, including advisory opinions, fraud alerts and special advisory bulletins, as well as compliance program guidance, which is designed to assist healthcare providers and suppliers to develop systems and structures to guard against fraud and abuse, to ensure appropriate billing, and to be responsible corporate citizens.

Second, our approach to compliance addresses healthcare providers that the Government alleges have defrauded Medicare, Medicaid, or other Federal healthcare programs. In such cases, the Department of Justice may seek dollar recoveries through the Civil False Claims Act and we may seek to exclude the provider from future participation in Federal healthcare programs.

The OIG will often agree not to pursue exclusion in exchange for the provider entering into an integrity agreement with us. Such integrity agreements require providers to establish or continue a compliance infrastructure, policies and procedures, training programs, internal controls and reporting mechanisms, review procedures and reporting to us. The OIG integrity agreements have been a catalyst for change in corporate culture and result in comprehensive internal control systems.

In conclusion, we remain committed to a comprehensive approach to protect the integrity of the Medicare Program and to ensure that its beneficiaries receive high quality care. I appreciate the opportunity to share with the Committee our efforts and I would be happy to answer any questions you have.

[The prepared statement of Mr. Levinson follows:]

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

Good morning, Chairmen Stark and Lewis, Ranking Members Camp and Ramstad, and distinguished members of the Committee. I am Daniel R. Levinson, Inspector General for the Department of Health and Human Services (HHS). I appreciate the opportunity to appear before you today to discuss the important oversight role of the Office of Inspector General (OIG) and the efforts we undertake to protect the integrity of all 300 programs the Department administers, including Medicare.

I am pleased to come before you at a time when OIG recently commemorated an unusual confluence of milestones: 2006 marked the 30th anniversary of the OIG's creation, the 20th anniversary of the 1986 amendments to the Federal False Claims Act, and the 10th anniversary of the Health Insurance Portability and Accountability Act (HIPAA). All three of these anniversaries are important milestones that have shaped the way our office carries out its work.

Since 1976, the world has dramatically changed and so has OIG. We have seen enormous changes in the health care delivery system, information technology, globalization, and public health emergency preparedness. These changes demand that we keep pace with our oversight efforts. What has remained constant, however, is our core mission to promote integrity, economy, and efficiency in the Department's programs. OIG's work benefits millions of Americans and generates substantial cost savings.

OIG's ability to combat fraud was greatly enhanced by the 1986 amendments to the False Claims Act. These amendments rejuvenated the Act's *qui tam* provisions, resulting in a public-private partnership that has proven invaluable in detecting and prosecuting health care fraud.

Enacted in 1996, HIPAA provided OIG with increased resources; stronger enforcement tools; and a management structure to coordinate the efforts of Federal, State, and local partners involved in combating health care fraud. As a result, our office expanded its presence throughout the country, launched nationwide initiatives directed at health care fraud, and increased the savings and recoveries returned to the taxpayers.

Ensuring the integrity of the Medicare program is challenging, given the program's size and complexity. You have asked me to provide today a broad overview of OIG's organizational structure, funding sources, and methods by which we identify our work priorities. I will also provide an overview of the Medicare program and its vulnerabilities and will touch on a select body of OIG's work that addresses these vulnerabilities. I will conclude with a prospective look at the challenges ahead.

Role and Responsibility of the HHS OIG

Our office was created in 1976 and was the first statutory OIG in the Federal Government. Two years later, the Inspector General Act of 1978 (IG Act), modeled after the law creating the HHS OIG, established OIGs at other Cabinet-level departments of the Federal Government, as well as at some independent Government agencies.

Congress created OIGs to be independent and objective units within Federal departments and agencies for the purpose of: (1) conducting audits and investigations of programs and operations; (2) coordinating and recommending policies to promote economy, efficiency, and effectiveness in the administration of programs; (3) preventing and detecting fraud and abuse; and (4) keeping the Department Secretary or Agency Administrator and Congress informed about the necessity for corrective action.

To achieve these objectives, our office reviews programs to identify systemic vulnerabilities and makes recommendations to improve their efficiency and effectiveness; investigates specific instances of fraud or abuse and takes appropriate enforcement actions; audits specific payments, providers, and programs to identify and recover overpayments; and promotes voluntary compliance by issuing guidance to health care providers and the health care industry.

OIG's effectiveness in protecting the integrity of Medicare relies heavily on leveraging the resources of our law enforcement partners. These partners include the Department of Justice's Civil, Criminal, and Civil Rights Divisions, U.S. Attorneys Offices, and the Federal Bureau of Investigation. Other key partners include the Centers for Medicare & Medicaid Services (CMS) and the Medicaid Fraud Control Units (MFCUs).

OIG Structure and Organization

As one of the largest OIGs in the Federal Government, our more than 1,500 full-time auditors, evaluators, investigators, and attorneys contribute their diverse expertise and skills to carry out our mission to protect the integrity of HHS programs. To ensure national coverage and presence, our staff are located in Washington, DC, Baltimore, Maryland, and 9 regional offices and 80 smaller field offices throughout the country.

Although OIG has five functional units, we take a comprehensive and multifaceted approach to protect the integrity of the Department's programs. These units are the: (1) Office of Audit Services, (2) Office of Evaluation and Inspections, (3) Office of Investigations, (4) Office of Counsel to the Inspector General, and (5) Office of Management and Policy. These units work closely together to accomplish a wide range of oversight and enforcement work involving audits, evaluations, investigations, and fraud enforcement and prevention efforts.

The Office of Audit Services (OAS) is instrumental in identifying improper payments and reimbursements and conducts financial and performance audits of departmental programs, operations, grantees, and contractors. This includes investigative audit work

performed in conjunction with other OIG components. Much of OAS's work in identifying improper payments is complementary to that of the Office of Evaluation and Inspections (OEI), which identifies systemic vulnerabilities in program operations and processes.

OEI conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

The Office of Investigations (OI) conducts and coordinates investigations of fraud and misconduct to safeguard the Department's programs and beneficiaries. The size and complexity of Federal health and human service programs require OI to leverage its resources with those of its law enforcement partners. As such, OI collaborates closely with the Department of Justice on investigations of HHS programs and personnel and interacts with CMS, State Licensing Boards, MFCUs, and other entities with regard to program exclusion, compliance, and enforcement activities. These investigative efforts lead to criminal convictions, civil settlements, program exclusions, or civil monetary penalties and assessments.

The Office of Counsel to the Inspector General (OCIG) performs three major functions within OIG. First, it provides general legal services to OIG, including advice and representation on HHS programs and operations, administrative law issues, criminal procedure, and internal OIG management matters. The second major function involves coordinating OIG's role in the judicial and administrative resolution of fraud and abuse cases involving HHS programs, including the litigation and imposition of administrative sanctions, such as program exclusions and civil monetary penalties and assessments; the global settlement of cases arising under the Civil False Claims Act; and the development and monitoring of corporate integrity agreements (CIA) for certain providers that have settled their False Claims Act liability with the Federal Government. Finally, OCIG plays an equally important role in assisting the regulated health care industry in complying with the fraud and abuse laws by issuing voluntary compliance program guidance, advisory opinions, fraud alerts and bulletins, and "safe harbor" regulations under the Federal anti-kickback statute.

The Office of Management and Policy provides mission support services to OIG and its components. Its principal responsibilities include formulating and executing the organization's budget and strategic plan, developing internal policy, and managing information technology resources.

Our staff expertise, national presence, organizational structure, and collaboration with law enforcement partners enable OIG to leverage scarce resources to achieve maximum return for the oversight dollars invested. For the 3-year period from FYs 2004-2006, average return on investment was nearly 13 to 1.

OIG Funding

HHS OIG's funding mechanisms are unique. Since 1997, our funding has come from two primary sources: (1) the Health Care Fraud and Abuse Control Account (HCFAC) allocation, which was established by HIPAA, and (2) a discretionary appropriation. OIG has also benefited from additional temporary funding that Congress has appropriated to augment existing resources.

HIPAA established an annual dollar amount to be funded from the Medicare Trust Fund to combat fraud, waste, and abuse in the Medicare and Medicaid programs. Our HCFAC allocation was determined jointly by the Secretary of HHS and the Attorney General, within the annual ranges specified under HIPAA. HCFAC funds comprise a major portion of OIG's annual operating budget, generally between 75 to 80 percent, which means that most of our activities involve the Medicare and Medicaid programs. In fiscal year (FY) 2003, OIG's HCFAC allocation was capped at $160 million. However, the Tax Relief and Health Care Act of 2006 established a set annual HCFAC funding amount for OIG beginning in FY 2007. It also establishes annual increases to that funding through FY 2010 by the percentage increase in the Consumer Price Index for all urban consumers.

Discretionary funding represents dollars appropriated by Congress each year to be used for activities related to departmental management issues and the Department's programs other than Medicare and Medicaid. Discretionary funds typically comprise approximately 20 percent of OIG's annual operating budget and in FY 2007 amounted to nearly $40 million.

Additionally, Congress has provided special funding for Medicare and Medicaid oversight over and above the HCFAC amount. For example, in FY 2005, OIG received $25 million to fight fraud, waste, and abuse associated with the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In addition, the Deficit Reduction Act of 2005 (DRA) increased OIG's funding for Medicaid fraud and abuse control activities. Pursuant to the requirements of the DRA, beginning in FY 2006 and continuing through FY 2010, OIG will receive an additional $25 million annually for Medicaid integrity activities.

Given the expansion of the Medicare and Medicaid programs, and increases in health care expenditures, OIG acknowledges how critical these additional resources are to meeting increased responsibilities for protecting these programs and their beneficiaries.

OIG Priority Setting, Reporting, and Followup

Each year, OIG develops a work plan, which guides our activities for the upcoming fiscal year. This plan is available to the public on our Web site. Although resource constraints preclude us from reviewing all 300-plus programs of the Department annually, OIG engages in a comprehensive work-planning process to identify the most important and timely issues for the upcoming fiscal year and to direct our resources accordingly.

Among the things that OIG considers in setting its work priorities are findings from previous OIG and external reviews (e.g., Government Accountability Office (GAO) and Medicare Payment Advisory Commission), size of the program (i.e., expenditures, number of beneficiaries served), specific requests from Congress and the Department, and the need to review program areas that warrant revisiting.

As part of the Department's mandated annual Performance and Accountability Report, each year our office identifies the most significant management and performance challenges facing the Department based upon OIG's body of work. This assessment also factors into the determination of work priorities for the upcoming fiscal year. For example, in our most recent assessment, OIG identified the integrity of Medicare payments, quality of care in long-term services, and Medicare Part D as three areas that warrant scrutiny and monitoring. I will elaborate on these areas later in my testimony.

In addition to identifying and planning the priorities for the upcoming fiscal year, OIG must also remain flexible enough to accommodate issues that emerge throughout the year. There is no clearer example of the need for this flexibility than the devastating Gulf Coast hurricanes of 2005. Following the hurricanes, we promptly redirected resources to address critical needs arising in the aftermath of the storms. Unexpected events of the magnitude of the 2005 Gulf Coast hurricanes are fortunately rare. However, each year brings new and emerging issues and our priorities and work-planning efforts evolve to meet new challenges as they arise.

Moreover, along with our work-planning process, and consistent with the requirements of the IG Act, OIG reports to Congress semiannually on our activities. Unlike the work plan, which sets forth OIG's ongoing work and work to be undertaken in the upcoming fiscal year, the semiannual report provides a 6-month summary of OIG's completed body of work during the reporting period. The semiannual report covers the spectrum of OIG audit, evaluation, and enforcement accomplishments.

Each semiannual report identifies significant recommendations described in previous semiannual reports for which corrective action has not been completed. Thus, appendices to each semiannual report list significant unimplemented recommendations. Because of the abbreviated nature of that list in the semiannual reports, OIG has historically issued two complementary publications: (1) the "Red Book," to further highlight the potentially significant impact of cost-savings recommendations resulting from previous audits and evaluations, and (2) the "Orange Book," a compilation of nonmonetary recommendations to improve economy and efficiency in departmental programs and operations.

In an effort to present a comprehensive listing of all recommendations that have not been fully implemented by the operating divisions of the Department, OIG is presently in the process of combining the "Red Book" and "Orange Book" into one publication that will be a "Compendium of Unimplemented Office of Inspector General Recommendations." This document will serve as a useful tool for Congress, the Administration, and the Department in their respective efforts to identify ways to contain costs, maximize the effectiveness of programs and services, and improve the efficiency of departmental

programs. Full implementation of the recommendations in this document could achieve substantial savings and increased effectiveness in the operation of the Medicare program. OIG expects to release this compendium in May 2007. We look forward to providing the Department and Congress with this compendium, as they seek to achieve significant programmatic savings and enhanced program effectiveness.

Medicare Program Size and Complexity

The Medicare program has grown dramatically since its inception in 1965 and now provides comprehensive health care insurance for more than 43 million persons. More than 1 billion fee-for-service claims are processed annually, and Medicare is the largest purchaser of managed care services in the country. Total Medicare expenditures have grown from $206 billion in FY 1996 to over $382 billion in FY 2006.

With Medicare's expansive network of health care activities comes a tremendous responsibility to protect the program's integrity. In a program as complex as the Medicare program, incorrect payments to providers will occur. OIG has worked extensively with CMS to develop a process to estimate incorrect fee-for-service payments and institute corrective actions to reduce erroneous payments. In 1996, OIG estimated that over $23 billion (about 14 percent of expenditures) in improper payments had been made by the Medicare fee-for-service program. CMS has reported that the estimate of incorrect Medicare fee-for-service payments was reduced to $10.8 billion (4.4 percent of expenditures) in 2006.

Although the Medicare program relies on the provider community to submit accurate and appropriate claims for payment, and the vast majority of providers are honest and trustworthy, provider efforts alone are not sufficient to ensure the integrity of the program. OIG's oversight responsibility plays a key role in protecting scarce program resources and the health and welfare of beneficiaries.

Medicare Vulnerabilities and Related OIG Activities

We are committed to proactively identifying program weaknesses and vulnerabilities to help prevent fraud, waste, and abuse and to improve quality of care. We also bring our investigative tools and enforcement authorities to bear against those who seek to defraud the Medicare program and its beneficiaries.

As noted above, the overall Medicare fee-for-service payment error rate has decreased in recent years. However, the size and complexity of the Medicare program place it at high risk for payment errors. Improper payments and problems in specific parts of the program continue to be identified by OIG audits and evaluations and by CMS's assessment of the Medicare payment error rate. These reviews have revealed payments for unallowable services, improper coding, and other billing errors.

During the course of our most recent annual assessment of the Department's "Top Management Challenges," we highlighted three broad areas of vulnerabilities related to

the Medicare program. These areas are: (1) integrity of Medicare payments, (2) quality of care in nursing facilities, and (3) Medicare Part D. Within the broad category of Medicare payments, we have also identified more specific vulnerabilities within certain services and provider types, some of which are outlined below. The following sections highlight selected areas of vulnerability and OIG's work to identify and mitigate risks and to pursue cases of fraud or abuse.

Integrity of Medicare Payments

Medical Equipment and Supplies

OIG and others have found significant vulnerabilities in Medicare's oversight of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and in Medicare payments for certain types of DMEPOS. Over the past 10 years, OIG and GAO have reported on weaknesses in Medicare's enrollment standards for and oversight of DMEPOS suppliers, and we have made recommendations to improve oversight, such as increasing unannounced site visits to DMEPOS suppliers.

In previous work, OIG determined that in 2001, Medicare and its beneficiaries paid an estimated $96 million for claims that did not meet Medicare's coverage criteria for any type of wheelchair or scooter and also spent an estimated $82 million in excessive payments for claims that could have been billed using a code for a less expensive mobility device. In addition, OIG has found that over the 36-month rental period, Medicare's total allowed rental payments for oxygen concentrators are 12 times higher than the average price to purchase a new concentrator. If Medicare limited rental payments for concentrators to 13 months, like other capped rental items, we estimated that the program and its beneficiaries could save more than $3 billion over 5 years. We recommended that CMS work with Congress to limit the rental period for concentrators.

We are continuing our examination of enrollment, compliance, and oversight of DMEPOS suppliers, including collaborations with CMS and the Department of Justice on specific efforts in high risk geographic areas. In addition, we also have ongoing work to determine the appropriateness of Medicare payments for certain medical equipment and supplies, such as wound care equipment.

A recent example of our collaborative enforcement efforts involved a DME company that was ordered to pay $8.4 million pursuant to its guilty plea to false statements relating to health care matters. This company provided equipment almost exclusively to beneficiaries residing in assisted living facilities. Over a period of several years, the DME supplier billed Medicare and Medicaid for equipment provided to beneficiaries who did not meet coverage criteria, created false documents to support the false claims, and routinely misled assisted living facility personnel and physicians when marketing and servicing the equipment.

Home Health Agencies

Our office has had long-standing concerns with the accuracy of payments made to home health agencies (HHAs). For example, we found that in developing the prospective payment system rates for HHAs, CMS did not adjust for substantial unallowable costs claimed by HHAs, which were identified in our prior audits. As a result, we are concerned that the base rates are inflated and that improper payments may ensue.

We have several reviews planned or underway that examine Medicare payments made to HHAs. We plan to review the extent to which Medicare HHAs accurately coded information on the assessment form that is used to determine payment rates and to identify the extent of inappropriate payments made to HHAs. We will also determine whether rehabilitation services provided by HHAs were provided by appropriate staff and were medically necessary. In addition to addressing our concerns about payments to HHAs, we are assessing the quality of care provided by HHAs. For example, we are examining trends and patterns in HHA survey and certification deficiencies and determining whether CMS is taking appropriate action against noncompliant HHAs.

We have also pursued cases of alleged fraud by HHAs. One recent enforcement case involved a corporation that operated home health care and medical staffing businesses across the country. The agency agreed to pay $8 million to resolve its liability for allegedly submitting false claims to Medicare, Medicaid, TRICARE, and CHAMPUS over a period of several years. The Government alleged that the company submitted claims for home health services that were not provided by a qualified person; lacked physician orders and plans of care; lacked sufficient documentation of the patient's homebound status; lacked an Outcome Assessment and Information Set evaluation; and/or were improperly coded.

Hospital Payments and Operations

OIG has also identified a number of vulnerabilities in hospital operations and has made recommendations to recover overpayments and improve payment accuracy and payment systems. For example, OIG audits identified more than $72 million in improper payments to hospitals that incorrectly coded claims as discharges to home rather than transfers to postacute care facilities. We recommended recovery of these overpayments, and CMS implemented claims processing system edits to identify future miscoded claims.

OIG audits of specific hospitals have also found hundreds of millions of dollars in misreported wage data, which are used to calculate wage indices that affect Medicare payments. Hospitals that overstate their wage data will receive higher payments at the expense of hospitals that report accurate or understated wage data. Our reviews found that there were wide-spread inconsistencies among hospitals in reporting certain wage-related costs. As a direct result of our work, CMS clarified in regulation its requirements for reporting these types of costs.

Our review of hospital outlier payments showed that changes were needed in how outlier payments were calculated to eliminate hospitals' ability to construct and manipulate charges, allowing them to receive payments to which they were not entitled. CMS issued a regulation to correct these problems, resulting in an estimated savings to the Medicare trust fund of $9 billion over 5 years.

To illustrate OIG's enforcement efforts involving hospitals, a hospital chain recently agreed to pay $265 million and enter into a 6-year CIA to resolve its civil liability. The Government alleged that the chain artificially inflated its cost-to-charge ratio, triggering the outlier payments to which it was not entitled.

We will continue to focus attention on hospital payments and operations to ensure the integrity of Medicare payments and to protect the health and welfare of Medicare beneficiaries.

Part B Prescription Drugs

Over the past decade, OIG has produced a large body of work on payments for prescription drugs under Medicare Part B. OIG has consistently found that Medicare's drug reimbursement methodology led to overpayments and was vulnerable to abuse. For example, one OIG review found that Medicare and its beneficiaries would save $761 million a year by paying for 24 drugs at the prices available to physicians and suppliers. For four of the drugs, the median catalog prices available to physicians and suppliers were less than half of the Medicare reimbursement amount. And for one drug, the Medicare reimbursement amount was more than 6 times higher than the median catalog price.

Consistent with the recommendations in our body of work, the MMA included provisions that instituted a new drug reimbursement methodology for Part B. Recognizing the critical role OIG played in reforming Part B drug reimbursement, Congress also included provisions in MMA mandating that OIG monitor Part B drug reimbursement and certain market prices for Part B-covered drugs on an ongoing basis. In addition to this required price monitoring, OIG has undertaken audits of the prices reported by pharmaceutical manufacturers to CMS for purposes of Part B reimbursement.

In addition to our substantial audit and evaluation work on Part B drug pricing issues, we have pursued a number of enforcement cases involving pharmaceutical manufacturers. For example, one drug manufacturer paid more than $875 million to resolve criminal and civil liability resulting from the sales and marketing of a prostate cancer drug. The company pled guilty to conspiring to violate the Prescription Drug Marketing Act by causing the sale of free samples and entered into a civil settlement related to the company's pricing, sales and marketing practices for the drug.

Another drug manufacturer agreed to enter a global criminal, civil, and administrative settlement that included the payment of $704 million plus interest and a 5-year CIA. The global settlement resolved allegations that included the illegal promotion of an

HIV/AIDS-related drug. The Government alleged that the company offered and paid illegal remuneration to Medicare participating physicians and pharmacies to induce them to prescribe and/or purchase the drug.

Quality of Care in Nursing Facilities

With the expected growth and vulnerability of the long-term care population, ensuring quality of care provided to beneficiaries in long-term care facilities warrants significant attention to ensure that Federal dollars are spent on appropriate care that meets Medicare's conditions of participation.

OIG's body of work over several years has led to a number of programmatic and legislative changes to improve quality of care in nursing facilities. For example, in response to several OIG reports, CMS promulgated regulations that established training requirements for nurse aides in nursing homes and required nursing homes to establish processes for handling abuse complaints. States, localities, and nursing homes also employed OIG recommendations to formulate plans and identify activities that will reduce the use of chemical and physical restraints used for nursing home residents. CMS issued a program memorandum to fiscal intermediaries designed to clarify Medicare's guidelines for psychotropic drug use in skilled nursing facilities, including the definition of an unnecessary drug, justification for drug use outside guidelines, and antipsychotic drugs.

Despite these improvements, we have some continuing concerns regarding oversight of nursing facilities. A recent OIG report found that for the majority of cases requiring mandatory termination of nursing facilities, CMS did not apply the remedy due to both late case referrals by States and CMS's staff reluctance to impose this severe remedy. In another recent review, OIG found that CMS did not investigate some of the most serious nursing home complaints within the required timeframe and that CMS's oversight of nursing home complaint investigations is limited.

OIG is currently conducting a series of reviews to further address payment and quality issues in nursing homes. Examples of topics include: use of psychotherapy services in nursing homes, impact of Medicare Part D on dual eligible residents in nursing homes, and appropriateness of payments and care for hospice beneficiaries residing in nursing homes.

Some nursing home care problems are so serious that they constitute "failure of care" and thereby implicate the civil False Claims Act. These cases often involve allegations of widespread or systemic problems such as excessive falls, medication errors, an undue number of residents with facility-acquired pressure ulcers, and chronic staff shortages. OIG continues to work with U.S. Attorneys and the Department of Justice on development and settlement of these egregious cases. OIG is also working on more cases jointly with the MFCUs to help protect the health and safety of this especially vulnerable population. OIG has developed exclusion actions against individuals and entities whose conduct causes the furnishing of poor care, with particular emphasis on higher-level

officials of nursing facilities and chains. Additionally, OIG continues to negotiate quality-of-care CIAs as part of the settlement of such False Claims Act cases.

In one example of such a case, a nursing home settled with the Government for $750,000 based upon allegations that the facility provided skilled nursing services that were not rendered in accordance with applicable laws, regulations, or rules and were so inadequate that they were not reimbursable under Medicare or Medicaid. The Government alleged that poor oversight and management of the facility's operations led to serious deficiencies in the beneficiaries' care, including bed sores, malnutrition, and the death of at least one beneficiary. The nursing home agreed to a permanent exclusion from participation in the Federal health care programs and also agreed to an indefinite suspension from the State Medicaid Program. Prior to the civil settlement, the facility pled no contest to one count of second-degree manslaughter involving the death of a beneficiary.

Medicare Part D

The MMA established the new Medicare prescription drug benefit, known as Medicare Part D, which took effect on January 1, 2006. This voluntary benefit is available to all 43 million Medicare beneficiaries. According to a recent Congressional Budget Office estimate, Medicare outlays for Part D in 2006 were $28 billion. The magnitude of expenditures and impact of this benefit on beneficiaries, from both a health and financial perspective, make it critical that Medicare Part D operate efficiently and effectively and be protected from fraud and abuse.

The structure and operation of the Part D benefit contain features that present significant management challenges. Administration of the Medicare Part D benefit depends upon extensive coordination and information sharing among a number of diverse entities, including Federal and State Government agencies, private drug plan sponsors, contractors, and health care providers. Payments to drug plan sponsors based on bids, risk-adjustments, and reconciliations add to the complexities of the benefit. In addition, for standard plan designs, the relative financial responsibilities of Medicare, drug plan sponsors, and beneficiaries vary through three distinct phases (the initial coverage period, the coverage gap, and catastrophic coverage), depending on the beneficiary's total drug costs at a given time. Alternate plan designs include variations of these relative responsibilities. Finally, the complexities of this benefit also create challenges for educating beneficiaries in selecting a Part D plan, because beneficiaries face a wide variety of drug plans with varying costs, formularies, and pharmacy networks.

To address the challenges of this new and complex benefit, OIG has developed and is implementing a strategic plan to fight fraud, waste, and abuse in Part D and to protect the health and welfare of its beneficiaries. Our work covers five broad areas:
(1) enforcement and compliance, (2) payment accuracy and controls, (3) beneficiary access and protections, (4) drug pricing and reimbursement, and (5) information technology and systems. We have ongoing investigations of Medicare Part D cases, along with audits and evaluations underway.

OIG Outreach and Guidance to Health Care Industry

One of the most significant ways in which OIG has effected change is by reaching out to the health care industry to promote a culture of compliance. Through outreach activities, OIG supports industry efforts to prevent fraud and abuse in the Federal health care programs. Over the past decade, OIG has implemented a comprehensive program to promote voluntary compliance by health care providers and suppliers. We have developed tools and incentives that encourage providers to prevent or reduce fraud and abuse.

OIG's approach to promoting industry compliance is twofold. First, OIG issues a variety of guidance, including advisory opinions, fraud alerts and special advisory bulletins, and compliance program guidance designed to assist health care providers and suppliers to develop systems and structures to guard against fraud and abuse, ensure appropriate billing, and be responsible corporate citizens. OIG has issued voluntary compliance program guidance for 11 major health care sectors. These guidances have received substantial support from the provider community. OIG has also issued 20 fraud alerts and special advisory bulletins, which identify practices in the health care industry that are particularly vulnerable to abuse and more than 150 advisory opinions to individuals and entities seeking advice on whether specific arrangements implicate the Federal anti-kickback statute or other fraud and abuse laws.

Second, our approach to compliance addresses health care providers that the Government alleges have defrauded Medicare, Medicaid, or other Federal health care programs. In such cases, the Department of Justice may seek money through the civil False Claims Act and OIG may seek to exclude the provider from future participation in Federal health care programs. In the context of a civil and administrative settlement of a health care fraud case, OIG often agrees not to pursue exclusion in exchange for the provider entering into an integrity agreement with OIG. Such integrity agreements require providers to establish or continue a compliance infrastructure, policies and procedures, training programs, internal controls and reporting mechanisms, review procedures, and reporting to OIG. OIG integrity agreements have been a catalyst for change in corporate culture and result in comprehensive internal control systems. Over the past decade, OIG has executed more than 1,100 integrity agreements.

Conclusion

Innovation continues to improve the efficiency of business, in turn, influencing the delivery of health care. However, as technological advances increase operational efficiency, they also create new vulnerabilities and opportunities for fraud. OIG has adapted, and will continue to adapt to, the ever-changing environment in which we operate. Additionally, we will continue to leverage our own resources and those of our law enforcement partners. We remain committed to staying at the forefront in our efforts to achieve effective oversight and enforcement in both our existing work and in meeting new challenges presented in the 21st century.

Thanks to the dedicated professionals of OIG and the additional funds recently appropriated by Congress, we will continue to carry out our mission to protect the integrity of HHS programs and their beneficiaries.

I thank you for the opportunity to be part of this important discussion today about the integrity of the Medicare program, as well as for the opportunity to highlight in detail the mandate, organization, and activities of the HHS Office of Inspector General.

I welcome your questions.

Chairman STARK. Thank you, Mr. Levinson. I think with your forbearance and the Committees' to move us along, we would ask Mr. Hill and Mr. Acosta to testify now and then we can inquire of all three of you if that is satisfactory with you, Mr. General. Thank you.

Mr. Hill, would you like to proceed?

STATEMENT OF TIMOTHY B. HILL, DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT, CENTERS FOR MEDICARE AND MEDICAID

Mr. HILL. Thank you. Good morning, Chairman Stark, Chairman Lewis, Ranking Member Ramstad, other distinguished Members of the Committee. I am pleased to be here to discuss the Centers for Medicare and Medicaid Services' efforts to ensure the integrity of the Medicare Program.

I would like to use my time today to briefly describe for you our approach to protecting the integrity of Medicare, give you an overview of some of our recent successes and describe to you some of our most pressing challenges.

The CMS is accountable for ensuring the accuracy and appropriateness of more than $400 billion in trust fund payments each year to health plans, providers and beneficiaries. Our approach to fulfilling this obligation rests on a foundation of innovation, private sector partnership and State, local and Federal cooperation.

Our first line of defense rests in the more than $700 million dollars worth of performance based contracts with private sector entities whose job it is to investigate complaints of fraud, perform data analysis to identify potential vulnerabilities, measure the extent of misspent program funds and work with law enforcement to further investigate and prosecute fraud. These contracts allow CMS to utilize cutting edge technology, the most advanced analytic tools and expert investigative resources to address program vulnerabilities.

We leverage this investment by driving cooperation between our contractors and our regional offices and State and local governments. The CMS now has field offices in high vulnerability areas around the country and they work directly with local contractors, local law enforcement, State Medicaid agencies and local provider communities to magnify the individual efforts of each of these groups to achieve better results.

The last link in our efforts rests with our law enforcement partners, the Health and Human Services (HHS) Office of the Inspector General in the Department of Justice who investigate and prosecute Medicare fraud. Working cooperatively with agents in the field and staff at main Justice and the HHS OIG we make referrals, support ongoing investigations and assist in the eventual prosecution of nefarious providers.

This intense level of collaboration with our contractors, partners, customers and stakeholders is critical to the success of our efforts. I am proud to say that in broad measure our approach has been successful. Since 2004 we have reduced the rate of improper payments in Medicare by 56 percent saving taxpayers nearly $11 billion. This is not to say that our job is complete. There is much more that needs to be done. Nonetheless, our aggressive pursuit of wrongdoers is paying off.

Let me give you just a few examples. A CMS fraud fighting contractor in Ohio, Advance MED, received the prestigious 2006 National Healthcare Anti-Fraud Association Investigation of the Year Award for their work on the case against Dr. Jorge Martinez, an Ohio physician. This case involved the death of two patients and Advance MED's efforts helped secure the doctor's conviction and sentence to life in prison, the first life sentence given in a healthcare fraud case.

On a different front, CMS has been matching data between Medicare and Medicaid in 10 States to identify providers who might be defrauding both programs. Using this collaborative approach, we can detect fraudulent patterns that we cannot see looking at these two programs separately. So, far, over 50 cases have been referred to law enforcement, $15 million in overpayments have been identified and $25 million have been saved through claims denials.

We are using new legislative authority to contract with contingency-fee-based contractors, recovery audit contractors (RACs) to root out improper payments. These types of arrangements are widely used in the private sector but have not been available in Medicare until 2004. Last year the RACs collected nearly 70 million in overpayments and identified an additional 300 million in overpayments that are awaiting recoupment.

We have put feet on the street in high fraud risk areas. We opened an office in Los Angeles, California to coordinate fraud and abuse efforts at the local level. In 2005 and 2006 the LA office identified over $2 billion in improper payments. We have been working with the local DA in LA to identify Medicare fraud through those who have not paid their taxes. So, far this Al Capone approach has resulted in three convictions of tax fraud, all including prison sentences, and in another 300 or so cases that are currently being developed.

Similarly, in Miami, Florida, we have worked with the State and local law enforcement to address a Medicare infusion scam that involves clinics recruiting HIV AIDS patients, paying them kickbacks and then billing Medicare for astronomical amounts of infusion services. Our administrative efforts alone to clamp down on this scam have resulted in more than $1.8 billion in savings.

We are also very active pursuing Part D fraud. Early in the program we identified an identity theft scam called the 299 Scam where unsuspecting Medicare beneficiaries were contacted by supposed agents of non-existent Medicare prescription drug plans and tried to sell them those plans for $299. Working with our partners in law enforcement, we informed the beneficiaries of the scam and recovered stolen funds.

Additionally through our data analysis of Part D drugs, we identified and stopped payments that were being made to an abandoned pharmacy in Miami, an effort that prevented approximately $3 million worth of improper payments from Part D plans.

As I said, while we are continuing to make strides more needs to be done. This year's President's budget proposed several initiatives to leverage our existing resources, to reduce improper payments and expand our initiatives. Key among these is a requested increase in our discretionary Health Care Fraud and Abuse Control

(HCFAC) appropriation of $183 million that would be allocated between Medicare, Medicaid, the OIG and the Department of Justice.

Since the Medicare Integrity Program budget was capped in 2003, CMS has sustained an approximate $90 million inflationary loss that has greatly diminished our purchasing power to undergo these activities. We believe that additional resources are needed to keep pace with inflation and allow us to devote needed antifraud efforts to an ever expanding program. With a return on investment of over 13-to-1, we believe the enactment of the President's proposal is a worthy investment.

We have made great strides and we continue to look forward to working with you and other Members of Congress to enhance our efforts. I look forward to answering any questions that you might have.

[The prepared statement of Mr. Hill follows:]

Prepared Statement of Tim Hill, Director, Office of Financial Management, Centers for Medicare and Medicaid Services

Good afternoon Chairman Stark, Chairman Lewis and distinguished Members of the Subcommittees. I am pleased to be here today to discuss the Centers for Medicare and Medicaid Services' (CMS) efforts to improve the accuracy and integrity of payments under the Medicare program.

Responsible and efficient stewardship of taxpayer dollars are critical goals of this Administration, as evidenced by the government-wide effort to improve financial management under the President's Management Agenda (PMA). Under the PMA, federal agencies are mobilizing people, resources, and technology to identify improper payments in high risk programs, establishing aggressive improvement targets, and implementing corrective actions to meet those targets expeditiously. Consistent with these efforts, CMS is firmly committed to ensuring the highest measure of accountability within the Medicare program. As part of that commitment, the President's FY 2008 budget requests $183 million in discretionary HCFAC funding to build upon programs with a proven record for maintaining the integrity of the Medicare Trust Fund.

Background on Medicare

Medicare is a Federal health insurance program that provides comprehensive health insurance to about 43 million people. About 36 million individuals are entitled to Medicare because they are over the age of 65 and about 7 million beneficiaries under age 65 are entitled because of disability; those under age 65 generally begin to get Medicare after they have been entitled to Social Security disability cash benefits for 24 months. Net Medicare spending for 2007 is projected to be about $372 billion.

The majority of Medicare spending is in fee-for-service (FFS), with hospital and physician services currently representing the largest shares of this spending. The FFS component of Medicare also covers a wide range of other items and services, including home health care, ambulance services, medical equipment, and preventive services. CMS processes claims and makes payments for FFS Medicare benefits through contracts with private companies: Carriers, Fiscal Intermediaries (FIs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs), and Quality Improvement Organizations (QIOs).[1] During 2007, CMS estimates that Medicare contractors will process well over one billion claims from providers, physicians, and suppliers for items and services that Medicare covers. Medicare contractors review claims submitted by providers to ensure payment is made only for Medicare-covered medical services that are reasonable and necessary, for eligible individuals. In addition, CMS contracts with Program Safeguard Contractors (PSCs) to detect and deter Medicare fraud and abuse. Quality Improvement Organizations

[1] With the implementation of Medicare Contracting Reform (MCR) enacted by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Medicare contractor functions are being consolidated, and all contractors processing Medicare claims are called "Medicare Administrative Contractors" or "MACs." Although the durable medical equipment regional carriers (DMERCs) have been fully replaced by the DME MACs, while MCR implementation is underway, the original contractor terms—Carrier and FI—remain commonly used.

(QIOs) are contractors that ensure that payment is made only for medically necessary services and investigate beneficiary complaints about quality of care.

In addition to FFS, Medicare also pays private plans. The Medicare Advantage plans, which include coordinated care plans, regional preferred provider organizations and private FFS plans, generally provide more benefits at a lower cost to beneficiaries. Both local and regional plans must provide all original Medicare benefits. In 2006, about 17 percent of beneficiaries were enrolled in Medicare Advantage local plans.

The Improper Payments Information Act of 2002

Given the staggering size of Medicare program expenditures, even small payment errors can represent a significant impact to the Federal treasury and taxpayers. For this reason, CMS, as part of a sound financial management strategy, has a relatively long history of using improper payment calculations as a tool to preserve the fiscal integrity of Medicare. CMS uses improper payment calculations to identify the amount of money that has been inappropriately paid, identify and study the causes of the inappropriate payments, and focus on strengthening internal controls to stop the improper payments from continuing.

In 1996, the Department of Health and Human Services' (DHHS) Office of Inspector General (OIG) began estimating improper payments in the Medicare FFS program as part of the Chief Financial Officer's Audit. The OIG produced FFS error rates from FY 1996 to FY 2002. Beginning in FY 2003, CMS, working with the OIG, implemented a much more robust process—the Comprehensive Error Rate Testing (CERT) program—to assess and measure improper payments in the Medicare FFS program. The CERT program not only produces a national paid claims error rate, but also very specific improper payment rates. These include:

- contractor-specific improper payment rates—which measure the accuracy of our claims processors;
- provider-type specific improper payment rates—which measure how well the providers who care for our beneficiaries are preparing and submitting claims to the program; and
- other management related information—which provides insight into payment errors by region and reason.

Thus, in 2002 when the IPIA was enacted, CMS needed to make only minor changes to our ongoing processes for FFS Medicare to come into compliance with the Office of Management and Budget (OMB) guidance on the IPIA. In fact, CMS has gone beyond the scope of the IPIA requirements and OMB guidelines to calculate additional improper payment rates for FFS Medicare, as discussed earlier. This enhanced scrutiny reflects the Agency's increased commitment to use more detailed data and analysis to identify and eliminate improper payments.

Calculating improper payment rates is only one step in the process. Remediation is the key part of CMS IPIA compliance activities. CMS, through its contractors, including the Carriers, FIs, DME MACs and QIOs use the error rates to identify where problems exist and target improvement efforts. The cornerstone of these efforts is our annual Error Rate Reduction Plan (ERRP), which includes agency level strategies to clarify CMS policies and implement new initiatives to reduce FFS Medicare improper payments. In the past, ERRPs have included plans to conduct special pilot studies (i.e. electronic medical record submission pilot) and specific education-related initiatives. CMS also directs Carriers, DME MACs, and FIs to develop local efforts to lower the FFS Medicare error rate by targeting provider education and claim review efforts to those services with the highest improper payments. The type and nature of the errors we see in the program all lend themselves to different types of corrective actions to mediate them.

For example, a primary cause of Medicare payment errors in the past has been providers not submitting the medical record documentation needed to verify the appropriateness of payment in response to our requests for documentation. Many providers were concerned that submitting medical records to a CMS contractor would be in violation of the Health Insurance Portability and Accountability Act (HIPAA) regulations. However, the HIPAA Privacy Rule permits disclosure of protected health information to carry out treatment, payment or health care operations. Thus, we expanded our education efforts to ensure that providers understand that responding to our requests does not violate HIPAA.

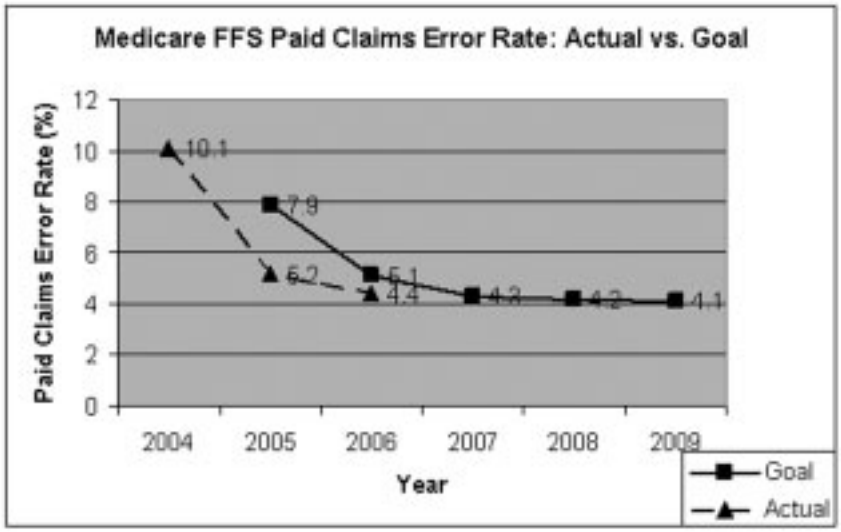
Another significant cause of errors has been providers not submitting the appropriate types of medical record documentation to support the types of services billed to the Medicare program. CMS implemented a number of corrective actions to reduce these types of errors, including education and more intensive efforts to locate

and contact providers. These corrective actions have resulted in an 83 percent decrease in documentation errors since 2004.

CMS also uses contractor-specific error rates to evaluate the performance of the contractors that process Medicare claims. While our previous contracting authority, limited CMS's ability to take action against contractors with high error rates, implementation of Medicare Contracting Reform (MCR) enacted by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) is changing the contracting process and the contractor incentive structure. One key outcome of this initiative is the ability to use incentives to get our contractors to eliminate improper payments. In 2004, CMS conducted a study to evaluate whether the Agency could reduce improper payments by using award fees as incentives for contractors to lower their paid claims and provider compliance error rates. The outcome of that pilot was positive and CMS plans to use award fees as incentives in the future to reduce improper payments as part of MCR.

We believe our efforts in Medicare have been a success. In November 2006, HHS reported a Medicare FFS paid claims error rate of 4.4 percent, a significant decrease from the 5.2 percent reported in 2005, and significantly lower than the 10.1 percent rate reported in FY 2004. We have far exceeded our expectations, having reduced the error rate beyond the 2006 goal of 5.1 percent. With continued monitoring and error reducing efforts we aim to achieve our future targets of 4.3 percent in 2007, 4.2 percent in 2008, and 4.1 percent in 2009.

Figure 1:



We also are looking carefully at IPIA compliance for the new prescription drug benefit (Part D) and the expanded Medicare Advantage. CMS recruited staff during FY 2006 to oversee the development of payment error rates for Part C, Part D, and Retiree Drug Subsidy programs. CMS also awarded a contract to assist with the error rate development for these programs. During FY 2007, the contractor is performing a risk assessment and developing a pilot methodology to evaluate a selected risk element in each program.

Finally, CMS, along with the States, have a strong interest in strengthening financial oversight and ensuring payment accuracy in the Medicaid program. The States provide a crucial first line of defense in safeguarding Medicaid program dollars. At the Federal level, our primary roles are to exercise proper oversight and review of State financial practices and to provide guidance and support for the States' program integrity efforts. To comply with the IPIA of 2002 and implementing guidance by OMB, CMS began measuring improper payments in Medicaid and the State Children's Health Insurance Program (SCHIP). In an effort to nationally implement IPIA for the Medicaid program, CMS published a proposed rule in August, 2004 which required states to measure improper payments in their Med-

icaid programs. Subsequently, CMS published an interim final rule in August 2006, lessening the burden of this process on the states. We hope to publish a final rule in the Fall. A component Medicaid FFS error rate will be reported in the FY 2007 PAR and full Medicaid and SCHIP rates will be reported in the FY 2008 PAR. The goals of the Payment Error Rate Measurement (PERM) project are:

- to report a national program error rate in the PAR for each fiscal year measured;
- to reduce improper payments in Medicaid and SCHIP through States' corrective actions; and
- to have States initiate recovery of erroneously paid Federal funds in these programs as identified through the PERM program.

Fraud, Waste and Abuse

As previously mentioned, CMS' actions to safeguard Federal funds are not just limited to the error rate programs described in this testimony. Program and fiscal integrity oversight is an integral part of CMS' financial management strategy, and a high priority is placed on detecting and preventing fraud, waste and abuse. To that end, CMS has made significant changes to its program integrity activities in recent years.

The Program Safeguard Contractors (PSCs) are CMS' fraud, waste and abuse detection contractors. As of 2006, PSC's were established nationwide across all provider and supplier types in the Medicare fee-for-service program. The PSCs perform data analysis to identify potential problem areas, investigate potential fraud, develop fraud cases for referral to law enforcement and coordinate Medicare fraud, waste and abuse efforts with CMS' internal and external partners (e.g., law enforcement, affiliated contractors (intermediaries, carriers, and Medicare Administrative Contractors).

To further supplement the PSCs fraud identification efforts, CMS is making improvements to its own data analysis efforts. To achieve this, we are collecting vulnerability data from many of our partners, including Medicare contractors, and using a variety of data analysis tools to review Medicare claims data. Much of our work will focus on addressing vulnerabilities early in their lifecycle, and those that have high estimated dollar impact to the Medicare program. Our program integrity efforts will focus on the Top 10 vulnerabilities identified through our data analysis and developing corrective actions to address these identified vulnerabilities.

CMS has taken several specific actions to ensure that Federal dollars are being properly spent and fraudulent billings are stopped when they are detected. In particular, we created a new satellite office in Los Angeles (LA), California to work in conjunction with an existing satellite office in Miami, Florida to help curtail fraudulent spending in those high risk areas. Through the combined efforts of the CMS LA satellite office, the PSC and the claims processing contractors operating in California, CMS has collectively identified over $2.1 billion in improper payments in Calendar Years 2005 thru 2006. This includes the prepayment denial of claims based upon fraud indicators and the postpayment identification of overpayments for claims identified as potentially fraudulent or highly suspect. The LA office has also conducted a special project that addressed improper billing and potentially fraudulent claims submitted by Independent Diagnostic Testing Facilities (IDTFs) operating in California. This Special Project resulted in approximately $163 million in denied charges and the termination of Medicare billing privileges for 83 IDTF providers..

Another important program integrity initiative is the Medicare-Medicaid (Medi-Medi) data matching program. Data mining health care claims for fraudulent activity has been commonplace for several years now. However, by jointly mining Medicare and Medicaid claims, new patterns are being detected that were not evident when viewed separately. The knowledge gleaned from our Medi-Medi activities helps both programs identify and address vulnerabilities. CMS has ten Medi-Medi projects in place in key states and, as mandated by the Deficit Reduction Act of 2005, will expand the program nationwide. To date, over fifty Medi-Medi cases have been referred to law enforcement, $15 million in overpayments have been referred for collection, and $25 million in improper payments have been denied before payment was made. This project is contributing to overall reductions in payment errors.

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) gave CMS additional authority to pilot a new contracting authority designed to detect improper payments. This MMA provision directs the Secretary to demonstrate the use of Recovery Audit Contractors (RACs) in identifying Medicare underpayments and overpayments, and collecting Medicare overpayments. CMS implemented RACs in three states—Florida, New York and California and in

FY 2006, the RACs collected $68.6 million in overpayments and identified more than $300 million in improper payments.

The RAC program is consistent with the President's Management Agenda objective to prevent improper payments in federal programs. CMS designed the demonstration to accomplish two specific goals: to demonstrate whether RACs can identify past improper payments in the Medicare FFS program; and to determine whether the RACs can provide information to CMS that could help prevent future improper payments. It is clear that the RAC demonstration program accomplishes both of these goals. Given the success of this effort, Congress mandated the expansion of the RAC effort nationally in the Tax Relief and Health Care Act of 2006. CMS is now in the process of developing its expansion and implementation plans.

Provider Enrollment

CMS has seen a marked increase in fraud and abuse activities over the past few years that can be directly tied to provider enrollment issues. These activities are primarily focused in high vulnerability areas of the country such as Los Angeles, Miami and Houston where there are a large number of beneficiaries and providers/suppliers. CMS has undertaken numerous aggressive actions to tighten the provider enrollment process, provide more rigorous oversight and monitoring once a provider/supplier enrolls in the program, and strengthen the provider revocation process.

The fraudulent business practices of unscrupulous durable medical equipment, orthotics, prosthetics, and supplies (DMEPOS) suppliers continue to cost the Medicare program billions of dollars. CMS is implementing new DMEPOS Accreditation Standards which will ensure DMEPOS suppliers meet CMS' supplier certification standards. All suppliers of DMEPOS must comply with the CMS quality standards in order to receive Medicare Part B payments and to retain a supplier billing number. The National Supplier Clearinghouse will not be able to issue a supplier billing number to any non accredited supplier, thus any nonaccredited supplier attempting to bill Medicare, will be automatically ?kicked-out' of the system.

To accommodate suppliers that wish to participate in the Medicare DMEPOS program, CMS will phase-in the accreditation process and require accreditation organizations to prioritize their surveys to accredit suppliers in the selected Metropolitan Statistical Areas and competitive bidding areas. All suppliers who require accreditation to bid in any CMS conducted DMEPOS competitive bidding need to be given priority by the approved accrediting bodies. Those suppliers in a non-competitive bidding area will be given a certain time frame in which to become accredited.

CMS is taking the following steps to better monitor a provider or supplier once it has entered the program:

- Implement claims specialty editing to ensure suppliers are only paid for items they are properly licensed to provide;
- Increase the number of random site visits to suppliers;
- Require greater claims scrutiny for high fraud risk suppliers;
- Deactivate providers with inactive provider numbers; and
- Provide additional resources for investigative staff to increase proactive initiatives by the NSC and the PSCs.

CMS is also implementing new strategies to remove fraudulent providers from the Medicare program. Our LA Office has recently identified situations in which some physicians are submitting claims for services that have not been furnished to a specific individual on the date of service. These instances include but are not limited to situations where the beneficiary is deceased, the directing physician or beneficiary was not in the state or country when the services were furnished, or when the equipment necessary for testing is not present where the testing is said to have occurred. We proposed through regulation that CMS have the authority to remove these fraudulent providers from the Medicare program.

Medicare Advantage and Prescription Drug Oversight

CMS has reduced the number of unsettled managed care cost reports. In FY 2006, CMS reduced the backlog of unsettled managed care cost reports by 16. Disallowances resulting from FY 2006 settlement activity amounted to about $33.5 million. For FY 2006, CMS had a rate of return of 36 to 1. The remaining backlog still represents a challenge to CMS because these cost reports have critical issues that must be resolved with Managed Care Organizations. These reports may eventually need audit adjustments. Many of the more recent cost reports sent to audit have fewer issues.

In 2006, CMS developed a suite of tools to oversee the Medicare Prescription Drug Benefit (Part D). This included development of a Part D audit guide; audit checklists and worksheets; a Part D audit discussion guide; and a Part D audit standard

operating procedure. These tools assist CMS in ensuring the accuracy of Part D payments.

Finally, CMS is using Medicare Drug Integrity Contractors (MEDICs) in the new Part D program to monitor and analyze information to help identify potential fraud; work with law enforcement, prescription drug plans, consumer groups and other key partners to protect consumers and enforce Medicare's rules; and provide basic tips for consumers so that they can protect themselves from potential scams. Since November 2005, Delmarva Foundation, the first MEDIC which has an Enrollment & Eligibility Task Order, has addressed over 6758 complaints and conducted over 2000 investigations. The MEDICs were expanded in September 2006 with two new contracts: Electronic Data Systems (EDS), which operates in the Northern region of the country, and Science Applications International Corporation (SAIC) operating in the South. In addition, the Delmarva MEDIC was regionalized to serve the Southeast.

Collaboration with Law Enforcement Partners

When instances of fraud or abuse are detected through any of these oversight mechanisms, CMS refers the cases to law enforcement. CMS has actively partnered with its law enforcement partners at the Department of Justice and HHS Office of Inspector General to aggressively pursue enforcement actions against those providers and suppliers that are found to be deliberately defrauding the Federal health care programs.

For example, in 2006 the Delmarva Foundation, a MEDIC, identified a pattern of so-called "$299 scams." Unsuspecting Medicare beneficiaries were being contacted by "agents" attempting to sell non-existent Medicare prescription drug plans for $299. CMS, in collaboration with Delmarva, responded by warning beneficiaries and their support groups about the scam pattern with a press release and a National Fraud Alert. Numerous referrals were made to federal law enforcement. To date, we have assisted beneficiaries in recovering more than $20,000 in funds stolen under these scams.

Conclusion

For eight fiscal years running, auditors have issued an unqualified opinion on CMS' financial statements. This accomplishment reflects the Agency's accountability for the public resources entrusted to us, and the dedication and commitment of our program and financial managers to achieve even stronger financial management. We will continue to work to fully meet our fiduciary and operating responsibilities to our beneficiaries in years ahead.

Chairman STARK. Thank you, Mr. Hill.

Mr. Acosta is the United States Attorney for the Southern District of Florida, headquartered in Miami.

Mr. ACOSTA. Correct.

Chairman STARK. Why do you not proceed with your testimony in any manner in which you are comfortable.

STATEMENT OF R. ALEXANDER ACOSTA, UNITED STATES ATTORNEY FOR THE SOUTHERN DISTRICT OF FLORIDA, MIAMI, FLORIDA

Mr. ACOSTA. Thank you, Mr. Chairman.

Chairman Stark, Chairman Lewis, Ranking Member Ramstad, Members of the Committee, good morning.

I appreciate the opportunity to appear before you to discuss our efforts to combat and to prosecute healthcare fraud. I'm the United States Attorney for the Southern District of Florida. Medicare and Medicaid spending in my district is quite substantial. As a result in my district we are extremely aggressive at engaging in investigating and prosecuting Medicare and Medicaid fraud.

My submitted testimony already describes the efforts of the Department nationwide in the healthcare fraud area. I would there-

fore like to use my time this morning to talk a little bit about our efforts in South Florida.

Since becoming United States Attorney I have made healthcare fraud a top priority. On the civil front, we in Miami are litigating a number of hospital and pharmaceutical healthcare fraud claims. This past December, for example, the University of Miami paid $2.2 million to resolve a claim related to billing by its teaching hospital, Jackson Memorial. The previous month, Larkin Hospital paid $15.4 million to resolve allegations of unnecessary medical treatments at that hospital. Earlier this year we entered into a whistle blower lawsuit against Abbott Labs that concerned fraudulent and inflated prices for pharmaceutical products causing excess reimbursements of over $175 million.

Our most significant challenge, however, is on the criminal front. To address this challenge, in late 2005 I formed a South Florida Healthcare Fraud Initiative to bring together the healthcare fraud prosecution resources of the United States Attorney's Office, the OIG, the Federal Bureau of Investigation (FBI) and the Florida Attorney General's Office. Although still in its early phase, this healthcare fraud initiative has begun to pay dividends.

Last fiscal year, the United States Attorneys across the Nation brought 355 criminal healthcare fraud claims, 355 claims nationwide. In South Florida, we filed 68 of these 355 claims, a 30-percent increase over the prior year's filings. Our conviction rate was 97 percent.

I am particularly excited about our South Florida initiative because our prosecutors are doing much more than merely coordinating resources. We are developing and we are testing new law enforcement methods to add to our litigation arsenal, the arsenal that we use to combat and to prosecute healthcare fraud.

I would like to describe two of these methods for you this morning. The first concerns the use of civil complaints to freeze or seize moneys paid because of healthcare fraud. A recent operation, "Equity Excise", is one example. In Operation Equity Excise, we identified clinics and durable medical equipment companies that engaged in healthcare fraud. We identified approximately 60 of these clinics. Often these companies closed abruptly to avoid detection by law enforcement and in the process, they abandoned accounts often with substantial sums of money. They walked away from these accounts.

The FBI and OIG agents interviewed the signatories on these bank accounts. Many of the signatories denied that the companies existed. They had no knowledge of the companies. They denied any knowledge of the funds and they handed the funds right over to us. In this way, we located 34 individuals, the voluntarily surrendered $10.5 million.

Twenty-three accounts, in 23 cases we could not locate the signatories on those accounts. Those accounts have $30 million in them. So we have filed claims against those accounts. We intend to provide notice by publication, proceed through default judgments, seize the money and return those 30 million in addition to the United States Treasury. That is $40 million returned the United States Treasury.

I think it is important to emphasize we also intend to pursue criminal action where appropriate. Civil complaints are not our

only option but for now at the very least by seizing these bank accounts through this Operation Equity Excise, we can return these $40 million of taxpayer money to the Federal treasury.

I would like to talk about a second method that we are also refining through a recently implemented short term pro-active search operation, actually an operation that has been underway for less than 1 month. Working jointly with the Criminal Division of the FBI, HHS, OIG and local law enforcement in Miami, we implemented this operation on February 14th. The operation uses proactive law enforcement methods adapted from our experience fighting illicit drug trafficking in South Florida, along with our experience in credit card fraud, our experience looking at real time data review that is often used to fight credit card fraud.

Here our Federal agents are reviewing near real time billing patterns. We are looking in particular for instances of unusual spikes in billing. When those unusual spikes are identified, we then look behind that information to identify high levels of billing of particular items that make no medical sense.

Once targets are identified, our FBI and OIG agents visit those offices an interview the providers where the fraud is taking place.

In the short weeks that this operation has been underway, our agents have already executed arrests and have several investigations pending. In about a month. Such caught-in-the-act cases are often easier to prosecute than the more typical healthcare fraud case that is based on historical evidence primarily.

Finally, to augment the cooperation between our prosecutors and agents, we have co-located the prosecutors and the agents in a fusion center modeled after similar arrangements more traditionally used in drug and organized crime prosecutions. We hope that the proximity of the investigators and prosecutors working together under the same roof in the same center will foster strong working relationships and a more proactive investigatory method.

Chairman Stark and Lewis, Mr. Ramstad, Members of the Committee, I would like to close with a few words about the men and women who do this work. My office receives approximately $981,000 from the HCFAC account. To make these initiatives a success, I have matched this $981,000 with about 200 percent, with about an additional $2 million from general funds. With this we fund about a dozen attorneys and their staff who focus on healthcare fraud. These public servants work hard typically litigating against attorneys that are much better paid. They are often outnumbered. There are some meetings where there are a dozen attorneys against one individual; but because they are experts in their field, they are not outgunned. The Southern District is proud of their accomplishments, our results, our civil matters, our moneys seized and collected and our criminal prosecutions cover our outlays many times over.

I thank the Committee for its time and I welcome your questions. Thank you.

[The prepared statement of Mr. Acosta follows:]

Prepared Statement of R. Alexander Acosta,
United States Attorney for the Southern District of Florida, Miami, Florida

Chairman Stark and Chairman Lewis, and distinguished members of the subcommittees, I appreciate the opportunity to appear before you to discuss some of the

issues that are the focus of today's hearing. We are grateful for the leadership of your subcommittees on this important topic and to you, Chairmen Stark and Lewis, for allowing us this opportunity to discuss the Department of Justice's enforcement efforts to combat Medicare fraud.

I am the United States Attorney for the Southern District of Florida, which includes three of Florida's largest metropolitan areas, Miami, Ft. Lauderdale, and West Palm Beach. These areas have a substantial population of senior citizens who are enrolled in the Medicare program. As a result, my district is extremely engaged in investigating and prosecuting those who take advantage of seniors, endanger the health and lives of seniors, and defraud the Medicare program.

In my written testimony I will describe the role the Department of Justice plays in Medicare program integrity, including the role of the Criminal and Civil Divisions of the Department of Justice, the Federal Bureau of Investigation, and the 93 U.S. Attorney's Offices across the country. I will address our sources of funding, our cooperative relationship with the Department of Health and Human Services, and our accomplishments. I will conclude by describing some of the particular initiatives we are launching in my district to fight fraud.

OVER $11 BILLION IN RECOVERIES RETURNED TO THE MEDICARE AND MEDICAID PROGRAMS SINCE 1997

The Department of Justice is committed to rooting out and punishing individuals and corporations who commit health care fraud, including providers and practitioners, equipment suppliers, and corporate wrongdoers. Medicare is the Federal Government's second largest social insurance program, behind only Social Security, with 42.5 million beneficiaries and estimated total expenditures of nearly $418 billion in 2006.

The Department of Justice is not, and cannot be, alone in the fight to combat fraud and preserve the integrity of the country's health care system. 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 (FDA–OCI), the Federal Employees Health Benefits Program (FEHBP) at the Office of Personnel Management and its Office of Inspector General, and with our State law enforcement partners in their Offices of Attorneys General and Medicaid Fraud Control Units.

Working with our colleagues, since the inception of the Health Care Fraud and Abuse Control (HCFAC) program in 1997, the Department has obtained, according to our preliminary estimates, $11.87 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, $10.4 billion has been transferred or deposited back into the Medicare Trust Fund and $604 million, representing the federal share of Medicaid fraud recoveries, has been transferred to CMS. 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.

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. This program provides the principal source of funding for Department of Justice efforts to combat Medicare fraud.

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 Health Care Fraud and Abuse Control 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:

(1) to coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse with respect to health plans;
(2) to conduct investigations, audits, inspections, and evaluations relating to the delivery of and payment for health care in the United States;
(3) to facilitate enforcement of all applicable remedies for such fraud;
(4) to provide guidance to the health care industry regarding fraudulent practices; and
(5) to 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 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 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.[1] All funds deposited in the Trust Fund as a result of the Act are available for the operations of the Medicare programs funded by the 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 Attorney General jointly certify 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 DOJ otherwise devoted to health care fraud investigation and prosecution. The Act specifies the annual maximum amounts available to HHS and DOJ for their health care fraud enforcement work, assigns specific authorities to the HHS Office of Inspector General (HHS–OIG), and stipulates the range of funding OIG must receive each year. In fiscal year (FY) 1997, HIPAA authorized HHS and DOJ to appropriate from the Account up to $104 million, and allowed the Departments to increase that appropriated amount by up to 15% annually until FY 2003. HIPAA also provided $47 million in dedicated funding for the FBI's health care fraud investigations beginning in 1997 which also increased annually until 2003.

Since FY 2003, the maximum available for HHS and the Department of Justice (DOJ) collectively was fixed by statute at $240.558 million annually. Of this total, the HHS–OIG received the statutory maximum amount of $160 million annually. The DOJ litigating components and other (non-OIG) HHS components split the remaining $80.558 million, which we refer to as the "wedge." Thus, of the $240.558 million maximum amount, the DOJ litigating components have received $49.415 million annually from FY 2003 through FY 2006. Separately, HIPAA appropriated $114 million annually to the Federal Bureau of Investigation (FBI) over this same time period to support the Bureau's health care fraud investigative activities.

Section 303 of Division B of the "Tax Relief and Health Care Act of 2006," signed by President Bush last December, provides for annual inflation adjustments to the maximum amounts available from the HCFAC Account and for the FBI starting in FY 2007 for each year through FY 2010. In FY 2010, a fixed funding level or "cap" is reinstated at the 2010 level. With the increasing pressures on the Department's discretionary funding and the resulting impact on resources for other critical Administration priorities and responsibilities, we are hopeful that the annual inflationary adjustments in the Tax Relief and Health Care Act of 2006 will help sustain the Department's current level of criminal and civil health care fraud enforcement activities during the period of 2007–2010. We anticipate, however, that current funding levels alone will be insufficient to address the accumulated numbers of pending cases resulting from the cap on HIPAA funding since FY 2003, the growth in the Medicare program due largely to the prescription drug benefit program, and an anticipated increase in referrals associated with the increases in anti-fraud funding to HHS agencies from the Deficit Reduction and Reconciliation Act of 2005. The President's FY 2008 budget includes an additional $17.5 million through a discretionary cap adjustment proposal for the Department to address these funding concerns.

HCFAC PROGRAM ACCOMPLISHMENTS FY 2006

During Fiscal Year 2006, the Department "won or negotiated" approximately $2.2 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings.[2] The Medicare Trust Fund received transfers of nearly $1.55 billion during this period as a result of these efforts, as well as those of preceding years, in addition to $117.1 million representing the

[1] Also known as the Hospital Insurance (HI) Trust Fund. All further references to the Medicare Trust Fund refer to the HI Trust Fund.

[2] Actual collections, transfers and deposits that ultimately result from healthcare fraud judgments and settlements may not equal the total "won or negotiated" during FY 2006.

federal share of Medicaid money similarly transferred to CMS as a result of these efforts.[3]

In criminal enforcement actions during 2006, prosecutors for the Department and U.S. Attorneys' Offices:

- Opened 836 new criminal health care fraud investigations involving 1,448 potential defendants, and had 1,677 criminal health care fraud investigations involving 2,713 potential defendants pending at the end of the fiscal year; and
- Filed criminal charges in 355 health care fraud cases involving charges against 579 defendants and obtained 547 convictions for the year.

In civil enforcement actions during 2006, attorneys for the Department and U.S. Attorneys' Offices:

- Opened 698 new civil health care fraud investigations, and had 1,268 civil health care fraud investigations pending at the end of the fiscal year; and
- Filed complaints or intervened in 217 civil health care cases.

Since the inception of the HCFAC program in 1997, the Department's criminal and civil enforcement efforts funded through that program have returned nearly $11.87 billion total to the federal government, including more than $10.4 billion transferred to the Medicare Trust Fund and $604 million representing the federal share of Medicaid fraud recoveries transferred to CMS. We have secured more than 4,500 criminal convictions for health care fraud related offenses, the vast majority involving Medicare fraud.

INTERAGENCY DOJ-HHS COOPERATION

Because the Department of Health and Human Services administers the Medicare Program and maintains all the payment records and data submitted by providers, successful prosecution of criminal cases and litigation of civil cases requires close cooperation between the Departments. Examples of this close cooperation include the following:

- Under auspices of HCFAC Program, DOJ 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, 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 also hold monthly CMS–DOJ conference calls involving CMS Program Integrity and other staff with our USAO 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 include private insurer investigators.
- The HHS–OIG shares summarized information about all Medicare contractor referrals for investigation with the FBI and DOJ, and the FBI exchanges copies of its health care fraud case opening memorandums with OIG.
- DOJ participated in the planning and presentation of a Medicaid Fraud training conference sponsored by the Inspector General of the Department of Health and Human Services, and it conducted a nationwide closed circuit training session for federal and state law enforcement officials on the HIPAA privacy rule and other privacy laws and regulations.
- Last year DOJ attorneys and support staff trained CMS regional and central office staff hired to administer the Medicare prescription drug benefit and monitor the prescription drug plans on federal health care fraud statutes and possible fraud schemes which may occur in the Medicare Prescription Drug (Part D) program. Department attorneys and staff also conducted two national training seminars for CMS Medicare Drug Integrity Contractor staff hired to conduct program integrity and anti-fraud work for the Part D program.

[3] Note that some of the judgments, settlements, and administrative actions that occurred in FY 2005 will result in transfers in future years, just as some of the transfers in FY 2005 are attributable to actions from prior years.

DEPARTMENT COMPONENTS INVOLVED IN MEDICARE 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 of the Department of Justice

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. The Civil Division also pursues these cases as criminal violations of the Food, Drug, and Cosmetic Act.

In FY 2006, the Civil Division opened or filed a total of 239 health care fraud cases or matters. In addition to any new cases that are filed, however, there remain a significant number of matters that the Division continues to move toward resolution. At the end of FY 2005, there remained 680 open cases. Many of these health care fraud cases, typically those involving corporate or institutional providers, involve millions of documents and hundreds of witnesses, require experienced litigation support personnel to amass and organize the evidence, and need knowledgeable consultants to provide their expertise about the fraudulent schemes.

Since the False Claims Act was substantially amended in 1986, the Civil Division, working with United States Attorney's Offices, has recovered $18.2 billion on behalf of the various victim federal agencies. Of that amount, $11.5 billion was the result of fraud against federal health care programs—primarily the Medicare program. Cases involving violations of the Food, Drug, and Cosmetic Act, or other types of fraud by pharmaceutical manufacturers in connection with federal health benefit programs, have resulted in total criminal and civil recoveries of over $5.2 billion since 1999.[4] The Civil Division's Office of Consumer Litigation works with many of the United States Attorney's Office on these prosecutions.

In addition to these accomplishments, the Department's Nursing Home and Elder Justice 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 is pursuing a growing number of cases under the FCA involving providers' egregious "failures of care."

United States Attorneys Offices

The 93 United States Attorneys Offices (USAOs) are the nation's principal prosecutors of federal crimes, including health care fraud. The USAOs pursue both civil and criminal cases and dedicate substantial resources to combating health care fraud. Each of the 93 districts has a designated Criminal Health Care Fraud Coordinator and Civil Health Care Fraud Coordinator. HCFAC funding supports about 100 attorney and 81 support positions, and many USAOs supplement the HCFAC program funding they receive by providing for additional attorneys, paralegals, auditors, and investigators, as well as funds for litigation expenses for these resource-intensive cases.

In FY 2006, USAOs received 836 new criminal matters involving 1,448 defendants, and had 1,677 health care fraud criminal matters pending,[5] involving 2,713 defendants. USAOs filed criminal charges in 355 cases involving 579 defendants, and obtained 547 federal health care related convictions. During the last fiscal year,

[4] A portion of this $5.3 billion is included in the reported False Claims Act recoveries for this same period.

[5] When a USAO accepts a criminal referral for consideration, the office opens it as a matter pending in the district. A referral remains a matter until an indictment or information is filed or it is declined for prosecution.

USAOs also opened 698 new civil health care fraud matters and had 1,268 civil health care fraud matters and cases pending.

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. Under the False Claims Act, a *qui tam* plaintiff (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 USAO must then decide whether the case warrants an intervention by the government to litigate the complaint.

The Executive Office for the 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. For instance, in FY 2006, EOUSA and the Civil Division participated in the planning and presentation of a Medicaid Fraud training conference sponsored by the Inspector General of the Department of Health and Human Services, and it joined with both the Civil and Criminal Divisions to conduct a nationwide closed circuit training for federal and state law enforcement officials on the HIPAA privacy rule and other privacy laws and regulations. EOUSA and the Office of Legal Education 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, and, most recently, it sponsored a Health Care Fraud Trial Practice Seminar for over 120 Department lawyers.

Criminal Division of the Department of Justice

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, training, and, in certain instances, provides trial attorneys to prosecute criminal health care fraud cases.

In FY 2006, the Fraud Section provided guidance to FBI agents, AUSAs and Criminal Division attorneys on criminal, civil, and administrative tools to combat health care fraud, and worked at an interagency level through the following activities:

- coordinating large scale multi-district health care fraud investigations;
- providing frequent advice and written materials on confidentiality and disclosure issues arising in the course of investigations and legal proceedings regarding patient medical records, including HIPAA health information privacy requirements, compliance with the Substance Abuse Patient Medical Records Privacy Act and regulations, and coordinating referrals from the HHS Office for Civil Rights of possible criminal violations of HIPAA privacy provisions providing training and training materials for AUSAs, investigative agents, support staff, program agency officials, and state and local law enforcement on health care fraud enforcement and medical records privacy issues;
- providing training and training materials for AUSAs, investigative agents, support staff, program agency officials, and state and local law enforcement on health care fraud enforcement and medical records privacy issues;
- monitoring and coordinating Departmental responses to legislative proposals, major regulatory initiatives, and enforcement policy matters related to prevention, deterrence and punishment of health care fraud and abuse;
- reviewing and commenting on health care provider requests to the HHS/OIG for advisory opinions, and consulting with HHS/OIG on draft advisory opinions per HIPAA requirements;
- working with USAOs and CMS to improve Medicare contractors' fraud detection, referrals to law enforcement for investigation, and case development work;
- preparing and distributing to all USAOs and FBI field offices periodic summaries of recent and significant health care fraud cases; and
- organizing, overseeing and participating in interagency working groups formed to address specific cases and initiatives, often in conjunction with the Civil Division and Executive Office for United States Attorneys.

In FY 2006, the Fraud Section handled or was involved in cases and investigations of a defunct health maintenance organization; a financial service holding company that serviced hospitals, nursing facilities, and other health care providers; and of durable medical equipment (DME) suppliers and pharmacies. Along with the USAO for the Northern District of Ohio, Fraud Section attorneys indicted seven individuals in a scheme involving a financial service holding company. Through its subsidiary corporations, the company bought accounts receivable from hospitals, nursing homes and other health care providers and medical concerns, and company executives illegally diverted the money for other unrelated purposes. In another case, Fraud Section attorneys and the USAO from the Eastern District of Louisiana filed a superseding indictment of four corporate executives in a case involving the collapse of Louisiana's third largest HMO and its subsequent takeover and liquidation by the state Department of Insurance.

My district is actively working with the Fraud Section. We recently indicted five defendants who were involved in a scheme to defraud Medicare by submitting prescriptions for groups of Medicare beneficiaries who were paid kickbacks by certain pharmacies to allow the fraudulent billing of aerosol medicines. All three of these cases are scheduled to go to trial in 2007.

Civil Rights Division of the Department of Justice

The Civil Rights Division vigorously pursues the Department's goals of eliminating abuse and grossly substandard care in Medicare (and Medicaid) funded nursing homes and other long-term care facilities. The Division undertakes this work pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA). CRIPA authorizes investigations of conditions of confinement at publicly operated nursing homes and other residential institutions and authorizes the initiation of civil action for injunctive relief from violations of federal rights. In performing this work, the Division often collaborates with United States Attorneys around the country and with the Department of Health and Human Services.

Division staff conducted preliminary reviews of conditions and services at 29 health care facilities in 12 states during Fiscal Year 2006. 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 Division 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 2006, the Division opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 45 health care facilities in 23 states, the District of Columbia, and the Commonwealth of Puerto Rico.

For example, in Fiscal Year 2006, the Division: (1) opened an investigation of a nursing home in South Carolina; (2) made findings that conditions and practices at another nursing home, Fort Bayard Medical Center, in Fort Bayard, New Mexico, violate its residents' federal constitutional and statutory rights; (3) entered a settlement agreement to remedy unlawful conditions at one of the largest public nursing homes in the country, A. Holly Patterson Extended Care Facility, in Uniondale, New York; and (4) monitored the implementation of remedial agreements for four nursing homes: Banks-Jackson-Commerce Medical Center and Nursing Home, in Commerce, Georgia; Nim Henson Geriatric Center, in Jackson, Kentucky; Reginald P. White Nursing Facility, in Meridian, Mississippi; and Mercer County Geriatric Center, in Trenton, New Jersey. More recently, in response to allegations of shocking mistreatment and neglect of elderly veterans, including an apparent homicide, the Division last month opened investigations of two veterans' homes in Tennessee.

The Division's recent findings regarding one nursing home are unfortunately illustrative. The investigation revealed a wide range of dangerously deficient medical and nursing care practices that not only failed to comply with federal regulations or meet professional standards, but were in fact aiding and contributing to the needless suffering and untimely deaths of residents. The Division found numerous situations where residents' last days of life were spent in misery, as they died from the effects of what appeared to be reckless and almost willful disregard to their health and safety. In fact, in virtually every record reviewed of deceased or current residents, the Division discovered life-threatening breakdowns of treatment that were substantial departures from the generally accepted standards in nursing home care. The Division is now negotiating an agreement to remedy these deficiencies.

Federal Bureau of Investigation

The FBI is the Department's primary investigative agency involved in the fight against health care fraud. The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as the HHS/

OIG, the FDA/OCI, the Drug Enforcement Administration (DEA), the Defense Criminal Investigative Service, the Office of Personnel Management, the Internal Revenue Service, and various state and local agencies. In FY 2006, the FBI was allocated $114 million in HCFAC funds for health care fraud enforcement. This yearly appropriation was used to support 775 positions (455 Agent, 320 Support) in FY 2006. The number of pending investigations has shown steady increase from 591 cases in 1992 to 2,423 cases through 2006. FBI-led investigations resulted in 535 criminal health care fraud convictions and 588 indictments and informations being filed in FY 2006.

The FBI initiates health care fraud cases from various sources of information. Information can come from such sources as Medicare contractors, private insurance company Special Investigations Units, the National Health Care Anti-Fraud Association, employees of businesses providing medical services (hospitals, doctor's offices, clinics, medical equipment suppliers, nursing homes, etc.), confidential sources or cooperating witnesses with access to information and complaints from public citizens which are often beneficiaries of the health care services.

FRAUD SCHEMES

To give you a sense of the types of fraud schemes the Department has seen and the enforcement results the Department has achieved, I will outline below some of the significant Medicare fraud cases the Department pursued over the last year. This list is not meant to be exhaustive; it is meant to illustrate some of the fraud schemes we are seeing.

Hospital Matters

- **Tenet Healthcare Corporation**, the nation's second largest hospital chain, agreed to pay $920 million to settle allegations of fraud against Medicare and other federally insured health care programs. The settlement included $806 million to resolve claims that Tenet billed Medicare for excessive "outlier" payments. Federal health insurance programs, including Medicare, typically reimburse hospitals a fixed amount for treating a patient with a specific condition or illness, but will reimburse extraordinary "outlier" costs when they are reasonably incurred. Congress enacted the supplemental outlier payment system to ensure that hospitals possess the incentive to treat inpatients whose care requires unusually high costs. The United States alleged that Tenet artificially inflated its charges to make it appear that many of its patients received extraordinary care when, in fact, the treatment that was given was fairly standard and far less costly. The settlement also included $49 million to resolve claims that Tenet paid kickbacks to physicians for patient referrals, $48 million to resolve claims that Tenet billed the Government at a higher rate than was justified by the services performed, and $20 million in pre-settlement interest.

Government-initiated claims accounted for nearly $770 million of the settlement, with the remaining $150 million attributable to six *qui tam* suits. The relators who filed those suits will share $12 million of the settlement amount.

- **St. Barnabas Health Care System**, the largest health care system in New Jersey, paid $265 million to resolve allegations that nine of its hospitals fraudulently increased charges to elderly patients to obtain enhanced Medicare reimbursement for outlier claims. The United States alleged that between October 1995 and August 2003, Saint Barnabas and nine of its hospitals purposefully inflated charges for inpatient and outpatient care to make these cases appear more costly than they actually were, and thereby obtained outlier payments from Medicare that they were not entitled to receive.

Saint Barnabas entered into a Corporate Integrity Agreement with the United States Department of Health and Human Services, Office of Inspector General. The Corporate Integrity Agreement contains measures to ensure compliance with Medicare regulations and policies in the future.

- Following a three-week trial, the former owner and chief executive officer of the now defunct **Edgewater Hospital** in Chicago was found liable under the False Claims Act for engaging in an illegal kickback scheme at Edgewater. The court found that the defendant paid physicians for Medicare and Medicaid patient referrals in violation of federal law. The court held that the hospital's cost reports and individual patient claims for patients referred in connection with the scheme were false claims and awarded treble damages and penalties on just over 1,800 claims.
- Two owners of a former San Diego psychiatric hospital were found liable after trial for more than $15.7 million in damages and penalties for having included

false claims in the hospital's cost report submitted to the Medicare program. Those cost reports sought reimbursement from the Medicare program for a variety of false costs, such as amounts for a fictitious lease, reimbursement for unused hospital space, and millions of dollars in costs that were actually attributable to the defendants' business enterprises unrelated to that hospital. The court awarded the United States $15,688,585 for treble damages and $31,000 in civil penalties.

Pharmaceutical Matters

- **Schering-Plough Corporation**, together with its subsidiary, Schering Sales Corporation, agreed to pay a total of $435 million to resolve criminal charges and civil liabilities in connection with illegal sales and marketing programs for its drugs Temodar, used in the treatment of brain tumors and metastasis, and Intron A, used in the treatment of superficial bladder cancer and hepatitis C. The resolution also pertained to Medicaid fraud involving Schering's drugs Claritin RediTabs, a non-sedating antihistamine, and K–Dur, used in the treatment of stomach conditions.

Schering Sales Corporation agreed to plead guilty to charges that it conspired with others to make false statements to the FDA in response to the FDA's inquiry concerning certain illegal promotional activities by the company's sales representatives at a national conference for oncologists. Schering Sales also agreed to plead guilty to charges that it conspired with others to give free Claritin Redi-Tabs to a major health maintenance organization (HMO) to disguise a new lower price being offered to the HMO to obtain its business.

- **Eli Lilly and Company** agreed to plead guilty and to pay $36 million in connection with its illegal promotion of its pharmaceutical drug Evista. In pleading guilty to a criminal count of violating the Food, Drug, and Cosmetic Act by misbranding its drug Evista, the Indianapolis-based company agreed to pay a $6 million criminal fine and forfeit to the United States an additional sum of $6 million. In addition to the criminal plea, Lilly agreed to settle civil Food, Drug, and Cosmetic Act liabilities by entering into a consent decree of permanent injunction and paying the United States $24 million in equitable disgorgement.

Evista is approved by the FDA for the prevention and treatment of osteoporosis in postmenopausal women. The government alleged that the first year's sales of Evista in the U.S. were disappointing compared to Lilly's original forecast; the company reduced the forecast of Evista's first year's sales in the U.S. from $401 million to $120 million. In order to expand sales of the drug, it was alleged, Lilly sought to broaden the market for Evista by promoting it for off-label uses, such as for the prevention and reduction in risk of breast cancer, and the reduction in the risk of cardiovascular disease. Lilly promoted Evista as effective for reducing the risk of breast cancer, even after Lilly's proposed labeling for this use was specifically rejected by the FDA.

- **Serono**, one of the world's largest biotech manufacturers, paid $704 million to resolve criminal charges and civil liabilities in connection with several illegal schemes to promote and sell its drug, Serostim, that resulted in the submission of false claims to Medicaid and Medicare. The FDA had granted accelerated approval for Serostim in 1996 to treat AIDS wasting, a condition involving profound involuntary weight loss in AIDS patients, then a leading cause of death in AIDS patients. Following the advent of protease inhibitor drugs, the incidence of AIDS wasting markedly declined, and Serono launched a campaign to redefine AIDS wasting to create a market for Serostim. Serono pled guilty to conspiring with RJL Sciences, a medical device manufacturer, to introduce on the market bioelectrical impedance analysis (BIA) computer software packages for use in measuring body cell mass and diagnosing AIDS wasting. The BIA software devices were adulterated medical devices in that FDA had not approved the devices for these uses. RJL and its owner also pled guilty to their roles in the conspiracy. In addition, Serono pled guilty to conspiring to offer doctors kickbacks in the form of free trips to Cannes, France, to induce them to prescribe Serostim.

Physicians

- An Ohio physician was convicted by a jury of 56 counts of mail, wire, and health care fraud, as well as illegal drug distribution and sentenced to life for operating "pain management" clinics in which he treated all patients with weekly injections and Schedule II and III narcotic drug prescriptions during visits that lasted no more than a few minutes, and then claimed thousands of dollars in

insurance reimbursements per visit. He saw upward of 100 patients per day and submitted $60 million in fraudulent bills to the victim health care benefit programs. The physician was also convicted of health care fraud resulting in death in this case which was recognized by the National Health Care Anti-Fraud Association as the Investigation of the Year for 2006.

- A Tennessee oncologist was sentenced to over 15 years' imprisonment for defrauding Medicare, TennCare and BlueCross BlueShield at the expense of cancer patients. The defendant mixed diluted versions of chemotherapy medications that were then given to patients, and instructed her nurses to draw up partial doses of one of medications to administer to patients.
- From 1996 through 2003, a physician employed an individual to work at the physician's medical practice in Connecticut. Although the individual was not licensed to practice medicine, he nonetheless treated patients in the physician's medical practice. During this time, he was referred to as "Doctor" by the physician and he wrote prescriptions. The physician then billed insurance companies for services that were rendered by the individual, representing them as services rendered by a physician. They both pled guilty to conspiracy to commit health care fraud. The physician also entered into a civil settlement with the Government and paid $160,000.

Hospice Care

- **Odyssey Healthcare, Inc.**, a Dallas, Texas-based hospice provider, agreed to pay the United States $12.9 million to settle allegations that the company billed the Medicare program for services provided to hospice patients who were not terminally ill and hence were ineligible for the Medicare hospice benefit. Odyssey Healthcare has also entered into a Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services. The Corporate Integrity Agreement addresses the company's practices regarding compliance with applicable Medicare regulations.
- **Faith Hospice, Inc.**, settled allegations that it submitted fraudulent claims to Medicare and Medicaid for ineligible hospice. The investigation was initiated when a review of a sample of its medical records showed that more than half of Faith Hospice's patients were ineligible for hospice care. Under the agreement, the owner and Faith Hospice forfeited $599,165.29 to the United States, one half of the funds seized pursuant to the civil forfeiture action. The case occurred in Alabama.

Skilled Nursing Facilities

- **USA Healthcare, Inc.**, (USAH) the owner of several skilled nursing facilities based in Cullman, Alabama, settled allegations of mischarging the Medicare Program by agreeing to pay the United States $1,217,808.00. The investigation arose out of an audit of cost reports filed by several of USAH's skilled nursing facilities which revealed that the company violated Medicare rules by failing to disclose that certain vendors were related to USAH by common ownership or control and therefore should have been reimbursed by Medicare at a lower rate based on actual costs and without inclusion of profit.

Medicare Devices

- The owner and operator of **V&A Services**, a medical equipment supply company located in Stone Mountain, Georgia, was convicted by a federal jury of 11 counts of Medicare fraud in a motorized wheelchair fraud scheme. He was sentenced to 2 years and 3 months in federal prison to be followed by 3 years' supervised release. He was ordered to pay restitution of $164,590 in connection with the scheme. The judge entered an order of forfeiture at sentencing by which the defendant forfeited $36,416 from a seized bank account and durable medical equipment having a value of approximately $11,000.
- The owner of a power wheelchair store was sentenced to 63 months in prison and ordered to pay over $4 million in restitution to the Medicare and Medicaid programs after he was convicted by a jury of paying recruiters to take beneficiaries to a medical clinic where a physician would perform medically unnecessary procedures and then sign false Certificates of Medical Necessity (CMN) forms authorizing the beneficiaries to receive motorized wheelchairs. The physician also was sentenced to 11 years and three months in prison for his participation in the scheme for receiving payment for signing the CMNs, and for submitting claims for services that either were not performed properly, or were not performed at all.
- The owner of a power wheelchair store pled guilty in Lynchburg, Virginia to conspiracy to commit health care fraud for his involvement in an intricate

scheme involving power wheelchairs and "power chair scooters." Among the allegations were that items not needed and not ordered by the physician, were simply added after the physician signed the Certificate of Medical Necessity.

- In the Southern District of Texas, the owner of a Houston-based durable medical equipment company was sentenced to 63 months in prison for his role in a motorized wheelchair scam. His company fraudulently billed Medicare and Medicaid for almost $5 million and defrauded these health care programs of at least $1.6 million.

SOUTH FLORIDA INITIATIVES

The United States Attorney's Office for the Southern District of Florida ("SDFL") has made health care fraud matters a top priority. We are litigating a number of hospital and pharmaceutical civil health care claims. This past December, for example, the University of Miami paid $2.2 million to resolve claims relating to bills submitted to Medicare Part B by its teaching hospital, Jackson Memorial Hospital. In November, Larkin Hospital paid $15.4 million to resolve a health care fraud suit concerning kickbacks and unnecessary medial treatments. Earlier last year, we entered into a whistleblower suit charging Abbott Labs with reporting fraudulent and inflated prices for pharmaceutical products to Medicare and Medicaid, causing over $175 million in excess payments.

Our most significant challenge, however, is on the criminal front. Because health care expenditures are so substantial in South Florida, we are particularly vulnerable to fraud. To address this challenge, in late 2005, we formed the South Florida Health Care Fraud Initiative to bring together the health care fraud prosecution resources of SDFL prosecutors, HHS–OIG and the FBI agents and Florida Attorney General's Office attorneys, cross-designated as Special Assistant United States Attorneys.

Although still in its early phase, our Health Care Fraud Initiative has begun to pay dividends. Last fiscal year, we filed criminal charges against 111 defendants in 68 health care fraud cases, a 30% increase over the previous year. Our conviction rate was 97%. These cases typically involve at least one, and often several, million dollars in fraud.

I am particularly excited about our Health Care Fraud Initiative because our prosecutors are doing much more than merely coordinating resources. We are developing and testing new law enforcement methods to add to our health care fraud litigation arsenal. I would like to describe two of these methods. The first concerns the use of civil complaints to freeze or seize money obtained through health care fraud as soon as our evidence will satisfy a civil standard.

Our recent "Operation Equity Excise" is an example. Working with HHS–OIG and the FBI, Operation Equity Excise identified clinics and durable medical equipment (DME) companies that engaged in health care fraud. Often, these companies closed abruptly to avoid detection from law enforcement, in the process abandoning bank accounts, often with substantial balances. Through this Operation, federal agents attempted to locate the signatories on the bank accounts. Many of the signatories, who were also typically listed as the president of the company, denied knowledge of the operation of the company and denied having any claim or right to the funds in the accounts. Thirty-four individuals were located; they voluntarily surrendered the funds, resulting in approximately $10.5 million returned to the United States Treasury. The signatories on twenty-three accounts, with a total balance of over $30 millions, have not been located. Last month, we filed civil health care fraud complaints against those individuals. We intend to provide notice through publication, proceed through default judgment, and return those funds to the Treasury as well. Importantly, our civil actions do not preclude a subsequent criminal prosecution. Where supported by facts, we continue to pursue criminal investigations of these companies. For now, at the very least, by seizing the bank accounts, we can recover some of the fraudulently paid moneys.

A second method is being refined through a recently-implemented short-term, proactive, surge operation that we are undertaking jointly with the Criminal Division, the FBI, HHS–OIG, and local law enforcement in Miami-Dade County. The surge operation uses proactive law enforcement methods adapted from experience fighting illicit drug trafficking along with real-time data review often used to fight credit card fraud. A typical health care fraud prosecution relies heavily on billing records and other historical evidence. In this operation, however, HHS–OIG agents are reviewing real-time billing patterns. In the few weeks of operation, our agents have identified patterns that standing alone reveal medically impossible claims. Our agents are visiting the offices and interviewing providers as the fraud is taking place. Such "caught-in-the-act" cases are often easier to prosecute than ones based solely on historical evidence.

Finally, to augment the cooperation between the prosecutors and agents, we have co-located the prosecutors and investigative agents in a "fusion center." Modeled after similar arrangements more traditionally used in drug and organized crime prosecutions, we hope that the proximity of the investigators and prosecutors, working closely together, helps foster strong working relationships and a more proactive investigative technique.

CONCLUSION

I hope my testimony has given you a comprehensive view of the Department's essential role in defending and protecting the financial integrity of the Medicare program 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 prosecute fraud and abuse in the Medicare program and restore the recovered proceeds of fraud to the Medicare trust fund. The HCFAC program pays for itself multifold and helps ensure the safety and availability of medical services to all beneficiaries.

Chairman STARK. Thank you, Mr. Acosta. I would like to recognize Chairman Lewis to inquire of our panel.

Chairman LEWIS OF GEORGIA. Thank you very much, Chairman Stark.

Let me thank each of you for your testimony.

Mr. Inspector General, I am appalled by the level of abuse in the Medicare system. Could you tell Members of the Committee of what role do Medicare beneficiary play in detecting the abuse?

Mr. LEVINSON. Medicare beneficiaries can play a very important part in uncovering abuse. Indeed, our Hotline is a very instrumental part of being able to detect patterns of abuse that occur in different parts of the country. Because of the nature of this national program and the fact that different forms of abuse can occur in different parts of the country, depending upon the demographics and the socioeconomic aspects of a particular part of the country, Hotline activity is a very key part of being able to uncover what is going on that might trigger the need for investigations either in southern California, in South Florida, as the United States Attorney has explained, and in other parts of the country. We certainly rely upon that as a very important vehicle, but that is only one of many tools.

Chairman LEWIS OF GEORGIA. Do you have a system, any program to inform the people who benefit from Medicare about fraud? Is that something that Mr. Hill or other agencies get involved in? Do you send out a notice? How do you publicize? "Be on guard. Be alert."

Mr. HILL. There's a couple of ways that we can talk about that, sir. First and foremost is the requirement under the statute that we inform beneficiaries every year through a handbook of the benefits that are available to them. Now in this world of Part D, the choices that are available to them.

A part of that handbook, and a significant part of that handbook, is a discussion of how to report fraud, how to look at the bills that they are getting, what they should be looking for to be sure that they are not being defrauded. So, the handbook is one element.

It is also the case that for every service that a beneficiary gets, they get what we call a Medicare Summary Notice, basically a bill like a credit card statement of the previous quarter listing all the

services that have been delivered on their behalf, what has been paid, what has not been paid, what the beneficiary owes. On that bill itself is the OIG hot line, the number to call the Medicare contractor if there are issues with the bill that they see. We encourage beneficiaries to review their bills because that, quite frankly, is one of the first places where we may see, or a beneficiary may see, that they did not get a service that we paid for. So, that is an ongoing exercise.

Finally, the Department's Administration on Aging has a fairly robust program that they have used through the Area of Councils on Aging in all fifty States where they give grants to groups of senior citizens in the Area Councils on Aging to train beneficiaries to sort of go out and give lectures and training for beneficiaries about how to look at their bills, what to spot for in terms of fraud. So clearly for us the beneficiary is the first link, the first place that we can look to where we may spot problems.

Chairman LEWIS OF GEORGIA. Thank you, Mr. Hill.

Mr. LEVINSON. Mr. Lewis, it will be especially important going forward that beneficiary education be a very critical part of the Part D continued roll-out because of the complexities of the program and the newness of the program, it is going to be very, very important that beneficiaries understand how this complex program works. We on the IG side will be watching closely and reporting on issues that arise over the course of the next few years as Part D fully matures as to where there are issues concerning a lack, or a potential lack, of information that beneficiaries need in order to make educated choices.

Chairman LEWIS OF GEORGIA. Thank you, Mr. Levinson.

Mr. Acosta, do you think you need additional tools for enforcement? Is there something that the Congress should do?

Mr. ACOSTA. Mr. Lewis, through our initiative, we are testing additional law enforcement methods and I think it is important to always look for better ways of prosecuting cases, of being more proactive and moving cases along. I think it is important that we do that.

That said, I would like to take that question back to the Department to see if there are some statutes or changes that the Department think are necessary. From my perspective in South Florida, my focus is on doing more with what we have. That said, I do think it is important to—and I know that resources have been referenced previously—the HCFAC account for a number of years was statutorily frozen at 240 million.

Chairman LEWIS OF GEORGIA. You said the HCFAC?

Mr. ACOSTA. The HCFAC account, correct, for a number of years was statutorily frozen at 240 million. Of that, the Department of Justice litigating components received 49 million. This past year Congress approved and the President signed a provision that permitted inflation adjustment to the account which is a good start.

This year's budget asked for an additional $17 million and particularly with Medicare Part D forthcoming, I think it is critical that those resources be provided. We have a very large healthcare fraud caseload. As I said, in South Florida I have 12 attorneys and I can afford that many because I supplement the HCFAC account with general funds. We have a very large caseload and that is be-

fore the anticipated caseload from Medicare Part D referrals as that program develops and goes forward. So I would put emphasis on fully funding the additional resources requested.

Chairman LEWIS OF GEORGIA. Mr. Acosta, before my time expires, I just want to ask you about a case that took place last year. Your office obtained $15.4 million from a hospital to settle a case alleging that it performed medically unnecessary procedures which were painful and uncomfortable for a resident of an assisted living facility. The hospital also allegedly paid kick-back to a physician to refer a Medicare patient to the hospital.

Mr. ACOSTA. The Larkin Hospital matter.

Chairman LEWIS OF GEORGIA. I think when I first came here, Chairman Stark, you were dealing with the whole question of referrals and kick-back. I cannot believe that it is still going on 20-some years later.

Could you tell me what percentage of your cases involve fraud and abuse by hospitals?

Mr. ACOSTA. I can tell you a number of our civil cases involve fraud and abuse by hospitals. For example, this past November—I'm sorry. This past December we settled $2.2 million claim against Jackson Memorial Hospital. The previous month in November, we settled the $15.4 million claim against Larkin Hospital.

In terms of the percentage of cases, the percentage of cases is small. We prosecuted 68 criminal cases out of the 350 national cases, but I do not want to put too much emphasis on that percentage because I think it can be misleading because often the cases that concern hospitals are some of the most significant cases because they involved a number of individuals. So I think it is important to not just look at the number of cases but the size and the scope. The Larkin Hospital case, for example, involved a number of individuals who allegedly received unfair—I'm sorry—who allegedly received unnecessary medical treatment. In those types of cases where people or individuals are suffering I think, I think we have to give those a high priority. I think in addition to the size and the number of the cases, we need to look at harm to individuals and understand that just a handful that involve harm to individuals can sometimes be more significant than a number of cases that involve only money.

If I could, I would like to add an additional point since you raised the Larkin Hospital case. I think it is also important to recognize that even where civil claims are made it is important to consider criminal matters. In cases like that, my office's policy is where criminal action is appropriate, too, to proceed and investigate criminally even after a civil matter has been resolved. So I just wanted to mention that to the Committee.

Chairman LEWIS OF GEORGIA. Thank you very much.

I yield back, Mr. Chairman.

Chairman STARK. Mr. Ramstad.

Mr. RAMSTAD. Thank you, Mr. Chairman.

Mr. Hill, as I'm sure you know, the Medicare Modernization Act transitioned the part A and part B payment carriers into larger Medicare administrative contractors to streamline the contracting process.

I have two questions. Is the new contracting process working? Secondly, when the number of administrative contractors was reduced, did the number of improper payments to Medicare fee-for-service providers also go down?

Mr. HILL. I think those are good questions. I think in terms of the transition to the Medicare Administrative Contractors (MAC), we are in the first phase of that so right now I believe four are up and running. So, we have 38 of the old contracts, 4 of the new ones and the 4 that we transitioned to first were durable medical equipment contractors who are the ones who process the durable medical equipment (DME) contracts. So, it is a little early to tell how much of an impact that they are going to have one way or another. I can tell you as a contracting matter that because we have the new authority, I can now hold the four contractors accountable for improper payments. The contracts are structured such that the payments or the incentives that the contractors get can be tied to, and in fact are tied to, their success at reducing the improper payments for the areas that they are processing claims for.

They also now have more of an incentive to be innovative and cooperative with folks like in law enforcement and otherwise to sort of seek out folks who are improperly billing the program. So, the overall construct of having a competitive process under Federal Procurement Rules we believe is going to give us a much better tool to reduce improper payments.

We are probably 6 months to a year away from having real results and having them on the contractors over time to see how well they are performing.

Mr. RAMSTAD. Thank you for that response and I look forward to following that up when there is enough data to make a judgment.

Mr. HILL. Absolutely.

Mr. RAMSTAD. I would like to ask you a question, Inspector General Levinson if I could, please. I never cease to be amazed by the vernacular that is used around here in the Federal Government, but I saw a new one in the President's recent budget. He proposes in that budget to eliminate payments for never events in hospitals.

Can you explain what in the world is a never event in Medicare and why is Medicare paying for events that never happened?

Mr. LEVINSON. The reduction of accidents and mistakes, those things that occur in hospitals that should, "never have occurred." Unfortunately, the expression used I do not think is especially revealing as to what the underlying issue is, but it is designed to presumably reduce the number of events—mistakes, accidents—the kinds of things that one would expect never to occur in a hospital.

Mr. RAMSTAD. I just wonder which creative mind down at the Office of Management and Budget (OMB) came up with that terminology. I appreciate the explanation. Also I want to ask you, Mr. Levinson, you mentioned in your testimony that for the 3-year period between fiscal year 2004 and 2006 the average return on investment was nearly $13 for every dollar spent. I do not think you articulated this today, but it is in your written testimony.

Mr. LEVINSON. Yes.

Mr. RAMSTAD. On enforcement that is. What areas of fraud investigation by the IG produced a significant return on investment? Which areas were the most fruitful?

Mr. LEVINSON. A very large part of those dollars in investigative receivables has to do with very large pharmaceutical cases concerning pricing and marketing. These are cases that by and large come out of the District of Massachusetts in Boston and the Eastern District of Pennsylvania in Philadelphia. These are very extensive national investigations that oftentimes can result in very significant multi, multi-million dollar settlements.

Mr. RAMSTAD. If we could get that return on investment across the board, that is the Federal Government, for every dollar invested $13 return, we would be a lot better off. I appreciate your responses and your testimony. Thank you.

I yield back.

Chairman STARK. Thank you. I guess I would inquire—I want to thank the panel for taking the time to be with us and to enlighten us and in particular Inspector General Levinson who has been in touch with us from time to time on many issues. I appreciate his willingness to inform us and keep us up to speed on the activities of his office.

In your testimony and prior to the introduction of the Thomas Memorial Stark Bill dealing with the end stage renal disease (ESRD) and dialysis payments, 10 years ago your predecessor recommended that reducing erythropoietin (EPO) reimbursements to more closely to resemble cost would save us $100 million a year, but since then Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MEDPAC) have both urged us to bundle in the drugs that are now separately billed.

We think that would have two effects. It would probably cut down on over-prescribing which we have found causes some health problems, but it also would save us a good bit of money. Have you had a chance, Mr. Levinson, to study this and would you recommend to us that the bundling the separately billed drugs would be a better way or not as good a way as cost reimbursement?

Mr. LEVINSON. Chairman Stark, we support the concept of developing a new comprehensive composite rate for ESRD services. The rate needs to be based on accurate cost information and medically justifiable usage of present separately billable services such as lab tests and drugs like EPO.

With such a new rate, we would hope that greater savings to the Medicare Program would be realized, but at this point we have not made a specific recommendation on a composite rate.

Chairman STARK. Thank you.

Mr. Hill, you have mentioned in your testimony provider-specific investigations. I also just parenthetically and very quickly how soon can we expect your plan for Part C error rates? Will we see that in the next few months or will it be longer?

Mr. HILL. For the Part C error rate, we are as part of the President's management agenda and our compliance with the IPIA clearly we are required under—the Improper Payments Information Act of 2003 which requires us to do——

Chairman STARK. When do you think we will see that? I only think of that. Will it be a year or six months?

Mr. HILL. Oh, no, no. I think this fall we will be able to sort of come up and talk to you about——

Chairman STARK. That is something that we will have some interest on other matters, but I just wondered.

Mr. HILL. Right.

Chairman STARK. In the provider-specific areas, you do not question the medical judgment of the providers. Do you? I mean do you make judgments to say, "Gee, they should have removed his lung instead of his heart."

Or do you just look at the action taken and make a determination as to whether it is fairly paid?

Mr. HILL. There are three levels of the review I think. First, you have got to make sure that the service is actually covered by Medicare. We do not pay for eye glasses and various other things.

Chairman STARK. Right.

Mr. HILL. Then the payment, is it the right payment amount, but finally there is a reasonable and necessary determination. We do make a determination in a gross sense as to whether or not that beneficiary needed that care.

Chairman STARK. With medical advice?

Mr. HILL. Correct.

Chairman STARK. Okay.

Mr. HILL. The physicians make these judgments of the carriers and we try very hard not to get into sort of gray areas in terms of where a physician's judgment should not be impinged upon, but there are certain instances where you can make a real clear cut case. Chairman Lewis was talking about patient issues. You can look at therapy services that are provided by a facility where you have got 10 hours——

Chairman STARK. Do you think that you now have the data and the personnel to make quality judgments for providers?

Mr. HILL. I think the quality issue is a challenge that we are going to need to face. As you know, the tax bill, recently enacted tax bill, has provided us some movement forward in terms of——

Chairman STARK, but my question is do you think there is enough data there now to do that or would we—will we need to see that you are provided with a broader database and more information?

Mr. HILL. I think the data that we would need to do real quality determinations comes from a patient health record more than just the claims data that we have and we are not quite there yet.

Chairman STARK. Mr. Acosta, you mentioned $175 million that an institution owes us. I would remind you that this has been going on. I can remember and I do not mean to prejudice anybody, but Stanford overbilled us some five or 10 years back, the hospital in Pennsylvania I remember was on the hook for 9 million. These were teaching institutions. You would call them centers of excellence.

I do not know whether Hopkins ever did it, but I mean there have been some prestigious public institutions that have helped themselves to perhaps more Medicare reimbursement than they were entitled to.

So, you have an institution or a provider, your are talking hundreds of millions. I again without being facetious, we have seen col-

leagues of ours go to jail on the Abscam traps and for a couple of hundred bucks worth of postage and for some big gifts or a golf trip. They will go and do 9 months hard time.

Do you think that there are areas in which we should by legislation change the penalties? I have always felt that the chief executive—I look at the Abu Ghraib cases. We put away a lot of sergeants and second lieutenants, but the colonels and the generals never got touched.

If, in fact, you were to prosecute on a criminal basis some of the CEOs of the institutions who walked away whether they are private, for profit or non-profit, that might have a very meritorious effect throughout the industry.

My sense is they pay the fine and it is insignificant to the individuals who are responsible for the bad behavior. I guess my bottom line is would you consider suggesting to us areas in which we might stiffen the penalty as it were that would aid you in your work?

Mr. ACOSTA. Chairman Stark, I think you raise a very important issue and one that needs a fair amount of consideration. Before this hearing I was speaking with one of my colleagues concerning an ongoing operation, actually the operation I mentioned earlier where we seized the funds in these bank accounts. We identified these 60 bank accounts for——

Chairman STARK. Thirty million or so you said, yes.

Mr. ACOSTA. Forty million total is what we are seeking. We have already collected ten million of those. What I was telling one of my colleagues is we have done this civilly. the next step we need to do is we need to pursue these individuals criminally because far too often individuals will look at that, at a civil fine, as the cost of doing business. I was actually mentioning it to one of my colleagues on this panel right before the hearing and that is exactly what we are doing in those civil cases. I mentioned when I rolled it out at the press conference it was important to pursue a criminal action where appropriate as well so that it is not the cost of doing business.

That said, I think one of the challenges that needs to be recognized—there are two parts, two challenges that I think need to be recognized. One is in terms of case law and I do not agree and the Department does not necessarily agree with some of the case law, but there is case law out there that especially in areas that are as complex as Medicare or Medicaid where we are prosecuting something criminally the Government bears the burden of proving beyond a reasonable doubt that a defendant's statement is not true under a reasonable interpretation of law. In other words, it is not only that the defendant made a false statement from a civil perspective, but that it went beyond—we have this complex scheme and that under a reasonable view of that scheme they were still acting criminally. So that, that is one challenge that we face.

The second point——

Chairman STARK. We need somebody to replace Fitzgerald so I figure you can put somebody away for those statements.

Mr. ACOSTA. As I said, we have some case law. We do not agree with the case law. That is not the Department's position, but it

does require that we find levels of proof sufficient to bring criminal charges.

The second comment that I would make in answer to your question is I think and I will change this into, if I could with your permission, into the banking area where we have been very aggressive in bank fraud. We recently obtained a 30-year sentence on a bank fraud case.

In part the reason that we had a 30-year sentence is in the post-Enron world, the penalties that we are obtaining in the bank fraud area are quite substantial. I can tell you that in my district putting someone away for 30 years for making inaccurate statements on a balance sheet has certainly sent quite a signal.

Chairman STARK. I would just repeat. I am sure that my colleagues would appreciate any suggestions that you would make to us as to areas in which that it would include historic laws, we should change the penalties or the standards for establishing what—the bright line I guess as you would call it—to help in your work because we are not the Judiciary Committee, but I suspect we do have the legislative authority to change penalties and would appreciate any suggestions that you could make to us along that line.

Mr. ACOSTA. I will confirm it with my colleagues. I think you raise a very important point in which you are correct.

Chairman STARK. Thank you.

Mr. Hulshof.

Mr. HULSHOF. Thank you, Mr. Chairman.

Chairman STARK. You were a prosecutor, were you not?

Mr. HULSHOF. Yes, sir, I was.

Chairman STARK. We will let him write it.

Mr. HULSHOF. In fact, as Mr. Acosta was talking about, being in a courtroom and being the sole white hat wearer and looking across the courtroom at ten attorneys, I had a flashback.

Let me follow up on this then, Mr. Chairman. I appreciate that.

As far as criminal penalties, is that an area that you say—because that is not what I heard you say, but perhaps you are suggesting. Do we need to beef up the criminal Mr. Acosta?

Mr. ACOSTA. Congressman, the general criminal penalties that we use in the healthcare fraud area are the fraud penalties. I would take the question back to the Department to get the input from my colleagues before making a specific proposal.

I do think and I will say that in the banking area, we have been very aggressive pursuing CEOs and executives. When you get a 30-year conviction that does get other CEOs' attention.

Mr. HULSHOF. Along that, I would say let's just follow line for a bit. In those banking cases and again I was never good enough to be a Federal prosecutor. I was just toiling in the courtrooms in the State of Missouri. You are not talking about changing the burden of proof on the Government. The Government would always continue to have the burden of proof. I presume you are not suggesting anything about the standard of guilt being beyond a reasonable doubt. You are shaking your head no.

As we all know, getting a civil judgment where the standard of proof is less as opposed to a criminal judgment is also—I mean there is a reason to have that dichotomy. I am not conversant with the case law you say specifically but—and I know you are speaking

for yourself and not for those above you necessarily, but are you saying that this reasonable person standard on statements? Like if a statement were made that that is something that we might be able to change legislatively?

Mr. ACOSTA. Congressman, what I am referring to is in the large civil cases where you have a lot—where you have many individuals involved in setting pricing, where you have a number of participants, it is exceedingly difficult to find a particular individual—because it is not a false statement's case.

Mr. HULSHOF. Right.

Mr. ACOSTA. It has to do with to find an individual whose intent to defraud went beyond a reasonable interpretation of an administrative scheme to a criminal level. You have as one of your colleagues referenced, a scheme that some say is more complex than the Tax Code and so it is not just enough to show that a mistake was made.

Mr. HULSHOF. Right.

Mr. ACOSTA. You have to show much more than that. What I am suggesting is that that level and some of the judicial interpretations—not the underlying burdens of proof, but some of the judicial interpretations do raise a challenge.

Mr. HULSHOF. Okay. I will let you get off the hot seat so you are not criticizing those Federal judges. Just a couple of more generic comments. Here is a curiosity. You all have been great to talk about where providers had overcharged. Has the reverse ever happened? That actually you have seen under charging by providers?

Mr. Hill, you are nodding.

Mr. HILL. This is a question we get a lot and I think it is a fair question because providers fairly can ask, "Well, if I make a mistake, will you give me the money back?" In all the activities, at least on the administrative side, that we undergo we do an improper payment measurement. That is where we get the error rates. That error rate is a net rate. Underpayments and overpayments. Where we have underpaid, providers are given that.

I also talked about the recovery audit contractors. The Congressional intent there was very clear. It is for overpayments and underpayments.

Mr. HULSHOF. Okay.

Mr. HILL. While it is a small percentage, there are those cases where folks have been underpaid.

Mr. HULSHOF. My time is very short and I want to be respectful of the Chairman and the time limits. I will do this very quickly.

I hear a lot about complexity. So I presented myself to a local hospital. They gave me a medical chart that I was a 70-year-old man with a certain medical condition and we went through triage and I was to report. The point of the exercise was because I failed to mention one detail during my admission that they were wrong. The hospital was wrong. The whole point being that sometimes they act in the best interests and yet through no fault of their own, there is this, this error.

Is the complexity something, Mr. Hill, that you can do this if you need in writing, but I mean is this something that we should focus on? Or is this more your purview and your bailiwick to try to help eliminate some of that complexity?

Mr. HILL. I think the answer to the question is sort of both. Right? I mean we have an obligation, providers are serving our beneficiaries. It is a complex program. At the same time, as we are carrying out our duties, we have an obligation to the trust funds. At the same time, we look at a record. We need to apply some level of clinical judgment as to whether it was just, "Oh, gee, I made a mistake. I forgot to check off that box." There is a reasonable basis to make that judgment versus where it is just clear out-and-out "You were over-billing us." We try very hard to make those distinctions.

I am not going to sit here and tell you we always get it right, but it is clearly something we try and get right on an ongoing basis.

As to the complexity of the statute and the underlying, we can always make it less complex I suppose but we do have an obligation on an ongoing basis to make it easier for the physicians caring for beneficiaries.

Mr. HULSHOF. I thank the panel. I thank the Chair.

Chairman STARK. Ms. Tubbs Jones is not here. Mr. Pascrell.

Mr. PASCRELL. Thank you, Mr. Chairman.

Inspector General, I had a question for you. There is approximately 1500 employees that you have right now as I understand your testimony. Is that correct?

Mr. LEVINSON. That is correct.

Mr. PASCRELL. How many did you have 4 years ago?

Mr. LEVINSON. Well, I was not in the office 4 years ago, but I would estimate that it would have been around 1400 to 1450 over the last 3 years.

Mr. PASCRELL. 1400.

Mr. LEVINSON. There was a reduction. Historically, there had been close to 1500. I think for several years we dipped below that. For the last couple of years, through the great help in large part of this Committee, there has been a restoration to numbers that I think historically have been around 1500.

Mr. PASCRELL. When you are investigating a $413 billion program which it was in 2006, I do not know how you do with your auditors and your inspectors, if that is adequate particularly in terms of what the return is of that investigation. It would seem to me that we are not doing enough, not nearly enough to reduce fraud.

My second question is to the gentleman from Florida, the U.S. Attorney Mr. Acosta. Who have you found to be the biggest culprits in your investigations? Would you define it as specifically as possible?

Mr. ACOSTA. Congressman, the most—South Florida has a particular problem with what I will call fly-by-night operations. They are operations that open up, often using false identification under assumed names, operate for three to 6 months. The billings spike. They then shut down and move on.

Mr. PASCRELL. Who are these people that open up these facilities?

Mr. ACOSTA. Individual—I am sorry. I do not understand the Congressman's question.

Mr. PASCRELL. What is the source? In other words, the biggest source is not the patient. The biggest source—or the recipient—the biggest source is somebody who is doing the business at hand.

Mr. ACOSTA. Absolutely.

Mr. PASCRELL. Tell me about them. Who are they?

Mr. ACOSTA. I would not call them providers. Criminals. An individual who is a downright fraudster who will decide "I want to make a little bit of money criminally and so I will go out there. I will use a false ID to open up and get a provider number and open up what I call to be a durable medical equipment company."

For example, one case that we had where an individual started throwing wheelchair parties, inviting people——

Mr. PASCRELL. Wheelchair parties?

Mr. ACOSTA. Wheelchair parties. Inviting people over to get their identifying information so that he could then bill the same wheelchair over and over and over again to the tune of several million dollars when in fact he never provided these individuals a wheelchair.

He would literally invite people over to show them the wheelchair. In the process he would get their Social Security Number, their information. He would then bill out. They start, they operate, they shut down.

One of the reasons that we started the fusion operation that I referenced in my opening is because these operations are fly by-night fraudsters who shut down, it is exceedingly difficult to use the traditional law enforcement model of a historical case, because a year from now they are long gone. The money is long gone. That is why the fusion center that started this past month that focuses on catches them in the act, a critical part of which is obtaining the near real time billing information is so important, because that way we can find them before they shut down and move on.

Mr. PASCRELL. But is it not true that DME providers need nothing more as I understand it than a provider number and an address to bill Medicare?

Mr. ACOSTA. Congressman, the frustration and the reason they are able to do this is because they do need an ID provider number and an address. That is exactly right.

Mr. PASCRELL. Well, what are we doing about that?

Mr. ACOSTA. Well, in the Southern District we prosecuted 68 cases last year.

Mr. PASCRELL. Sixty-eight?

Mr. ACOSTA. Sixty-eight cases which compared to a national level is actually quite high. We have $981,000. We have a dozen individuals that used that money to pursue these. They do a very good job at going after these, but I will tell you, sir, it is a problem. It is a substantial problem and anything that we can do to further fight it I would welcome.

Mr. PASCRELL. What is the punishment on the books if you get one of these DME providers who obtained a provider number and an address to bill Medicare. This seems to be widespread. This is not something isolated in Florida, that's for sure, but what do you do? What happens? How do you prosecute them?

You said you prosecuted over 60 cases. Let's say people are found guilty of doing these things. Does the punishment fit the crime? Is

this enough to be a detriment to those who want to get into this shady business and taking advantage of Medicare dollars?

Mr. ACOSTA. Congressman, first, with respect to the punishment, the punishment would be a function of the amount of the fraud. So it would be referenced in the Federal Sentencing Guidelines. In the wheelchair case, for example, under the Federal Sentencing Guidelines, the punishment would range between three and I believe seven years. I am basing this on memory and so that is an approximate, but that is the punishment under the Federal Sentencing Guidelines. Those are the guidelines that are given to us that judges abide by.

So when we prosecute a case, that is realistically the upside in terms or the top in terms of what we can obtain as a punishment. That references Mr. Stark's question I believe earlier where I alluded to, for example, the banking fraud area.

Let me, if I could, also throw out an idea and a suggestion. This is one that we have been in talks with HHS about, because I do believe that prosecution is an important tool, but as in the case with credit card fraud prosecution has to come only after prevention.

Credit card companies learned long ago that it is much better to have a strong prevention program that reviews billing statements. We have all gotten those calls from credit card companies.

One discussion that we had with HHS is a bonding requirement in areas of particularly high levels of fraud. The advantage that that would have is it would in essence duplicate, triplicate our resources because the bonding company would become an additional investigative agent. They would be on the hook. Particularly where you have small fly by-night operations that are operating in the one to five million dollar range having a high bond level is something that I think is worth considering.

We have been in discussions with HHS about that and I just propose that to the Committee as something that might merit further conversations.

Mr. PASCRELL. If you want to go into business and let's say many HMOs in many States I sure as in Florida, we have increased the bonding, not the Federal Government, there is an increase in the bonding so that there is a risk here if you want to try to shaft people out there.

There does not seem to be a risk involved and I am not so sure—maybe you can—I have overstayed my welcome here, but I am not so sure we have a sense of urgency about how much money is involved in fraud that your auditors and investigators are looking.

I would tend to think that this is very vast. It is a shock to find out the kinds of practices and the amount of dollars that are being lost into the system. Medicare faces a greater danger than the Social Security in the trust fund. If we do not do something materially and have a sense of urgency I do not know how we are going to really catch up.

Thank you, Mr. Chairman, I appreciate it.

Chairman STARK. Okay. Mr. Tiberi has waited patiently and I am happy to recognize him at this point.

Mr. TIBERI. Thank you, Mr. Chairman.

Kind of following up on Mr. Pascrell's questioning on the durable medical goods, Mr. Acosta, you have mentioned it already regarding what you have done in Miami, Florida.

Clearly reports have shown that the entities that you have prosecuted were not legitimate DME providers and they did not have legitimate provider numbers under current law.

The question is how in the world were they able to receive numbers and how can we prevent that from happening in the future?

Mr. ACOSTA. I will answer briefly and then with your permission I will defer to my colleagues. First, let me do say that there is a great sense of urgency on this. I think it is critical. Our prosecution numbers in Miami are up 30 percent. We receive from the HCFAC $981,000 and with that our prosecutions last year accounted for I believe $137 million give or take in fraud. So I do want the Committee to be aware of that because the resources are an important matter.

With respect to provider numbers I will say that this is often closely tied to identity theft where both the individual seeking provider numbers as well as physician numbers that are used belong to actual individuals but identities are sometimes stolen. Beyond that I would defer to CMS. The CMS is the one that provides the numbers and so they are in a better position to answer.

Mr. HILL. On the DME number—I mean clearly the sense of urgency is acute. There are two issues for us here. The first is that in fact, and this is a sort of mark on our process if you will, in many cases suppliers do have a legitimate supplier number. They have got in the system and they have got a number.

The fact of the matter is they are able and are more nimble to stay one step ahead of us. When we do the site visit, they have got a building and they have got a plaque on the wall that says they are there and there is inventory and we do all the things and they have filled out the paperwork and they look like a legitimate business. Then when they begin to bill, it is clear that they are not. At one level the resources that we can make available to do the review and to do the on-sites sometimes just cannot keep up.

Having said that, we are moving forward through the Medicare Modernization Act to require now this year sort of along the lines of the surety bonds a requirement for accreditation which is another level of review for the suppliers. So, not just CMS but an outside entity will come in, do unannounced site visits, there will be requirements for the DME suppliers that they will have to meet to be able to get accredited and then get numbers. So, again, it is more eyes looking at the entity to be sure that in fact they are meeting the requirements that are set out in the statute.

Mr. TIBERI. Thank you.

Mr. Levinson, do you have a comment on that?

Mr. LEVINSON. Yes. We are also looking at DME providers' compliance with CMS standards so that CMS has a more comprehensive picture of providers who are not paying attention to the minimum standards that CMS does impose upon them such as properly obtaining the provider number and being eligible to participate in the program. We are involved in that work as we speak.

Mr. TIBERI. Thank you.

Mr. Hill, one other question that I would categorize under the term "waste" and not fraud. My aunt a couple of weeks ago had knee replacement surgery in a Columbus, Ohio, hospital. After she was recovering in the hospital, she was given a choice to either go home and have a shot at home that would cost $50 a day out of pocket and she is a Medicare Part D recipient as well or she could go to a nursing home and have that shot and she didn't have to pay anything.

Now, obviously somebody is paying something and a lot more at a nursing home for 14 days than her being home for 14 days. I have heard this is a problem that is not just my aunt that this is pretty widespread. Can you comment on that?

Mr. HILL. The issue here gets somewhat to Chairman Stark's question in terms of judgment, clinical judgment as to what should happen. Not knowing your aunt, not knowing the situation, typically to be discharged to a nursing home—I am not a physician, so I will get this wrong—you have got to be sick enough to be in a nursing home. You cannot go to a nursing home just to get a shot. So clearly there are incentives to get somebody into a nursing home because you are going to get reimbursed more in the nursing home.

As we look at payment errors and as we look at areas where we need to refine our policies, one is the policy area of what we characterize as the site of service differential, the fact that you get paid more to do the same thing more in one site than another site, is an issue that we need to deal with.

There is a proposal in the President's budget that does not quite get to the issue you are describe here but it is clearly one that we have to get to where there are incentives for delivering care in more expensive places just for the purposes of getting the expense not because the patient may not have necessarily needed it.

Mr. TIBERI. I hope you look at that because there is a lot of money to be saved there.

Mr. HILL. Absolutely.

Mr. TIBERI. Thank you. Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman. May I say from the outset, Mr. Chairman, that I hope that we will do more of these hearings because as we talk about how we take care of things like the SGR and other issues that we have to come up with in terms of savings, I think probably the best way to go is to try to figure out where the abuse is so we do not have to go after those good providers who are paying the price for our need to have savings. I hope will continue to do more of these hearings so that we are able to target our efforts to try to make appropriate savings where possible within the healthcare field and certainly within Medicare.

I want to thank the three of you for your testimony. If I can just try to clarify something. Mr. Levinson, I think there is general agreement—and please tell me if there is not—but there is general agreement that every dollar that you have been able to use to investigate any waste, fraud or abuse has translated into more than a dollar's worth of savings to the Medicare or certainly our healthcare programs to date.

Mr. LEVINSON. That is correct. It has varied over the last few years from $11 to as much as $18 in terms of the return on investment (ROI).

Mr. BECERRA. That type of return anyone on Wall Street would die to have. Let me ask you this. How much more money, how much more in resources could you efficiently handle before you say, "Wait a minute. There is enough room to do the work, but I cannot staff up quick enough and I cannot given my limitations in size and space deal with more than x-amount."

What could you use without us coming back and having a hearing and saying we hear that we gave you money for 100 new investigators but you only got 50 and you still spent the money for 100?

Mr. LEVINSON. Well, first let me again thank the Committee for the support it has given OIG over these last several years in getting us——

Mr. BECERRA. Do me a favor. Cut to chase because we want to support you. Give me a sense of—the 5 minutes that I have, I want to ask other questions. Give us something that we can work with that is on the record. How can we help you realistically? We are not going to give you as much as you in the future can use, but maybe we can give you something now that you know you can make use of today?

Mr. LEVINSON. I very much appreciate that. One of the great benefits of having the three organizations here represented at the table is that it underscores for the full Committee, for the full two Subcommittees, the understanding that this is a process in which every one of us has an important but related part.

I run no program. Mr. Hill is involved in running the program.

Mr. BECERRA. What could your shop use?

Mr. LEVINSON. No matter how much money I might have if Mr. Acosta does not have resources——

Mr. BECERRA. I will ask Mr. Acosta and Mr. Hill in a second. You tell me what your shop can use.

Mr. LEVINSON. We are quite, I think, effectively integrating the new money that was most recently provided for our office. For better or for worse, I cannot give you a specific dollar figure this morning about how much more money we can ingest and state with assurance any particular result that we could accomplish without detailed analysis.

Mr. BECERRA. That is fair. Let's do this. Let's stay in communication. I think, Mr. Chairman, we are going to continue to do that.

I hope what you will do is you will look discretely at your various programs and you will tell us earnestly and to the degree that you can realistically how we could make a great investment of the taxpayer dollar in your shop and know that we are going to get that 11 or 18fold return on that investment. Again, you are not going to double the size of your operation. We know that, but there are things that you know and if we knew that you could do that we would try to help you do because it just helps us.

We are going to be talking about how we cut programs within Medicare to save money. We are going to do it with a meat axe. We are going to try to be more surgical, but some of it is going to hit good providers and what you do is you go after those providers

that are not doing that good. So, I would rather see us put a dollar in getting you more to return more than us going after providers simply because we could not find a better approach to tailor our need for savings.

Mr. HILL. I understand.

Mr. BECERRA. Let me ask a question that relates to the quality——

Chairman STARK. Before you do, could the record just show at this that the staff behind Mr. Levinson have been holding up five fingers, eight fingers suggesting that that would be the percentage of raises that they feel they are entitled to. I thought that ought to just be part of the record.

Mr. LEVINSON. As I said previously, I think the fact that you are holding this hearing has given all 1500 of us a little bit more power, a little bit more effectiveness in being able to accomplish the job. So, the hearing itself accomplishes a great deal on our behalf.

Mr. BECERRA. I do not think any one of us here is looking to go after—this is not a witch hunt to try to go after a particular provider or go after particular government agencies saying, "You are not doing enough."

We know that if we do this work right, the good providers will be able to take care of themselves and there may be some who are innocently doing things that they should not. If we just have someone just overseeing them saying, "You know you are stepping out of bounds a bit." They would get right back in there, but there are some that are not. So, let's figure out where we go.

Mr. Chairman, if I could just ask one last question.

Chairman STARK. Go ahead. I stepped on your time.

Mr. BECERRA. Thank you.

Quality improvement organizations. The CMS, Mr. Hill, contracts with these quality improvement organizations to conduct these in-patient utilization reviews at hospitals and to try to determine if care is being provided appropriately.

You are aware I am assuming of this Institute of Medicine (IOM) Report that said that we have to wonder if we are actually getting the best out of these organizations because they end up developing a very strong relationship, cozy relationship with the providers.

It is not unlike the situation you see in cities when the building inspectors become very familiar with a lot of the developers in the area and the developers become friends of these building inspectors and it sometimes occurs that the building inspectors do not do right by the people because they have developed a friendship with the developers and the developers get away with some things.

Tell me how you are responding to the IOM's recommendations with regard to the quality improvement organizations to make sure that we really are getting quality and appropriate care.

Mr. HILL. Absolutely. I think—I do not think, I know that the quality improvement, not necessarily through the Quality Improvement Office (QIO), but quality improvement is a key priority for the Administration for Secretary Levinson—pardon me, Secretary Levitt.

I did not mean to promote you there.

The IOM report really gives us a good view into what is going on with the QIOs. Some of it is stuff that we were sort of aware of and sort of understanding. As you may or may not know, the way that they are funded and the way that we contract is on a 3-year cycle. We are at the end of the previous 3-year cycle and so we are going through a process now of looking at the recommendations and looking at what changes we can make to the structure of the QIOs, to the relationships that they have with the providers and the things that we ask them to do. Sort of what are the right things for them to be doing in the way our contracts are structured with them.

So hopefully as we work our way through the fall we will be ready to sort of come up and talk in a very robust way about exactly how it is we are going to proceed with what we characterize——

Chairman STARK. Would you yield at this point?

Mr. BECERRA. Yes, Mr. Chairman.

Chairman STARK. I thank the gentleman for yielding.

A further point, Mr. Hill, though. You cannot do that with the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) now can you because you do not contract with them?

Mr. HILL. Correct.

Chairman STARK. Would there be any reason that you shouldn't contract with JCAHO which would then give you the authority to say, "Look. Let us review what you are doing." We have had several examples of their overlooking tragic errors.

Mr. HILL. Right.

Chairman STARK. I am going to meet in a little while with Senator Grassley and he and I both have felt that—and I would ask Mr. Levinson and Mr. Hill, is there any good reason that you can think of that you ought not to contract with JCAHO as you do the other quality agencies?

Mr. HILL. I think that the JCAHO is, they are an organization that sort of attests that they meet our standards, so I am not quite sure it is a contract issue. There is a lot to discuss there.

I think I am beginning to get out of the bounds of my——

Chairman STARK. I am just wondering, to Mr. Levinson, there is no real reason that if you had a contract with them other than you allow them to deem hospitals, but you really—and we do not therefore really have any oversight. They just operate out there with absolutely no one reviewing their results and there have been instances where they have overlooked some things that are pretty serious.

Mr. BECERRA. Mr. Chairman, if we could—I am sorry, Mr. Levinson. Go right ahead.

Mr. LEVINSON. I just wanted to add, Chairman Stark, that we do not have any—we have not done any recent work with JCAHO but we do have QIO work in progress which we hope to share with you relatively soon.

Chairman STARK. Thank you.

Mr. BECERRA. Mr. Chairman, could I suggest in that regard?

Mr. Hill, when are these QIO contracts going to be out again? Is it this fall?

Mr. HILL. The fiscal year 2008, during the fiscal year 2008 process.

Mr. BECERRA. So, Mr. Chairman, it sees appropriate for us to be in touch right now with CMS before you go forward and start to let out these new contracts that we talk to you about what revisions you are making to the process to ensure that quality will be part of that requirement.

Mr. HILL. Absolutely.

Mr. BECERRA. Mr. Chairman, I know that we have votes in, but I see no more Members. Could I be indulged?

Chairman STARK. Go right ahead.

Mr. BECERRA. Thank you.

Mr. Acosta, a question for you. We know that you get thousands of cases referred to you of reported Medicare fraud and abuse. I know that you do not have the capacity to deal with each and every one of those cases and many of those cases probably do not pan out to be more than just some complaint that is not legitimate, but obviously there are many of those that are.

Give me a sense of the numbers. How many come to your office? How many do you investigate? How many do you prosecute? How many do you get a verdict or conviction or if it is a civil action some type of award or damage?

Mr. ACOSTA. Thank you. Thank you for the question, Congressman Becerra. If I could, I am going to tie that into the question you brought to Mr. Levinson earlier about resources.

We receive $981,000 from the HCFAC account as I said previously. I match that with my own general funds to the tune of approximately $2 million. That allows me to fund about 12 attorney positions within my office. With that, last year, our criminal filings were up 30 percent to 68 cases, up from about 50 the year before. The conviction ate is about 97 percent.

Mr. BECERRA. Wow.

Mr. ACOSTA. In addition to that we brought a number of civil cases. This fiscal year alone, our civil recoveries included the $15 million recovery from Larkin Hospital that Chairman Lewis referenced earlier.

Mr. BECERRA. That is just one recovery.

Mr. ACOSTA. That is just one recovery. The $2.2 million from Jackson Memorial Hospital, a teaching hospital, as Mr. Lewis referenced earlier. The $10 million that has been returned to the Federal treasury——

Mr. BECERRA. Stop. Stop. You have already told me with one case you paid for your 12 attorneys that you have.

Mr. ACOSTA. That is correct, Congressman.

Mr. BECERRA. Stop. Stop. Stop.

So, what could you efficiently ingest?

Mr. ACOSTA. Well, this past year we requested and did not receive $11 million overall budget increase. The budget increase requested for this year is $17 million, part of which my office would receive.

In addition, I have several—I have special Assistant United States Attorneys that are on loan to me from the State Attorney General's Office to prosecute more cases. We are willing to work with you to suggest a number. I am not in a position to suggest

a number nationwide, but I think our point that our folks work very hard and more than pay for themselves is quite obvious.

Mr. BECERRA. You have been gracious in providing us the information because everyone has constraints on the type of information and how it can be used that we can discuss. I appreciate that.

Mr. Chairman, I think it is obvious that if you have a 97 percent conviction rate, if you have got awards that single-handedly pay for the 12 attorneys for the next 5 years, you are doing something that we should be trying to concentrate on more.

Again, you are not convicting—the 97 percent conviction rate is not of those providers that are doing what we ask them to do under Medicare, it is folks that are not. Mr. Chairman, I hope that we take this and, as I said, I hope we continue to have follow-up conversations both publicly, formally and informally so we could figure out how we could concentrate some of our moneys because I know we are going to come here in about 4 months and we are going to be agonized by what we have to do in Medicare to providers, many of whom are not in that percentage of those who you are trying to convict.

I think you, Mr. Chairman, for yielding and I think the gentlemen for all their information and good testimony.

Chairman STARK. Thank you, Mr. Becerra.

I would just emphasize that the making public all of the tools which would come under at least the observation of Inspector General Levinson I think would have a meritorious effect on all providers.

In other words, this is not like over-deducting your meals and figure you will never get audited by the IRS. These guys are looking and saying, "Wait a minute. You know 97 out of 100 people are getting caught." That is a whole different issue and I think is worth publicizing to some extent. It could very well be that you issue a report beyond The Red Book that might be a little be more oriented toward the average public and I think it would help.

I think it would help Mr. Acosta and Mr. Hill's efforts. I want to thank Chairman Lewis for urging us to proceed on this matter today and to thank all of you for your help and your continued work for, principally for the beneficiaries but also for the taxpayers and all of the people involved in the Medicare system.

You are to be commended and thank you for your assistance to us. We will be back to you because you are going to need more help as Mr. Becerra pointed out. I know that beyond just the fraud and abuse that Inspector General Levinson has indicated and his office has some areas and Mr. Hill as well where we might find savings beyond fraud and abuse. We are looking for that all the time.

Chairman LEWIS OF GEORGIA. I do not have anything to add, Mr. Chairman, but thank you for conducting this hearing. I thank all of the witnesses for being here. I think this has been most helpful.

Thank you so much for the job that you are doing.

Chairman STARK. I would ask, I know Mr. Kind and perhaps others on the minority side will have questions and they could not remain, we will keep the record open and I would ask the witnesses if they would mind responding to any letters that the Committee Members send to them in the form of inquiry.

With that, this hearing is ended.

[Whereupon, at 11:46 a.m. the Subcommittees adjourned.]

[Questions submitted by the Members to the Witnesses follow:]

Question Submitted by Mr. Kind to Mr. Hill

Question: Mr. Hill, in your testimony, you stated that "responsible and efficient stewardship of taxpayer dollars are critical goals" of the Administration. You also stated that "[t]he States provide a crucial first line of defense in safeguarding Medicare Program dollars." Given these stated goals of CMS, I would like the agency to explain its resistance to renewal of Wisconsin's SeniorCare program waiver.

Extension of this 1115 Pharmacy Plus waiver is expected to save the Federal Government, and Medicare in particular, an estimated *$404 million* through 2010. Wouldn't rejection of a SeniorCare extension be contrary to the Administration's own stated Medicare fiscal goals?

Answer: Established in 2002, SeniorCare is the prescription drug assistance program for most lower income seniors in Wisconsin not qualified for full Medicaid benefits—specifically, Medicare beneficiaries and others with family incomes up to 200 percent of the Federal Poverty Level (FPL). SeniorCare was devised as a model 'Pharmacy Plus' demonstration, authorized under the Social Security Act's Medicaid section 1115 waiver authority.

The goal of this demonstration was to test how the provision of a pharmacy benefit to a non-Medicaid-covered low-income population would affect Medicaid costs, utilization, and future eligibility trends. As with other section 1115 demonstrations, CMS approval for Pharmacy Plus required the State to establish budget neutrality, meaning that the services provided under the demonstration would need to be offset by other savings in the Medicaid program. The overall theory behind Pharmacy Plus was that prescription drug programs for seniors would target scarce resources more effectively because participants would remain healthier, thereby reducing future health care costs that may result in their becoming eligible for Medicaid.

The enactment of Medicare Part D has altered the landscape in which States provide prescription drug coverage to the age 65 and over population. Before January 1, 2006, SeniorCare was the only affordable prescription drug coverage option for most lower income seniors in Wisconsin not qualified for full Medicaid benefits. Today, seniors in Wisconsin and across the country have access to comprehensive prescription drug coverage through Medicare. Individuals eligible for full benefits under both Medicare and Medicaid now receive their prescription drug coverage through Medicare as well. At last count, more than 571,000 Wisconsin seniors, including dual eligibles, are receiving drug coverage through Medicare Part D or another creditable source.

In addition to the standard Part D benefit, many beneficiaries with limited incomes qualify for the Low-Income Subsidy (LIS). Indeed, certain beneficiaries enrolled in Wisconsin's SeniorCare would be eligible for the LIS. The LIS provides substantial help to Medicare beneficiaries with limited incomes, including a generous Federal premium subsidy and minimal cost-sharing for covered drugs. Most LIS-qualified beneficiaries receive the 100 percent subsidy, and therefore have no premium for Part D coverage.

However, the establishment of a Federal Medicare prescription drug benefit had significant impact on the ability of Pharmacy Plus demonstrations to be budget neutral. Specifically, the advent of Part D and the low-income subsidy altered the circumstances under which CMS originally approved SeniorCare because now Medicare Part D, and not the Pharmacy Plus demonstration, is the main source for Medicaid savings by diverting individuals from full Medicaid eligibility. As a result, we believe it would be very difficult for Pharmacy Plus waivers, as they were originally structured, to meet the budget neutrality requirements in light of Part D.

We greatly appreciate the leadership Wisconsin has demonstrated in providing prescription drug coverage to Wisconsin's most vulnerable citizens at a time when they had no other options for drug coverage. CMS does not want current SeniorCare beneficiaries to suffer any interruptions in drug coverage, and we are committed to partnering with Wisconsin officials to establish a transition and outreach plan in which we can all take confidence. That being said, we believe the transition must be made as quickly as possible. Wisconsin has deemed SeniorCare as creditable coverage relative to Part D, so individuals transitioning to Part D will not face a late enrollment penalty.

[Submissions for the Record follow:]

Statement of the Power Mobility Coalition

The Power Mobility Coalition (PMC), a nationwide association of suppliers and manufacturers of motorized wheelchairs and power operated vehicles, applauds the House Ways and Means Subcommittee on Health and the Subcommittee on Oversight for holding a joint hearing examining ways to identify and eradicate fraud within the Medicare program.

The PMC has long supported efforts aimed at removing unscrupulous actors from the Medicare program. In fact, it was several PMC members who first identified pockets of suspicious activity in the delivery of power mobility devices (PMDs) in Harris, Country Texas and then brought these concerns to the attention of the Centers for Medicare and Medicaid Services (CMS) as early as April, 2003. The PMC, along with other leaders of the durable medical equipment (DME) industry, then partnered with CMS in the implementation of the "Wheeler Dealer" program that sought to root out fraudulent activity in the Medicare PMD benefit.

The PMC was very supportive of anti-fraud initiatives contained in the Medicare Modernization Act (MMA), including the requirement that a Medicare beneficiary see a health care practitioner for a face-to-face examination prior to the submission of a PMD claim, increased quality standards for PMD suppliers, and the provision that requires all DME supplies to be accredited by a nationally recognized accreditation body. While these are all positive steps in efforts to clean up the Medicare program, the PMC feels that more could be done and, as a result, offers the following recommendations to the Subcommittees:

1. All New DME Suppliers or DME Suppliers Who Are Renewing Their Supplier Number Must be Accredited

CMS has released the new quality standards for all DME suppliers and has named the nationally recognized accreditation bodies that have "deemed status" to ensure Medicare quality standards are being met. Since all the pieces of the accreditation puzzle are now in place, CMS must insist that all new DME suppliers become accredited before they can be awarded a Medicare supplier number. Further, DME suppliers who have to recertify for a supplier number should also be immediately subject to the accreditation requirement.

2. Accreditation Must Happen Prior to Implementation of Competitive Bidding

Program integrity is paramount to ensure Medicare beneficiaries receive the highest quality of products and services from lawful suppliers. Stringent quality standards coupled with mandated accreditation of suppliers will rid the Medicare program of unscrupulous actors and reinforce the integrity of those suppliers who play by the rules.

Implementing competitive bidding and allowing non-accredited suppliers to participate in the bidding process is contrary to CMS' priority to safeguard Medicare resources and beneficiaries. Allowing non-accredited suppliers to bid and be awarded contracts will cause major disruption if the contracted supplier cannot obtain accreditation and the contract must then be terminated and subject to a "rebid." In addition, non-accredited suppliers would have lower overhead and, as a result, would be able to submit lower bids which could artificially lower the single payment amount for accredited contracted suppliers.

3. Establish a DME Program Integrity Advisory Group

DME manufacturers and suppliers know their business better than anyone and are constantly monitoring the marketplace. Lawful DME suppliers and manufacturers are anxious to share intelligence about potential fraudulent actors with CMS. The PMC recommends that CMS establish an advisory group comprised of DME suppliers, manufacturers and beneficiaries to work with CMS officials on developing proactive solutions to help detect and eliminate fraud.

4. Require Physician Certification on Documentation Supporting a PMD Claim

As part of recent administrative changes to the Medicare PMD benefit, while a physician must provide a prescription for PMDs, CMS no longer requires that the physician certify the need. The PMC recommends that the algorithmic formula contained in the PMD National Coverage Determination be codified in a form that will then need to be certified, under penalty of law, by the physician. Such certification

will strengthen the role of the physician as gatekeeper of the Medicare PMD benefit and put the physician in a position to ensure that the beneficiary meets the requirements necessary under the Medicare program to qualify for PMDs. A physician-certified document will also provide some much needed objectivity to the PMD claims process.

The PMC appreciates the opportunity to comment on efforts to strengthen Medicare program integrity and provide recommendations for additional tools to help identify and prevent fraud. Moreover, the PMC agrees with many members of the Subcommittees who took pains to differentiate between innocent mistakes and omissions as a result of the complexities of the Medicare program and real fraud that harms beneficiaries, rips-off the taxpayers and taints the reputation of thousands of lawful PMDs suppliers nationwide. We must raise caution that overly restrictive anti-fraud measures that fail to distinguish between lawful suppliers and unscrupulous actors will only serve to further restrict access to PMDs, drive up program costs and deny needy beneficiaries high-quality PMDs.

The Medicare PMD benefit provides thousands of beneficiaries with freedom, independence and the ability to live more healthier and active lives. PMDs save the Medicare program money by keeping beneficiaries with compromised or limited mobility out of more costly institutional settings and decreasing the need for hospitalizations. We look forward to working with the Committee to ensure that appropriate program safeguards are in place to protect both the Medicare trust fund as well as Medicare beneficiaries.

Dear Mr. Chairman:

The House Ways and Means Committee held a hearing last week on Medicare program integrity. As requested by Chad Shearer, First Coast Service Options (FCSO), the primary Medicare administrator in Florida, is submitting the enclosed document for inclusion in the hearing record. The document is a progress report for a pilot program approved by CMS to combat Medicare fraud in Dade and Broward Counties.

We appreciate the Committee's consideration of this material.

Sincerely,

Curtis W. Lord

Report for South Florida Pilot

(Through February 28, 2007)

I. Executive Summary

This report updates progress on First Coast Service Option's South Florida Pilot (SFP) through February 2007. Section II of this report continues to be framed in terms of the components of the statement of work for the SFP.

First and foremost, prepayment safeguards designed to detect and prevent fraudulent infusion drug claims prior to payment, continue to be highly effective. In February 2007, only $8M was paid for these services in Dade and Broward Counties. At that level of payment, we believe the remaining degree of fraud in infusion drug payments is quite minimal. But as reported in previous monthly reports, unscrupulous providers in Dade and Broward Counties continue to bill significant volumes of infusion drug claims. Over $80M was billed in February 2007. A significant portion of that total, we think, was associated with fraudulent activity.

Also as previously reported, efforts to steal from Medicare have moved beyond drug claims to claims for other services, mainly billed from Dade County. We believe unscrupulous providers have gravitated toward expensive diagnostic tests and procedures in an effort to replace income lost to the infusion scheme clean up. The prepayment intervention installed by the SFP in January, an edit that suspends claims with allowed amounts above $500 billed by general and family practice physicians in Dade and Broward Counties, has been highly effective in combating this shift, stopping $4.9M in billed charges in February 2007.

To date, over 250 unique procedure codes have been billed with claims stopped by this new prepayment edit. The common denominator for these codes is that they describe expensive diagnostic tests or procedures not generally provided in an office setting by a general or family practice physician. Given the wide range of procedure

codes involved in this scheme, the widespread (rather than provider or procedure specific) edit that has been installed to develop for medical records is ideal.

Since the edit was turned on in very early January, providers have responded to only 40% of our requests for medical records. While this response rate has created a great deal of claim review, two things are clear:

(1) The 60% of claims for which we never get medical records suggests a high degree of fraud is present in these suspended claims, and
(2) The 40% of claims for which we do get medical records often contain medically unbelievable quantities of diagnostic tests or procedures; for example, one beneficiary allegedly received 59 nerve blocks over a six month period.

In an effort to make this edit more efficient, we are evaluating three new potential medically unbelievable edits for pulmonary tests, vestibular tests and injections of nerve agents (nerve blocks). Medically unbelievable edits are designed to automatically deny services once they exceed the "unbelievable" threshold, avoiding the process of requesting medical records for those services. That would allow us to request medical records only in situations where suspended claims have a relatively greater chance of being legitimate.

Provider enrollment results follow trends from prior months as the volume of new provider applications from Dade and Broward Counties continue to be lower than originally expected. As reported last month, however, the screening process has been tightened resulting in a considerable increase in the number of pre-enrollment site visits. Since the launch of the pilot only 33% of the provider enrollment applications in Dade and Broward Counties have been unconditionally approved.

The objective of the SFP is to reduce CERT error rates in Dade and Broward Counties to levels seen elsewhere in Florida and ultimately below CMS' national target. To better track our progress, we have revised our charts that compare payments in South Florida against payments outside the SFP area. Specifically, these charts now show payment on a per beneficiary per month (PBPM) basis for Dade County, Broward County and the rest of the state. Separate charts have been prepared for drug and non-drug services.

In terms of the Pilot Metrics, results for February 2007 reflect the following:

- CERT Scores: Please note this metric has been modified to track quarterly, not monthly, results increasing the sample size and reducing error rate variability.
  —CERT scores continue to trend down in the SFP counties.
  —For the Q3 2006 sample period, the Dade County CERT score currently stands at 11.7%; this compares to a previous quarter rate of 57.8%.
  —For the Q3 2006 sample period, the Broward County CERT score currently stands at 5.3%; this is up slightly from the previous quarter but compares very favorably to the last full year (November 2006) rate of 20.2%.

- Drug Payments: Per Beneficiary Per Month (PBPM): As noted previously, the Target Drug metrics have been replaced with new per beneficiary per month measures.
  —The drug PBPM for Dade County peaked at $2,641 in May 2006 compared to a PBPM of $352 that month for Florida with Dade and Broward Counties excluded. The Broward County PBPM peaked in June 2006 at $1,183 compared to a PBPM of $338 that month for Florida with Dade and Broward Counties excluded.
  —The drug PBPM for Dade County was $283 in February 2007, an 89% decrease from the peak in May 2006.
  —Similarly, the drug PBPM for Broward County was $310 in February 2007, a 74% reduction from the peak in June 2006
  —Based on the level of billed charges, the risk level of infusion drug fraud in and outside the SFP area remains high.

- Non-Drug Payments: Per Beneficiary Per Month (PBPM): The non-drug target metrics have also been replaced with PBPM measures. Separate PBPM measures are also included for services provided by general and family practice physicians.
  —The non-drug PBPM for Dade County peaked in October 2006 at $279. The non-drug PBPM for Dade County for February 2007 was $129, a 54% reduction from peak. This reflects the positive impact of the new general/family practice edit.
  —The statewide non-drug PBPM, excluding Dade and Broward Counties, however, is only $71 suggesting there is still considerable work to be done in the SFP area.

—The non-drug PBPM for February 2007 in Dade is 82% higher than the statewide PBPM excluding Dade and Broward Counties. The Broward non-drug PBPM is 24% higher than the statewide number.

In summary, the threat of infusion drug fraud remains high but is largely contained in Dade and Broward Counties. The focus of the SFP has shifted to fraud involving non-drug services where there is still plenty of work to do.

II. Progress Against Statement of Work

A. *Provider Enrollment*

1. *Site Visit Process*

- In February, 22 sites were added to the list of providers to be visited prior to enrollment.
- Of the ten site visits completed during the month, three applications were denied because the providers were not operational. Of the seven applications approved, three were considered high-risk and will be placed on pre-payment claim review for all services billed.
- A total of 20 site visits to *existing* providers were made this month. Of that total, seven resulted in the revocation of the provider's billing number. Five site visits were inconclusive and will require follow-up work in March.
- Since the beginning of SFP site visits, 56 applications have been denied or approved with 100% claim monitoring, while 41 billing numbers have been revoked.
- The site visit process has been modified to cease appointment scheduling for new provider visits. The revised process instead simply notifies the provider that a site visit will occur during the reported normal hours of operation. This will make extensive staging and preparation work that is observed on some visits more difficult.

2. *Five or More Reassignment Process*

- A total of 29 providers have been identified since inception that meet the five or more reassignment criteria. Of that total, 22 applications have completed processing, resulting in the deactivation of 118 provider numbers. The remaining seven responses are pending.

B. *Data Analysis*

1. *Spike Billing/Monitoring Report Development*

- An early detection report is being developed to track movement of physicians from Dade and Broward Counties to other areas of Florida using provider enrollment information. The goal is to run a weekly report of newly enrolled providers that are, or have been, enrolled in Dade and Broward Counties and assign a risk level. High-risk providers will be immediately placed on pre-payment review even before we receive their initial claims. This report will be ready by the end of March.
- As mentioned in the Executive Summary, analysis of claims suspended by the non-drug $500 edit for general and family practitioners shows that development of certain medically unbelievable edits is needed. The evaluation and edit criteria will be ready by the end of March.
- A statistical tool is being developed to assist with the analytical work needed to implement medically unbelievable edits that span a period of time. This new statistical tool, which will be modified to analyze data over time to help insure legitimate providers are not affected, will be ready by the end of March.
- An evaluation of the expansion of the infusion "specialty edits" statewide for general and family practitioners was completed. Movement of some infusion clinics outside South Florida prompted the evaluation. The results show that over 150 legitimate providers would have had their claims hit the existing edit structure. These providers typically are designated as family practice, but have had additional training in cardiology, rheumatology and other specialties. We will work with the PSC on alternative solutions to statewide editing.

2. *Predictive Modeling*

- The scoring of high-risk providers in South Florida has been completed. The results of the scoring will be used to prioritize providers for enrollment revalidation.

3. *Pending Claims Analysis*

- A new pending claim data report is being developed that will compare a provider's pending billed amounts to billed and paid amounts for the previous

month. A statistical evaluation of the results will also be developed. This report, which will assist in identifying aberrancies in pending claim data, will be ready in early April.

C. *Claims Editing*

1. *Provider-Specific Edits*

- Total savings from edits for new providers and providers previously cleared by the PSC in February are approximately $900K.

2. *Widespread Edits*

- The non-drug edit designed to suspend claims for medical record development for amounts over $500 billed by general and family practitioners in Dade and Broward Counties saved $4.9 million in February.
- The widespread edit for internal medicine physicians implemented by the SFP in November saved $2.2 million in February. This edit was not expected to generate large savings like the general and family practitioner specialty edits illustrating that unscrupulous providers continue to bill for drug services.

3. *Medically Unbelievable Edits*

- As noted in the Executive Summary of this report, work on designing medically unbelievable edits for three groups of services: vestibular testing, pulmonary testing and injection of nerve agents (nerve blocks).

D. *Payment Suspensions*

- No payment suspensions have been necessary to date given the effectiveness of other corrective actions.

E. *Infusion Reporting*

- The February monthly reports were produced and forwarded to the PSC on March 12.
- A new request for two additional (100% pre-payment review) edits was submitted by the PSC. The criteria are currently being developed.

III. Reporting

A. *SFP Claims Editing Savings*

	February	*Cumulative*
• Provider Specific Edits:	$ .9M	$ 2.2M
• Widespread Edits:	$7.1M	$10.3M

B. *Provider Enrollment Activity*

- The "Site Visit of Existing Providers July 2006 through February 2007" chart includes three follow-up visits of providers from last month which resulted in one additional provider going operational without monitoring; results from the other two are still being evaluated.

C. *Pilot Metrics*

- A summary of each metric being used to measure the success of the SFP is included in the Executive Summary.
  —CERT Scores
  —Drug Reimbursement: PBPM
  —Non-Drug Reimbursement: PBPM
  —General and Family Practices: PBPM

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