

**ANATOMY OF A FRAUD BUST:  
FROM INVESTIGATION TO CONVICTION**

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**HEARING**

BEFORE THE

**COMMITTEE ON FINANCE  
UNITED STATES SENATE**

**ONE HUNDRED TWELFTH CONGRESS**

SECOND SESSION

APRIL 24, 2012



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## **ANATOMY OF A FRAUD BUST: FROM INVESTIGATION TO CONVICTION**

**TUESDAY, APRIL 24, 2012**

U.S. SENATE,  
COMMITTEE ON FINANCE,  
*Washington, DC.*

The hearing was convened, pursuant to notice, at 10:07 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Wyden, Nelson, Carper, Hatch, Grassley, and Coburn.

Also present: Democratic Staff: David Schwartz, Chief Health Counsel; Russ Sullivan, Staff Director; Matt Kazan, Professional Staff; Callan Smith, Research Assistant; and John Angell, Senior Advisor. Republican Staff: Chris Campbell, Staff Director; and Kim Brandt, Chief Healthcare Investigator.

### **OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. The committee will come to order.

Julius Caesar once said, "Experience is the teacher of all things."

This morning we are here to learn from the experience of Federal officials who fight health care fraud. Each year, the Federal Government loses \$60 billion to health care fraud. This crime adds to the deficit. It wastes taxpayer dollars. It forces seniors to spend more out of their tight budgets on Medicare premiums.

Fighting health care fraud involves agencies across the Federal Government. The Centers for Medicare and Medicaid Services, or CMS, puts tools into place to investigate and prevent fraud. The Department of Health and Human Services' Inspectors General conduct criminal and civil investigations. And the Department of Justice prosecutes the criminals who steal taxpayer dollars.

A problem this big requires teamwork. The agencies involved need to work together seamlessly. They must have the right tools for the job and the resources available to deploy those tools.

Today we are here to learn from the success story where CMS, the HHS Inspector General, and the Justice Department were able to work together as a team. We will hear how the investigators rooted out the criminals, how the agents led the investigation, and whether the government recouped its losses.

This case was made public last September, and, at the time, it was the largest Medicare fraud bust in history. This Miami local news report from last fall shows one of the schemes involved.

At this point, I would like to show that video.

[Whereupon, a video was played.]

The CHAIRMAN. I think that is a pretty good summary. These schemes were spread across eight cities, involved 91 defendants and almost \$300 million in fraudulent billing.

From this case we hope to learn valuable lessons to further protect Medicare from criminals. I would like to know, in talking to the witnesses and hearing from you, what challenges you faced during the investigation; what lessons you learned; what barriers, if any, existed then and continue to exist today among the agencies; and how we can help you work better together to make sure that more fraud is uncovered more quickly.

I would also like to hear how the Affordable Care Act is helping to prevent and fight fraud. We gave law enforcement an unparalleled set of new tools in health care reform to prevent fraud. Before the health care law, even suspicious claims were paid, then investigated later.

Health reform changed that. It gives law enforcement the authority to stop payment and investigate suspicious claims before taxpayer money goes out the door. Health care reform also improves screening to ensure criminals cannot get into Medicare or Medicaid. Prior to health reform, most information was entered by hand into an inadequate and out-of-date database. As a result, Medicare paid providers who should have been prevented from joining the program in the first place.

Yesterday, GAO released a report, at my request, detailing the implementation of the new provider screening tools that health reform created. The report says that a new automated system should ensure the provider enrollment system is up-to-date and accurate. As a result, criminals attempting to enter Medicare will not slip through the cracks and be able to defraud the government.

As we build upon our achievements fighting fraud, we, of course, must remain vigilant. Medicare has been growing at a fast rate for a long time. We all have concerns over the program's effect on the budget deficit and the health of the Medicare trust fund.

However, we have been making some progress. Our nonpartisan scorekeeper, the Congressional Budget Office, says that per beneficiary spending in Medicare will grow 1 percent above inflation in the next 10 years. This is a major reduction compared to the past 2 decades, when Medicare grew 5 percent above inflation.

Our fight against health care fraud is only one key piece to this progress. And it is a small piece, but it is still a piece, nevertheless. Last year, the Federal Government recovered a record \$4.1 billion as a result of health care fraud prevention and enforcement efforts. That is out of about \$500 billion we spend on Medicare annually.

This is a worthy accomplishment, but, of course, much more must be done. So let us heed Julius Caesar's advice, learn from the success that you have had. Let us take the experience we gained achieving the success and use it as a valuable teacher.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

**OPENING STATEMENT OF HON. ORRIN G. HATCH,  
A U.S. SENATOR FROM UTAH**

Senator HATCH. Thank you, Mr. Chairman. I appreciate your work in this area. And I want to thank all of our witnesses today for appearing to discuss this timely issue.

American citizens are sick and tired of stories about government's failure to act as a faithful steward of taxpayer dollars, and there are few programs as rife with waste as Medicare. Estimates of the amount of fraud, waste, and abuse in the Medicare system vary widely, anywhere from \$20 billion to \$100 billion. With numbers like those, it is no wonder that Americans, on average, believe the Federal Government wastes over half of what they pay in Federal taxes each year.

Taxpayers have reason to be angry about the levels of waste, fraud, and abuse in Medicare and Medicaid. We have scheduled this hearing, in part, to address their concerns. And, as today's written testimony illustrates, progress is being made on this front, but much more needs to be done.

Two years ago, Congress significantly expanded the authorities and resources given to the Centers for Medicare and Medicaid Services to shore up CMS's historically underfunded program integrity efforts. CMS now has over \$1 billion available annually to use in its fight to ensure payments are made properly.

While CMS has begun to make some strides in this fight against fraud, the implementation of congressionally mandated program integrity efforts has been lackluster, at best. The CMS report card is not one to be proud of, in my opinion.

Now, this chart is a pretty important chart. CMS has not put in any temporary moratoriums to prevent new providers or suppliers from enrolling and billing the Medicare program, even in areas where more than enough already exists to furnish health care services.

CMS has not established a surety bond on home health agencies, even though CMS considers new home health agencies a high risk. CMS has not established mandatory compliance programs as a condition of participation for suppliers despite HHS OIG's continued finding that those programs help prevent fraud from recurring.

CMS has not implemented limits on how much high risk suppliers and providers can bill. CMS has not established procedures to deny additional Medicare billing privileges to suppliers who have an existing overpayment or suspension.

Until this morning, CMS had not even finalized a rule to implement checks to make sure that physicians actually refer a Medicare beneficiary for a medical service before paying the claim. And CMS has not implemented claims edits to verify that Durable Medical Equipment, Prosthetics, Orthotics, and Supplies suppliers are accepted for each item or service for which they bill Medicare.

CMS does have new, enhanced provider screening tools designed to ensure that only legitimate providers and suppliers are allowed into the Medicare program. Yet a recent search, by our offices, of convicted felons who are also physicians showed that many, including a physician convicted of conspiracy to commit murder, still appear on Medicare's public ordering and referring file as active Medicare providers.

Historically, CMS has claimed that for every \$1 invested in program integrity efforts, the return is at least \$14. If that is the case, taxpayers and Congress should expect to see proof of \$14 billion in recoveries in the very near future. Yet, given the results provided to date and the effectiveness of many of the efforts highlighted by the OIG, I am not going to hold my breath.

Despite many public announcements about enhanced tools, flashy new systems and high-profile collaborations to combat waste, fraud, and abuse, CMS can show few tangible results from these investments. Recoveries by CMS law enforcement partners are at their highest rate of return ever, \$4.1 billion for the last reporting period. That is a 58-percent increase over the year before. But the administrative actions and recoveries which were under CMS's sole control are far less robust.

The failure to address fraud, waste, and abuse appropriately is a longstanding problem for CMS. Perhaps a fresh perspective is necessary, and that is why later this week I, along with my colleague, Dr. Coburn, will begin soliciting ideas from all interested stakeholders for combating the billions in waste, fraud, and abuse in the Medicare and Medicaid programs.

Together we hope to identify innovative solutions that will provide taxpayers with a return on the investments being made to combat the waste in these programs. Now, I want to be absolutely clear. Waste and fraud in the Medicare system is not a minor issue. Government agencies can harm U.S. taxpayers by acting improperly, as appears to be the case with the GSA scandal. But they can also hurt taxpayers through inaction.

The failure of CMS to address waste, fraud, and abuse, in spite of billions in taxpayer dollars dedicated to doing so, is quickly becoming its own scandal. Waste in the programs that CMS supervises directly harms U.S. taxpayers. That is the way that CMS needs to think about this issue.

This is not some victimless crime. Fraud and waste in these programs hurt the American taxpayer no less than if someone lifted their wallets. It harms the integrity of a program that our seniors depend on, and it undermines citizens' confidence in the government's ability to perform its most basic functions.

Thanks, again, Mr. Chairman. I look forward to the testimony of our witnesses. And I really appreciate your holding this hearing.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. You bet. Thank you, Senator.

I would like to now welcome our witnesses.

First, Health and Human Services Inspector General Dan Levinson. Welcome, Mr. Levinson. Second, U.S. Attorney for the Southern District of Florida, Wifredo Ferrer. Good job in that video, and a good job done in this prosecution. Next is CMS Deputy Administrator Dr. Peter Budetti. And the GAO Director of Health Care, Kathleen King.

Mr. Levinson, please begin. And our usual rule, as you know, is about 5 minutes per statement, and we will put the rest of your statement automatically in the record. And I encourage you to tell it like it is. Do not pull your punches. Life is short.



**STATEMENT OF HON. DANIEL LEVINSON, INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Mr. LEVINSON. Carpe diem.

The CHAIRMAN. Exactly. [Laughter.]

Mr. LEVINSON. Good morning, Chairman Baucus, Ranking Member Hatch, and Senator Coburn. I am pleased to provide you with insight into how OIG agents investigate Medicare fraud and coordinate national strike force takedowns.

We face a challenging task. Medicare fraud costs billions of dollars each year and, in some cases, endangers patients' lives. Fraud perpetrators range from street criminals with sham operations to practitioners in institutions who may provide some legitimate care, but also exploit Medicare.

Fraud schemes are increasingly sophisticated and dangerous. OIG agents often confront lethal weapons. But OIG and our partners at Justice and HHS are fighting back. We have leveraged data, technology, and expertise. We have cut the average time from fraud detection to indictment, and we are achieving record-setting recoveries. From 2009 to 2011, we returned \$7 for every \$1 invested in the health care fraud and abuse control program.

The investigation of the ABC and Florida Home Health agencies—I will refer to them as ABC—exemplifies one of many Strike Force successes. More than 50 individuals have been convicted in connection with a \$25-million fraud scheme.

ABC billed Medicare for home health services that were not provided or were not medically necessary. They paid doctors up to \$300 per prescription to falsely certify that patients needed diabetes care in their homes. They paid patients up to \$1,500 per month to falsely attest that they needed and received the services.

So how did we unravel this scheme? In late 2008, the Miami Strike Force team began investigating ABC based on a lead from another case. ABC's billing was suspicious. For example, ABC claimed that virtually all of its patients needed daily insulin injections by nurses or physical therapy. Yet we know a small proportion of Medicare patients truly need those services.

We also looked at the time being billed by ABC nurses and aides. In some cases, it would be literally impossible for one person to provide all of the services billed for on a given day. It did not add up.

Further, we examined bank records and found evidence of kick-back payments. Within about 6 months, we indicted two ABC owners and six co-conspirators. But the investigation did not end there. Working with cooperating witnesses, we continued to analyze billing data and medical records to ferret out co-conspirators. Patient recruiters in the ABC case have also led us to some other home health agencies running similar schemes.

Individuals in one of these spinoff cases were among those charged in the national takedown announced last September. This operation charged 91 defendants across eight cities. These fraud schemes in Miami, Houston, Brooklyn, NY, Dallas, Detroit, Los Angeles, Chicago, and Baton Rouge, involved almost \$300 million in Medicare billings.

Nationwide takedowns start with investigations like the ABC case. At present, our Strike Forces have about 300 active investigations. Coordinating cases into a major takedown provides tactical, efficiency, and deterrent benefits.

When the Justice Department determines that numerous cases are nearing indictment, our office or the FBI begins tactical planning. This includes conducting surveillance of subjects in arrest locations, investigating histories of violence and possession of weapons, determining what protective equipment and forensic tools are needed, and mapping routes to nearest hospitals and emergency services.

Simultaneously, we support the Justice Department's prosecutors in obtaining warrants. Our office and the FBI execute the arrests and search warrants with support from partner agencies. Ensuring success and safety requires extensive planning and communication and long hours of preparation and training.

The September takedown involved more than 400 agents government-wide, and forensic specialists. Our suspects were arrested and searches conducted without incident. All of our agents returned home safely.

OIG's special agents are on the front lines every day, tirelessly fighting fraud and bringing criminals to justice. We appreciate your support for our mission and their service.

Thank you. And I will be happy to answer your questions.

[The prepared statement of Mr. Levinson appears in the appendix.]

The CHAIRMAN. You bet. Thank you very much. That is a good summary. It just scratched the surface, I am sure.

Next, Mr. Ferrer?

**STATEMENT OF HON. WIFREDO A. FERRER, U.S. ATTORNEY,  
OFFICE OF THE U.S. ATTORNEY FOR THE SOUTHERN DISTRICT OF FLORIDA, MIAMI, FL**

Mr. FERRER. Good morning, Chairman Baucus, Ranking Member Hatch, and Senator Coburn. I am honored to speak with you today and to thank you, first of all, for your leadership in combating health care fraud.

As you know and as you have mentioned, health care fraud is an extremely costly law enforcement problem. Every year, taxpayers spend hundreds of billions of dollars to provide health care to the most vulnerable in our society—the elderly, the needy, the disabled, and our children.

We have a duty to ensure that these funds are spent on providing proper Medicare treatment to those who need the treatment. And, while most doctors and health care providers are doing the right thing, there are, unfortunately, others that target Medicare and other government health care programs to line their own pockets. That is unacceptable, and that is why fighting health care fraud is a priority, a top priority for the Department of Justice.

Now, the 93 U.S. Attorney's offices are the principal prosecutors of Federal crimes, including health care fraud. And, together with the attorneys of the department's civil, criminal, and civil rights divisions, we represent the United States in both criminal and civil cases in Federal courts all across the country. And, with the agents

from the FBI, from HHS, and with CMS, we are fighting back against this epidemic.

We investigate, we prosecute, and we secure prison sentences for hundreds of defendants every year, and we are recovering billions of dollars every year. And, with the additional resources provided by Congress, we have made incredible strides in this battle.

As you mentioned right at the start, in fiscal year 2011 alone, the government was able to recover approximately \$4.1 billion that went back to the Medicare trust fund, the U.S. Treasury, other Federal agencies, and individuals. This is the highest amount ever recovered in 1 year. The criminal prosecutors, the Federal prosecutors, also charged the highest number of defendants in 1 year, and that was in fiscal year 2011, to combat this case and this issue.

Now, one particular case, the ABC case that was mentioned—that is more fully described in my testimony—is a perfect example of the tools that the department is using to fight this problem, and we are talking from data analysis all the way through old-fashioned police work.

ABC, which is a home health care agency—or was—and Florida Health Home Providers, they were home health care agencies that, as described, billed Medicare for services that were not provided or never needed. And, by looking at the data, the agents were able to make sure and see that every beneficiary seemed to be getting the same treatment. They were either getting insulin, daily insulin injections by nurses or other aides and/or they were receiving physical therapy, or both. And we know that not every patient needs this every single day, and we also know that the same treatment—it does not make sense to give the same treatment to every single person.

This scheme involved kickbacks and bribes to doctors who filled out forms falsely certifying that the services were needed and to refer the patients to these two providers instead of sending them to legitimate providers. This case involved a lot of kickbacks, as Mr. Levinson stated, thousands of dollars to patient recruiters and patients.

The task of dismantling this fell on the Miami Strike Force. And I have to tell you that this was incredible work, collaborative work. The agents reviewed bank records. They used an informant. They looked at data. They saw that the bank records showed that the money was going to sham companies. And the agents and prosecutors also used judicially authorized search warrants to seize these falsified patient files in order to make our case.

And, in less than 18 months, the Medicare Strike Force in Miami resulted in the criminal convictions of 51 defendants in just this one case. Since 2009, the defendants convicted by the Miami Strike Force, including ABC, collectively billed Medicare and Medicaid for more than \$127 million, and I am just talking about home health care fraud.

The success of this case was the result of one Strike Force. The factors—such as co-location of the agents with the prosecutors, reviewing the data in a timely fashion—that is what brought our cases to success and what brought our cases to a resolution in a much faster fashion.

The success of this approach demonstrates that the model, in fact, not only works, it exceeds traditional models of prosecution.

We will fight this battle up and down the chain of the health care fraud scenarios, and we are happy to tell this good story, and we look forward to any questions.

[The prepared statement of Mr. Ferrer appears in the appendix.]

The CHAIRMAN. Thank you very much, Mr. Ferrer.

Dr. Budetti, you are next.

**STATEMENT OF DR. PETER BUDETTI, DEPUTY ADMINISTRATOR AND DIRECTOR OF THE CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC**

Dr. BUDETTI. Good morning, Chairman Baucus, Ranking Member Hatch, and other distinguished members of the committee. I am delighted to be here this morning to discuss with you the significant progress that we have made at the Centers for Medicare and Medicaid Services in our fight against health care fraud.

In conjunction with our law enforcement partners, we have played a substantial role in takedowns and busts, fraud busts such as the one that is being described today. This is a very good example of how the government agencies are working together to identify, investigate, and prosecute health care fraud.

CMS and our antifraud investigators play an important role in this process. In this particular scheme that my colleagues have already mentioned, the ABC Home Health Care case that was just described, CMS's data and analytic and investigative work played an important role in helping to build the case, and our investigators and members of our staff played important roles during the entire prosecution of the case, providing both data analysis and witnesses at the trial itself.

The case demonstrates that the team from different government entities working together can be extremely successful in coming in, identifying, and prosecuting fraud cases such as the one that you have heard about.

What I would like to discuss right now really picks up, Mr. Chairman, on the point that you made about learning our lessons. We have learned lessons from these investigations and from similar kinds of activities to fight fraud. In the past, all too often, we have been behind the fraudsters and having to catch up to them as we did in this case.

That has long been known as the pay-and-chase approach, and our new, innovative approaches at the Centers for Medicare and Medicaid Services are moving forward to prevent these kinds of problems from occurring in the first place.

Our initiatives are built around what we are calling the "twin pillars." The first pillar is the Fraud Prevention System that a number of you have heard me talk about before. That is the claims-based analytics, predictive analytics, that was put into place under the authority and requirements of the Small Business Jobs Act to detect aberrant billing patterns and is now screening all Medicare Part A, B, and DME claims.

The second pillar is the one that was referred to a little bit earlier and was also mentioned in the GAO report, which is our new, enhanced provider enrollment and screening initiatives. This is the Automated Provider Screening (APS) system that will provide rapid and automated screening of all providers and suppliers when they seek to enroll in the program, when they come up for revalidation, and on an ongoing basis while they are enrolled in the program.

The APS technology is a major step forward in bringing about a way to keep the people out of the program who do not belong in the program, to keep them out and to identify them and kick them out should they get into the program.

The other point I would like to make about our twin pillars is that they are not stand-alone entities. They interact with each other. Information from the Fraud Prevention System that looks at claims in an innovative, new way can feed into the system that looks at the enrollments, and vice versa. When we find out something about a provider or supplier during the enrollment screening process, that information can be used to strengthen the way that we are looking at the claim.

These are interactive and very advanced and sophisticated systems.

We recently, very recently, in fact—just this past week and weekend—had a situation in which the advanced systems helped us identify aberrant billing patterns with a certain kind of provider and supplier. And, working closely with our colleagues at the Office of the Inspector General, we are at this moment in the process of taking administrative actions to cut off payments to the providers and suppliers who were identified in this new way.

This allows us to investigate, coordinate, and rapidly take action. We share very much the passion that many of you have expressed that this is a situation that needs to be brought under control, and we are dedicated to doing that.

Thank you very much. And I look forward to taking your questions.

The CHAIRMAN. Thank you, Dr. Budetti.

[The prepared statement of Dr. Budetti appears in the appendix.]

The CHAIRMAN. Ms. King, you are next.

**STATEMENT OF KATHLEEN KING, DIRECTOR OF HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC**

Ms. KING. I am pleased to be here today to discuss our work regarding fraud and recent agency actions and recent laws that could help the agency and their law enforcement agencies fight fraud.

Multimillion-dollar convictions demonstrate that fraud is a serious problem in Medicare, but the full extent of the problem is not known. There are no reliable estimates of fraud in the Medicare program or in the health care industry as a whole. This is because fraud is difficult to detect because people are acting with ill intent and trying to deceive the program.

My testimony today focuses on the steps CMS has taken to reduce fraud and on additional steps we have recommended to them.

Congress provided new tools to CMS to reduce fraud in the Patient Protection and Affordable Care Act and the Small Business Jobs Act. I want to focus on three key strategies: strengthening provider enrollment standards and procedures; improving pre- and post-payment claims review; and developing a robust process for addressing vulnerabilities, which are weaknesses that can lead to improper payments.

With respect to provider enrollment, CMS has taken important steps to ensure that only legitimate providers and suppliers are enrolled to bill Medicare. Specifically, in accordance with the Patient Protection and Affordable Care Act, CMS designated three levels of risk. Those at the highest risk level are subject to the most rigorous screening.

In addition, as Dr. Budetti mentioned, CMS recently contracted with two companies to automate enrollment processes and to conduct site visits for new providers in the moderate- and high-risk categories.

We urge CMS to fully implement other key PPACA provisions, such as requiring surety bonds for providers designated as high-risk; conducting fingerprint-based criminal background checks; and requiring key disclosures from providers and suppliers before enrollment, such as whether they have ever been suspended from a Federal health care program.

Our work has also shown that prepayment reviews are essential to help ensure that Medicare pays correctly the first time. CMS's contractors use automated prepayment controls called edits, which are instructions programmed into IT systems to check if providers are eligible for payment and if the claims comply with Medicare's coverage and payment policies. We have previously found weaknesses in some of these edits and are currently evaluating prepayment edits that implement coverage and payment policies.

We are currently reviewing CMS's newest effort, the Fraud Prevention System, which uses predictive analytic technologies to analyze fee-for-service claims on a prepayment basis. These technologies are used to review claims for potential fraud by identifying unusual or suspicious patterns or abnormalities in Medicare provider networks, claims billing patterns, and beneficiary utilization.

We have also found that CMS could take additional steps in improving post-payment review of claims, which is critical to identifying payment error. In particular, the agency could make better use of two information technology tools designed to help provide them with more data and analytical tools for fighting fraud. These are the Integrated Data Repository and One Program Integrity.

We have found that CMS needs a more robust process for addressing vulnerabilities. In our work on the Medicare recovery audit program, we recommended that CMS improve its process for implementing corrective actions regarding vulnerabilities.

In conclusion, CMS has several tools at its disposal and has taken important steps toward preventing fraud. However, more work is ahead. Those intent on committing fraud will find ways to do so. So, continuing vigilance is critical.

We will continue to assess efforts to fight fraud and provide recommendations to CMS based on our work that we believe will as-

sist them in this important task. We urge CMS to continue its efforts as well.

Thank you very much for allowing me to speak today.

[The prepared statement of Ms. King appears in the appendix.]

The CHAIRMAN. Thank you very much, Ms. King. Thank you all.

My first question is, what is the biggest area of fraud? Is it home health? Is it just medical clinics? Is it hospitals? Is it equipment—medical equipment manufacturers? What is it? What is probably the biggest, richest asset—what is your target asset in trying to fight fraud? Any of the four of you could answer that question.

But what areas are most fraudulent? I will start with you, Mr. Levinson.

Mr. LEVINSON. Chairman Baucus, in terms of financial recoveries, actually, pharmaceutical cases constitute by far the largest recoveries. But for purposes of what we are talking about mostly this morning, there are, I think, significant challenges in Part B, the range of outpatient services.

You mentioned home health, and home health is a very, very important subject to focus on, because we are heading really into an era where there is going to be increasing reliance on using community-based health facilities, getting people out of hospitals, out of institutions, and trying to do more care at home.

That, at least in theory, should be good for the taxpayer. It should reduce costs, because you are getting out of significant overhead costs, creating venues, places where health care can be delivered less expensively.

But there is also risk. It is a more fluid and flexible environment. It is more difficult to exercise appropriate internal controls. So, for example, we did do a study of home health agency compliance records and found actually that, from a compliance records standpoint, home health agencies looked to be doing very good. Then we uncover cases like this, where you have conspiracies between various providers, doctors, nurses, and others, and, all of a sudden, notwithstanding that people are getting the paperwork right, the people who are doing the paperwork right, in an unfortunate number of cases, are people who know exactly what they are doing. They are stealing from the taxpayer in just the right way that gets the boxes correct.

So areas like home health, I think, present an especially sophisticated challenge. And we, I think, have done a more successful job of attacking DME fraud, which, to a certain extent, is a lazy man's fraud—I mean, having a sham storefront and being able to simply provide durable medical equipment is, in many cases, or historically has been, an easier scam.

Once you get into home health, now you are getting into professionals who need to document more extensive paperwork records.

The CHAIRMAN. What is the most efficient way to prevent home health fraud?

Mr. LEVINSON. Well, I think there is still a challenge in developing the analytics that will do a better job of being able to assure that those who are in the home health field are legitimate providers who are also not just filling in boxes, and that we have the technology that will demonstrate that those services actually are necessary and being delivered correctly.

The CHAIRMAN. Could you expand on that a little bit more? Like analytics; what do you mean, “better analytics”?

Mr. LEVINSON. Well, I think this is—in the ABC case, I think this is a good example of being able to see that the record was clinically incoherent. It did not make sense for people to be able to provide the level of services.

Once you were able to drill down and understand the pattern of data—for someone to provide 15 patients that many visits in the course of a given day is literally impossible. Being able to get that kind of information quickly and to be able to act on it promptly is very, very important.

The CHAIRMAN. That is more prosecution, remedial. What about prevention? How do you prevent home health care fraud?

Mr. LEVINSON. I think it is very important to focus on who gets into the field and to be able to come up with measures of being able to see, what actually is the performance like over the course of a period of time, to be able to monitor that more effectively.

The CHAIRMAN. In your judgment, what is probably the most effective way to screen, the most effective way to prevent fraud in the first place? If you could expand just a little bit more, please.

Mr. LEVINSON. Well, I think, ultimately, it is a matter of the program being able to come up with metrics that will do a better job of being able to separate out—hopefully before they get into the program, but at least early into the program—those who really do not belong in that field, in that area of health care activity.

The CHAIRMAN. And you think the metrics are not yet developed.

Mr. LEVINSON. I have not seen them. And when I get a report, which I certainly share with the Congress, about how good home health agencies generally seem to be in terms of compliance records, and knowing that there are cases like ABC that we see, I know that we are not there.

The CHAIRMAN. Thank you.

Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

Dr. Budetti, let me just say, in your testimony and other public statements, you have indicated the array of new tools and approaches CMS is utilizing to do more on the front end to prevent fraud, waste, and abuse from occurring.

While there is certainly much to point to in terms of enforcement results over the past year, I am somewhat curious about what tangible and quantifiable results CMS has seen from the money and tools specifically given to them.

Can you please give us some specific examples of where CMS has seen some actual return on investment from the money provided from PPACA, the Patient Protection and Affordable Care Act? What other types of results can this committee expect to see from this investment, and how will you be measuring the success of these efforts?

Just one last question. Why do you believe that these new approaches will deter or prevent the rampant fraud that has continued unabated over the last 20 years?

Dr. BUDETTI. Thank you for those questions, Senator Hatch, and I very much appreciate your interest in this matter.

Senator HATCH. Thank you.



Dr. BUDETTI. I can tell you that just looking, for example, at the results from the application of our Fraud Prevention System so far, as of the end of January, we were able to identify some \$35 million in funds that had either been stopped, identified, or avoided.

And I would like to make the point that the way that our systems work is going to force us to think in terms of a new way of identifying when we have solved a problem, because recoveries mean that money has already gone out the door. And when we do get money back in as, of course, we should, when we can, that is a relatively easy thing to measure.

When we identify a provider or supplier who does not belong in the program and we toss them out, as we have, when we identify providers and suppliers who are still on the books but who are not licensed to practice in the areas where they are enrolled in Medicare or are, in fact, dead, that is a vulnerability that we have addressed.

So we have to think in terms of the return on our investment in a broader fashion than we have in the past, other than simply the recoveries.

When we stop somebody from submitting a claim, that could be a very large amount of money, but it is a difficult one to measure. Nevertheless, that is what we want to do, and we do want to measure it. And as you know, at the end of the first year of the Fraud Prevention System this summer, we will be preparing our first annual report, and we will have a wide range of metrics in there to look at how well that system has performed; and not just that system in isolation, but that system as part of our overall efforts, because, after all, the Fraud Prevention System is not yet even a year old and is still a relatively moderate part of our overall activities.

But when we installed the claims processing edits to follow-up on some of the leads that were identified in the Fraud Prevention System, we were able to identify over \$14 million that we would have paid out over the coming year. When we installed a variety of other kinds of edits, we were able to block millions in addition.

So we are looking at it on every level. We are looking at it in terms of the providers and suppliers who do not belong in the program that we are investigating, and we are revoking their billing privileges or otherwise getting them out. We are looking at it in terms of the dollars that are saved by getting them out. We are also looking at the actual payments that we are blocking one way or another, either through payment suspensions or through prepayment controls or through automatic denials.

So we are very much committed to looking at the outcomes of our efforts. But I just want to make the point that we need to move beyond just thinking in terms of money that actually comes back into the government, because we do not want it to go out the door in the first place.

Senator HATCH. Thank you, Doctor.

Inspector General Levinson, in your oral and written testimony, you have noted the length of time it takes to investigate and prosecute a case. However, how long does it take between a conviction and when OIG finalizes the exclusion of a provider from the Federal health care programs?

And what can be done to streamline this process to ensure less of a gap between sentencing and exclusions from the Federal health care programs? And how are you working with CMS to ensure administrative actions, such as payment suspensions, are occurring much sooner in the process to stop Federal dollars from going out the door rather than having taxpayer dollars at risk for months, if not years, before your investigation is completed?

Mr. LEVINSON. Senator Hatch, on payment suspensions, we do see real progress being made on being able to act more promptly. There is a recent case actually in which 78 payment suspensions were made very quickly once the fraud was understood.

That is a matter really of CMS and OIG working cooperatively, and I think that we have really done an increasingly better job together being able to make those things happen. We have an increasing number of payment suspensions. They need to happen quickly, I would agree.

The area which I think remains a major challenge for us that we have at this point only limited control over is that point between conviction and exclusion. Right now, we are probably—when you look at the total—we have several thousand exclusions a year. On average, we are within the range of about 8 months from one to the other, and that is too long. Government should be able to do a better job of that.

I think that the structural issue outside of our office is that we have 50 different programs in the States and we have various licensing boards and courts, and so much of it is a paper process. We have both a jurisdictional challenge, we have still paper, getting it to an IT, getting it really to a 21st-century way of being able to provide prompt notice.

Within our own office, we have taken significant measures to streamline what we do, but we still need to look at the record, because the exclusion is not for any specific period of time necessarily. We need to actually look at the record, our agents do, to determine the period of exclusion, to look at mitigating factors and the more serious circumstances.

So there is a certain amount of due process built in that is going to trigger some delay, but government needs to do a better job.

Senator HATCH. Thank you.

The CHAIRMAN. Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman. And thank you folks for helping us with this very important issue, because there is so much waste. We have to get to the bottom of it, and I know you are trying to.

Dr. Budetti, Senator Hatch and I have sent two separate letters asking for answers on why you have not yet used the temporary moratorium authority given to you under the Patient Protection Act which you finalized regulations on in February.

Despite numerous requests for information and an in-person briefing, we have yet to receive a satisfactory explanation of why you are not aggressively using the authority in areas where it is clear there are a high number of providers and suppliers and where fraud seems to be rampant.

It is unacceptable that we sent our first letter in October last year and still have not received the information requested or an ac-

ceptable answer for why you are not moving forward to utilize the tool.

When can we expect to get more detailed answers to our questions and for you to begin using this authority?

Thank you.

Dr. BUDETTI. Senator, it is good to see you again. And I appreciate your question. And we certainly do intend to use this very powerful tool of imposing a moratorium. I think it is very important for us to focus on which tool is the most appropriate for a given circumstance, and one of the characteristics of imposing a moratorium, which we have every intention of using, is that it will block new people, new providers and suppliers from coming into an area or coming in to deliver a type of service.

It does not do anything about the existing fraudsters who are already there. It just blocks the new ones, and it could also apply equally to new fraudsters, but to new legitimate providers or suppliers who want to come in.

So we think that we need—we, in fact, are demonstrating that we need to be very thoughtful about making sure that the moratorium is the right tool to address a specific problem. And we are developing the analytics to see what kinds of situations are the most promising for a moratorium, where it would be a temporary block for all providers and suppliers of a given type to come into the market in a given area.

And we want to make sure, when we look at that, first of all, that we can demonstrate that stopping new ones from getting in serves exactly the purpose that we are getting at, number one; number two, that we are not threatening the potential access of Medicare beneficiaries by limiting perhaps new legitimate providers and suppliers from coming in.

So we have every intention of using this tool. We appreciate very much the authority that was granted to the agency. We have been working at great lengths to identify exactly the right circumstances, and we will be using this tool.

Senator GRASSLEY. Also, Dr. Budetti, on another issue, earlier this month, Senator Kohl and I sent a letter to CMS requesting a status report on the implementation of the Physician Payment Sunshine Act. Most importantly, we asked that the final rule on implementation of the Sunshine Act be released “no later than June of this year so that partial data collection for 2012 can commence.”

I also asked you to work with stakeholders to finalize the rule so that your team can comprise a feasible approach to providing the data to the public. I understand there were a significant number of comments that CMS is sorting through, and the technical and complicated nature of the comments make your task a challenge.

We are here today talking about how to stop fraud and abuse. And so I think the Sunshine Act, getting it up and running, is a concrete way to help achieve that goal.

So my question to you: is CMS on track to promulgate the final rule for the Sunshine Act in June of this year?

Dr. BUDETTI. Senator, again, as you mentioned, we are dealing both with complicated issues and with the substantial number of

comments that we received on this complicated issue, but we have every intention of putting the system into place and promulgating the final rule as soon as we have finished dealing with all of the comments and getting through all of the requirements of a properly promulgated rule.

And we do anticipate getting that rule out—I cannot tell you for sure that it will be done by June, but we do anticipate getting it out during the course of this year and getting the information out that is necessary for the manufacturers and distributors who have to report under that system to have sufficient advanced warning to know what it is that they will have to report and when.

And I appreciate your interest in this, sir.

Senator GRASSLEY. General Levinson, we spent resources figuring out who was committing fraud so we can prevent it. In the case that we are discussing today, you spoke about how important it was that we had boots on the ground where fraud was being committed. As more information was gathered, the number of defendants grew.

So my question: Congress has made investments to increase the number of people trying to stop Medicare fraud. Do you believe having more eyes and ears on the ground will lead to more fraud investigations and convictions?

Mr. LEVINSON. It certainly should, although that is only half of it. I think it is important to have boots on the ground, to have people, and to have people who are trained. But they need to be trained in computer forensics. They need to understand the IT part of that equation.

It really is a combined effort of the right talent—and I am a strong believer in the talent that we have been able to assemble in our office—and we actually could use more of the kind of folks that we already have.

They are being trained in the new Fraud Prevention System as we speak. And what is really important is that we keep current with, if not ahead of, the IT curve—the need to get really modern technology that will master what the experts call big data. Because, when you are dealing with 1.4 million claims a day and more than \$1 billion that the government spends a day, you are dealing with a universe of data that really is on a scale much larger than anything we experienced in the 20th century in this field.

So we really need to keep up with modern IT. That is a very important resource challenge.

Senator GRASSLEY. Mr. Chairman, may I call to the chairman's attention the bill that Senator Wyden and I introduced called the Medicare Data Act that we think would bring more public attention and accountability to the claims submitted? It basically overturns a court decision of a long time ago that I think would be very helpful.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Coburn?

Senator COBURN. Thank you all for your efforts.

Mr. Ferrer, did the doctors who falsely certified home health needs in your case go to jail, and if not, why not?

Mr. FERRER. In the case of ABC, two doctors pled guilty.

Senator COBURN. Did they go to jail?

Mr. FERRER. I believe so. Yes. They were sentenced to jail.

Senator COBURN. That is an important signal for you all to publicize. When we are talking about home health, there are a lot of things—one of the things we have is—this is a gray area because nobody looks at it closely. If the doctors who are signing false certifications for home health are not going to jail, you are not sending the signal for other doctors to change their behavior. That is number one.

Number two is, all that it would require is the simple rule that home health care cannot solicit patients. In other words, they would have to come from a doctor's referral based on need rather than home health care soliciting patients who then go to the doctor to get the certification. And all that it would require is to make it illegal for home health to solicit patients themselves rather than a doc or a caregiver knowing who needs it and who does not, because the pressure on the physicians in this country is to certify it to get it out of the way.

So, if you would just tweak the rule as to where the doctor or the primary caregiver, whether it be a PA or a nurse practitioner, is certifying this, because it should be based on a need rather than being solicited.

Dr. Budetti, you sent me a letter on January 27th of this year outlining a couple million dollars in terms of the new system. Yet, you just quoted \$35 million to the committee. So that is where we are today.

Dr. BUDETTI. The number that I just quoted, Dr. Coburn, is as of the end of January. Those were numbers that we were collecting at the time that we brought back to you, sir.

Senator COBURN. Thank you. Let me talk with General Levinson just for a moment. The Medi-Medi program, where we spent \$60 million, 10 States chose to participate in it and recouped \$57.8 million.

So, are we going to continue that program? Is it going to work? We are spending more than we are recouping. The same thing in terms of Medicaid integrity contractors. We recouped less than \$300,000 on that program. Should we continue that? That is a negative return on investment as well.

The third point I would make is, we collected \$4 billion this year. Half of that was with corporate settlements. But we spent \$1 billion. But the reports—what we are hearing all the time is that there is a 14-to-1 return on investment.

I see a 4-to-1 return on investment. Straighten me out on that, if you would.

Mr. LEVINSON. Well, with respect to return on investment, we use a figure, and I will readily say that sometimes you will get different figures from different parts of the government—

Senator COBURN. But you will not disagree that we spent \$1 billion and got \$4 billion back.

Mr. LEVINSON. Well, our 7-to-1, when the government invests a dollar, when the Congress puts a dollar into OIG, we return \$7, we do have documentary work that we can share with you and your staff.

Senator COBURN. But overall, government total spending was \$1 billion, and we got \$4 billion in savings. So maybe 7-to-1 for you all, but overall, we are getting a 4-to-1 return.

I have a lot of questions, but it seems to me we are working on some of the areas that are very hard to try to defraud when, in fact, the system is designed to be defrauded.

In other words, what can we do structurally in the rules for Medicare to take away the opportunity to defraud, like I just suggested on home health? In other words, if you have a rule where you cannot solicit other than a doctor or a provider—if we change the rules, a lot of the fraud would go away. And if, in fact, we have publicized the fact that if you violate this, not only are you going to lose your ability to be a provider for Medicare, you are actually going to spend time in jail, that has a cold, hard effect on doctors who are certifying services that do not need to be done.

Mr. LEVINSON. And on the Medi-Medi match and on the Medicaid integrity contractors, when you have a negative rate of return, which right now, as you pointed out, we have, we have recommended to CMS that they need to reevaluate and restructure, because it is one thing to be thinking about whether it is a 4-to-1 return or a 7-to-1, but when you have a negative rate, which you have in the ones that you mentioned, that is structurally a problem.

Senator COBURN. I would make one other point to the panel. There is more we need to do. You all recognize that. We applaud your efforts. But what we need to see is, how is it working? And in terms of Dr. Budetti, Senator Grassley and I sent you a letter several weeks ago and asked for a response by April 20th on the fraudsters' use of shell companies and nominees.

GAO work has shown that CMS has still not utilized all its screening tools. You have explained some of that. Can you give us a firm date on when you are going to have the tools that are available to you in place and working?

Dr. BUDETTI. On the specific issue of the nominee owners and shell companies or more broadly?

Senator COBURN. More broadly.

Dr. BUDETTI. Many of our tools, as I have described, are certainly in place right now. The Automated Provider Screening system will allow us to look in much greater depth at who the owners are, and we will also be able to, with the analytics that were developed that we have in place and that we are putting into action, we will be able to look at the—

Senator COBURN. I understand that. I am asking when.

Dr. BUDETTI. Well, many of them are already in place.

Senator COBURN. Well, the ones that are not, when will they be in place?

Dr. BUDETTI. I would have to take it tool-by-tool, Senator. But the Automated Provider Screening system, for example, we already ran all 800,000 physicians who were in our database through it to check for licensure.

We then ran all 1.5 million providers and suppliers through it in order to establish a baseline of all of the information on all of their credentials and other relevant information so that we can detect changes over time.

We are going through the revalidation process, which, as you know, we started with the highest-risk providers and suppliers, and we have done several hundred thousand towards the 1.5 million already, and we will then be implementing later this year the direct connection between the Fraud Prevention System and the claims payment system.

We now have a somewhat more indirect connection that is going into effect later this year. So there are a variety of tools that are in place. There are a number of others that are being phased in.

Our goal is the same as yours, which is to get them in place as quickly as possible and to get them to be as effective as possible.

Senator COBURN. Thank you.

The CHAIRMAN. Senator Carper?

Senator CARPER. Mr. Chairman, thanks very much for holding this hearing. This is important stuff.

And Senator Coburn and I have worked in these venues for a number of years, as Dr. Budetti and others know. And I think we are actually starting to make a little progress, and we do not take time and say that, but I think we are.

My father used to say, if a job is worth doing, it is worth doing well, and from that I have taken away life's lesson. Everything I do, I know I can do better. And when you have fraud that is \$40 billion or \$50 billion a year and you have some improper payments that could be \$115 billion a year, then we can do better here, and we need to.

Senator Coburn and I have introduced legislation—we have 34 cosponsors, plus ourselves—something called the FAST Act, that is designed to go after more really wasteful spending and fraudulent spending, principally within Medicare and Medicaid.

We do it through a number of provisions. They include increasing the antifraud coordination from Federal and State governments, increasing criminal penalties, and making sure we do a better job deploying some of the data analysis technologies that are commonly used, for example, in the credit card business and also, in the private sector, health insurance companies.

Also, we have the Senior Medicare Patrol out there. They need to be energized. Frankly, one of the things that helps to make them more energized and more effective in helping to identify fraud in the first place is that the Department of Health and Human Services said, "You know, we are going to simplify these statements, these monthly statements that come to the senior citizens who are on Medicare so they can actually read the stuff and understand it and say, 'Well, this doesn't look right.'"

So there are a number of things that we want to do with our FAST Act legislation on top of the things we are already doing. And I understand, Dr. Budetti, you have expressed a willingness to spend a little time with Dr. Coburn and myself to talk about how we might want to make some modest changes to that bill to make it even more effective. So we welcome that.

Here is what I want to ask. Ms. King, you have been working this beat for a while. We thank you and your colleagues at GAO for your efforts.

Listening to what has been done down in Florida—good work—listening to some of the efforts that Dr. Budetti and others are

leading in Medicare, what seems to be working? Where do we seem to be doing a good job, and where are we not doing a good job? Where do we need to do more? Where do we, especially us, need to do more in terms of our oversight responsibilities?

Ms. KING. We have several efforts underway to evaluate Medicare safeguards. The enrollment report that we just issued yesterday points out that CMS has taken important steps to get those new screening efforts in place and the new contractors, but it is too soon, I think, for us to evaluate how effective they will be. They are definitely a step in the right direction.

We are also evaluating prepayment edits to see how effective they are, what more could be done there. We are looking at fraud convictions and trying to identify for the first time the types of providers who have been involved in fraud so that that can inform future efforts on the fraud fighting front.

So there are things that are going on that we are evaluating that look to us like steps in the right direction. But, since we are an evidence-based organization, we are going to wait until the evaluations are done and then come back and tell you what we think.

But, certainly, the enrollment and the Fraud Prevention System, the ability to detect claims, not just on a one-by-one basis, but to look at patterns by providers and beneficiary utilization—

Senator CARPER. The kind of patterns that our second witness mentioned, where you had—some of the providers were basically saying there are two things or two kinds of treatments that are being provided. One was physical therapy. And what was the other one?

Mr. FERRER. Daily insulin shots.

Senator CARPER. Daily insulin shots. It seems like we would not need a very complicated detection system to look at that and say, “You know, that just seems strange.”

My wife allowed our oldest son, when he was traveling in India, to use her credit card, and the first time he used it over there, the credit card company called and said, “Mrs. Carper, are you in India? What is going on with your credit card in India?” It turned out it was a legitimate use, but that was just by phone. They picked it up like that and got it right back to her and to us.

We ought to be able to take that kind of technology that is used broadly across the world to help ferret out fraud, and I know we want to. I am not sure we are doing it or realizing the potential there.

Dr. BUDETTI. Senator, just on that particular point, the technology that we are using is very similar to the credit card technology. But I would like to remind everyone that, when the credit card company called you because the card was in India, somebody at some point had to actually associate the use of the credit card out of an area with a fraud problem and tie that in.

That is our predictive modeling technique, to learn from experience what things look like problems and how do you build them into the system so that you not only can spot things, but you know what to spot.

And so that is the—

The CHAIRMAN. I am sorry, if I might interrupt here. But credit card companies look at outliers. It seems to me you could find



outliers. I do not mean to encroach upon the Senator's time here at all.

Senator CARPER. It is all right.

The CHAIRMAN. But it is an outlier. That should not be difficult to find outliers.

Dr. BUDETTI. No. It is not difficult, Senator, at all.

The CHAIRMAN. I am sorry. I do not want to take Senator Carper's time, but I was just—

Senator CARPER. Liars and outliers.

Dr. BUDETTI. Liars and outliers. [Laughter.]

Senator CARPER. All right. Let me close with—go ahead, and then I need to wrap it up.

Ms. KING. Maybe I can be helpful here, because, in the claims payment system, they look at things one by one. They look to see if that provider eligible, does that claim meet the claims payment requirements. If it does, they pay it.

Compare that to the Fraud Prevention System, where you are able to look at patterns across providers, across beneficiaries, across services. So it is a big step up in terms of the ability to look at patterns of billing rather than looking at claims one by one.

Senator CARPER. Mr. Chairman, I know my time has expired. If I can just wrap it up really quickly.

The CHAIRMAN. Go ahead. Take your time.

Senator CARPER. This is really not rocket science, all right? Part of what I think you are trying to do is to make sure that the providers and the suppliers who are getting into the system, that they are legitimate.

Part of what we are trying to do is to make sure that the names of beneficiaries stay out of the hands of the bad guys. Part of what we are trying to do is to make sure that criminal sanctions that we have in place really bite on people who are miscreants.

Part of what we are trying to do is make the Senior Medicare Patrol relevant and to make sure that we seize the full advantage of that. Part of what we are trying to do here is have recovery audit contractors in the field recovering moneys that have been overpaid, improperly paid, recover that money and learn lessons from what they have seen and learned in doing so.

And part of what we are trying to do here is just the data analysis that has shown great promise in other fields. But we need to do it all. We need to do it all. We need to do it well. We know what works. We need to do more of what works.

Thank you very much.

The CHAIRMAN. Thank you, Senator.

Senator Nelson?

Senator NELSON. Thank you, Mr. Chairman.

Mr. Chairman, when we were doing the health care bill, you were very kind to this Senator. And given the fact that so much of this fraud is down in Miami, we went through and reduced outlier payments. We encouraged face-to-face visits with physicians. And very importantly, we increased the provider screenings before they would be allowed to bill Medicare.

Of course, what was happening, especially in Miami, was people would open up a storefront and it never provided any services or equipment, and they would bill Medicare. And how are you going

to know unless you have some kind of check, some kind of screening?

And yet, it has been explained to me that we cannot do this for everybody, that CMS just does not have enough people to do this.

So I want to ask our U.S. Attorney. What do you think about these kind of things that we put in the health care bill? And, when you went after the ABC Florida case, if that had been in place, what do you think would have been the outcome with regard to ABC?

Mr. FERRER. Good morning, Senator Nelson. It is good to see you again.

I think that the tools that we now have will help us in following the patients' billing records and looking at the data in a much more advanced manner to see where the outliers are, to find out which providers are really doing suspicious activity and basically providing services supposedly for things that just do not make sense.

The ABC case, a lot of the cases that we had in the past, we used the data to point us in the right direction, to make sure that we could start looking at a particular company or area. And then we use the old-fashioned police work and follow and do interviews and maybe have consensual recordings of someone who is cooperating with the government.

But I think that what we now have with the data, the more advanced data analysis, what you have all done with the Affordable Care Act and expanding the definition of what health care fraud is, what the offense is like, and allowing us to bring more charges, you have given us more subpoena power, you have increased the sentences, which also serve to be an incredible deterrent in this type of crime.

Senator NELSON. In the case of ABC, for example, in the home health aide who had billed for visits that never occurred, was this a home health aide who was working through a home health agency that was actually a legitimate Medicare provider, that had actually provided legitimate services before?

Mr. FERRER. That is what makes these cases very difficult, because a lot of these providers in the home health field will provide some legitimate services, but they funnel—they create all this wealth by going and recruiting, getting doctors to help them in referring patients who really should not be referred to their agencies.

And what makes it very difficult as well is that we are dealing in an area where everything is doctored—the patient records, all those forms. It is very different from what you described early on, the durable medical equipment companies, which are really shell, they are abandoned storefronts, no one is there, there is no personnel. This is very different.

When you look at it from the outside, it looks legitimate. That is why advanced data analysis can help us pinpoint those home health care agencies that are really an aberration when it comes to the billing. But then we also need the other side, which are the informants, those who really are in the inside who will cooperate with law enforcement.

And that is why I think it is very important that we prosecute up and down the health care fraud chain, because, if we are prosecuting not only the managers, but we are also prosecuting some

lower-level employees, that gives them the incentive to cooperate and come to us and tell us what is going on.

Senator NELSON. To what degree do you think the storefronts that are shells are still a problem?

Mr. FERRER. Well, I will tell you, I am now seeing an evolution of the health care fraud problem in Miami. The durable medical equipment types of cases are declining, because now the fraudsters know that we are looking. They know that that is an area that we have really focused on.

So what have they done? They now have gone to home health care.

And to answer another question that you had, Senator Baucus, in the beginning, what is the new trend in Miami, community mental health is now the new thing after home health. The fraudsters will always look for programs and different services that give them the biggest return and the biggest reimbursement.

It is like that game of whack-a-mole. You hit them in one area, they will find another scheme; you hit them there and another scheme will come up.

So we are now seeing a transition from the DMEs to HIV infusion therapy to home health and now community mental health.

Senator NELSON. Well then, Mr. Chairman, it is certainly a compliment to you and the health care bill that at least those shells, those storefronts, that is moving out of there. But they always find a way to try to stay one step ahead of us.

So I want you to know how much I appreciate you having this hearing.

I want to ask Dr. Budetti one final question. What about the Senior Medicare Patrol? Is this a way of involving senior citizens on Medicare to really be our eyes and ears, like we have tried to do with citizens with regard to the terrorist threat?

Dr. BUDETTI. Senator Nelson, thank you for that question. When I started on the job, one of my first goals was to invent the Senior Medicare Patrol, and then I found out it already existed. That is how much a supporter I am of the idea of using all of our Medicare beneficiaries.

And so we have actually funded grants to Senior Medicare Patrol through our CMS funds. We have actually funded grants to support the Senior Medicare Patrol activities over the last couple of years.

We believe very strongly in them. We are working on a number of other activities that will create even larger incentives for people to participate in the Senior Medicare Patrol. We think that the idea of 45 million, 46 million, 47 million people out there, virtually all of whom are not only honest and legitimate beneficiaries but also are absolutely outraged at the money being stolen from them, from their program, that the more they can help us, the better.

So we are a big supporter of that, sir.

Senator NELSON. Thank you.

The CHAIRMAN. Thank you, Senator. Boy, no one fights harder than the Senator from Florida. I want to thank you very much for what you are doing to help protect seniors. Obviously, Florida is a big State and a big senior interest, but, obviously, you are fighting very, very hard to make sure that seniors are getting their fair

share out of Medicare and not being ripped off. But I really appreciate your efforts very much.

Senator Wyden?

Senator WYDEN: Thank you, Mr. Chairman. I think it has been an excellent hearing. I want to commend you. And I think your point, Mr. Chairman, about Senator Nelson is absolutely right. He has been on the vanguard of senior rights for a lot of years.

And I really want to pick up on Senator Nelson's point and perhaps direct this toward you, Mr. Levinson, and you as well, Mr. Ferrer.

What Senator Nelson is really talking about with respect to seniors on patrol really elaborates on the concept you have been talking about, Mr. Levinson, which is really to have more people looking at the data.

I have listened to you talk about this for a number of years, and you have talked about data analytics and data forensics, and it really is another way of addressing what Senator Nelson was talking about, which is having seniors on patrol and sort of getting more eyes on this whole topic.

Now, Senator Grassley and I have proposed an effort to open up the Medicare database to make it possible for us, in a fashion that allows for more eyes to be on the subject, to stop these sort of abnormal trends, the kind of people who are ripping off the system, acknowledging what Dr. Budetti said, that most people are honest.

Given the fact that I may even be one of the last Senators to ask questions, is this not really what the panel is trying to get us to zero in on, to have more eyes on the data, more people trying to give us an early warning sign of developments?

As you know, we have had some of the most outlandish cases on the west coast, one of them in Portland, but we have tried to follow this. And I would just ask you, Mr. Levinson and Mr. Ferrer, about this question of trying to really put more people looking at the data, whether it is the approach Senator Grassley and I are talking about in terms of opening up the Medicare database or other approaches.

That is really the bottom line here. Is that your view, Mr. Levinson?

Mr. LEVINSON: Thank you, Senator Wyden. Well, I have been on record for a long time as encouraging as much transparency as policymakers and the lawyers will allow us. I think it is very, very healthy for the system.

And the notion of citizen involvement and especially Medicare beneficiary involvement is absolutely crucial in trying to ensure the integrity of the system. And in every summit that HHS has held on the fraud prevention challenge around the country—and there have been half a dozen over the last year—in my remarks, I always underscore the importance of having our beneficiaries as our front-line protectors, if you will.

And, when you look at the record of our OIG cases open for investigation, I have to assume that a considerable number of the hotline complaints that come in and that are then forwarded to CMS, their sources, their origins most likely are from exactly this cohort, the people who are on the front lines.

So, while all parts of our government, enforcement and compliance structure, have very critical roles to play, a crucial partner needs to be the beneficiaries themselves.

Senator WYDEN. Mr. Ferrer, tell me about your thoughts with respect to approaches like the Medicare database, because that is the one place where you can really, on an ongoing basis, spot abnormalities, spot trends.

Do you have any thoughts on that?

Mr. FERRER. Well, I could not agree with you more with respect to the importance of reviewing that data. And let me tell you why we have been so successful in the Strike Forces and in our efforts.

In Miami, we actually have what we call the fusion center for Medicare fraud. It is a stand-alone facility, the only one of its kind in the Nation. Why has that worked? Because we have a CMS contractor working in that facility with agents, with a nurse investigator and agents whose job really is to look at the data.

So we have a national database, and it is called STARS. They review the STARS database to see where there is some aberration, some suspicious billing spikes, and then they then come to us and to the agent and then point us in the right direction so we can know which providers we need to sort of examine and investigate.

The beneficiaries getting involved also in this effort is crucial. We have cases where it is the beneficiary, it is the patient who comes to us after examining their explanation of benefits from Medicare and says, "Hey, listen, I am being—Medicare just got billed for a prosthetic, and, look here, I don't need anything."

One of the beneficiaries, a Federal judge—someone got his information and was billing Medicare for some prosthetics, and he had to go to court and tell the judge, "Here I am, and I've got my limbs."

I mean, we need everybody. We go out there, do a lot of public outreach. The regional summits that Inspector General Levinson is talking about are crucial. We tell everybody that they need to speak up and be aware.

And I have to tell you that—at least I can speak for South Florida—the community there is fed up. That is why we put a lot of research into this. That is why our sentences have increased.

Senator Coburn was asking about doctors being sentenced. We have had doctors sentenced to 19.5 years and 30 years. The judges are trying to send a message in this area.

But reviewing the data and anything we can do to continue to facilitate the sharing of quality data in a timely fashion is crucial in our efforts.

Senator WYDEN. Mr. Chairman, my time is up. I just look forward to working with you. And Senator Grassley and I have put a lot of years into this, and the fact that you are constantly looking for ways to beef up the fight against fraud and these kinds of rip-offs is really appreciated. I look forward to working with you.

The CHAIRMAN. Thank you, Senator, very much.

Are there any areas other than data-sharing that we should explore here? Does anybody have a thought? I am kind of blue-skying here, just curious whether somebody has an idea.

Dr. BUDETTI. Senator, did you particularly want to—did you have anything particular in mind, or are you just brainstorming?

The CHAIRMAN. No, just brainstorming. You are the guys on the ground. I am just curious, from your perspective. It is kind of the point, the more people—if you have more data, you might be able to connect more dots than otherwise would be connected.

Dr. BUDETTI. That is a very intriguing challenge, Senator. In fact, in the two systems that I have been talking about, the goal of each system is to have as much capacity to deal with inputs from various sources.

So the Automated Provider Screening system, that will tap into literally thousands of data sources in order to create the most robust picture possible of just who it is who is trying to get into the program.

In the Fraud Prevention System, we are tying together information not only from claims, but we are also tying information from 1-800-MEDICARE calls. We are tying information from prosecutions and other kinds of investigations, a wide range of kinds of information, as well as data.

So any ideas that you or anybody else might come up with for additional aspects of this would be not only welcome, but our systems are now constructed so that we could actually deal with even a wider range of information.

The CHAIRMAN. Now, with fraud—to what degree are these fraudsters independent operators and to what degree are they organized; that is, either organized as two or three in some location or more or across a city, across the country? Is organized crime involved in this at all? I am just curious to what degree are these individuals small groups, small entrepreneurs, if you will, or to what degree is this some organization.

Mr. FERRER. Senator, we have seen all types of groups involved in this. One interesting sort of tidbit that I would see in the cases in South Florida is, a lot of families would do this together. Sometimes the idea or the venom started with the grandmother, and then it went to the son and then to the grandchildren.

We have also seen organized crime. We have also seen criminals who do organize and commit health care fraud to sort of fund their criminality. We have seen single bystanders. We have seen medical professionals involved in this because of the lucrative nature of this type of crime.

I think that it all depends on where you are. There are different cities or regions around the country where you will see different trends in fraud. Like I said, in South Florida, home health and community mental health seems to be the big one. In other jurisdictions, I have heard of the independent diagnostic testing facilities, of hospices' services being targeted. It depends on where you are, but we have seen all types of groups involved in this fraud, unfortunately.

Mr. LEVINSON. Mr. Chairman, if I can just point to the poster on your right. We had a case out west in which our agents were investigating a clinic that was suspected of health care fraud and money laundering as part of an organized crime enterprise, and agents executing a search warrant found 15 guns, including assault rifles, submachine guns, handguns, and an Uzi, as well as other weapons, including clubs, knives, and brass knuckles.

There are enough instances like this so that our agents, I can honestly tell you, put their lives on the line with respect to some of the investigative work that they do.

So in terms of the health care fraud portfolio, it ranges in a very broad spectrum from corporate front offices down to the kind of very dangerous street crime demonstrated by posters like this.

The CHAIRMAN. I am just curious how well organized all of you are. Clearly, you have put together this strike team, and you described the organizations working together, and that seemed to have worked in the ABC case.

But to what degree do you continually talk and compare notes, share ideas, and so forth? Are you it, or are there other folks who are involved?

Mr. FERRER. We talk all the time. In South Florida, we meet on a monthly basis where we have CMS down there in South Florida with the agents, the prosecutors, investigators, and analysts, and we go through our cases. And something that Dr. Budetti was talking about, when the prosecutors—when we see a particular trend or something in our cases, we share that immediately so that they can then start looking at that in terms of their data to figure out who else is doing the same sort of scheme.

So at least—and I know that we all—we talk on a regular basis. This is a priority.

The CHAIRMAN. In South Florida, you are basically it. We are looking at the team, basically.

Mr. FERRER. Yes. Right. In South Florida, we have the local CMS, we have my office, we have the department's criminal division here in the Department of Justice, and the civil division and civil rights also working in South Florida as part of our team.

So it is not just the South Florida agents, but it is also the lawyers and prosecutors.

The CHAIRMAN. Next to South Florida, what is another rich target to go after in the country? What geographic location?

Mr. LEVINSON. Well, when you look at the Strike Force cities, I think that gives a pretty good indication of where concentrations of fraud schemes exist. It is certainly not an exclusive—it is not a comprehensive list.

But when you are talking about not just Miami, but Houston and Los Angeles, these are cities where there are significant concentrations of scams—

The CHAIRMAN. Right.

Mr. LEVINSON [continuing]. And where the Strike Force model is especially effective. It really brings in the efficiency.

The CHAIRMAN. So the U.S. Attorney in Houston is just as involved as Mr. Ferrer?

Mr. LEVINSON. And we also get great support from—

The CHAIRMAN. Is that right?

Mr. FERRER. There is no question. I mean, we have nine—so far, nine Strike Forces. But it is not just the U.S. Attorneys and the Strike Forces. All 93 U.S. Attorneys work on this, because the Strike Force is just—it is a supplement. It is a very specific sort of model to help us target Medicare fraud in the hotspots, but Medicare fraud, as you know, is nationwide.

All the prosecutors in the U.S. Attorney's offices and in the department nationwide are working on this. That is why last year the 1,430 defendants that we charged, that is nationwide. That is not just the Strike Forces.

So this is all about partnership, Senator. I have to tell you that as a prosecutor, as someone who worked on these cases as a line prosecutor back in 2004 and 2005, the level of collaboration, partnership, sharing of information, is remarkable. We have come a long way since then.

The CHAIRMAN. Well, it is partnership and, clearly, you can tell from the questions asked by members of this committee that we want to be a partner with you, and that means you need to tell us if there are any changes in the law you think would be advisable.

It also means, to me, that it would be helpful if we just delegate to you to get the job done. After all, you are the executive branch of government. And it would help if you were to give some benchmarks to us, like by what date would you like to have recovered Y dollars in terms of fraudulent billing.

Does it make sense that your team, your Strike Force in South Florida, set some benchmarks to say, all right, we have done this well this year, next year we would like to recover, conservatively, Y number of dollars? Does that make sense?

Mr. FERRER. We do that all the time. And, as I was explaining, we have seen an evolution of the types of fraud. The criminals now are getting more sophisticated.

The CHAIRMAN. So are you.

Mr. FERRER. Yes. And that is becoming a real challenge, because they know the techniques that we have used in the past. They are no longer in the business of—or, I should say, they are less in the business of the empty storefronts. Now, everything is masked under the veil of legitimacy.

They are getting more sophisticated in the way that they doctor their files and in making sure they have all their stories straight.

The CHAIRMAN. I am sure they are. I will ask a loaded question. To what degree are the fraudsters winning the war, and to what degree are the Feds winning the war?

Mr. FERRER. Well, I think we have made an incredible amount of progress, but, as we have mentioned here before, prevention—we cannot prosecute our way out of this, at least from my point of view.

We can continue to prosecute this over and over and over again, but—

The CHAIRMAN. I think that is right. It gets more on the prevention side.

Mr. FERRER. On the prevention.

The CHAIRMAN. So what is your benchmark for next year? Do you have a number?

Dr. BUDETTI. I am sorry. Are you asking me, sir?

The CHAIRMAN. Yes. Do you have a number?

Dr. BUDETTI. Well, my number ultimately is zero.

The CHAIRMAN. Of course.

Dr. BUDETTI. No fraud anywhere. But we are right now in the process, for purposes of knowing what the effect is that we are hav-



ing and, also, in order to file our first annual report with you, we are in the process of developing all of those metrics.

But we have every intention of keeping score, of seeing where we are going. One thing that I think is important to note is that one of the things that we have set out to do, and we are in the final stages of getting this underway, is to actually measure fraud.

We have a probable fraud measurement project underway that is going to, for the first time, establish a baseline of fraud. We are starting off in the home health area.

It is a very difficult thing to do. You heard Ms. King refer to this early on. But as far as I am concerned, the best benchmark will be, when we can establish a benchmark, a baseline for how much fraud there is, and then we can see whether we are having an effect or not, because recoveries alone are not going to do it if we are moving into the prevention area.

The CHAIRMAN. That is a good question. Ms. King said it is unknown how much health fraud there is. When will it be known?

Ms. KING. Well, I wish I could answer that. Part of it is that people are lying, cheating, and stealing. So not being detected is a measure of how successful they are at that. And, as a legal matter, fraud is only determined in a court of law.

So it is not fraud until a court determines that. But I think there are other strategies. There are efforts that you can put in place, as Congress has granted CMS authority to do and they have done, to try to keep people out of the programs who are intent on fraud.

The other thing government-wide that is being done is to measure improper payments, some of which includes fraud, but which also includes waste and abuse. And it is a useful thing, I think, for everyone to focus on trying to drive that number down. That number is known, it is measurable, and agencies can push forward on that.

The CHAIRMAN. Right. I do not want to be too difficult here, but is it possible to have a rough guess as to how much fraud, Medicare fraud, is committed? By a certain date, is it possible to have a rough guess?

Ms. KING. Well, GAO is not in the guessing business. [Laughter.]

So I cannot answer that, but perhaps—

Dr. BUDETTI. Everything that Ms. King said is accurate, Senator. That is why the project that we have started is called “probable fraud,” because we are going to use very sophisticated techniques to get to the point where we will then turn it over to people who are expert and experienced in deciding when something looks enough like fraud that they would refer it to law enforcement for investigation. And so that will be the baseline that will be established.

The CHAIRMAN. Is it reasonable to assume that you three will, by a year from now, have reduced fraud, Medicare fraud? Is that a reasonable assumption?

Dr. BUDETTI. I certainly hope it is.

The CHAIRMAN. That is not my question, whether you hope it is. Do you think it is—is it reasonable for the Congress to assume that your Strike Force will reduce fraud even more a year from now, or have more cases prosecuted, or have uncovered more, put more heat on the bad guys in some measurable way?

Mr. FERRER. We will not relent. This is a priority. We put a lot of resources into this. You have heard that the return on the investments, for every \$1 that is allocated to fight fraud, the government gets \$7 back, which is pretty good.

The CHAIRMAN. I hear that. I know you will not relent, but we need to have some way to measure how well we are doing.

Mr. FERRER. I think we are doing well. We keep going up every year. Now, I can only talk about the prosecutions. Every year, nationwide, the number of defendants is going up. I do not know if that means we are decreasing fraud, but we are certainly on it, and we are basically sending a message of deterrence; that if you do cheat the taxpayers and Medicare of their dollars, we will come after you.

The CHAIRMAN. But is the number of dollars uncovered also going up?

Mr. FERRER. Well, yes; we recovered \$4.1 billion last year, and that was more than the previous year. So we are making progress, but, again, that is not—prosecutions is not the answer.

Mr. LEVINSON. And I would just add that, when we established this very effective partnership in the Southern District of Florida back in 2007, the DME billings were at a certain level. And I do not have the figures at my fingertips, but DME billings are significantly down from what they were a few years ago.

And when we talk about recoveries, we really cannot capture—at least I do not know a way to capture the sentinel effect, the idea that government has become more nimble and more effective in shutting down avenues for fraud.

So I am not sure exactly how you account for dollars saved, fraud dollars avoided, but there unquestionably, I think, is an impact that I feel we make not just over the course of the year, but every day our agents walk into the office saying, we are going to reduce fraud today.

The CHAIRMAN. Do you think you are the most effective Strike Force in the country? [Laughter.]

Mr. FERRER. Our Strike Forces are all very effective. [Laughter.]

We have been at it longer, Senator. In South Florida, we started our health care fraud initiative in 2005, and then we created the first Strike Force in 2007. So it has been a growing problem.

The CHAIRMAN. Obviously, I am just trying to find ways to make sure we get to the bottom of all this, because I think most people believe, and I think accurately, that there is just too much Medicare fraud in this country, and we have to stop it the best we can.

And I can tell that you are surely working at it. You have done a pretty good job, but we have just begun to fight. We have further to go, and I am trying to determine the degree to which your intensity and your efficiency can be duplicated in other parts of the country so that we get a handle on this problem.

Do you have any advice on how we—I know you say the right things, the Strike Forces are doing a great job—but any advice for the Strike Forces?

Mr. FERRER. I think that we could always do more with more resources, which is why we support the President's budget plan, which calls for a lot more money for the Strike Forces and for the

general health care fraud initiatives in the Department of Justice—criminal, civil, and civil rights.

I think that what you have done with the Affordable Care Act has given us great tools. You have allowed us to pursue more charges. You have made it easier for us to bring our cases. You have given us more subpoena power. All of those tools will help us. And, again, that was just last year.

So those things—and we have already seen in our cases how that has helped us, where we can bring money laundering charges on kickbacks, which we were not allowed to do before in health care fraud.

So I think the combination of the legislation that you have provided and the tools you provided us, with an increased partnership in reviewing the data—we have a subcommittee in our initiative that constantly reviews ways that we can be better at sharing quality data in a timely fashion. All of those things are helpful.

The CHAIRMAN. Well, I compliment you, all of you, on your efforts here very, very much. I think, though, to keep on the ball here, to keep the pressure up, it would be advisable for us to review this question, say, a year from now. And so we are going to have another hearing on this very subject, hopefully with the same cast of characters, a year from now. So be ready. We are going to take stock.

Thank you very much for all that you are doing. The hearing is adjourned.

[Whereupon, at 11:50 a.m., the hearing was concluded.]



# APPENDIX

## ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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**Hearing Statement of Senator Max Baucus (D-Mont.)  
On the Anatomy of a Fraud Bust: From Investigation to Conviction**  
*As prepared for delivery*

Julius Caesar once said, "Experience is the teacher of all things."

This morning we are here to learn from the experience of federal officials who fight health care fraud.

Each year, the federal government loses \$60 billion to health care fraud. This crime adds to the deficit, it wastes taxpayer dollars and it forces seniors to spend more out of their tight budgets on Medicare premiums.

Fighting health care fraud involves agencies across the federal government. The Centers for Medicare and Medicaid Services, or CMS, puts tools into place to investigate and prevent fraud. The Department of Health and Human Services Inspector General conducts criminal and civil investigations, and the Department of Justice prosecutes the criminals who steal taxpayer dollars.

A problem this big requires teamwork. The agencies involved need to work together seamlessly. They must have the right tools for the job and the resources available to deploy those tools.

Today, we're here to learn from a success story where CMS, the HHS Inspector General, and the Justice Department were able to work as a team. We will hear how the investigators rooted out the criminals, how the agents led the investigation and whether the government recouped its losses.

This case was made public last September, and at the time, it was the largest Medicare fraud bust in history. This Miami news clip from last fall shows one of the schemes involved.

These schemes were spread across eight cities, involved 91 defendants and almost \$300 million in fraudulent billing.

From this case, we hope to learn valuable lessons to further protect Medicare from criminals. I want to know what challenges you faced during the investigation.

What lessons were learned? What barriers, if any, exist between the agencies? How can we help you work together better? I also want to hear how the Affordable Care Act is helping to prevent and fight fraud.

We gave law enforcement an unparalleled set of new tools in health reform to prevent fraud. Before the health care law, even suspicious claims were paid and then investigated later.

Health reform changed that. It gives law enforcement the authority to stop payment and investigate suspicious claims before taxpayer money goes out the door.

Health reform also improved screening to ensure criminals can't get in to Medicare or Medicaid. Prior to health reform, most information was entered by hand into an inadequate and out-of-date database. As a result, Medicare paid providers who should have been prevented from joining the program in the first place.

Yesterday, GAO released a report at my request detailing the implementation of the new provider screening tools that health reform created.

The report says that a new automated system should ensure the provider enrollment system is up-to-date and accurate. As a result, criminals attempting to enter Medicare won't slip through the cracks and be able to defraud the government.

As we build upon our achievements fighting fraud, we must remain vigilant. Medicare has been growing at a fast rate for a long time. We all have concerns over the program's effect on the budget deficit and the health of the Medicare Trust Fund.

However, we have made real progress. Our non-partisan scorekeeper, the Congressional Budget Office, says that per-beneficiary Medicare spending will grow one percent above inflation in the next ten years. This is a major reduction compared to the past two decades, when Medicare grew five percent above inflation.

Our fight against health care fraud is one key piece to this progress. Last year, the federal government recovered a record \$4.1 billion as a result of health care fraud prevention and enforcement efforts. This is a worthy accomplishment, but we must do more.

So let us heed Julius Caesar's advice and learn from this success story. Let us take the experience we gained achieving this success and use it as a valuable teacher.

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STATEMENT OF

**PETER BUDETTI, M.D., J.D.**

Deputy Administrator and  
Director, Center for Program Integrity  
Centers for Medicare & Medicaid Services

ON

“Anatomy of a Fraud Bust: From Investigation to Conviction”

BEFORE THE

UNITED STATES SENATE COMMITTEE ON FINANCE

April 24, 2012

U.S. Senate Committee on Finance  
Hearing on “Anatomy of a Fraud Bust: From Investigation to Conviction”  
April 24, 2012

Chairman Baucus, Ranking Member Hatch, and Members of the Committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services’ (CMS) role in the prevention, detection and prosecution of fraud, waste, and abuse in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).

Over the last two years, CMS has designed and implemented large-scale, innovative improvements to our program integrity strategy that include a new focus on preventing fraud. In conjunction with these historic antifraud actions at CMS, our law enforcement partners have recovered \$4.1 billion in fiscal year 2011, including \$2.5 billion to the Medicare Trust Funds. The Department of Health and Human Services (HHS) and the Department of Justice (DOJ) have made a cabinet-level commitment to prevent and prosecute health care fraud with the Health Care Fraud Prevention & Enforcement Action Team (HEAT). HEAT includes the efforts of the Medicare Fraud Strike Force teams that are currently operating in nine cities that have been identified as fraud “hot spots.”<sup>1</sup> The Strike Force teams use data analysis and administrative action capabilities of CMS, the investigative resources of State and Federal law enforcement, including the Federal Bureau of Investigation (FBI), the HHS Office of the Inspector General (OIG), and Medicaid Fraud Control Units (MFCUs), and the prosecutorial resources of DOJ’s Criminal Division’s Fraud Section and the United States Attorneys’ Offices. In fiscal year 2011, these efforts led to 132 indictments against defendants who collectively billed the Medicare program more than \$1 billion, 172 guilty pleas negotiated and 17 jury trials litigated and imprisonment of 175 defendants.<sup>2</sup> One of these coordinated takedowns in September 2011 resulted in charges against 91 defendants in eight cities involving more than \$290 million on false billing. As part of the coordinated actions involved in this takedown, prosecutions relating to a fraud scheme involving two home health providers in Florida were

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<sup>1</sup> The Strike Force cities are Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; Baton Rouge, LA; Tampa, FL; Chicago, IL; and Dallas, TX.

<sup>2</sup> The Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011, accessed at: <http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2011.pdf>.



announced: ABC Home Health Care and Florida Home Health Care Providers. The efforts to uncover this scheme help illustrate how the Strike Force and contributing government agencies work together to identify, investigate and prosecute health care fraud. In this process, CMS and its antifraud investigators play an important role in building the investigations that led to many of these takedowns and settlements, and CMS has taken numerous actions that demonstrate its commitment to continuing to expand and enhance its partnership with law enforcement to detect and pursue fraud

To support the momentum gained by recent successful cases, CMS continues to identify and implement improvements to program integrity controls. CMS recognizes fraud cannot be eliminated through prosecutions alone, and we are working to move beyond “pay and chase” by developing new methods and technologies to stay ahead of criminals and identify their patterns of behavior early on. Building upon our traditional program integrity efforts focused on detecting and prosecuting fraud, CMS recently implemented a twin pillar approach to fraud prevention in Medicare. The first is the new Fraud Prevention System (FPS) that enables CMS to use predictive analytic technology to identify aberrant and suspicious billing patterns in claims before payment is made; the second is the Automated Provider Screening (APS) system that is identifying ineligible providers or suppliers prior to enrollment or revalidation. Together these innovative new systems, the FPS and APS, are growing in their capacity to protect patients and taxpayers from potentially bad actors seeking to defraud our programs, as discussed in more detail below.

#### *CMS Role in Detecting and Investigating Fraud Cases*

CMS plays a fundamental role in detecting potential fraud and bringing fraudsters to justice by working closely with key law enforcement partners, including the OIG, DOJ, and State Medicaid agencies through HEAT and the Medicare Fraud Strike Forces. For example, a large number of health care fraud schemes that ultimately resulted in successful federal criminal convictions were originally uncovered by CMS and its antifraud contractors, then referred to law enforcement for further investigation and prosecution.

Taking down a fraud scheme can often start with a tip from any number of sources such as a call from a Medicare beneficiary or caregiver, an employee or a concerned citizen to 1-800-MEDICARE. CMS screens every complaint to the hotline for potential fraud and has implemented a geospatial toolset to create a national “heat map” of tips that raise a question about possible fraud. The technology has the ability to track such calls to identify changing trends and new hot spots just as they are emerging. Recognizing that beneficiaries are vital partners in our fight against fraud, CMS has also enhanced its role in supporting the Senior Medicare Patrol (SMP) over the past two years. Led by the HHS Administration on Aging, the SMP program empowers seniors to prevent, identify and fight fraud through increased awareness and understanding of Federal health care programs. To support this work, CMS provided grant funding to SMP projects in recent years. As a result of these and other outreach and engagement efforts, 1-800 MEDICARE sent almost 50,000 inquiries for fraud investigation in 2011.

CMS also compiles provider-specific complaints to identify providers that are the subject of multiple fraud or abuse. Using existing data in this innovative way enables CMS to target providers and suppliers with multiple beneficiary complaints for further investigation. The information from these reports is integrated with the FPS.

Once suspect behavior or billing activity is reported or identified by our systems, CMS relies on its antifraud investigators, called Zone Program Integrity Contractors (ZPICs), to perform specific program integrity functions for the Medicare Fee-For-Service program. Under the direction of CMS’ Center for Program Integrity, ZPICs develop investigative leads generated by the FPS and perform data analysis to identify cases of suspected fraud, waste and abuse; make referrals to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars; make referrals to law enforcement for potential prosecution and provide support for ongoing investigations; and identify improper payments to be recovered. Several ZPICs also match Medicare-Medicaid data to detect potential fraud across both programs.

In the scheme involving ABC Home Health Care and Florida Home Health Care Providers, CMS’ data analysis and ZPIC investigative work played an important part of the investigation and prosecution. In this instance, a Strike Force team identified potential fraud. According to

court documents, ABC Home Health Care and Florida Home Health Care Providers were billing the Medicare program for expensive physical therapy and home health services that were not medically necessary or never provided. Prescriptions, plans of care (POCs), and home health certifications for medically unnecessary therapy and services were issued through doctors' offices in return for kickbacks and bribes.

During the course of the Strike Force's investigation into these entities, CMS' anti-fraud investigators performed data analysis and provided the data and summary reports to the Strike Force team. Initial data showed suspicious billing patterns for ABC Home Health Care and Florida Home Health Care Providers including billing for home health services for the same beneficiaries but different dates of service. One entity would admit the patient, bill for services, and discharge the patient, and then the other entity would admit the patient and bill for services. CMS data analysis supported the Strike Force investigation and contributed to Federal Grand Jury indictments against 2 owners of ABC Home Health Care and Florida Home Health Care Providers as well as 6 other individuals on June 24, 2009.

In addition to ZPICs, CMS contracts with Medicare Drug Integrity Contractors (MEDIC) to perform program integrity functions for Part C (Medicare Advantage) and Part D Drug Plan contracts, such as complaint intake and response; data analysis and investigation; outreach and education; and technical assistance for law enforcement. Similar to the work of the ZPICs in Medicare Fee-For-Service, MEDIC analyzes complaints from Medicare Advantage and Part D plan sponsors, beneficiaries, and other individuals for fraud and abuse trends. The MEDIC is also responsible for coordinating all Part C and Part D program integrity outreach activities for all stakeholders, including plan sponsors and law enforcement. The MEDIC assists OIG and DOJ in criminal prosecutions with data analysis and corresponding investigative case development.

CMS dedicates significant human and financial resources to our partnership with law enforcement. Successful health care prosecutions often involve CMS collaboration on undercover operations, trial support including providing expert witnesses for the prosecution, and requests for information during all stages of an investigation, trial, and sentencing. CMS has

developed considerable in-house expertise in Medicare and Medicaid fraud both at central office headquarters and in the regional offices. For the more sophisticated fraud schemes CMS policy and data analysts oftentimes provide technical assistance on Medicare payment and billing policies. Our regional office fraud experts who have boots-on-the-ground experience in fraud hot spots work closely with law enforcement. For example, throughout the trials of several individuals associated with ABC Home Health Care and Florida Home Health Care Providers, CMS continued to provide data support to the prosecution efforts. The ZPIC investigator also provided trial support and testified as a Medicare fact witness at the trials of several individuals connected with these entities. CMS has made significant improvements to its databases and analytical systems in recent years, and has made these tools increasingly available to law enforcement and provided extensive training in their use to identify and investigate fraud. These enhancements allow our law enforcement colleagues to have improved access to more timely and useful CMS data and analytic tools, which has assisted greatly in the prosecution of criminals.

Beyond our collaboration with law enforcement, CMS is now better poised to take a wide range of administrative actions such as revocation of Medicare billing privileges and payment suspensions when facts and circumstances warrant such action. In 2011, CMS revoked the Medicare billing privileges of 4,850 providers and suppliers and deactivated an additional 56,733 billing numbers as we took steps to eliminate vulnerabilities in the Medicare program. CMS also employs a variety of measures to stop payment to suspect providers and suppliers. In 2011, CMS saved \$208 million through pre-payment edits that automatically stop implausible claims before they are paid.

CMS took administrative action against ABC Home Health Care and Florida Home Health Care Providers and took appropriate action against additional individuals who participated in this scheme. On June 30, 2009, CMS imposed an immediate Medicare payment suspension on both ABC Home Health Care and Florida Home Health Care Providers, which stopped payment of any claims pending in the system. In addition, the Medicare provider numbers for both ABC Home HealthCare and Florida Home Health Care Providers were revoked by CMS. In December 2009, a default final judgment was entered against the owners of ABC Home Care

and Florida Home Health Care Providers for over \$12 million that resulted from the health care fraud scheme. CMS consequently liquidated the payment suspension, permanently terminated the provider's enrollment in Medicare, and returned the accompanying funds to the Medicare Trust Funds. These entities were removed from Medicare less than a year following the first data request from the Strike Force, demonstrating that through collaboration, CMS and our partners can move quickly and efficiently to protect the integrity of our programs. To date, prosecutors have obtained more than 50 convictions of health care operators, providers and recruiters associated with the ABC Home Health Care and Florida Home Health Care Providers.

The Affordable Care Act enhances CMS' authority to suspend Medicare payments to providers or suppliers during the investigation of a credible allegation of fraud. This strengthens CMS' ability to halt claims payment before funds go out the door, and helps move us toward a more prevention-focused approach to fighting fraud. CMS payment suspensions led to over \$27 million in recoveries against suspect providers in calendar year (CY) 2011. In addition, States are now similarly required in most situations to suspend payments to Medicaid providers against whom there is a credible allegation of fraud.

*The New "Twin Pillars" Strategy - Medicare*

In the past, the government was often two or three steps behind perpetrators, quickly paying out nearly every apparently proper claim -- then later trying to track down the fraudsters after we got a tip or identified a problem. That meant we were often showing up after criminals had already skipped town, taking all of their fraudulent billings with them. Under this model, CMS was unable to keep up with the fraudsters and was forced to chase fraud instead of preventing it. CMS has learned valuable lessons from our successes and challenges in recent fraud investigations, which have greatly informed the development of new approaches and tools to fighting fraud. Thanks to the Affordable Care Act and the Small Business Jobs Act and the efforts of this Committee, CMS is now using additional innovative tools to further enhance our collaboration with law enforcement in preventing, as well as detecting, fraud.

Our recent innovations are built around a new twin pillar strategy. The first pillar is our Fraud Prevention System (FPS), the predictive analytic technology we were pursuing that was greatly

aided under the Small Business Jobs Act of 2010. The FPS uses predictive analytics and other sophisticated analytics to detect aberrant billing patterns and other vulnerabilities by running predictive algorithms against all Medicare Part A, Part B, and Durable Medical Equipment (DME) claims before payment is made.

The second pillar is the new enhanced provider enrollment and screening initiatives we have undertaken. At the heart of this work is the Automated Provider Screening (APS) system. The APS will ultimately perform rapid and automated screening of all providers and suppliers seeking to enroll or revalidate their enrollment in Medicare, and already conducts ongoing monitoring of the eligibility status of currently enrolled providers and suppliers.

These two systems, —FPS and APS— are designed to interact and feed information into one another regarding suspect providers or claims, creating a truly integrated data management and analysis capability. For example, we can analyze characteristics of fraud identified by the predictive algorithms in the FPS and use that information as we screen the providers in APS. Similarly, the APS can flag providers for closer review in FPS. We are also making it easier for law enforcement officials and local jurisdictions to share data and access claims information shortly after they are submitted to Medicare. Together, these pillars represent an integrated approach to program integrity – preventing fraud before payments are made, while at the same time keeping out bad providers and suppliers in the first place, and knocking wrongdoers out of the program quickly once they are detected.

*The First Pillar: The Fraud Prevention System*

CMS had already begun exploring the application of advanced predictive modeling technology to fighting fraud at the time Congress enacted the Small Business Jobs Act of 2010 that provided resources and required CMS to adopt such technology to identify and prevent fraud, waste, and abuse. CMS implemented this provision aggressively and efficiently only nine months after the President signed the bill into law. The FPS has been using predictive analytic technology to detect aberrant billing patterns and other vulnerabilities by running predictive algorithms and other sophisticated analytics against all Medicare Part A, Part B, and Durable Medical Equipment (DME) claims nationwide since June 30, 2011. This put CMS well ahead of the

statutory schedule, which called for phasing in the technology in an initial ten States in the Medicare fee-for-service program by July 1, 2011. Nationwide implementation of the technology maximizes the benefits of the predictive models and also helps CMS efficiently integrate the technology into the Medicare fee-for-service program as well as train our anti-fraud contractors.

With the FPS, CMS is using our investigative resources to target suspect claims and providers and to take administrative action when warranted. The technology does this by identifying providers who exhibit the most egregious, suspect, or aberrant activity. Program integrity analysts begin investigations of such individuals when the system generates the top-priority alerts. The FPS has enabled CMS and its program integrity contractors to stop, prevent, and identify improper payments using a variety of administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement. In the first seven months of implementation, 846 active Zone Program Integrity Contractor (ZPIC) investigations have been supported by data provided using these new technological tools. Specifically, the FPS has directly resulted in 510 new investigations, while 336 pre-existing investigations are being supported by the real-time FPS data.

The FPS has also led to 417 direct interviews with providers suspected of participating in potentially fraudulent activity, and over 1,262 interviews with beneficiaries to confirm whether they received the services for which the Medicare program had been billed, numbers that are increasing every day. Information CMS learns from these beneficiary interviews is used along with historical claims data to help identify the characteristics of potentially bad actors, which are used to inform the predictive algorithms and other sophisticated analytics that run in FPS. Additionally, if a beneficiary has submitted a complaint or suspicion of fraudulent activity to 1-800-MEDICARE about a specific provider, that information is also incorporated into the FPS and becomes an important data point that feeds into our analytics.

The FPS provides a national view in near “real-time” of Medicare fee-for-service claims across lines of business for the first time, and has enabled our program integrity contractors to expand their analysis beyond designated regions to reveal schemes that may be operating with similar

patterns across the country. For example, in the past it was burdensome for ZPIC investigators to determine whether a beneficiary had ever seen a doctor ordering services and supplies. This is because such claims data was dispersed among different systems-- visits with a doctor or orders for DME are billed under Part B while hospital and other provider services are billed through Part A. FPS presents this information across Part A, Part B and DME in near-real time. This comprehensive view allows our investigators to see and analyze billing patterns as claims are submitted, instead of relying primarily on review of post-payment data. CMS is evaluating strategies for expanding predictive modeling to Medicaid and CHIP. CMS is currently identifying the range of performance metrics that will fully capture the success of the FPS, and these will be reported in the first implementation year report due to Congress this fall.

*The Second Pillar: Enhanced Provider Enrollment and Automated Provider Screening*

The second pillar of our strategy is enhanced provider enrollment and screening improvements for providers and suppliers seeking to enroll or revalidate their enrollment in Medicare. This innovative approach is designed to do two things simultaneously: make it easier and more efficient for legitimate providers and suppliers to enroll and more effectively screen out the ones who do not belong in the Medicare program. The new APS technology was launched on December 31, 2011. Medicare Administrative Contractors (MACs) are responsible for provider and supplier enrollment and have historically relied on paper applications and crosschecking information manually against various databases to verify enrollment requirements such as licensure status. Today, CMS is using the new APS technology to conduct routine and automated screening checks of providers and suppliers against thousands of private and public databases to more efficiently identify and remove ineligible providers and suppliers from Medicare. CMS anticipates that the new process will decrease the application processing time for providers and suppliers, while enabling CMS to continuously monitor the accuracy of its enrollment data, and to assess applicants' risk to the program using standard analyses of provider and supplier data.

Provider enrollment is the registration and verification gateway to the Medicare Program, and CMS has made additional improvements that have begun to change the way providers and suppliers interact with CMS. The Provider Enrollment, Chain, and Ownership System (PECOS)



maintains the official record of information for all providers and suppliers and any associated group. Provider enrollment data supports claims payment, fraud prevention initiatives, and law enforcement activities. A key strategy for improving the process for honest providers while making it easier to find bad actors is to create an all-digital process for web-based PECOS. Key improvements include the ability to pay the application fee directly through the website and the implementation of electronic signatures on applications that eliminates the requirement that providers and suppliers mail a paper signature at the end of the application process. As a result, CMS has seen a significant increase in the submission of web applications – especially for institutional providers, group practices and DME suppliers.

The APS technology is a major component of our approach to implementing the enhanced screening requirements enacted in the Affordable Care Act, and has strengthened the enrollment process and improved the controls that assist in the identification of providers and suppliers that do not meet enrollment requirements. When CMS identifies ineligible providers and suppliers, it results in the denial of an enrollment application or revocation of billing privileges for those already enrolled. This new screening strategy is tailored to both categorical and individual provider risk, rather than a one-size-fits-all approach.

Under a CMS final rule implementing the Affordable Care Act's enhanced screening requirements that became effective March 25, 2011, providers and suppliers designated as limited risk undergo verification of licensure, and a wide range of database checks to ensure compliance with any provider or supplier-specific requirements; these database checks will now be conducted through the APS.

Categories of providers and suppliers in the moderate level of risk are now required to undergo an on-site visit prior to enrolling or upon revalidation of their Medicare billing privileges. This new requirement expanded on-site visits to many providers and suppliers that were previously not subject to such site visits as a requirement for enrolling in the Medicare program. In addition to announced and unannounced site visits, providers and suppliers who are designated in the high-risk level will be subject to fingerprint-based criminal background checks. CMS has estimated that approximately 50,000 additional site visits will be conducted between March 2011

and March 2015 to ensure providers and suppliers are operational and meet certain enrollment requirements. CMS has completed the procurement of a national site visit contractor to increase efficiency and standardization of the site visits and the contractor has recently started performing these site visits.

CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. Since March 25, 2011, CMS has enrolled or revalidated enrollment information for approximately 217,340 providers and suppliers under the enhanced screening requirements of the Affordable Care Act. These efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries.

The FPS, APS and our other enrollment enhancements promote synergy in CMS program integrity activities. For example, based on FPS leads, we have identified specific providers and suppliers as top priorities for the revalidation effort. As a result of screening providers and suppliers that pose an elevated risk as identified by the FPS, CMS has begun to revoke or deactivate providers and suppliers that do not meet Medicare enrollment requirements. These initiatives complement the traditional program integrity work and additional provider enrollment enhancements that CMS continues to implement.

*Supporting State Efforts to Combat Fraud, Waste, and Abuse*

Many of these tools are also useful in ongoing efforts to promote integrity in the Medicaid program. We are working in collaboration with our State partners to ensure that those who are caught defrauding Medicare will not be able to defraud Medicaid, and those who are identified as fraudsters in one State will not be able to move easily to another state's Medicaid program. The Affordable Care Act and our implementing regulations require States to terminate from Medicaid providers or suppliers who have been revoked by Medicare, or terminated for cause by another State's Medicaid program or CHIP. Similarly, under current authority Medicare may also revoke providers or suppliers that have been terminated by State Medicaid agencies or CHIP.

Because of Medicaid's unique Federal-State partnership, we have developed initiatives that specifically work to assist States in strengthening their own efforts to combat fraud, waste, and abuse. For the continuing education of State program integrity employees, the Medicaid Integrity Institute (MII) stands out as one of CMS's most significant achievements. The MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to States in a structured learning environment. In its four years of existence, the MII has offered numerous courses and trained over 2,464 State employees at no cost to the States. To provide and gauge effective support and assistance to States to combat Medicaid fraud, waste, and abuse, CMS conducts triennial State Program Integrity Reviews and follow-ups to review each State's program integrity activities and identify and disseminate best practices. CMS also developed the State Program Integrity Assessment (SPIA), which annually collects standardized, national data on each State's Medicaid program integrity activities. CMS uses this data to effectively support and assist the States in their program integrity efforts. States and CMS use SPIA to gauge their collective progress in improving the overall integrity of the Medicaid program.

CMS also provides States assistance with "boots on the ground" for special investigative activities. Since October 2007, CMS has participated in 12 projects in three States, with the majority occurring in Florida. CMS helped States review 654 providers, 43 home health agencies and DME suppliers, 52 group homes and 192 assisted living facilities. During those reviews, CMS and States interviewed 1,150 beneficiaries and took more than 540 actions against non-compliant providers (including, but not limited to fines, suspensions, licensing referrals, and State Medicaid Fraud Control Unit (MFCU) referrals). States reported these reviews have resulted in \$40 million in savings through cost avoidance.

Additionally, CMS implemented a web-based application that allows states to share information regarding terminated providers and to view information on Medicare providers and suppliers that have had their billing privileges revoked for cause. If one program knows a provider has been terminated, then each program – Medicare, Medicaid, and CHIP – should know. This tool is the beginning of a smarter, more efficient Federal-State partnership, integrating technology solutions to routinely share relevant program information in a collaborative effort.

*Looking Forward*

Medicare, Medicaid, and CHIP fraud affect every American by draining critical resources from our health care system, and contributing to the rising cost of health care for all. Fraud, waste, and abuse harm multiple parties, including some of our most vulnerable citizens, not just the Federal government.

The Administration has made a firm commitment to rein in fraud and waste. With the new “twin pillars” of program integrity, bolstered by the Small Business Jobs Act and the Affordable Care Act provisions discussed today, we have more tools than ever before to move beyond “pay and chase” and implement important strategic changes in pursuing and detecting fraud, waste, and abuse.

No one group, agency, or business owns all of the resources or expertise we need to keep criminals out of our health care system. Through partnerships between public and private stakeholders, we are learning how to better protect our health care system. I am confident that the harder we work today, the stronger our system will be for years to come.

I look forward to working with you in the future as we continue to make improvements in protecting the integrity of Federal health care programs and safeguarding taxpayer resources.

SUBMITTED BY SENATOR COBURN

**Who's Winning: Fraudsters or Taxpayers?**

**Up to \$100 B Medicare/Medicaid  
waste, fraud, abuse annually**

**What is detected?**

**What is prevented?**

**Who is prosecuted?**

**Who is convicted?**

**Recovered? \$4.1 Billion**  
**(Federal Anti-Fraud Spending: \$1 Billion)**



**Department of Justice**

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STATEMENT

OF

WIFREDO A. FERRER  
UNITED STATES ATTORNEY  
SOUTHERN DISTRICT OF FLORIDA

BEFORE THE

SENATE FINANCE COMMITTEE

ENTITLED

"ANATOMY OF A FRAUD BUST:  
FROM INVESTIGATION TO CONVICTION"

PRESENTED ON

APRIL 24, 2012

**Statement of  
Wifredo A. Ferrer  
United States Attorney  
Southern District of Florida**

**Before the  
Senate Finance Committee  
Entitled  
“Anatomy of a Fraud Bust: From Investigation to Conviction”**

**Presented on  
April 24, 2012**

#### **INTRODUCTION**

Chairman Baucus, Ranking Member Hatch, and distinguished Members of the Committee. Thank you for inviting me to speak with you today about the Department of Justice’s efforts to combat health care fraud. I am honored to appear before you on behalf of the Department of Justice (the Department), along with my colleagues, Peter Budetti from the Centers for Medicare and Medicaid Services (CMS), and Daniel Levinson from the Office of Inspector General, Department of Health and Human Services (HHS-OIG). The Department is grateful to the Committee for its leadership in this area, and we appreciate the opportunity to appear before you here today.

Health care fraud is a serious and costly law enforcement problem facing our country. It threatens the integrity of Medicare, as well as all Federal, State, and private health care programs. Every year the Federal Government spends hundreds of billions of dollars to provide health care to the most vulnerable of our society - our seniors, children, disabled, and needy. We have a duty to ensure that these funds are spent on providing proper medical treatment to our citizens, and while most medical providers and health care companies are doing the right thing, there are some health care providers, as well as criminals, that target Medicare and other

government and private health care programs for their own financial benefit. Every dollar stolen from our health care programs is one dollar too many. Medicare and Medicaid fraud can also corrupt the medical decisions health care providers make with respect to their patients, placing patients at risk of harm from unnecessary or unapproved treatments. For these reasons, fighting health care fraud is a priority of the Department of Justice. As you know, the 93 United States Attorneys and their assistants, or AUSAs, are the principal prosecutors of Federal crimes, including health care fraud, representing the Department of Justice and the interests of the American taxpayer. Together with attorneys from the Civil, Criminal and Civil Rights Divisions (the Civil Rights Division enforces the Civil Rights of Institutionalized Persons Act) we appear in both criminal and civil cases in the Federal courts in the 94 judicial districts across the country. And with agents from the FBI, our colleagues at HHS-OIG and CMS, and other affected Federal agencies, we are fighting back. We investigate, prosecute, and secure prison sentences for hundreds of defendants every year, and we are recovering billions of dollars in stolen funds. With the additional resources provided to us by Congress over the past 3 years, we are making significant strides in this battle.

**FIGHTING MEDICARE AND MEDICAID FRAUD IS A PRIORITY  
OF THE DEPARTMENT OF JUSTICE**

Because coordination across Departments is an integral part of preventing and prosecuting health care fraud, Attorney General Holder and Secretary Sebelius together have pledged to strengthen our fight against waste, fraud and abuse in Medicare and Medicaid. As you know, to improve that coordination, in May 2009, they announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a senior level, joint task force, designed to marshal the combined resources of both agencies in new ways to combat all facets of the health care fraud problem. With the creation of HEAT, we are committed to making fighting



health care fraud a Cabinet-level priority for both DOJ and HHS. By joining forces to coordinate Federal, State, and local law enforcement activities to fight health care fraud, our efforts have seen unprecedented success. In FY 2011 alone, the government's health care fraud and prevention efforts recovered nearly \$4.1 billion related to health care fraud and false claims and returned these funds to CMS, the U.S. Treasury, other Federal agencies, and individuals. This is the highest annual amount ever recovered from doctors and companies who attempted to defraud seniors and taxpayers or who sought payments to which they were not entitled.

#### **THE DEPARTMENT'S CIVIL HEALTH CARE FRAUD WORK**

The Department's civil attorneys – both in the United States Attorneys' Offices and the Department's Civil Division – aggressively pursue civil enforcement actions to root out fraud and recover funds stolen in health care fraud schemes, often through the use of the False Claims Act (FCA), 31 U.S.C. §§ 3729-3733, one of the Department's most powerful civil enforcement tools. This success under the FCA is perhaps best illustrated by the results: Nearly every year since 2000, our attorneys, working with the Federal Bureau of Investigation (FBI), HHS-OIG, and other Federal, State, and local law enforcement agencies, have obtained total settlements and judgments under the FCA that exceeded \$1 billion. In FY 2011, the Department secured approximately \$2.4 billion in civil health care fraud settlements and judgments—amounts that contributed to \$4.1 billion recovered that year. This marked the second year in a row that more than \$2 billion has been recovered in FCA health care matters. Since the HEAT initiative began, the USAOs and the Department's Civil Division have obtained more than \$8.8 billion in settlements, judgments, fines, restitution and forfeiture in health care matters pursued under the FCA and the Food Drug and Cosmetic Act.

In one such matter in which my office played a key role, Abbott Laboratories Inc., and three other pharmaceutical manufacturers paid more than \$700 million to settle False Claims Act allegations that they engaged in a scheme to report false and inflated prices for numerous pharmaceutical products knowing that Federal healthcare programs relied on those reported prices to set payment rates. The actual sales prices for the products were far less than what defendants reported. The difference between the resulting inflated government payments and the actual price paid by healthcare providers for a drug is referred to as the “spread.” The larger the spread on a drug, the larger the profit for the health care provider or pharmacist who gets reimbursed by the government. The government alleged that these manufacturers created artificially inflated spreads to market, promote and sell the drugs to existing and potential customers. Because payment from the Medicare and Medicaid programs was based on the false inflated prices, we alleged that the defendants caused false claims to be submitted to Federal healthcare programs, and as a result, the government paid millions of claims for far greater amounts than it would have if the manufacturers had reported truthful prices.

#### **THE DEPARTMENT’S CRIMINAL HEALTH CARE FRAUD WORK**

The Department’s criminal health care fraud efforts have also been a tremendous success. Since 2009, the Department and HHS have enhanced their coordination through HEAT, steadily increasing the number of Medicare Fraud Strike Force (MFSF) teams, a supplement to the Department’s criminal health care fraud enforcement efforts. Strike Force teams are collaborative efforts that combine prosecutors from the USAOs, prosecutors from the Criminal Division’s Fraud Section, who are devoted exclusively to the prosecution of health care fraud cases, and Federal agents from the FBI, and HHS-OIG. In some cases, local law enforcement agents also participate. In FY 2011, the total number of cities with strike force prosecution

teams was increased to nine. The Criminal Division and each USAO in the strike force cities together allocate several prosecutors and support personnel to this important initiative. The MFSFs use advanced data analysis techniques to identify high, or unusual billing patterns in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. This model is working. The strike forces have been an unqualified success.

Today, our criminal enforcement efforts are at an all-time high. In FY 2011, strike force operations charged a record number of 327 defendants, who allegedly collectively billed the Medicare program more than \$1 billion. Strike force teams secured 201 criminal convictions, and sentenced 175 defendants to prison. The average prison sentence in strike force cases in FY 2011 was more than 47 months. Including strike force matters, Federal prosecutors filed criminal charges against a total of 1,430 defendants for health care fraud related crimes. This is the highest number of health care fraud defendants charged in a single year in the Department's history. Including strike force matters, a total of 743 defendants were convicted for health care fraud-related crimes during the year.

Typical strike force cases include schemes to submit claims to Medicare for treatments that were medically unnecessary or never provided; or allegations that patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers so that those providers could submit false Medicare claims using the names of beneficiaries.

**RECENT MFSF OPERATIONS****91 Individuals Charged for Approximately \$295 Million in False Billing**

In September, 2011, Attorney General Holder and Secretary Sebelius announced a nationwide takedown by MFSF operations in eight cities that resulted in charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$295 million in false billing. This coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history.

As previously detailed, the MFSFs consist of multi-agency teams of Federal, State, and local investigators designed to combat Medicare fraud through the use of Medicare data analysis techniques and an increased focus on community policing. For this Strike Force operation, approximately 400 law enforcement agents from the FBI, HHS-OIG, multiple Medicaid Fraud Control Units, and other State and local law enforcement agencies participated in the takedown. In addition to making arrests, agents also executed 18 search warrants in connection with ongoing strike force investigations.

The defendants charged are accused of various health care fraud-related crimes, including conspiracy to defraud the Medicare program, health care fraud, violations of the anti-kickback statutes and money laundering. The charges are based on a variety of alleged fraud schemes involving various medical treatments and services such as home health care, physical and occupational therapy, mental health services, psychotherapy and durable medical equipment (DME).

The defendants allegedly participated in schemes to submit claims to Medicare for treatments that were medically unnecessary and oftentimes never provided. In many cases, indictments and complaints allege that patient recruiters, Medicare beneficiaries and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could submit fraudulent billing to Medicare for services that were medically unnecessary or never provided. The following is a breakdown of the MFSF takedown by district:

In Miami, 46 defendants, including one doctor and one nurse, were charged for their participation in various fraud schemes involving a total of \$159 million in false billings for home health care, mental health services, occupational and physical therapy, DME and HIV infusion. In one case, 24 defendants were charged for participating in a community mental health center fraud scheme involving more than \$50 million in fraudulent billing. The defendants allegedly paid patient recruiters to refer ineligible beneficiaries to the mental health center. In some instances, beneficiaries who were residents of halfway houses were allegedly threatened with eviction if they did not agree to attend the mental health center.

In Houston, two individuals were charged with fraud schemes involving \$62 million in false billings for home health care and DME. One defendant allegedly sold beneficiary information to 100 different Houston-area home health care agencies in exchange for illegal payments. The indictment alleges that the home agencies then used the beneficiary information to bill Medicare for services that were unnecessary or never provided.

Ten defendants were charged in Baton Rouge, La., for participating in schemes involving more than \$24 million related to false claims for home health care and DME. According to one

indictment, a doctor, nurse and five other co-conspirators participated in a scheme to bill Medicare for more than \$19 million in skilled nursing and other home health services that were medically unnecessary or never provided.

Six defendants, including two doctors, were charged in Los Angeles for their roles in schemes to defraud Medicare of more than \$10.7 million. In Brooklyn, three defendants, including two doctors, were charged for a fraud scheme involving more than \$3.4 million in false claims for medically unnecessary physical therapy. And in Detroit, 18 defendants, including three doctors, were charged for schemes to defraud Medicare of more than \$28 million. According to an indictment, 14 of the defendants participated in a home health care scheme that submitted more than \$14 million in false claims to Medicare. Finally, four defendants including one doctor were charged in Chicago for their alleged roles in schemes to defraud Medicare of more than \$4.4 million.

**U.S. ATTORNEY'S OFFICE FOR THE SOUTHERN DISTRICT OF FLORIDA**

The AUSAs in my own district, the Southern District of Florida, have handled a wide variety of health care matters, including false billings by doctors and other providers of medical services, overcharges by hospitals, Medicaid fraud, kickbacks to induce referrals of Medicare and Medicaid patients, fraud by pharmaceutical and medical device companies, and failure of care allegations against nursing home owners. The following is a recent example of a case brought by the Miami Strike Force, which demonstrates the health care fraud efforts in my district:

**ABC HOME HEALTH CARE INC. AND FLORIDA HOME HEALTH CARE PROVIDERS, INC.****The Home Health Care Scheme**

Beginning in approximately 2006 and lasting until early 2011, there was a pervasive health care fraud scheme in South Florida in which home health care agencies billed Medicare for home health care services that were either not provided or were not medically necessary. Medicare pays home health care agencies to provide services such as skilled nursing and physical and occupational therapy to patients who are homebound, i.e., patients who cannot leave their home to go to the office of a health care provider. In a typical case, a patient may have just been released from the hospital following surgery, and may need a therapist or nurse to come to their home for a period of time until they are well enough to leave the home. In the typical case, the hospital or physician would refer a patient to a list of home health care agencies, from which the patient would select one, which in turn would provide the necessary home health care.

From 2006 to 2011, fraudulent home health care agencies operating in the Miami area, rather than obtaining legitimate referrals from physicians or hospitals for patients who needed home health care, employed, or contracted with, patient recruiters, who were paid kickbacks and bribes to obtain patients who had Medicare benefits. The home health agencies primarily billed Medicare on behalf of these patients for two types of home health services -- physical and occupational therapy, and skilled nursing for diabetic patients who supposedly required insulin injections. The home health care agencies paid larger kickbacks to recruiters for patients who were diabetic, since they could then bill Medicare for a skilled nurse to provide the patient with insulin injections three times a day, seven days a week. In reality, many patients can control their diabetes with oral medications, and do not require injections. Even among those that

require injections, more than 90% of diabetic patients can self-inject, and do not require a skilled nurse to treat their diabetes. But fraudulent providers would obtain prescriptions from doctors for home health for any patient who was diabetic, and Medicare would be billed for hundreds of home visits for nurses who would purportedly inject the patient with insulin.

**ABC Home Health, Inc.**

ABC Home Health, Inc. (ABC) was a Miami home health care agency that operated under the direction and ownership of Gladys Zambrana (Zambrana), Enrique Perez and Alex Hernandez from approximately January 2006 through December 2008. A review of Medicare billing data showed that almost every Medicare beneficiary who received home health care services from ABC during this period purportedly received the exact same treatment: daily insulin injections by nurses and home health care aides and/or physical therapy. According to Medicare data, ABC submitted false claims to the Medicare program for approximately \$17 million in home health services that ABC purportedly rendered to approximately 391 beneficiaries. As a result of the submission of these claims, Medicare made payments to ABC totaling approximately \$11.2 million.

**Florida Home Health Care Providers, Inc.**

Florida Home Health Care Providers, Inc. (Florida Home Health) was a Miami home health care agency that was also operated by Zambrana, assisted by Carlos Castaneda, from approximately October 2007 through March 2009. A review of Medicare billing data showed that each Medicare beneficiary who received home health care services from Florida Home Health during this period of operation purportedly received the exact same treatment: daily insulin injections by nurses and home health care aides and/or physical therapy. According to Medicare data, from approximately October 2007 through March 2009, Florida Home Health



submitted to the Medicare program false claims for approximately \$7.8 million in home health services that Florida Home Health purportedly rendered to approximately 223 beneficiaries. As a result of the submission of these claims, Medicare made payments to Florida Home Health totaling approximately \$5.4 million.

Ultimately, the total amount in fraudulent billing to the Medicare program by ABC and Florida Home Health was approximately \$25 million.

#### **ABC and Florida Home Health Scheme**

ABC and Florida Home Health existed for the purpose of billing the Medicare program for expensive home health services that were not medically necessary and not provided. Zambrana's scheme was for her and co-conspirators to pay doctors kickbacks and bribes in order to qualify patients for home health care, refer them to ABC and Florida Home Health, and sign Plan of Care (POC) forms for ABC and Florida Home Health to use as justification for the billings to Medicare. The POCs for the patients were created at the ABC and Florida Home Health offices and then given to the physicians to sign, which they did in exchange for kickbacks and bribes.

As part of the scheme, ABC and Florida Home Health employed patient recruiters to recruit and place patients with ABC and Florida Home Health. The owners paid kickback payments to the recruiters in various forms – cash and check. At ABC and Florida Home Health, patient recruiters were paid between \$800 and \$1000 per patient per month for patients that could be billed for physical therapy. Further, at ABC and Florida Home Health, patient recruiters were paid between \$1200 and \$1500 per patient per month for patients that could be billed for skilled nursing care for diabetes injections. ABC and Florida Home Health maintained a ledger that listed many of the patient recruiters and the beneficiaries recruited by that recruiter.

In most instances, the Medicare beneficiaries were in on the scheme. For example, if ABC and Florida Home Health paid a recruiter \$1500 per month for a patient that could be billed for diabetic injections two and three times a day, that recruiter would often pay that patient up to \$1200 of that \$1500 in a kickback.

At ABC and Florida Home Health, patient recruiters and patients were paid huge sums of money because for each patient prescribed home health care for diabetic injections and referred to ABC and Florida Home Health, ABC and Florida Home Health billed Medicare approximately \$10,000 - \$14,000 in fraudulent billings every 60 days. Many of the patients at ABC and Florida Home Health were prescribed home health services month after month. ABC and Florida Home Health primarily billed Medicare for home health skilled nursing visits two and three times a day for patients that purportedly needed insulin injections two and three times a day. These types of patients were billed by ABC and Florida Home Health because Medicare would reimburse the most money for these types of patients. In reality, the patients did not need the injections, but rather treated their diabetes with oral medications. If the patients did, in fact, need insulin injections, the patients generally could have self-injected.

As part of the scheme, ABC and Florida Home Health hired nurses. Through ABC and Florida Home Health, the nurses would purportedly provide home care services, including insulin injections to beneficiaries that had been prescribed home health by the co-conspirator doctors. ABC and Florida Home Health paid these nurses \$25 per visit, but knew that the nurses often did not visit the patients. In most instances, the nurses did not actually provide the nursing visits two and three times a day as prescribed because the patients did not qualify and did not need the diabetic injection services.

At ABC and Florida Home Health, the nurses falsified their nursing notes to make it appear that the patients qualified for the services. Specifically, the nurses manipulated the nursing notes to show not-existent symptoms. This process would ensure that patients appeared to qualify for home health care and that ABC and Florida Home Health could bill Medicare for home health services. These symptoms included hand tremors, unsteady gait and shortness of breath – all symptoms that would make it appear that the patients could not leave their homes and could not inject themselves.

#### **The Strike Force Combats the Scheme**

The task of dismantling this complex scheme fell to one of the Strike Force teams of the Miami Strike Force, which is a joint effort between the Criminal Division's Fraud Section, the USAO for the Southern District of Florida, the FBI, and HHS-OIG. The particular team tasked with taking down the ABC scheme included one prosecutor from the Criminal Division's Fraud Section, three agents from the FBI and three agents from HHS-OIG.

The investigation into ABC and Florida Home Health began in Winter of 2008. Sophisticated data analysis revealed that ABC and Florida Home Health billed for medical services for massive amounts of Medicare beneficiaries that would only be necessary for a small portion of the Medicare beneficiary population – a clear aberration. Analysis of ABC and Florida Home Health bank records showed large sums of money transferred to sham companies and subsequently turned into cash. Agents conducted search warrants simultaneous with initial arrests to seize patient files, which had been doctored.

Approximately six months after the investigation began, in June 2009, the two owners of ABC and Florida Home Health, together with six other defendants were indicted. The eight defendants in that case pled guilty. Many of the initial defendants cooperated, allowing the team

to charge fifteen additional defendants in December 2009, including Dr. Fred Dweck, a physician who signed prescriptions and POCs for ABC and Florida Home Health, eleven nurses who purportedly provided home health services for which the two agencies billed the Medicare program, two patient recruiters, and one beneficiary. Fourteen of the fifteen defendants pled guilty. One defendant, Antonio Ochoa, a patient recruiter, was convicted of conspiracy to commit health care fraud and substantive kickbacks counts after a trial in September 2010.

In July 2010, ten additional defendants were indicted who were connected to the scheme, including one doctor, eight nurses who purportedly provided home health services for which the two agencies billed the Medicare program, and one beneficiary. Of the ten defendants, eight nurses and one beneficiary pled guilty to conspiracy to commit health care fraud.

In February 2011, twenty-one additional defendants were indicted, including Dr. Jose Nunez (Nunez), a physician who signed prescriptions and POCs for patients of ABC and Florida Home Health. In addition to Nunez, the February 2011 indictment included: one doctor, six nurses, eleven patient recruiters and two office administrators. Of the twenty-one defendants included in the Nunez Indictment, nineteen pleaded guilty to conspiracy to commit health care fraud, including Dr. Jose Nunez.

In sum, beginning with the initial indictment in June 2009 and continuing through February 2011, in less than 18 months, the Medicare Fraud Strike Force's investigation of ABC and Florida Home Health resulted in four separate indictments totaling 54 defendants. 51 of those defendants were convicted of felony offenses. The unprecedented success of the ABC/Florida Home Health case, which involved a complex fraud involving multiple physicians, dozens of nurses and hundreds of patients, was the result of just one Strike Force team. The

team work and success of this team demonstrates that the model, in fact, not only works, but exceeds traditional models of prosecution.

#### **The Results of the Strike Force Model**

As noted above, the Strike Team that led the ABC/Florida Home Health investigation demonstrated that health care fraud, even especially complex health care fraud, can be targeted quickly and successfully. This team successfully facilitated the identification and charging of defendants at all levels of the scheme; owners, nurses, patient recruiters, doctors and Medicare beneficiaries.

To date, Miami Medicare Fraud Strike Force's home health care fraud initiative, which started in June 2009 with the ABC case, has led to 63 defendants being charged, and resulted in 60 convictions. The defendants charged to date collectively billed Medicare and Medicaid more than \$127 million.

#### **CONCLUSION**

In 1996, the Health Insurance Portability and Accountability Act (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS). The program was designed to coordinate Federal, State, and local law enforcement activities with respect to health care fraud and abuse. In its sixteenth year of operation, , strengthened by the new tools and resources provided by the Affordable Care Act, and reaffirmed by the commitment of the HEAT initiative to improve that coordination, the program's continued success again confirms the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud or abuse, and to protect program beneficiaries.

AUSAs in the U.S. Attorneys' Offices, trial attorneys in the Civil, Civil Rights, and Criminal Divisions, FBI and HHS agents, as well as other Federal, State, and local law enforcement partners are working together across the country with unprecedented success. Since the HCFAC Program was established, working together, the two Departments have returned over \$20.6 billion to the Medicare Trust Funds. We are poised to continue these successes in the years ahead, and look forward to continuing this important work with our Federal, State, and local partners to that end.

Thank you for the opportunity to provide this overview of the Department's health care fraud efforts and successes. I would be happy to respond to any questions you might have.

**STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER  
U.S. SENATE COMMITTEE ON FINANCE HEARING OF APRIL 24, 2012  
ANATOMY OF A FRAUD BUST: FROM INVESTIGATION TO CONVICTION**

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today delivered the following opening statement at a committee hearing examining the anatomy of a Medicare fraud bust – from investigation to conviction:

American citizens are sick and tired of stories about government's failure to act as a faithful steward of taxpayer dollars. And there are few programs as rife with waste as Medicare. Estimates of the amount of fraud, waste, and abuse in the Medicare system vary widely, anywhere from \$20 billion to as much as \$100 billion. With numbers like those, it is no wonder that Americans, on average, believe the federal government wastes over half of what they pay in federal taxes each year.

Taxpayers have reason to be angry about the levels of waste, fraud, and abuse in Medicare and Medicaid. We have scheduled this hearing in part to address their concerns. As today's written testimony illustrates, progress is being made on this front, but much more needs to be done.

Two years ago, Congress significantly expanded the authorities and resources given to the Centers for Medicare & Medicaid Services to shore up CMS' historically underfunded program integrity efforts. CMS now has over \$1 billion dollars available annually to use in its fight to ensure payments are made properly.

While CMS has begun to make some strides in its fight against fraud, its implementation of congressionally mandated program integrity efforts has been lackluster at best. The CMS report card is not one to be proud of.

CMS has not put in any temporary moratoriums to prevent new providers or suppliers from enrolling and billing the Medicare program, even in areas where more than enough already exist to furnish health care services.

CMS has not established a surety bond on home health agencies even though CMS considers new home health agencies a high risk.

CMS has not established mandatory compliance programs as a condition of participation for suppliers and providers despite HHS-OIG's continued finding that those programs help prevent fraud from recurring.

CMS has not implemented limits on how much high risk suppliers and providers can bill.

CMS has not established procedures to deny additional Medicare billing privileges to suppliers who have an existing overpayment or suspension.

Until this morning, CMS had not even finalized a rule to implement checks to make sure that physicians actually refer a Medicare beneficiary for a medical service before paying the claim.

And CMS has not implemented claims edits to verify that DMEPOS suppliers are accredited for each item or service for which they bill Medicare.

CMS does have new enhanced provider screening tools designed to ensure that only legitimate providers and suppliers are allowed into the Medicare program. Yet a recent search by our offices of convicted felons, who are also physicians, showed that many — including a physician convicted of conspiracy to commit murder — still appeared on Medicare's public ordering and referring file as active Medicare providers.

Historically, CMS has claimed that for every \$1 invested in program integrity efforts the return is at least \$14. If that is the case, taxpayers and Congress should expect to see proof of \$14 billion in recoveries in the very near future. Yet, given the results provided to date and the ineffectiveness of many of the efforts highlighted by the OIG, I am not going to hold my breath.

Despite many public announcements about enhanced tools, flashy new systems, and high profile collaborations to combat waste, fraud, and abuse, CMS can show few tangible results from these investments. Recoveries by CMS' law enforcement partners are at their highest rate of return ever — \$4.1 billion for the last reporting period, a 58 percent increase over the year before. But the administrative actions and recoveries which are under CMS' sole control are far less robust.

The failure to address fraud, waste, and abuse appropriately is a long-standing problem for CMS. Perhaps a fresh perspective is necessary. That is why later this week I, along with my colleague Dr. Coburn, will begin soliciting ideas from all interested stakeholders for combatting the billions in waste, fraud, and abuse in the Medicare and Medicaid programs. Together, we hope to identify innovative solutions that will provide taxpayers with a return on the investments being made to combat the waste in these programs.

I want to be absolutely clear. Waste and fraud in the Medicare system is not a minor issue. Government agencies can harm U.S. taxpayers by acting improperly, as appears to be the case with the GSA scandal. But they can also hurt taxpayers through inaction. The failure of CMS to address waste, fraud, and abuse — in spite of billions in taxpayer dollars dedicated to doing so — is quickly becoming its own scandal. Waste in the programs that CMS supervises directly harms U.S. taxpayers. That is the way that CMS needs to think about this issue. This is not some victimless crime. Fraud and waste in these programs hurt the American taxpayer, no less than if someone lifted their wallets. It harms the integrity of a program that our seniors depend on. And it undermines citizens' confidence in the government's ability to perform its most basic functions.

Thank you again Mr. Chairman. I look forward to the testimony of our witnesses.

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## MEDICARE ANTI-FRAUD REPORT CARD



Anti-Fraud Provisions	Yes	No
Implement a temporary moratorium for new Medicare providers and suppliers		✓
Implement a surety bond on home health agencies and certain other suppliers		✓
Establish a compliance program for fee-for-service providers and suppliers		✓
Implement limitations on how much high-risk providers and suppliers can bill		✓
Implement checks to make sure that a physician actually referred a Medicare beneficiary for a medical service (e.g., clinical laboratory)		✓
Establish procedures to deny additional Medicare billing privileges to suppliers who have an existing overpayment or payment suspension		✓
Implement claims edits (checks) to verify that a supplier of DMEPOS is accredited for each item or service billed the Medicare program		✓

INTERIM IMPLEMENTATION GRADE: INCOMPLETE

Inc.

United States Government Accountability Office

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**GAO**

Testimony  
Before the Committee on Finance, U.S.  
Senate

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For Release on Delivery  
Expected at 10:00 a.m. EDT  
Tuesday, April 24, 2012

## MEDICARE

# Important Steps Have Been Taken, but More Could Be Done to Deter Fraud

Statement of Kathleen King  
Director, Health Care





Highlights of GAO-12-671T, a testimony before the Committee on Finance, U.S. Senate

### Why GAO Did This Study

GAO has designated Medicare as a high-risk program, in part because its complexity makes it particularly vulnerable to fraud. Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. The deceptive nature of fraud makes its extent in the Medicare program difficult to measure in a reliable way, but it is clear that fraud contributes to Medicare's fiscal problems. Reducing fraud could help rein in the escalating costs of the program.

This statement focuses on the progress made and steps that remain to be taken by CMS to implement recent legislation and GAO's past recommendations to prevent or reduce fraud in Medicare. It is based on relevant GAO products issued from April 2004 through April 2012 using a variety of methodologies, such as analyses of Medicare claims, review of relevant policies and procedures, and interviews with officials. In April 2012, GAO also received updated information from CMS on agency actions.

View GAO-12-671T. For more information, contact Kathleen King at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov).

April 24, 2012

## MEDICARE

### Important Steps Have Been Taken, but More Could Be Done to Deter Fraud

#### What GAO Found

The Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—has made progress in implementing several key strategies GAO identified in prior work as helpful in protecting Medicare from fraud; however, some actions that could help combat fraud remain incomplete.

**Provider Enrollment:** GAO's previous work found persistent weaknesses in Medicare's enrollment standards and procedures that increased the risk of enrolling entities intent on defrauding the program. CMS has strengthened provider enrollment—for example, in February 2011, CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for categories of providers at each level. However, CMS has not completed other actions, including implementation of some relevant provisions of the Patient Protection and Affordable Care Act (PPACA). Specifically, CMS has not (1) determined which providers will be required to post surety bonds to help ensure that payments made for fraudulent billing can be recovered, (2) contracted for fingerprint-based criminal background checks, (3) issued a final regulation to require additional provider disclosures of information, and (4) established core elements for provider compliance programs.

**Pre- and Post-payment Claims Review:** GAO had previously found that increased efforts to review claims on a prepayment basis can prevent payments from being made for potentially fraudulent claims, while improving systems used to review claims on a post-payment basis could better identify patterns of potentially fraudulent billing for further investigation. CMS has controls in Medicare's claims processing systems to determine if claims should be paid, denied, or reviewed further by comparing information on claims with information on providers and Medicare coverage and requirements. These controls require timely and accurate information about providers that GAO has previously recommended that CMS strengthen. GAO is currently examining CMS's use of prepayment edits to implement coverage and payment policies and CMS's new Fraud Prevention System, which uses analytic methods to examine claims before payment. CMS could better use post-payment claims review to identify patterns of fraud by incorporating prior GAO recommendations to develop plans and timelines for fully implementing and expanding two information technology systems it developed. These systems are a central storehouse of Medicare and other data and a Web portal to the storehouse with tools for analysis.

**Robust Process to Address Identified Vulnerabilities:** Having mechanisms in place to resolve vulnerabilities that lead to erroneous payments is critical to effective program management and could help address fraud. Such vulnerabilities are service- or system-specific weaknesses that can lead to payment errors—for example, providers receiving multiple payments as a result of incorrect coding. GAO has previously identified weaknesses in this process, which resulted in vulnerabilities being left unaddressed. GAO is evaluating the current status of the process for assessing and developing corrective actions to address vulnerabilities.

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Mr. Chairman, Ranking Member, and Other Members of the Committee:

I am pleased to be here today to discuss our work regarding fraud in the Medicare program, and provisions in recent laws and agency actions that may help address this problem.<sup>1</sup> Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain. Although there have been convictions for multimillion dollar schemes that defrauded the Medicare program, the extent of the problem is unknown. There are no reliable estimates of the extent of fraud in the Medicare program or for the health care industry as a whole. By its very nature, fraud is difficult to detect, as those involved are engaged in intentional deception. For example, fraud may involve providers submitting a claim with false documentation for services not provided, while the claim on its face may appear valid. Fraud also can involve efforts to hide ownership of companies or kickbacks to obtain beneficiary information. Although the full extent of the problem is unknown, it is clear that the Medicare program is vulnerable to fraud, which contributes to Medicare's fiscal problems. Reducing fraud could help rein in the escalating costs of the program.

We have repeatedly designated Medicare as a high-risk program, as its complexity, and susceptibility to payment errors from various causes, added to its size, have made it vulnerable to loss.<sup>2</sup> As one example, the fee-for-service (FFS) portion of the Medicare program processes over a billion claims a year from about 1.5 million providers and suppliers; working to ensure that those payments are accurate is a complex, ongoing task. Medicare has many individual vulnerabilities, which are service- or system-specific weaknesses that can lead to payment errors,

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<sup>1</sup>Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Parts A and B are known as Medicare fee-for-service (FFS). Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional, and covers hospital outpatient, physician, and other services. Medicare beneficiaries have the option of obtaining coverage for Medicare services from private health plans that participate in Medicare Advantage—Medicare's managed care program—also known as Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Part D, either as a stand-alone benefit or as part of a Medicare Advantage plan.

<sup>2</sup>In 1990, we began to report on government operations that we identified as "high risk" for serious weaknesses in areas that involve substantial resources and provide critical services to the public. Medicare has been included among such programs since 1990. See GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011). [http://www.gao.gov/highrisk/risks/insurance/medicare\\_program.php](http://www.gao.gov/highrisk/risks/insurance/medicare_program.php).

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including those due to fraud.<sup>3</sup> If the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers the program, suspects that providers or suppliers are billing fraudulently, it can take action, including suspending claims payment, revoking billing privileges, or referring cases to law enforcement for investigation.<sup>4</sup> Further, it can impose a moratorium on new enrollment of providers or suppliers.<sup>5</sup> Since 1997, Congress has provided funds specifically for activities to address fraud, as well as waste and abuse,<sup>6</sup> in Medicare and other federal health care programs. In addition, Congress created the Medicare Integrity Program to conduct activities to reduce fraud, waste, abuse, and improper payments.<sup>7</sup> In 2010, Congress passed the Patient Protection and Affordable Care Act (PPACA), which provided additional funding for such efforts and set a number of new requirements specific to Medicare.<sup>8</sup> Furthermore, the Small Business Jobs Act of 2010<sup>9</sup> established new Medicare fee-for-

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<sup>3</sup>CMS defines vulnerabilities to the Medicare program as issues that can lead to fraud, waste, or abuse, which can either be specific, such as providers receiving multiple payments as a result of incorrect coding for a service, or general and programwide, such as weaknesses in online application processes.

<sup>4</sup>In this testimony, the term provider includes entities such as hospitals or physicians, and supplier means an entity that supplies Medicare beneficiaries with durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) such as walkers and wheelchairs.

<sup>5</sup>Enrolling as a provider or supplier in Medicare allows an entity to provide services or equipment to beneficiaries and bill for those services.

<sup>6</sup>Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

<sup>7</sup>An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

<sup>8</sup>Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029, which we refer to collectively as PPACA. The provisions discussed in this statement are generally located in sections 6401 through 6411 and 10603 and 10605 of PPACA, as well as sections 1303 and 1304 of HCERA.

<sup>9</sup>Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599.

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service claims review requirements and provided funding to implement these requirements.

My testimony today focuses on the progress made and steps that remain to be taken by CMS to reduce fraud in Medicare. It is informed by 8 years of our work on Medicare fraud, waste, abuse, and improper payments, including our most recent report assessing CMS's efforts to strengthen the screening of providers and suppliers, which can help prevent entities intent on committing fraud from obtaining billing privileges.<sup>10</sup> I will focus on several key strategies CMS can undertake to help reduce fraud identified in our prior work from 2004 to 2012, namely:<sup>11</sup>

- strengthening provider enrollment standards and procedures,
- improving pre- and post-payment claims review, and
- developing a robust process for addressing identified vulnerabilities.

The products on which this statement is based were developed by using a variety of methodologies, including analyses of Medicare claims, review of relevant policies and procedures, interviews with agency officials and other stakeholders, and site visits.<sup>12</sup> We also received updated information from CMS in April 2012 on its actions related to the laws, regulations, guidance, and open recommendations that we discuss in this statement. Our prior work was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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<sup>10</sup>See GAO, *Medicare Program Integrity: CMS Continues Efforts to Strengthen the Screening of Providers and Suppliers*, GAO-12-351 (Washington, D.C.: Apr. 10, 2012).

<sup>11</sup>These strategies were among those identified in our June 2010 testimony as critical to helping prevent fraud, waste, and abuse in Medicare. See GAO, *Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D.C.: June 15, 2010). A list of related products appears at the end of this statement.

<sup>12</sup>The products listed at the end of this statement contain detailed information on the methodologies used in our work.

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**CMS Has Made Progress in Strengthening Provider Enrollment, but Further Actions Are Needed**

CMS has made progress strengthening provider enrollment to try to better ensure that only legitimate providers and suppliers are allowed to bill Medicare. However, CMS has not completed other actions that could help prevent individuals intent on fraud from enrolling, including implementation of some relevant PPACA provisions.

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**Past CMS efforts to strengthen provider enrollment**

Our previous work found persistent weaknesses in Medicare's enrollment standards and procedures that increased the risk of enrolling entities intent on defrauding the Medicare program.<sup>13</sup> We, CMS, and the HHS Office of Inspector General (OIG) have previously identified two types of providers whose services and items are especially vulnerable to improper payments and fraud—home health agencies (HHA) and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). We found weaknesses in oversight of providers' and suppliers' enrollment. For example, in 2008, we identified weaknesses when we created two fictitious DMEPOS companies, which were subsequently enrolled by CMS's contractor and given permission to begin billing Medicare.<sup>14</sup> In 2009, we found that CMS's contractors were not requiring HHAs to resubmit enrollment information for re-verification every 5 years as required by CMS.<sup>15</sup>

To strengthen the Medicare enrollment process in 2006 CMS began requiring all providers and suppliers—including those who order HHA services or DMEPOS for beneficiaries to be enrolled in Medicare. The agency also required all providers and suppliers to report their National

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<sup>13</sup>See GAO, *Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs*, GAO-05-43 (Washington, D.C.: Nov. 17, 2004); *Medicare: More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers*, GAO-05-656 (Washington, D.C.: Sept. 22, 2005); *Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies*, GAO-07-59 (Washington, D.C.: Jan. 31, 2007); and *Medicare: Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185 (Washington, D.C.: Feb. 27, 2009).

<sup>14</sup>GAO, *Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process*, GAO-08-955 (Washington, D.C.: July 3, 2008).

<sup>15</sup>GAO-09-185.

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Provider Identifiers (NPI) on enrollment applications, which can help address fraud because providers and suppliers must submit either their Social Security Number or their employer identification number and state licensing information to obtain an NPI.<sup>16</sup> In 2007, CMS initiated the first phase of a Medicare competitive bidding program for DMEPOS.<sup>17</sup> This program requires suppliers' bids to include new financial documentation for the year prior to submitting the bids. Because CMS can now disqualify suppliers based in part on scrutiny of their financial new documents, competitive bidding can help reduce fraud. Finally, in 2010, CMS also required that all DMEPOS suppliers be accredited by a CMS-approved accrediting organization to ensure that they meet certain quality standards. Such accreditation also increased scrutiny of these businesses.

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**CMS Has Taken Action on Certain PPACA Provider Enrollment Provisions**

PPACA authorized CMS to implement several actions to strengthen provider enrollment. As of April 2012, the agency has completed some of these actions.

*Screening Provider Enrollment Applications by Risk Level:* CMS and OIG issued a final rule with comment period in February 2011 to implement some of the new screening procedures required by PPACA.<sup>18</sup> CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for categories of Medicare providers at each level. Providers in the high-risk level are subject to the most rigorous

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<sup>16</sup>HIPAA required that HHS adopt standards for unique health identifiers. CMS adopted the NPI as the standard unique health identifier for its health care providers and suppliers in its Final Rule: *HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers*, 69 Fed. Reg. 3434 (Jan. 23, 2004). Consistent with the NPI Final Rule, beginning in 2006, the Medicare program required providers and suppliers to report their NPIs on their enrollment applications.

<sup>17</sup>Competitive bidding is a process in which suppliers of medical equipment and supplies compete for the right to provide their products on the basis of established criteria, such as quality and price.

<sup>18</sup>*Medicare, Medicaid, and Children's Health Insurance Programs: Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 Fed. Reg. 5862 (Feb. 2, 2011). In discussing the final rule, CMS noted that Medicare had already employed a number of the screening practices described in PPACA to determine if a provider is in compliance with federal and state requirements to enroll or to maintain enrollment in the Medicare program.



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screening.<sup>19</sup> To determine which providers to place in these risk levels, CMS considered issues such as past occurrences of improper payments and fraud among different categories of providers. Based in part on our work and that of the OIG, CMS designated newly enrolling HHAs and DMEPOS suppliers as high risk and designated other providers at lower levels. (See table 1.) Providers at all risk levels are screened to verify that they meet specific requirements established by Medicare such as having current licenses or accreditation and valid Social Security numbers.<sup>20</sup> High- and moderate-risk providers are additionally subject to unannounced site visits. Further, depending on the risks presented, PPACA authorizes CMS to require fingerprint-based criminal history checks, and the posting of surety bonds for certain providers.<sup>21</sup> CMS may also provide enhanced oversight for specific periods for new providers and for initial claims of DMEPOS suppliers.

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<sup>19</sup>PPACA specified that the enhanced screening procedures would apply to new providers and suppliers beginning 1 year after the date of enactment and to currently enrolled providers and suppliers 2 years after that date.

<sup>20</sup>Screening may include verification of the following: Social Security number; NPI; National Practitioner Databank licensure; whether the provider has been excluded from federal health care programs by the OIG; taxpayer identification number; and death of an individual practitioner, owner, authorized official, delegated official, or supervising physician.

<sup>21</sup>A surety bond is a three-party agreement in which a company, known as a surety, agrees to compensate the bondholder if the bond purchaser fails to keep a specified promise.

**Table 1: Categories of Medicare Providers and Suppliers Designated by Risk Level for Enrollment Screening**

Risk level	Categories of Medicare providers and suppliers
Limited	Physician or nonphysician practitioners and medical groups or clinics, with the exception of physical therapists and physical therapy groups. Ambulatory surgical centers, competitive acquisition programs/Part B vendors, end-stage renal disease facilities, federally qualified health centers, histocompatibility laboratories, <sup>8</sup> hospitals, including critical access hospitals, Indian Health Service facilities, mammography screening centers, mass immunization roster billers, <sup>9</sup> organ procurement organizations, pharmacies newly enrolling or revalidating, radiation therapy centers, religious nonmedical health care institutions, rural health clinics, and skilled nursing facilities.
Moderate	Ambulance suppliers, community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent diagnostic testing facilities, independent clinical laboratories, physical therapy including physical therapy groups, portable X-ray suppliers, and currently enrolled (revalidating) home health agencies.
High	Prospective (newly enrolling) home health agencies and prospective (newly enrolling) suppliers of durable medical equipment, prosthetics, orthotics, and supplies.

Source: GAO analysis of CMS Final Rule with Comment Period, Medicare, Medicaid, and Children's Health Insurance Programs: Additional Screening Requirements, Applications Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 76 Fed. Reg. 5862 (Feb. 2, 2011).

<sup>8</sup>Histocompatibility laboratories provide evaluations of certain genetic data and pertinent patient immunologic risk factors to allow clinician and patient to make decisions about whether transplantation is in the patient's best interest.

<sup>9</sup>Mass immunization roster billers are providers and suppliers who enroll in the Medicare program to offer influenza (flu) vaccinations to a large number of individuals, and they must be properly licensed in the states in which they plan to operate influenza clinics.

CMS indicated that the agency will continue to review the criteria for its screening levels on an ongoing basis and would publish changes if the agency decided to update the assignment of screening levels for categories of Medicare providers. This may become necessary because fraud is not confined to HHAs and DMEPOS suppliers. We are currently examining the types of providers involved in fraud cases investigated by the OIG and the Department of Justice (DOJ), which may help illuminate risk to the Medicare program from different types of providers. Further, in their 2011 annual report on the Health Care Fraud and Abuse Control Program, DOJ and HHS reported convictions or other legal actions, such as exclusions or civil monetary penalties, against several types of Medicare providers other than DMEPOS suppliers and HHAs, including pharmacists, orthopedic surgeons, infusion and other types of medical

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clinics, and physical therapy services.<sup>22</sup> CMS also has established triggers for adjustments to an individual provider's risk level. For example, CMS regulations state that an individual provider or supplier at the limited- or moderate-risk level that has had its billing privileges revoked by a Medicare contractor within the last 10 years and is attempting to re-enroll, would move to the high-risk level for screening.

*New National Enrollment Screening and Site Visit Contractors:* In a further effort to strengthen its enrollment processes, CMS contracted with two new entities at the end of 2011 to assume centralized responsibility for automated screening of provider and supplier enrollment and for conducting site visits of providers.

- **Automated screening contractor.** In December 2011, the new contractor began to establish systems to conduct automated screening of providers and suppliers to ensure they meet Medicare eligibility criteria (such as valid licensure, accreditation, a valid NPI, and no presence on the OIG list of providers and suppliers excluded from participating in federal health care programs).<sup>23</sup> Prior to the implementation of this new automated screening, such screening was done manually for the 30,000 enrollees each month by CMS's Medicare Administrative Contractors (MAC), which enroll Medicare providers, and the National Supplier Clearinghouse (NSC), which enrolls DMEPOS suppliers. According to CMS, the old screening process was neither efficient nor timely. CMS officials said that in 2012, the automated screening contractor began automated screening of the licensure status of all currently enrolled Medicare providers and suppliers. The agency said it expects the automated screening contractor to begin screening newly enrolling providers and suppliers later this year. CMS expects that the new, national contractor will enable better monitoring of providers and suppliers on a continuous basis to help ensure they continue to meet Medicare enrollment requirements. The new screening contractor will also help the MACs and the NSC maintain enrollment information in CMS's

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<sup>22</sup>The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011 (Washington, D.C.: February 2012).

<sup>23</sup>Licensure is a mandatory process by which a state government grants permission to an individual practitioner or health care organization to engage in an occupation or profession.

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Provider Enrollment Chain and Ownership System (PECOS)—a database that contains details on enrolled providers and suppliers. In addition, CMS officials said the automated screening contractor is developing an individual risk score for each provider or supplier, similar to a credit risk score. Although these individual scores are not currently used to determine an individual provider's placement in a risk level, CMS indicated that this risk score may be used eventually as additional risk criteria in the screening process.

- **Site visits for all providers designated as moderate and high risk.** Beginning in February 2012, a single national site visit contractor began conducting site visits of moderate- and high-risk providers to determine if sites are legitimate and the providers meet certain Medicare standards.<sup>24</sup> The contractor collects the same information from each site visit, including photographic evidence that will be available electronically through a web portal accessible to CMS and its other contractors. The national site visit contractor is expected to validate the legitimacy of these sites. CMS officials told us that the contractor will provide consistency in site visits across the country, in contrast to CMS relying on different MACs to conduct any required site visits.

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**CMS Has Not Completely Implemented Some PPACA Enrollment Provisions**

Implementation of other enrollment screening actions authorized by PPACA that could help CMS reduce the enrollment of providers and suppliers intent on defrauding the Medicare program remains incomplete, including:

- **Surety bond**—PPACA authorizes CMS to require a surety bond for certain types of at-risk providers, which can be helpful in recouping erroneous payments. CMS officials expect to issue a proposed rule to require surety bonds as conditions of enrollment for certain types of providers. Extending the use of surety bonds to new entities would augment a previous statutory requirement for DMEPOS suppliers to

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<sup>24</sup>Starting March 25, 2011, CMS required the MACs to conduct site visits for categories of providers and suppliers designated as moderate and high risk. The national site visit contractor assumed these responsibilities in 2012. The NSC continues to conduct site visits related to provider enrollment of DMEPOS suppliers. In addition, CMS at times exercises its authority to conduct a site visit or requests its contractors to conduct a site visit for any Medicare provider or supplier.

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post a surety bond at the time of enrollment.<sup>25</sup> CMS issued final instructions to its MACs, effective February 2012, for recovering DMEPOS overpayments through surety bonds. CMS officials reported that as of April 19, 2012, they had issued notices to 20 surety bond companies indicating intent to collect funds, but had not collected any funds as of that date.

- **Fingerprint-based Criminal Background Checks**—CMS officials told us that they are working with the Federal Bureau of Investigation to arrange contracts to help conduct fingerprint-based criminal background checks of high-risk providers and suppliers. On April 13, 2012, CMS issued a request for information regarding a contract to conduct Medicare provider and supplier fingerprint-based background checks. The agency expects to have the contract in place before the end of 2012.
- **Providers and Suppliers Disclosure**—CMS officials said the agency is reviewing options for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, such as whether the provider or supplier has been subject to a payment suspension from a federal health care program.<sup>26</sup> In April 2012, agency officials indicated that they were not certain when the regulation would be published. CMS officials noted that the additional disclosure requirements are complicated by provider and supplier concerns about what types of information will be collected, what CMS will do with it, and how the privacy and security of this information will be maintained.

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<sup>25</sup>42 U.S.C. § 1395m(a)(16)(B). As of October 2009, DMEPOS suppliers were required to obtain and submit a surety bond in the amount of at least \$50,000. A DMEPOS surety bond is a bond issued by an entity guaranteeing that a DMEPOS supplier will fulfill its obligation to Medicare. If the obligation is not met, Medicare will recover its losses via the surety bond. *Medicare Program; Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)*, 74 Fed. Reg. 166 (Jan. 2, 2009).

<sup>26</sup>At the time of initial enrollment or revalidation of enrollment, PPACA requires providers and suppliers to disclose any current or previous affiliation with another provider or supplier that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from participation under Medicare, Medicaid, or the State Children's Health Insurance Program; or has had its billing privileges denied or revoked.

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- **Compliance and Ethics Program**—CMS officials said that the agency was studying criteria found in OIG model plans as it worked to address the PPACA requirement that the agency establish the core elements of compliance programs for providers and suppliers.<sup>27</sup> In April 2012, CMS did not have a projected target date for implementation.

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**Additional Action May Help Better Identify Potential Fraud through Pre- and Post-Payment Claims Review**

Increased efforts to review claims on a prepayment basis can better prevent payments that should not be made, while improving systems used to review claims on a post-payment basis could better identify patterns of fraudulent billing for further investigation.

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**Additional Efforts to Improve Prepayment Claims Review May Help Reduce Fraud**

Having robust controls in claims payment systems to prevent payment of problematic claims can help reduce loss. As claims go through Medicare's electronic claims payment systems, they are subjected to automated prepayment controls called "edits," instructions programmed in the systems to prevent payment of incomplete or incorrect claims. Some edits use provider enrollment information, while others use information on coverage or payment policies, to determine if claims should be paid. Most of these controls are fully automated; if a claim does not meet the criteria of the edit, it is automatically denied. Other prepayment edits are manual; they flag a claim for individual review by trained staff who determine if it should be paid. Due to the volume of claims, CMS has reported that approximately 25 in a million Medicare claims are subject to manual medical record review by trained personnel.

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<sup>27</sup> A compliance program is an internal set of policies, processes, and procedures that a provider organization implements to help it act ethically and lawfully. In this context, a compliance program is intended to help provider and supplier organizations prevent and detect violations of Medicare laws and regulations. CMS has used the phrase "compliance and ethics program" and indicated it may base its program on the seven elements of effective compliance and ethics programs found in the U. S. Federal Sentencing Guidelines Manual.

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Having effective pre-payment edits that deny claims for ineligible providers and suppliers depends on having timely and accurate information about them, such as whether the providers are currently enrolled and have the appropriate license or accreditation to provide specific services. We have previously identified flaws in the timeliness and accuracy of PECOS—the database that maintains Medicare provider and supplier enrollment information. We noted that weaknesses in PECOS data may result in CMS making improper payments to ineligible providers and suppliers.<sup>28</sup> These weaknesses are related to the frequency with which CMS's contractors update enrollment information and the timeliness and accuracy of information obtained from outside entities, such as state licensing boards, the OIG, and the Social Security Administration's Death Master File, which contains information on deceased individuals that can be used to identify deceased providers in order to terminate those providers' Medicare billing privileges. These sources vary in the ease in which CMS contractors have been able to access their data and the frequency with which they are updated. CMS has indicated that its new national screening contractor should improve the timeliness and accuracy of the provider and supplier information in PECOS by centralizing the process, increasing automation of the process, continuously checking databases, and incorporating new sources of data, such as financial, business, tax, and geospatial data. However, it is too soon to tell if these efforts will better prevent payments to ineligible providers and suppliers.

Having effective edits to implement coverage and payment policies before payment is made can also help to deter fraud. The Medicare program has defined categories of items and services eligible for coverage and excludes from coverage items or services that are determined not to be "reasonable and necessary for the diagnosis and treatment of an illness or injury or to improve functioning of a malformed body part."<sup>29</sup> CMS and its contractors set policies regarding when and how items and services will be covered by Medicare, as well as coding and billing requirements for payment, which also can be implemented in the payment systems through edits. We have previously found Medicare's payment systems did not have edits for items and services unlikely to be provided in the normal

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<sup>28</sup>GAO-12-351.

<sup>29</sup>42 U.S.C. § 1395(a)(1)(A).

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course of medical care.<sup>30</sup> CMS has since implemented edits to flag such claims—called Medically Unlikely Edits. We are currently assessing Medicare's prepayment edits based on coverage and payment policies, including the Medically Unlikely Edits, and oversight of its contractors implementing these edits.

Additionally, suspending payments to providers suspected of fraudulent billing can be an effective tool to prevent excess loss to the Medicare program while suspected fraud is being investigated. For example, in March 2011, the OIG testified that payment suspensions and prepayment edits on 18 providers and suppliers stopped the potential loss of more than \$1.3 million submitted in claims by these individuals. Furthermore, HHS recently reported that it imposed payment suspensions on 78 home health agencies in conjunction with arrests related to a multimillion dollar health care fraud scheme. While CMS had the authority to impose payment suspensions prior to PPACA, the law specifically authorized CMS to suspend payments to providers pending the investigation of credible allegations of fraud.<sup>31</sup> This ability would enable CMS to suspend payments beyond the 180-day time limit established by regulation prior to PPACA. CMS officials reported that the agency had imposed 212 payment suspensions since the regulations implementing the PPACA provisions took effect. Agency officials indicated that almost half of these suspensions were imposed this calendar year, representing about \$6 million in Medicare claims.

We are currently evaluating a new CMS effort, the Fraud Prevention System (FPS) which uses predictive analytic technologies to analyze FFS claims on a prepayment basis. The Small Business Jobs Act of 2010 requires CMS to use predictive analytic technologies both to identify and to prevent improper payments under Medicare FFS.<sup>32</sup> The law requires

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<sup>30</sup>GAO-07-59.

<sup>31</sup>CMS is required to consult with the HHS OIG in determining whether a credible allegation of fraud exists. Based on how CMS used its previous payment suspension authority, in November 2010, the OIG found weaknesses in CMS's implementation of payment suspensions that could lead to delays in the suspension process. Such delays would allow payments to continue to providers suspected of fraud. Specifically, the OIG found that CMS's guidance to its contractors on procedures for implementing payment suspensions was incomplete and inconsistent. Although the OIG made no recommendations, it suggested that these weaknesses could be addressed through CMS rulemaking pursuant to PPACA.

<sup>32</sup>Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599.



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these predictive analytic technologies to be used to review claims for potential fraud by identifying unusual or suspicious patterns or abnormalities in Medicare provider networks, claims billing patterns, and beneficiary utilization. According to CMS, FPS may enhance CMS's ability to identify potential fraud because it analyzes large numbers of claims from multiple data sources nationwide simultaneously before payment is made, thus allowing CMS to examine billing patterns across geographic regions for those that may indicate fraud. The results of FPS could lead to the initiation of payment suspensions, implementation of automatic claim denials, identification of additional pre-payment edits, investigations, or the revocation of Medicare billing privileges. CMS began using FPS to screen all FFS claims nationwide prior to payment as of June 30, 2011. Because FPS is relatively new, and we have not completed our work, it is too soon to determine whether FPS will improve CMS's ability to address fraud.

"Bust-out" fraud schemes in which providers or suppliers suddenly bill very high volumes of claims to obtain large payments from Medicare could be addressed by adding a prepayment edit. Such an edit would set thresholds to stop payment for atypically rapid increases in billing thus helping to stem losses from these schemes. In our prior work on DMEPOS, we recommended that CMS require its contractors to develop thresholds for unexplained increases in billing and use them to develop pre-payment controls that could suspend these claims for further review before payment.<sup>33</sup> Members of this Committee have recently requested information from CMS about what the agency is doing to implement payment caps to protect Medicare from "bust out" schemes. CMS officials told us that they are currently considering analytic models in FPS that could help them address billing practices suggestive of "bust outs."

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<sup>33</sup>See GAO, *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*. GAO-12-342SP (Washington, D.C.: Feb. 28, 2012) and GAO-07-59.

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**Actions Needed to Improve Use of Systems Intended for Post-payment Claims Review**

Further actions are needed to improve use of two CMS information technology systems that could help analysts identify fraud after payment.<sup>34</sup>

- The Integrated Data Repository (IDR) became operational in September 2006 as a central storehouse of Medicare and other data needed to help CMS program integrity staff and contractors prevent and detect improper payments of claims. However, we found IDR did not include all the data that were planned to be incorporated by fiscal year 2010, because of technical obstacles and delays in funding. Further, as of December 2011 the agency had not finalized plans or developed reliable schedules for efforts to incorporate these data, which could lead to additional delays.
- One Program Integrity (One PI) is a web portal intended to provide CMS staff and contractors with a single source of access to data contained in IDR, as well as tools for analyzing those data. While One PI is operational, we reported in December 2011 that CMS had trained few program integrity analysts and the system was not being widely used.

GAO recommended that CMS take steps to finalize plans and reliable schedules for fully implementing and expanding the use of both IDR and One PI. Although the agency told us in April 2012 that it had initiated activities to incorporate some additional data into IDR and expand the use of One PI, such as training more CMS staff and contractors, they have not fully addressed our recommendations.

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<sup>34</sup>GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, GAO-11-475 (Washington, D.C.: June 30, 2011).

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### A Robust Process to Address Identified Vulnerabilities Could Help Reduce Fraud

Having mechanisms in place to resolve vulnerabilities that lead to improper payments is critical to effective program management and could help address fraud.<sup>35</sup> However, our work has shown weaknesses in CMS's processes to address such identified vulnerabilities.

CMS's Recovery Auditing Contractors (RAC) are specifically charged with identifying improper payments and vulnerabilities that could lead to such payment errors. However, in our March 2010 report on the RAC demonstration program, we found that CMS had not established an adequate process during the demonstration or in planning for the national program to ensure prompt resolution of such identified vulnerabilities in Medicare; further, the majority of the most significant vulnerabilities identified during the demonstration were not addressed.<sup>36</sup> We therefore recommended that CMS develop and implement a corrective action process that includes policies and procedures to ensure the agency promptly (1) evaluates findings of RAC audits, (2) decides on the appropriate response and a time frame for taking action based on established criteria, and (3) acts to correct the vulnerabilities identified.<sup>37</sup>

Our recommendations will not be fully addressed until CMS has put policies and procedures in place that will lead the agency to act promptly to correct identified vulnerabilities. In December 2011, the OIG found that CMS had not resolved or taken significant action to resolve 48 (77 percent) of 62 vulnerabilities reported in 2009 by CMS contractors specifically charged with addressing fraud. Only 2 vulnerabilities had

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<sup>35</sup>We have reported that an agency should have policies and procedures to ensure that (1) the findings of all audits and reviews are promptly evaluated, (2) decisions are made about the appropriate response to these findings, and (3) actions are taken to correct or resolve the issues promptly. These are all aspects of internal control, which is the component of an organization's management that provides reasonable assurance that the organization achieves effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Internal control standards provide a framework for identifying and addressing major performance challenges and areas at greatest risk for mismanagement. GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

<sup>36</sup>GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, GAO-10-143 (Washington, D.C.: Mar. 31, 2010).

<sup>37</sup>GAO-10-43.

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been fully resolved by January 2011.<sup>38</sup> The OIG made several recommendations, including that CMS have written procedures and time frames to assure that vulnerabilities were resolved. CMS has indicated that it is now tracking vulnerabilities identified by several types of contractors through a single vulnerability tracking process. We are currently examining aspects of CMS's vulnerability tracking process and will be reporting on it soon.

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## Concluding Observations

Although CMS has taken some important steps to identify and prevent fraud, including implementing provisions in PPACA and the Small Business Jobs Act, more remains to be done to prevent making erroneous Medicare payments due to fraud. In particular, we have found that CMS could do more to strengthen provider enrollment screening to avoid enrolling those intent on committing fraud, improve pre- and post-payment claims review to identify and respond to patterns of suspicious billing activity more effectively, and identify and address vulnerabilities to reduce the ease with which fraudulent entities can obtain improper payments. It is critical that CMS implement and make full use of new authorities granted by recent legislation, as well as incorporating recommendations made by us, as well as the OIG. Moving from responding once fraud has already occurred to preventing it from occurring in the first place is key to ensuring that federal funds are used efficiently and for their intended purposes.

As all of these new authorities and requirements become part of Medicare's operations, additional evaluation and oversight will be necessary to determine whether they are implemented as required and have the desired effect. We have several studies underway that assess efforts to fight fraud in Medicare and that should continue to help CMS refine and improve its fraud detection and prevention efforts. Notably, we are assessing the effectiveness of different types of pre-payment edits in Medicare and of CMS's oversight of its contractors in implementing those edits to help ensure that Medicare pays claims correctly the first time. We are also examining the use of predictive analytics to improve fraud prevention and detection. Additionally, we have work underway to identify the types of providers and suppliers currently under investigation and

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<sup>38</sup>HHS-OIG, *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*, OEI-03-10-00500 (December 2011).

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those who have been found to have engaged in fraudulent activities. These studies may enable us to point out additional actions for CMS that could help the agency more systematically reduce fraud in the Medicare program.

Due to the amount of program funding at risk, fraud will remain a continuing threat to Medicare, so continuing vigilance to reduce vulnerabilities will be necessary. Individuals who want to defraud Medicare will continue to develop new approaches to try to circumvent CMS's safeguards and investigative and enforcement efforts. In particular, although targeting particular types of providers whom the agency has identified as high risk may be useful, it may allow other types of providers committing fraud to go unnoticed. We will continue to assess efforts to fight fraud and provide recommendations to CMS, as appropriate, that we believe will assist the agency in this important task. We urge CMS to continue its efforts as well.

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Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other members of the committee may have.

For further information about this statement, please contact Kathleen M. King at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Sheila Avruch, Assistant Director; Jennie Apter; Jennel Harvey; Anne Hopewell; Lisa Rogers; and Jennifer Whitworth were key contributors to this statement.

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## Related GAO Products

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*Medicare Program Integrity: CMS Continues Efforts to Strengthen the Screening of Providers and Suppliers.* GAO-12-351. Washington, D.C.: April 10, 2012.

*Improper Payments: Remaining Challenges and Strategies for Governmentwide Reduction Efforts.* GAO-12-573T. Washington, D.C.: March 28, 2012.

*2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue.* GAO-12-342SP. Washington, D.C.: February 28, 2012.

*Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Expand Efforts to Support Program Integrity Initiatives.* GAO-12-292T. Washington, D.C.: December 7, 2011.

*Medicare Part D: Instances of Questionable Access to Prescription Drugs.* GAO-12-104T. Washington, D.C.: October 4, 2011.

*Medicare Part D: Instances of Questionable Access to Prescription Drugs.* GAO-11-699. Washington, D.C.: September 6, 2011.

*Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness.* GAO-11-592. Washington, D.C.: July 29, 2011.

*Improper Payments: Reported Medicare Estimates and Key Remediation Strategies.* GAO-11-842T. Washington, D.C.: July 28, 2011.

*Fraud Detection Systems: Additional Actions Needed to Support Program Integrity Efforts at Centers for Medicare and Medicaid Services.* GAO-11-822T. Washington, D.C.: July 12, 2011.

*Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use.* GAO-11-475. Washington, D.C.: June 30, 2011.

*Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments.* GAO-11-409T. Washington, D.C.: March 9, 2011.

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**Related GAO Products**

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*Medicare: Program Remains at High Risk Because of Continuing Management Challenges.* GAO-11-430T. Washington, D.C.: March 2, 2011.

*High-Risk Series: An Update.* GAO-11-278. Washington, D.C.: February 2011.

*Medicare Part D: CMS Conducted Fraud and Abuse Compliance Plan Audits, but All Audit Findings Are Not Yet Available.* GAO-11-269R. Washington, D.C.: February 18, 2011.

*Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments.* GAO-10-844T. Washington, D.C.: June 15, 2010.

*Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight.* GAO-10-143. Washington, D.C.: March 31, 2010.

*Medicare Part D: CMS Oversight of Part D Sponsors' Fraud and Abuse Programs Has Been Limited, but CMS Plans Oversight Expansion.* GAO-10-481T. Washington, D.C.: March 3, 2010.

*Medicare: CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program.* GAO-10-27. Washington, D.C.: November 6, 2009.

*Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments.* GAO-09-628T. Washington, D.C.: April 22, 2009.

*Medicare: Improvements Needed to Address Improper Payments in Home Health.* GAO-09-185. Washington, D.C.: February 27, 2009.

*Medicare Part D: Some Plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited.* GAO-08-760. Washington, D.C.: July 21, 2008.

*Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process.* GAO-08-955. Washington, D.C.: July 3, 2008.

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**Related GAO Products**

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*Medicare: Thousands of Medicare Providers Abuse the Federal Tax System.* GAO-08-618. Washington, D.C.: June 13, 2008.

*Medicare: Competitive Bidding for Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical.* GAO-08-767T. Washington, D.C.: May 6, 2008.

*Improper Payments: Status of Agencies' Efforts to Address Improper Payment and Recovery Auditing Requirements.* GAO-08-438T. Washington, D.C.: January 31, 2008.

*Improper Payments: Federal Executive Branch Agencies' Fiscal Year 2007 Improper Payment Estimate Reporting.* GAO-08-377R. Washington, D.C.: January 23, 2008.

*Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies.* GAO-07-59. Washington, D.C.: January 31, 2007.

*Medicare: More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers.* GAO-05-656. Washington, D.C.: September 22, 2005.

*Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs.* GAO-05-43. Washington, D.C.: November 17, 2004.

*Medicare: CMS Did Not Control Rising Power Wheelchair Spending.* GAO-04-716T. Washington, D.C.: April 28, 2004.



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

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Good morning, Chairman Baucus, Ranking Member Hatch, and other distinguished Members of the Committee. Thank you for the opportunity to testify about the Office of Inspector General's (OIG) role in the prevention, investigation, and prosecution of fraud, waste, and abuse in the Federal health care programs.

In September 2011, the Department of Health and Human Services (HHS) and the Department of Justice (DOJ) announced indictments against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$295 million in false billing. At that time, this coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history. My testimony provides an inside view of how OIG conducts health care fraud investigations and coordinates national Strike Force takedowns.

#### **OIG and Its Partners Are Leading the Fight Against Health Care Fraud**

##### *Recordbreaking Recoveries Through the Health Care Fraud and Abuse Control Program*

In fiscal year (FY) 2011, the work of OIG, the Centers for Medicare & Medicaid Services (CMS), and DOJ resulted in criminal health care fraud charges against more than 1,430 defendants, 743 criminal convictions, 977 new investigations of civil health care fraud, and recoveries of nearly \$4.1 billion in taxpayer dollars. This is the highest annual amount ever recovered from individuals and companies through the Health Care Fraud and Abuse Control (HCFAC) Program.

Accomplishments such as this are the result of collaboration and innovation in the fight against health care fraud. HHS-DOJ collaborative efforts are rooted in the HCFAC Program. The HCFAC return-on-investment is at an all-time high. Over the past 3 years, for every \$1 spent on the HCFAC Program, the Government has returned an average of \$7.20. From 1997 to 2011, HCFAC activities have returned more than \$20.6 billion to the Medicare Trust Funds. In FY 2011, for the second consecutive year, coordinated interdepartmental anti-fraud efforts have resulted in more than \$4 billion in recoveries.

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) has been integral to these successes. The HEAT initiative marshals significant resources across the Government to prevent health care fraud, waste, and abuse; crack down on those who commit fraud; and enhance existing partnerships between HHS and DOJ.

*Medicare Fraud Strike Forces Are a Proven Success In Fighting Fraud*

Medicare Fraud Strike Force Teams are an essential component of HEAT.<sup>1</sup> Strike Force teams are designed to identify and investigate fraud, and prosecute perpetrators quickly. Strike Force teams are composed of dedicated prosecutors from DOJ and U.S. Attorneys Offices and Special Agents from OIG; the Federal Bureau of Investigation (FBI); and, in some cases, State and local law enforcement agencies. These “on the ground” enforcement teams are supported by data analysts and CMS program experts. This coordination and collaboration has accelerated the Government’s response to criminal health care fraud, substantially decreasing the average time from the start of an investigation to its prosecution.

Strike Force Teams use sophisticated data analysis and a collaborative approach to focus enforcement resources in geographic areas at high risk for fraud. Strike Force cases are data driven to pinpoint fraud hot spots through the identification of suspicious billing patterns as they occur in real time. The Strike Force model has proven highly successful. Since their inception in 2007, Strike Force operations in nine cities have led to more than 1,200 individuals being charged for fraud schemes involving approximately \$3.7 billion in claims.

**Case Study: ABC Home Health and Florida Home Health**

The fraud scheme involving ABC Home Health and Florida Home Health (ABC/Florida) provides a case study into the investigative underpinnings of Strike Force activities.<sup>2</sup> In ABC/Florida, more than 50 individuals were convicted in connection with a \$25 million fraud scheme relating to home health and physical therapy services. ABC/Florida billed the Medicare program for expensive physical therapy and home health services that either were not medically necessary, never provided, or both.

The scheme involved kickbacks and bribes paid to patients, patient recruiters, and doctors. Doctors were paid up to \$300 per prescription, plans of care (POCs), and medical certifications for medically unnecessary therapy and services. These providers falsified patient files with descriptions of non-existent medical conditions, such as hand tremors, unsteady gait and poor vision, to make it appear that beneficiaries qualified for home health and therapy services. Patients were paid up to \$1,500 per month to attest to services that were not medically necessary or never rendered. Patient recruiters were paid up to \$500 per patient to keep patients enrolled with the home health agency.

*Initial Phase of the Investigation*

In late 2008, the Miami Strike Force team began investigating ABC, based on a lead from a law enforcement source. ABC, as with most of our Strike Force cases, followed an investigative

<sup>1</sup> OIG and DOJ launched their Strike Force efforts in 2007 in south Florida to identify, investigate, and prosecute DME suppliers and infusion clinics suspected of Medicare fraud. Building on the success in Miami, Strike Force teams have been established in eight more locations—Los Angeles; Detroit; Houston; Brooklyn; Baton Rouge; Tampa; and, most recently, Dallas and Chicago.

<sup>2</sup> Press releases available at <http://www.justice.gov/usao/fls/PressReleases/111206-02.html> and <http://www.justice.gov/usao/fls/PressReleases/110204-03.html>.

model that has proven highly successful in these cases: 1) analyze and evaluate Medicare claims data, 2) obtain the Medicare enrollment application, 3) identify the medical biller, 4) obtain and analyze relevant banking information, and 5) identify the “true” owner of the Medicare provider that is under investigation as well as suspected co-conspirators. As part of this process, we analyzed Medicare billing data to look for billing anomalies, examined bank records for evidence of kickback payments, and interviewed witnesses and cooperators with inside information. Through this process, we developed an “investigative snapshot” of the suspected fraudulent activity.

As part of the investigation, we conducted time analysis reports – for example, a report flagged as an indicator of potential fraud might show a home health aide billed for visits to 15 people 3 times per day. Analyzing such data could reveal that it is physically impossible to actually conduct that many visits due to traffic considerations, complexity of services, and hours in the day. We also learned that different home health agencies were billing for the same beneficiaries – patient recruiters sometimes shop beneficiaries to different home health providers in an attempt to get more money.

We also worked with cooperating medical providers who reviewed the data with the investigating agents and helped determine whether billings matched what was actually on patient charts. The investigation revealed falsified patient files and aberrant billing patterns attributable to ABC/Florida. Bank records showed large sums of money transferred to sham companies and subsequently turned into cash.

Within about 6 months, we had built a strong enough case to obtain indictments for eight subjects, including two owners of ABC/Florida. These indictments included charges of health care fraud, conspiracy to commit health care fraud, kickbacks, and conspiracy to commit money laundering.

These indictments are not the end of the story, but rather led to a series of follow up investigations and indictments based on evidence obtained from search warrants executed at ABC/Florida and owner Gladys Zambrana’s home. Agents discovered incriminating evidence at both locations including payment kickback ledgers and cash payments designated for health care personnel and patient recruiters. After procuring this evidence, we continued to analyze billing data, medical records, financial records, and interviews with cooperators to ferret out co-conspirators in the fraud.

Simultaneously, we worked with CMS to guard against similar fraud schemes. ABC/Florida’s scheme exploited Medicare’s “outlier” payments – additional payments to home health for beneficiaries who incur unusually large costs. ABC/Florida and its conspirators were claiming that beneficiaries were sicker than they really were to cash in on undue outlier payments. OIG took a broader look and found that ABC/Florida was not an isolated case. In fact, in 2008, Miami-Dade County accounted for 52 percent of the \$1 billion Medicare paid nationally in home health outlier payments, while only 2 percent of all Medicare beneficiaries receiving home health

services resided there.<sup>3</sup> To address these abuses, CMS set a limit on the percentage of outlier payments that each home health agency may claim.

Claims data indicate that these program integrity efforts have had a significant impact. In Miami, Medicare's total home health payments dropped by more than a third and its home health outlier payments dropped by more than 90 percent from 2009 to 2011.

As the investigation continued from June 2009 through December 2011, agents secured cooperation from ABC/Florida personnel who had been indicted. Actionable intelligence developed from these cooperators revealed that many other home health agencies were engaged in frauds similar to ABC/Florida.

This intelligence, coupled with medical record reviews and analysis of financial and billing data, helped agents identify additional co-conspirators, which in turn led to supplementary indictments in the February 2011 national Strike Force roundup.

As a result of additional intelligence from cooperating witnesses, search warrants were executed at Courtesy Medical Center (Courtesy Medical), which was instrumental in perpetuating the ongoing fraud—the attending physician (Dr. Dweck) at Courtesy Medical was responsible for prescribing home health services for beneficiaries billed by ABC/Florida. Agents obtained a ledger from Courtesy Medical that detailed all the home health agencies that were paying kickbacks to Courtesy Medical and Dr. Dweck for home health prescriptions. The foregoing led to additional indictments that were part of the September 2011 national Strike Force takedown.<sup>4</sup>

#### **September 2011 Takedown**

On September 7, 2011, HHS and DOJ announced a nationwide Strike Force takedown in 8 cities resulting in charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$295 million in false billing. At that point, this coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history.

The schemes included submitting claims to Medicare for treatments that were medically unnecessary and often were never provided. In many cases, patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers so that the providers could submit fraudulent billing to Medicare for services that were medically unnecessary or were never provided.

In Miami, over 40 defendants, including 1 doctor and 1 nurse, were charged for their participation in various fraud schemes involving a total of \$159 million in false billings for home health care, mental health services, occupational and physical therapy, durable medical equipment (DME), and HIV infusion. In some instances, beneficiaries who were residents of halfway houses were allegedly threatened with eviction if they did not agree to attend the mental health center.

<sup>3</sup> <http://oig.hhs.gov/oei/reports/oei-04-08-00570.pdf>.

<sup>4</sup> <http://www.justice.gov/opa/pr/2011/September/11-ag-1148.html>.

Additional defendants were charged in Houston, Baton Rouge, Los Angeles, Brooklyn, Detroit, and Chicago for schemes involving home health and DME. One defendant allegedly sold beneficiary information to 100 different Houston-area home health care agencies in exchange for illegal payments.

#### *Orchestrating a Strike Force Round Up*

The September 2011 takedown exemplifies the numerous benefits of conducting large-scale operations. Because of the viral nature of health care fraud, it is more effective to make multiple arrests on the same day in particular geographic areas with high volumes of fraud. Once it becomes public that a subject has been arrested, others that may be involved in the criminal activity may try to flee to avoid arrest or send their illegal proceeds off-shore. Executing searches and arrests of numerous suspects simultaneously helps law enforcement maintain the element of surprise. In addition, we can save money and increase efficiency when we leverage resources from local law enforcement partners in these fraud-intense areas, instead of transporting agents from across the country. Finally, the national recognition given to large-scale nationwide operations serves as a deterrent.

Once DOJ determines that numerous cases are nearing indictment, senior officials with OIG and DOJ coordinate with the Strike Force teams to plan the execution of search and arrest warrants. Coordination meetings may begin on weekly basis and ramp up to daily briefings nearing the date of a takedown.

Close coordination among the takedown cities is critical. For example, prior to the September 2011 operation, subjects of cases worked by the Detroit Strike Force were determined to be living in Miami, necessitating coordination between the two Strike Forces.

Senior officials ensure that the Strike Force teams have the necessary tools and appropriate number of agents to safely and efficiently carry out the operation. We may also request personnel assistance from other Inspector General (IG) offices, through the Mutual Assistance Program, to help execute search and arrest warrants. During the September 2011 operation, we were assisted by 14 agents from IGs of 5 different agencies, including the United States Postal Service, the Department of Homeland Security, the Social Security Administration, the Department of Transportation, and the Railroad Retirement Board.

The scale of a roundup, i.e., the number of people who will be arrested and the number of search warrants executed, evolves throughout the planning process based on investigative case developments.

#### *Agents On the Ground*

Agents planning large-scale strike force operations are responsible for locating subjects to be arrested and verifying where those individuals reside. This includes researching subjects' background for criminal history; weapons possession; and other information, such as family members that may be encountered during the arrest. Agents may also conduct surveillance of the arrest location.

Each lead case agent develops an operational plan, which includes subject information, including criminal history and background; team assignments; emergency information, including the address to the nearest hospital; and detailed information about the location where the search and/or arrest warrant will be executed.

Prior to the execution of the operation, the case agent is responsible for securing arrest and/or search warrants. The agent must also coordinate with the U.S. Marshals Service and Pre-Trial Services for support with prisoner processing.

The lead case agent also conducts an operational briefing for arrest teams, often the evening prior to an operation. Agent assignments are given during this time based on particular agent's skill sets and operational needs. For example, assessments are made regarding the need for weapons and tactical support, linguistic skills for witness interviews, and computer forensics. This intricate, detailed planning is done to not only ensure a successful operation, but to guarantee the safety of all participants.

On the day of an operation, we typically hold a pre-dawn meeting proximate to the place where the warrant will be executed. During these meetings, agents review information with a focus on safety, such as whether arrest subjects have a violent criminal history and whether there are firearms known to be at the location.

Arrest warrants are often served in conjunction with search warrants. Evidence seized during an operation might include billing ledgers, phone records, receipts, computers, thumb drives, and other electronic and non-electronic evidence. Criminals are increasingly using technology to defraud Medicare. We have a team of expert computer forensic examiners to seize and analyze electronic evidence.

After an arrest, the suspect is processed, which includes taking photos, fingerprints, and obtaining basic biographical information. We may also conduct post-arrest interviews to obtain additional information related to the alleged scheme. Once the prisoner is processed, s/he appears before a Magistrate for an initial appearance, typically on the same day as the arrest.

Post-arrest, OIG agents are still on the job providing pre-trial support, such as preparing witnesses for trial, ensuring witnesses are available for interviews, reviewing evidence, gathering additional evidence, preparing evidence for trial, and ultimately testifying at trial.

*Dedicated, Resourceful, and Well-Trained Agents Are the Cornerstone of Every Investigation*

Highly specialized and advanced training underpins our successful investigations and operations. OIG special agents participate in a rigorous 12-week basic training program at the Federal Law Enforcement Training Center (FLETC). That regimen, known as the Criminal Investigator Training Program, trains agents on skills including interviewing, surveillance, undercover operations, criminal case management, legal training, writing and execution of search and arrest warrants, courtroom testimony, physical techniques and conditioning, tactical training, firearms,

vehicle handling skills, physical evidence, and other courses that provide the essential knowledge, skills, and abilities needed by new special agents.

Upon completion of FLETC basic training, OIG agents complete 6 weeks of specialized training geared toward OIG's health care mission. OIG is the only agency focusing full time on combating fraud, waste, and abuse in Medicare and Medicaid, and OIG special agents develop extensive subject matter expertise in health care fraud investigations. This specialized training covers, among other things, an in-depth education on Medicare and Medicaid, a wide range of health care fraud schemes and current trends, medical identity theft, organized criminal activity in health care fraud, undercover operations related to health care fraud, and advanced law enforcement training in areas such as firearms and defensive tactics.

As OIG continues to encounter more sophisticated and dangerous criminal enterprises in health care fraud, OIG special agents hone their defensive skills through quarterly firearms and defensive tactics training. Many OIG agents undergo advanced technical training on investigative technology, data analysis, advanced tactics, and use of the law enforcement rifle system during enforcement operations.

#### **The Future of Fraud Fighting**

We are at a turning point in our fight against fraud. For typical Strike Force cases, we have significantly decreased the average time from the start of an investigation to its prosecution. Our specialized training and advanced data analytics have changed the way we investigate cases. Historically, we had built cases from the bottom up, investigating individual criminals and working our way to the top of the pyramid. Data analytics now enable us to more quickly identify the head of a criminal enterprise from which we can also more swiftly identify the co-conspirators and related schemes.

With new enforcement tools in the Affordable Care Act, payment suspensions will help ensure that the Government can effectively stop perpetrators from absconding with ill-gotten program funds. Important changes to the False Claims Act, the Federal anti-kickback statute, OIG's administrative authorities, and the Federal Sentencing Guidelines, among others, will help the Government more effectively prosecute those who defraud or abuse Federal health care programs.

As we continue to fight fraud in the face of technologically sophisticated criminals, we must continually build on our capabilities to maintain our success. We will utilize our resources to develop knowledgeable professionals able to collect and analyze the growing volume of computer and other electronic evidence seized during search warrants. As we confront increasing violence and weapons in the field, we will continue to provide our agents the training and equipment necessary to ensure their safety. Finally, we will continue to utilize data analytics to identify the locations and program areas most vulnerable to fraud and allocate our resources accordingly. This strategy has resulted in significant accomplishments, including achieving a return on investment of more than \$7 to \$1 over the past three years.

**Conclusion**

Our fraud investigations are one essential tool among many that OIG brings to bear to protect HHS programs, beneficiaries, and taxpayers. OIG employs a comprehensive and holistic approach to:

- prevent and detect health care fraud, waste, and abuse;
- ensure that programs are run efficiently and effectively;
- promote compliance by health care providers and suppliers;<sup>5</sup> and
- hold accountable those who defraud Medicare or Medicaid.

Through the dedicated efforts of OIG professionals and our collaboration with HHS and DOJ partners, we have achieved substantial results in the form of recoveries of stolen and misspent funds, enforcement actions taken against fraud perpetrators, improved methods of detecting fraud and abuse, and recommendations to remedy program vulnerabilities.<sup>6</sup> Finally, we have enhanced tools and authorities and have engaged in new initiatives aimed at achieving our mission. Thank you for your support of this mission.

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<sup>5</sup> More information on OIG's compliance initiatives is available at <http://oig.hhs.gov/compliance/>.

<sup>6</sup> More information on OIG's program integrity activities can be found in OIG's Semiannual Report to Congress, available at <http://oig.hhs.gov/reports-and-publications/semiannual/index.asp>, Compendium of Unimplemented Recommendations, <http://oig.hhs.gov/reports-and-publications/compendium/2011.asp>, Top Management & Performance Challenges, <http://oig.hhs.gov/reports-and-publications/top-challenges/2011/>, and the annual Health Care Fraud and Abuse Control Program (HCFAC) Report, <http://oig.hhs.gov/reports-and-publications/hcfac/index.asp>.





