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PROTECTING MEDICARE AND MEDICAID: EFFORTS TO PREVENT, INVESTIGATE, AND PROSECUTE HEALTH CARE FRAUD

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME AND TERRORISM

OF THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

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PROTECTING MEDICARE AND MEDICAID: EFFORTS TO PREVENT, INVESTIGATE, AND PROSECUTE HEALTH CARE FRAUD

MONDAY, MARCH 26, 2012

U.S. SENATE,
SUBCOMMITTEE ON CRIME AND TERRORISM,
COMMITTEE ON THE JUDICIARY,
Providence, Rhode Island

The Subcommittee met, pursuant to notice, at 10 a.m., East Providence Senior Center, 610 Waterman Avenue, East Providence, RI, Hon. Sheldon Whitehouse, Chairman of the Subcommittee, presiding.

Present: [None.]

OPENING STATEMENT OF HON. SHELDON WHITEHOUSE, A U.S. SENATOR FROM THE STATE OF RHODE ISLAND

Senator WHITEHOUSE. Good morning, everyone. Welcome to today's field hearing of the Senate Judiciary Committee's Subcommittee on Crime and Terrorism.

We have convened this hearing in Rhode Island today to consider a topic that is extremely important to Rhode Island seniors, families and children, and that is protecting Medicare and Medicaid from fraud and abuse.

Thousands of Rhode Islanders rely on Medicare and Medicaid for effective and affordable care, and rising costs, particularly from fraud and abuse, threaten to undermine these critical programs.

I want to thank the East Providence Senior Center for hosting us. Bob Rock has done a lot to make this go smoothly. Thank you very much, Bob.

I want to recognize John Martin, who is here representing the AARP. And in addition to our witness, Ted Doolittle from CMS, Ray Herd, who is the Deputy Regional Administrator for CMS, Sylvia Yu from the Office of Legislation of CMS, and Maureen Kerrigan, who is CMS' liaison to the Senior Medicare Patrol, are all here and I want to thank them for joining us.

We all have a role to play in protecting Medicare and Medicaid from fraud and abuse. I have been working with my colleagues in Congress to enact new tools for our investigators and prosecutors to fight fraud. Law enforcement at the State and Federal level play an important role in investigating and prosecuting bad actors. And Rhode Island seniors and health care providers can function as eyes and ears on the ground, identifying possible fraud and protecting themselves and their neighbors.

We have in the audience today Edla Fortin, who is a member of our State Senior Medicare Patrol, which works to protect beneficiaries from fraud and billing mistakes.

By coordinating efforts between Congress, Medicare and Medicaid administrators, law enforcement, seniors, and providers, we can reduce fraud and strengthen Medicare and Medicaid so that Rhode Islanders can continue to rely on these vital programs without having to bear the burden of fraud.

A serious effort in Congress, unfortunately, is underway to do away with Medicare, as we know it, and to slash the support the Federal Government provides for Medicaid. Last year, the House of Representatives passed a Republican budget which would have privatized Medicare and required seniors to pay the majority of their health expenses on their own.

We defeated the House Republicans' plan last year, but just last week, they announced that they will try again.

I believe we need to stem the rising costs of health care rather than just forcing seniors and families to pay more of those costs. One way to do this is to fight fraud and abuse in all of its forms—patients being billed for services they did not receive, drug companies seeking reimbursement for improper uses of prescription drugs, scam artists using scare tactics or bogus mailings to sell phony health insurance plans, or organized crime groups stealing seniors' Medicare, Medicaid, or banking information through deceptive sales pitches.

Federal authorities in Dallas recently arrested a Texas doctor and six others in a scheme using homeless people to charge for home health services that they, of course, never received.

Authorities say the fraud operation cheated the government out of nearly $375 million in Medicare and Medicaid fees. This shameful criminal behavior hurts individual seniors, taxpayers, the vast majority of honest health care providers who receive reimbursement from Medicare and Medicaid, and, of course, the financial stability of the programs themselves.

I have been working hard in the Senate to fight health care fraud. In 2010, for example, I cosponsored and helped to pass bipartisan Medicare fraud-fighting legislation that was signed into law as part of the Small Business Jobs Act. The law required Medicare to adopt state-of-the art technology, the same kind of predictive modeling systems that are used by the credit card and banking industries to identify unusual or anomalous billing, and that will help identify fraudulent claims and billing patterns before taxpayer funds are spent.

This year I cosponsored the bipartisan Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayer Dollars Act, which would further improve CMS' ability to stop fraudulent claims before they are paid out, cut down on fraud in the Medicare Part D prescription drug program, and strengthen penalties for certain types of fraud.

And along with three other Senators, I have requested from the Government Accountability Office a report on vulnerabilities for fraud in Medicare data bases and prescription drug programs. These actions will help support the great work that our law en-

forcement officials do to prevent and punish Medicare and Medicaid fraud.

I look forward to learning more today about their efforts. I also look forward to hearing from our representatives of the senior and health care provider communities, two groups that can help us fight the fraud that threatens our system.

As many of you know, a hearing is a formal opportunity for Congress to learn more about an issue. The witness testimony becomes part of the official legislative record and provides valuable guidance to Congress in conducting oversight of government activities and updating our Nation's laws.

We are fortunate this morning to have two panels of expert witnesses. The first panel consists of our State's Attorney General, Peter Kilmartin; Rhode Island's U.S. Attorney, Peter Neronha; and Ted Doolittle of the Centers for Medicare and Medicaid Services, or CMS, the Federal agency that administers Medicare and Medicaid.

On the second panel, we will hear from Catherine Taylor, the head of Rhode Island's Division of Elderly Affairs; and Mary Benway, President of the Rhode Island Partnership for Home Care.

I will take what we learn from today's discussion in Rhode Island back to Congress and will continue to work on bipartisan solutions to keep these crucial programs working for Rhode Island seniors and families.

I thank the witnesses for coming to share their expertise and all of the attendees today for recognizing the need to protect these programs.

If I can ask first that the first panel stand and be sworn for the hearing.

[Witnesses sworn.]

Senator WHITEHOUSE. Please be seated. We will start with our Attorney General, Peter Kilmartin.

Peter was elected to Rhode Island's Attorney General office in 2010. Before taking office, he had served for nearly 20 years as a State Representative in Rhode Island's General Assembly. Concurrent with that time, Attorney General Kilmartin served the community as a member of the Pawtucket Police Department for 24 years.

He earned his bachelor of arts from Roger Williams University and later returned to earn his jurist doctorate from Roger Williams School of Law.

Attorney General Kilmartin has received numerous public service awards from organizations including Mothers Against Drunk Driving, the Boys' and Girls' Club, Gateway Healthcare, and the Northern Rhode Island Chamber of Commerce.

His office is active in health care fraud investigation and prosecution. And I am delighted to have him here and thank him for his testimony.

Attorney General Kilmartin.

STATEMENT OF HON. PETER F. KILMARTIN, ATTORNEY GENERAL FOR THE STATE OF RHODE ISLAND, PROVIDENCE, RI

Mr. KILMARTIN. Thank you, Senator. First, let me thank you for inviting me to be here today and be part of this panel on such an important issue, especially for Rhode Island seniors. And it is an

issue that the Rhode Island Attorney General's office takes extremely seriously.

We have a Medicaid Fraud and Patient Abuse Unit, which consists of 11 individuals from two attorneys, case investigators, and field operatives who basically go out and try to investigate fraud in the Medicaid field, patient abuse, and we try to work collaboratively—and this is what I think is part of the key and one of the things that I want to express to Congress—that we work collaboratively with so many organizations at the State level, be it Department of Elderly Affairs, Health and Human Services.

We work with private entities, Alliance for Long-Term Care, and many organizations, and we work closely with my colleague who you are going to hear from in a moment, U.S. Attorney Peter Neronha's office. And that collaboration is really what I consider the key to the success of our unit, because it does two things. One, we know what each other are doing as far as the prosecution and investigation goes; and, No. 2, these collaborations bring information to us.

Most people think that the Rhode Island Attorney General's office is an investigatory agency. They'll say—you'll hear on the news, "And call the Attorney General and have them investigate this immediately." Well, for the most part, we handle the prosecution. Most things are investigated by the Rhode Island State Police.

But on this issue, when it comes to Medicaid fraud and abuse, we are the enforcement agency. We are the investigatory agency, and we are the folks who determine, in the final analysis, whether there is someone who we could charge either with a crime or maybe seek civil remedies or, if necessary, turn the case over to the U.S. Attorney's office for prosecution.

So it's an extremely specialized unit. Last year, we took in over $1 million, I think it was $1.1 million in moneys from fraud and abuse, and we think there is much more money out there and we're working diligently to get that money.

I have provided some written testimony, copies of which are available at the back of the room. So I didn't want to read to you all of the nuts and bolts of what the office does. I wanted to give you a brief oversight now orally and then I'm sure as we get into this, Senator, we'll get into a little more detail as to the nuts and bolts of what we do.

[The prepared testimony of Mr. Kilmartin appears as a submission for the record.]

Senator WHITEHOUSE. Thank you, Attorney General. Your full statement will be, without objection, entered into the record of this proceeding.

Our next witness is Peter Neronha, who—I guess we are all graduates—almost all of us are graduates, one way or the other, of the Department of Attorney General. He currently serves as United States Attorney for the District of Rhode Island. He was nominated for that position by President Obama and confirmed by the Senate on September 15, 2009.

Mr. Neronha began his career in public service in 1996, when he was appointed a Special Assistant Attorney General in the Rhode Island Department of Attorney General.

In 2002, he joined the office of the United States Attorney for the District of Rhode Island. Prior to being named United States Attorney, Mr. Neronha was chief of the district's Organized Crime Strike Force.

He graduated summa cum laude from Boston College and earned his JD magna cum laude from Boston College Law School. And we are delighted to have him with us.

Mr. Neronha.

STATEMENT OF HON. PETER F. NERONHA, U.S. ATTORNEY FOR THE DISTRICT OF RHODE ISLAND, U.S. DEPARTMENT OF JUSTICE, PROVIDENCE, RHODE ISLAND

Mr. NERONHA. Thank you, Senator. And thank you for inviting me to speak with you today about the Department of Justice's efforts to combat health care fraud. I'm also delighted to be here in East Providence, where I see so many friends, including my friend, Jim Dooby, who I haven't seen for longer than I'd like.

"At no cost to you." Those five words have become synonymous with health care fraud. When you're sitting at home and you receive a phone call from someone you don't know telling you that you can get a piece of medical equipment or home health care services at no cost to you because the government will pick up the cost, alarm bells should be going off in every American's head. More likely than not, you are being asked to participate in a fraudulent scheme.

Such schemes are underway all over the United States, including right here in Rhode Island. These types of schemes and other types of health care fraud are costing American taxpayers billions of dollars and are misdirecting health care dollars which could be spent on those actually in need.

Health care fraud threatens the long-term health 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, our children, disabled, and the needy.

While most health care providers are doing the right thing, some target Medicare and other government and private health care programs for their own financial benefit. With the rising cost of medical care, every dollar stolen from our health care programs is $1 too many.

Accordingly, together with our colleagues at the Department of Health and Human Services, CMS and our State partners, like Attorney General Kilmartin and his office, we are aggressively investigating and prosecuting health care fraud cases, securing prison sentences for hundreds of defendants every year across the Nation, and recovering billions of dollars in stolen funds.

With the additional resources provided to us by Congress over the past 3 years, we are doing more than ever before. In fiscal year 2011, the government's health care fraud and prevention efforts recovered nearly $4.1 billion in taxpayer dollars. 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 are not entitled.

Assistant United States Attorneys from my office, working with our law enforcement partners, have handled a wide variety of health care fraud matters, including false billings by doctors and other providers of medical services, overcharges by hospitals, 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.

I want to discuss with you this morning, briefly, just three recent examples of the kinds of health care fraud cases we're seeing right here in Rhode Island.

The first matter I'd like to discuss involves Rhode Island Hospital. This case was resolved just this past February, when the hospital agreed to reimburse Federal health care programs approximately $2.6 million and pay approximately $2.7 million in double and treble damages for ordering medically unnecessary overnight patient stays and then submitting claims for payment to federally funded Medicare and Medicaid programs.

Our investigation determined that for approximately 6 years, from 2004 to 2009, medically unnecessary overnight hospital admissions were ordered for approximately 260 patients who underwent radio-surgery, otherwise known as gamma knife treatment.

Rhode Island Hospital's claims for reimbursement for the overnight admissions to Medicare and Medicaid falsely represented that the admissions were medically necessary, when, in fact, they were not.

A second case worth noting involves Planned Elder Care, a nationwide supplier of durable medical equipment, headquartered in Illinois. The owner of the company recently was sentenced to 37 months in Federal prison right here in Rhode Island for defrauding the Medicare program.

This health care fraud scheme was a classic example of an "at no cost to you" scheme. From 2005 until 2009, the company owner told his employees to call people like you and me out of the blue and ask them if they suffered from diabetes or arthritis. If you or I said that we did, the Planned Elder Care employee told that person they could provide them with products at no cost to you.

They then asked the person for their physician's name, information, and their Medicare information, and then they ordered useful products, literally, useless products, billing Medicare for the cost to the tune of approximately $2.2 million.

One last example involves Med Care Ambulance, a Warwick ambulance company. In November of 2011, Med-Care Ambulance's owner was sentenced to 24 months in Federal prison, again, right here in Rhode Island, for defrauding Medicare and Blue Cross of more than $700,000. This was a classic over-coding scheme in which Med-Care Ambulance charged Medicare and Blue Cross for specialty ambulance runs when, in fact, those runs were routine.

Unfortunately, these cases are not unique. The good news is that Federal, State and local law enforcement, using both traditional and new data-driven techniques of the kind Senator Whitehouse alluded to, are working effectively and efficiently to combat these schemes.

Working together, we have had tremendous success, returning over $20.6 billion to Medicare trust funds since the inception of the

program in 1997. I expect that the success will continue. And I thank you for being with you today.

[The prepared testimony of Mr. Neronha appears as a submission for the record.]

Senator WHITEHOUSE. Thank you, Peter. Without objection, your full written statement will also be made part of the record.

Our final witness on this panel is Ted Doolittle. Ted is the Deputy Director for Policy at the Center for Program Integrity at the Centers for Medicare and Medicaid Services.

Mr. Doolittle is a former Federal prosecutor, with a long career in health care and law enforcement. Prior to his current position, he worked for UnitedHealthcare's legal and regulatory affairs department. Before that, he served as an assistant attorney general in the health care fraud and whistleblower department of the Connecticut Attorney General's office. Mr. Doolittle has also served as a trial attorney in the U.S. Department of Justice's Tax Division.

He completed his undergraduate studies at Harvard University and earned his JD from the University of Connecticut School of Law.

Thank you, Mr. Doolittle.

STATEMENT OF MR. TED DOOLITTLE, DEPUTY DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. DOOLITTLE. Thank you so much, Senator Whitehouse, and it's good to be in East Providence. I'm not from East Providence, but I have close family ties here. My in-laws are here today. My wife is a 1977 graduate, I believe, of East Providence High School, and she was actually voted most likely to succeed, which the plan was going according to plan until she met me in our third year of law school.

[Laughter.]

Mr. DOOLITTLE. So, anyway, as the Senator said, I am the Deputy Director of the part of Medicare and Medicaid that's responsible for waste, fraud and abuse.

Chairman Whitehouse, thank you so much for the invitation to be here in Rhode Island to discuss how the Centers for Medicare and Medicaid Services, which we call CMS, has improved program integrity and has continued to reduce waste, fraud and abuse in Medicare and Medicaid and the Children's Health Insurance Program.

This Administration has made a truly historic commitment to fighting fraud and developing unprecedented new tools to do so. Fraud, waste and abuse in our health care system is a problem that affects both public and private health insurance plans and it drains critical resources from our health care system, contributes to the rising cost of health care for all, and endangers the quality of care, in fact, that patients receive.

It's important to keep in mind that most health care providers and suppliers who work for Medicare and Medicaid are honest. We're trying to target those who are not. We're trying to target those who are trying to defraud us, the American people and taxpayers.

Thanks to recent laws that the Senator alluded to, such as the Affordable Care Act, which is also known as the health care reform law, and the Small Business Jobs Act that was passed by Congress and that Senator Whitehouse had a great deal to do with, CMS has more tools than ever before to protect the Federal health programs.

Our recent innovations in fighting Medicare fraud we call our "twin pillar" strategy. The first pillar is to keep fraudulent providers out using our new automated provider screening system, where we're able to quickly and—using computers that do screening that had to be manually done before. And the other part of the program is what we call the fraud prevention system, which I'll probably allude to at various times during my testimony. The fraud prevention system is the new computer modeling system, the type of protection that the credit card companies use so that you know that you're going to get a call if you try to charge five flat screen TVs in Idaho and you live in East Providence.

This is the kind of technology that we're trying to bring for the first time to the public health care programs.

So in just 8 months, the system got up and running on June 30 of last year, and we've shown impressive results. It has identified thousands of fraud alerts, which are matters that need to be investigated by us or our law enforcement partners.

The system so far has led to over 800 active investigations by our fraud contractors around the country. And, in addition, we've done 400 direct interviews with providers that we would not have otherwise identified. This is in addition to our very large traditional work. I'm just telling you what we're getting out of our new computer modeling system.

Also, like credit card companies, we're using the new system to identify beneficiaries—that's the folks who are our Medicare patients, we call them beneficiaries—when they might be a target of a fraud scam.

And as a result, again, of this computer system, this new computer system we call the FPS, we've conducted over 1,200 interviews with beneficiaries to confirm that they received services that Medicare was billed for.

I really want the folks in the room who are Medicare beneficiaries to understand that our beneficiaries are really probably our single most valuable partner in fighting fraud. Last year alone, our 1–800–Medicare line received over 49,000 beneficiary calls that had to do with fraud.

We use those calls—we follow-up on them and we use them in various ways to try to detect fraud. You're our eyes and ears, you're our antenna on the ground, and we really need you to pay attention and if you suspect anything, please call 1–800–MEDICARE or you can contact the local Senior Medicare Patrol. And I thank Maureen and Edna for being here today.

As a reminder, any beneficiary whose tip leads to the recovery of dollars associated with Medicare fraud can, in fact, be eligible for a cash award of up to $1,000. So there is some incentive to scan those explanations of benefits which we call the Medicare summary notice that comes to you quarterly.

Let me give you an example of this type of tip to 1-800–MEDICARE. There was a local beneficiary who reported to us that his

Medicare ID had been stolen and that somebody, he suspected, was billing for services that were not provided. So we quickly worked to confirm that the providers in both Rhode Island and Massachusetts were, indeed, billing for services that had not been provided to our beneficiary and then we placed a flag on that Medicare beneficiary's number, noting that the number was compromised, and protecting the beneficiary from further abuse and illegitimate charges on the account; and, of course, still allowing the person to use it for their necessary services, but we would just flag the unnecessary services and be aware of them as they came through. And we're taking appropriate action on that provider. So that's a local case.

So, again, I urge you to, as a beneficiary or as a family member or caregiver, stay alert and vigilant and review those Medicare billing statements online, if you've got computer capability. That's at myMedicare.gov. Again, that's myMedicare.gov, or look for the mailed quarterly Medicare summary notices.

And we've just—those quarterly forms are good. They're packed with information. We've actually just improved it and made it simpler and easier to understand. Those new notices you should start seeing in your mailboxes in early 2013. The new notice is available right now, the simplified notice, which is easier to use, at myMedicare.gov.

Recently, some bad actors have targeted beneficiaries with scams claiming to offer durable medical equipment for free or at a reduced cost to the patient. Peter really went into that very well, but—so I would just add.

There is no such thing as a free lunch, that's true, and if something sounds too good to be true, it generally is. And think about this. You should guard your Medicare card and your Medicare number like you would your debit card, if that debit card had your PIN on it. That's a level of security you need to think about.

And I ask you to think about this. Would your bank call you up and ask for your account number? Your bank doesn't call you up and ask for your account number. Medicare doesn't either. So keep that in mind.

So in addition to the beneficiaries and the families that we have to work so closely with, we're working closely with our other key partners to protect Medicare and Medicaid. And I'm pleased to be joined by two of my colleagues in the fight, U.S. Attorney Peter Neronha and Attorney General Petr Kilmartin.

Our partners include the office of the Inspector General, the Department of Justice, State Medicaid offices, and I see that Jim Dubay and Ralph Rocca are here. I know them from our partnership, with training our State Medicaid officials. And partners, of course, from the health care sector, the private industry.

We're committed to working with all of our partners to combat waste, fraud and abuse, and we're continuing to improve and expand the ways that we work with these groups.

Thank you, Chairman Whitehouse, for this opportunity to outline CMS' efforts to cut waste, fraud and abuse in Medicare, Medicaid and CHIP. With the new tools Congress has provided and the coordinated efforts of that outlined above, the Administration and CMS have been successful in combating waste, fraud and abuse,

and we look forward to working with beneficiaries, providers, community partners, and Congress to continue our efforts to prevent and identify health care waste, fraud and abuse.

And, Senator Whitehouse, if I could just end on a personal note, it's always an honor for any citizen to be able to address any arm of Congress. But this has particular personal resonance for me, because my great-grandfather, George Norris of Nebraska, was, for many years, the Chairman of the full Judiciary Committee in the 1920s and 1930s. So it's a great privilege for me to be here today.

Thank you.

[The prepared testimony of Mr. Doolittle appears as a submission for the record.]

Senator WHITEHOUSE. Not to mention that your wife is from East Providence.

[Laughter.]

Senator WHITEHOUSE. A more important thing, at least to us here in Rhode Island. But thank you very much, Director Doolittle. And, also, without objection, your entire written statement will be made a part of the record of this proceeding.

What I would like to bring up, and I will start with a question for Attorney General Kilmartin, is the new predictive modeling software.

I worked very closely with Senator Lemieux of Florida, our Republican colleague, on that legislation. We worked on it for months and months and, eventually, when I was satisfied with it, I joined him on the bill, and then he went to his leadership and I went to mine and we were able to get it into the Small Business Jobs Act. And it's been a while getting up and implemented, but it's in place now.

And as I said in my opening statement, it is the difference between basically a flood of payments going out of Medicare and then you discover that there has been fraud and then you have to go and chase down the person who was paid versus having the same kind of computer program that causes you to—if you have traveled, if you have ever had a phone call from your credit card company saying, "Were you just in Fort Lauderdale" or "Were you just in Arizona," and they are calling because they got a bill from there and they were not tracking you, the computer said, "This is different than usual, somebody should give a call and check it out."

And so the program that—it is called predictive modeling that does that, and that is now being implemented by CMS.

Now, Rhode Island was actually ahead on this. And so I want to talk to Peter, because his Medicaid fraud control unit, Attorney General Kilmartin, has been working with a program like this that has dealt with Medicaid fraud through the State Department of Health and Human Services.

And if you could describe a little bit what your experience with it has been and if you have any advice for us as the Federal program that is nationwide and a little bit broader goes forward, I would love to hear your thoughts, because you have worked with this longer than we have.

Mr. KILMARTIN. Thank you, Senator. Basically, what this program is is something that's done by Hewlett Packard and it's a form of—I guess you would call it maybe data mining.

It's an analysis of the trends, as the Senator mentioned, that are happening and they pick up on abnormalities in those trends and then try to extract that data and investigate it and turn it over to us.

We, as an agency, are barred from doing any data mining type activities. So we rely on this Hewlett Packard model, and it is an effective model and it is—the analogy was made to credit cards.

I can remember once my wife and I being on vacation and getting a call from the credit card company, "We saw a charge here, are you there." And it is—that's the analogy. They see these abnormalities in these charges to Medicaid and Medicare.

So it's a very effective tool and it's one that works on a couple of levels, not the least of which it gets that information to us for further investigation. But from our perspective, one of the nice things is it's a 90/10 split as far as funding. The Federal Government pays 90 percent of it, 10 percent of it is paid by the State.

That being said, Senator, the data analysis and all of the work that is done and the statistics that are being drawn out is a very expensive program, even at 10 percent from the State. And I know in Congress these days, there's a lot of debate as to funding, but a block grant for States who are actively pursuing this, to help them with the 10 percent, I think, would go a long way toward helping us.

The other thing is Chairman Constantino, to help get some of this data, has put in for more investigators under Health and Human Services, something we support, because when that is done and we can root out more for more abuse and get it turned over to us, it's more that we can, No. 1, protect the seniors and, No. 2, hopefully, recover dollars, precious dollars for the State and the national government.

The other point that I want to bring up about it—and one thing I do appreciate about the model is that they are not averse to getting new information. If we find a trend or we find a better way to help that model, they are receptive to it. They encourage us to say, "You know, you may be seeing this area where we can do a little more improvement," and they are receptive to that, and that's good, because they are not stuck in one mode, if you will, where "Here's the model, this is what it is, take it." It's, "Give us your feedback, help it grow," and that's a positive.

The other part, though, one thing where we do potentially see an area of improvement would be, for instance, if there was a crossover from Medicaid and Medicare, and I'll give the example of maybe someone who is on a non-Medicaid transport and going to a doctor's office. And you'll see that charge and that charge will go to Medicare.

What will happen, though, is the transport might get charged to Medicaid. So Medicare gets the bill, Medicaid gets the bill for the transport, and the data mining system may pick up that. "What is this transport? We don't see anything—any nexus. Is it a fraudulent billing," and you have to take the time and the resources to investigate that and then you find out it was for a non-emergency situation.

So for those crossover types of billings, to have the system communicate, that may stop us from wasting precious time, if you will,

to do the investigation to find that there was nothing wrong, there was nothing abnormal, it was just a dual billing and a crossover billing. So to have the system somehow talk down the line, I think, would be a great improvement and streamline us in our investigation.

Senator WHITEHOUSE. Well, I think that's a very good and logical next step. We've gone from having just the local Medicaid fraud control units have access to this, and they're all different state-by-state, to having the national program just for Medicare to a bill that is pending that would actually tie all the Medicare programs together under it, and then the next logical step would be to tie Medicare and Medicaid so that there is that cross-reference. So that's a very good suggestion.

Director Doolittle, let me ask you. How is it going on the rollout? Are you seeing any results? What would be good next steps to strengthen the predictive modeling program?

Mr. DOOLITTLE. Let me thank you for the question, Senator. Let me just go off what Attorney General Kilmartin says.

I think it is important for Medicaid to be able to talk to Medicare. It's a tremendous data challenge, because the States we've got, and then we've got territories and so forth, and so we've got 56 different data—types of data that need to be worked together in a way that—you know when you change a computer system, you know how difficult that is. We've got 56 that we need to get together.

That was mentioned in the Small Business Jobs Act. We need to ultimately mesh our fraud prevention system that works with Medicare, fee-for-service data, with the Medicaid programs, as well. So that is an important next step that we need to take and that we're committed to taking.

You asked about the rollout of the predictive modeling, and let me just give you some statistics. We're very pleased with how it's going so far. We started on June 30 of last year and we've identified so far over $35 million in improper payments. This has also resulted, Senator—and as a former prosecutor, you know the importance of this—this has resulted in over 800 active investigations.

These are the conservative numbers that I'm telling you, which are only—which wouldn't have been found without our new predictive modeling. Our new predictive modeling can also help ongoing cases that were found through traditional leads. I'm just giving you the conservative view of what only we know would not have been found at all thus far without the predictive modeling.

So we've got 846 active investigations. We've had over 400 interviews with providers, and those are important not only as investigative tools, but if you are a provider who is either over the line or close to the line and somebody comes to talk to you, it can have a dramatic effect on your behavior, because you know now you're on our radar screen. So those are important.

We've conducted close to 1,300 telephone interviews with beneficiaries to confirm that the services were rendered as they were billed to us.

So as you know, under the bill that you were active with, Senator, the Small Business Jobs Act, we are required to make a full

report on all our results and our measures of success by September 30 of this year. We're working toward developing those metrics. It's a new system, much different from our old pay-and-chase model, which is easy to score how much was stolen and how much are we trying to get back.

Here we're trying to figure out what we caught up front and what we prevented going forward. So it's a very interesting and difficult measurement problem, but we really look forward to getting you a report that we can all mull over that is thoughtfully and thoroughly done by September 30 of this year.

So by this time next year, we'll have a much better view, but that's a preliminary look at how we're doing so far.

Senator WHITEHOUSE. Good. Well, I will look forward to the September 30 report.

I wanted to ask you and U.S. Attorney Neronha. There is health care fraud prevalent throughout the system, and U.S. Attorney Neronha listed three cases that our U.S. Attorney's office has done very recently.

But for all of that, it does strike me that some of these real whopper cases, when I read about them—maybe this is just an anecdotal view, but they seem to disproportionately emerge from Florida, Texas and, somewhat, California.

In terms of the national picture, are there hot spots that we should be concerned about; and, I guess I'd ask, is Rhode Island one of them?

Mr. NERONHA. Well, Senator, my answer to that is that certainly the department recognizes that there are hot spots. Florida has traditionally been one, particularly in the area of durable medical equipment. And the trend seems to be that that issue is moving north into Georgia.

That is why the department has stood up, I believe, nine strike forces in some of those hot spots around the country. There is one in Boston, and certainly there is a good connection between HHS since the SAC, the special agent in charge, is in Boston.

So there are hot spots around the country. I can get the specifics of these, if the Senator would like. I know Detroit is another; certainly, Miami or south Florida. Boston is another. But, certainly, there are those hot spots.

But leads are pushed out not only to and from the strike force cities, but from the department generally. There is data that is pushed out from the department through both the department itself. Some information comes directly to the U.S. Attorneys' offices from DOJ.

We have access to an HHS data base called the STARS data base, from which people in my own office can search for anomalies and outliers to run down cases. And then HHS, as I said pushes out information to the various field offices, as well.

But there's no question there are hot spots around the country.

Mr. DOOLITTLE. I certainly agree with everything that Mr. Neronha stated. At this point, the HEAT program, which is a joint effort between DOJ and the Department of Health and Human Services, who really bring to bear, in a very focused way, our investigative and prosecution resources and to try to get as small as pos-

sible, as short as possible, the time between when we detect crime and when there's an ultimate indictment.

Those nine cities, Attorney Neronha is absolutely right. There are a couple in Florida. In Florida, it's Miami and Tampa. And then the other—there are nine at this point. There's ambition and a plan to move it out to a larger group of cities, but right now there's nine.

So in Florida, we have Miami and Tampa, and then, also, Baton Rouge, Louisiana, Los Angeles, California, Houston, Texas, Detroit, Michigan, Brooklyn, New York, Dallas, Texas, and Chicago. Those are where we're concentrating right now.

As I mentioned, we are—DOJ and HHS are, I'm hopeful, going to expand that. We recently were going through an exercise at my office to analyze where some good likely candidates for HEAT and strike force expansion were and, as part of that, because I knew I was coming here, I did have a little bit of work done around Providence in Rhode Island. And I will say that there is fraud everywhere in the Nation, but we don't have any plans to expand to a strike force or anything like that around here.

Senator WHITEHOUSE. Well, I think I will conclude the panel with a last question, which I think is connected to this. And I think one of the reasons that Rhode Island is not a hot spot and that people can get away with these huge billing scams in other places is that in Rhode Island, we do tend to know each other. And if somebody set up a shop someplace in Warwick or East Providence and put out millions of dollars in fraudulent Medicare billing, somebody would notice.

[Laughter.]

Senator WHITEHOUSE. It would be hard to kind of pull that off for long, we would hope. And a lot of that has to do with the activity of seniors and other folks who are alert to fraud. We will talk about that more in the next panel.

But my last question for this panel is that Director Doolittle mentioned that a senior could get a cash award of up to $1,000 if a tip on fraud through the 1–800–MEDICARE hotline number proved productive. And I wanted to find out a little bit more about what we might be able to do to raise that limit, knowing that it would be a good thing. And if you are looking at even a $1 million fraud, set aside a $375 million fraud, $1,000 is not a particularly big piece of it, and, in particular, by comparison to—I am going to get lawyery on this, but there is a thing called a qui tam action in which somebody can file a lawsuit basically in the name of the government for fraud and if they proceed with it, they get a very significant share of the proceeds. In fact, people can retire off what they get off a good, successful qui tam action.

So somewhere between the $1,000 limit and requiring people to become qui tam plaintiffs, is there room to—do you think it is something that we should look at to provide a greater incentive to seniors and others to report Medicare fraud?

Attorney General Kilmartin, I would ask you to lead and go right across the panel to U.S. Attorney Neronha and Director Doolittle.

Mr. KILMARTIN. I do, and, actually, it's something that was mentioned earlier. I forget who if it was by Ted or Peter, when they

said the best eyes and ears we have are the folks who are the recipients of Medicare and Medicaid.

And I view one place in particular as ripe for fraud and abuse and while the dollars don't add up or seemingly are small, when you take them all combined, they add up to significant dollars, and that's in the area of home health care and personal care attendants at home. Because if you're having a personal care attendant at home, one of the best things you folks can do to help us is keep a log of the time they're going to be there, how many hours they're there a day or a week, because that's where a lot of over-billing can occur, at the very small face-to-face level, if you will. And that's a place that can be ripe for abuse.

Now, you may say it'll only be a few hundred dollars a day, but if you times that by all of the patients and all of the days, that can run into significant dollars.

So I think that's one place, in particular, where we can get a lot of help from seniors and from folks who are recipients of these Federal programs.

And the other thing that—if I can just diverse a little bit off of that. In Rhode Island, we got a $1.3 million grant for a pilot program to do national background checks of these home health care attendants who can come into your homes, and we are trying to get the legislature to pass that to enable us to do that so we can protect seniors, so you know that someone coming into your home doesn't have a criminal record and so forth. So anything you folks can do on that.

Again, it's at this home—really, the trend now, as you folks know better than I, nationally is to have home health care, keep people out of hospitals, keep people out of nursing homes, and that's a wonderful thing. It was a goal we had with my mother right up until the day she passed away 6 months and 6 days ago.

So with that, you can be very helpful with us, though, on those two things. Home health care is so important, and that's one place I think seniors and all of us can really pay attention to. To, number one, protect each other, but, No. 2, for the system itself, maintain its integrity and watch the dollars and cents, because they add up to millions and billions in the end.

Senator WHITEHOUSE. Thank you, Attorney General.

U.S. Attorney Neronha.

Mr. NERONHA. Senator, just a quick housekeeping matter. Apparently, I mentioned Boston as one of those strike forces. Apparently, I was wrong. I thought that they were. I know they're acting, but let me correct that, first of all.

But I think, Senator, you are absolutely right. Just a couple things. One, you are absolutely right to focus on data mining. Of the three cases that I mentioned, which I consider to be high impact cases in Rhode Island, two of them were the result of data mining.

But to address the final point that you asked us to address, the third one, the planned elder care case, in which this company was calling elders out of the blue and saying, "Here's all this equipment and no cost to you," we got onto that case because a Medicare beneficiary, somebody like all of us sitting in this room, went to their physician and said, "Hey, you know, they're charging Medicare for

all this stuff. What's up with this," and the physician called HHS and we were off to the races.

So I think you are absolutely right in hitting in those two ways of getting leads and attacking this problem.

Certainly, any incentive that would encourage people to come forward would be wonderful. But I will say we are getting so many leads from seniors who just recognize that, look, something is wrong here, that the program has really been very successful because of that.

Senator WHITEHOUSE. Director Doolittle.

Mr. DOOLITTLE. Yes. Thank you for your question. The program that we have now in place, it's called the incentive reward program, and when I first took this job, one of the first things I wanted to do, almost, I think, literally the first day on the job, was can we get an incentive reward program of this type, because the beneficiaries are so important to our anti-fraud efforts. They are our best eyes and ears. How can we reward it and how can we get it onto their billing statements that come?

Well, we've got it onto the billing statement. Well, excuse me, it turned out that I wasn't aware of it, because it was little publicized, it turned out that there was already this incentive reward program in place. It was little used. There is the limitation, which doesn't make any sense, because $1,000 is a lot of money, but it doesn't have that—the umph that you're looking for and that we are, too; and, also, the timing of when the rewards can be given out and the difficulty—I won't get into the technicalities of it. But these rewards are, unfortunately, difficult for us to give out as frequently as we'd like.

Now, the good news here is that we do have the necessary statutory authority, Senator, but what we don't have is we don't have the right regulations in place. So one of our regulatory priorities for this year is actually to get some improvements to that statute.

Our basic idea, just to give you a preview of coming attractions, is to kind of parallel a similar incentive reward program that the IRS has, and that is a 15 percent reward program. There is a cap. It doesn't go up to the hundreds of millions of dollars, but there is a cap at like $10 million.

So we're thinking of something along those lines, but we also need to get changes in place and we may need statutory changes, but we also may not, to make sure that we can pay the claims—any claim against this quickly.

Right now, the status is we can't actually pay until we recover the money. As you know, that could be years. So where is the incentive there?

So we've made the improvement of getting a reference to the incentive reward program onto the new Medicare summary notice, and that will be rolled out into everybody's mailboxes in 2013 and is available now online.

So at least we're having the advertisement part of it right, and we need to get the speed and the amount right. So we're working on that right now.

Senator WHITEHOUSE. Good. Well, that gives me a project, too, to ride herd on that and try and make sure it gets done quickly and effectively.

So let me conclude with this panel by thanking the three witnesses. Attorney General Kilmartin is doing a wonderful job as attorney general, but I know that it is an extremely busy office and I appreciate that he took the time out today.

We are very proud of you, Peter. Thank you very much for your great service.

Mr. KILMARTIN. Thank you, Senator.

Senator WHITEHOUSE. U.S. Attorney Neronha, thank you very much. I know a little bit about that office, as well, and it is a demanding one, and I am grateful to you that you have taken time out for this.

Mr. NERONHA. Glad to be here.

Senator WHITEHOUSE. You are also doing a superb job, and very grateful to have you here.

And, Director Doolittle, thank you for coming up from Washington for this. I am glad I gave you a chance to connect with the in-laws.

[Laughter.]

Senator WHITEHOUSE. We will take a 5-minute recess while we change the tables for the next panel.

[Recess.]

Senator WHITEHOUSE. The hearing will come back to order. And I will begin by asking the second panel to please stand and be sworn.

[Witnesses sworn.]

Senator WHITEHOUSE. Thank you very much. Please be seated.

I am delighted to have these witnesses here and appreciate very much that they have taken the trouble to come.

Let me start with Director Taylor. Catherine Taylor is our Director of the Rhode Island Division of Elderly Affairs within the Rhode Island Department of Human Services. Prior to her appointment to head the Division of Elderly Affairs, Ms. Taylor was a partner at Lang Taylor, Limited, a Providence-based public affairs consulting firm, which she co-founded in 2007.

She previously worked for 20 years as an aide to the late and great Senator John Chafee, and then to Senator Lincoln Chafee. She is a graduate of Yale University, and I am delighted to have her here.

Please proceed with your testimony, Ms. Taylor.

STATEMENT OF MS. CATHERINE TAYLOR, DIRECTOR, RHODE ISLAND DIVISION OF ELDERLY AFFAIRS, STATE OF RHODE ISLAND DEPARTMENT OF HUMAN SERVICES, PROVIDENCE, RI

Ms. TAYLOR. Thank you, Senator. I really appreciate your inviting me here to call attention to the highly successful activities of the Rhode Island Senior Medicare Patrol, and I'm delighted to be here in East Providence at Bob Rock's fantastic senior center and to see so many partners in the work here.

And thank you for calling attention to my service for Senator Chafee. Senator Whitehouse, I always know how to get in touch with you, because it is my old phone number. So we've got the hotline going on.

[Laughter.]

Ms. TAYLOR. Several significant—and can people in the back hear? I understand that there was a problem hearing in the back. So raise your hand if you can't.

Several significant cases of suspected Medicare fraud have occurred in the last few years in Rhode Island, and these aren't redundant, I don't think, from the previous panel.

Between March 2008 and December 2010, a Warwick, Rhode Island ambulance company owner allegedly defrauded Medicare and Blue Cross/Blue Shield of Rhode Island out of more than $700,000 by soliciting beneficiaries to receive medically unnecessary ambulance transportation.

In 2010, a Massachusetts-based dermatologist agreed to repay $275,000 for Medicare payments for unnecessary pathology services.

In April 2011, CVS Pharmacy paid the United States, Rhode Island, and nine other states a collective $17.5 million to resolve allegations of over-billing Medicaid for prescription claims.

And in January 2012, a Woonsocket, Rhode Island woman pleaded guilty to committing Medicare fraud by obtaining Medicare numbers from seniors at senior centers, senior housing facilities, and assisted living facilities and ordering numerous diabetic shoes and arthritis equipment at no cost to the seniors and without their knowledge. Medicare was charged more than $70,000.

Now, Rhode Island's 184,000 Medicare beneficiaries can play an active role in ensuring that the Medicare trust fund remains solvent by working on the front lines to prevent the multi-billion dollar annual drain on the program nationwide attributable to fraud.

The Senior Medicare Patrol, or SMP program, keeps our Medicare beneficiaries alert to possible fraudulent activity and, importantly, arms them with the knowledge and the tools to combat it.

The Rhode Island Division of Elderly Affairs, DEA, has administered the Senior Medicare Patrol program since 2006, with funding from the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services.

The SMP program marshals the efforts of senior volunteers to teach their peers how to fight Medicare fraud. And I think it's important to point out, too, that unlike a lot of other financial abuse that seniors suffer, that we work very hard at Elderly Affairs and with our ombudsman to combat, this fraud is not felt directly by the seniors. It is passed through their bills straight to Medicare. So that's why the SMP is important. And this year, pursuant to the Affordable Care Act, the Federal Government is ramping up its anti-fraud effort, offering grants to States to beef up volunteer recruitment and to provide rigorous training to volunteers.

Rhode Island was fortunate to receive a 1-year grant to engage a volunteer recruiter and trainer, Louanne Marcello, who is here in the audience today, along with DEA's SMP program manager, Aleatha Dickerson, in the back. They do a great job.

The Rhode Island Division of Elderly Affairs and our SMP partners have worked diligently over the last 3 years to publicize the SMP message. In the 2011 SMP funding year, we conducted the following activities that may have resulted in decreased Medicare fraud, waste or abuse and maybe it's the explanation why we're not a hot spot, Senator. 8,016 Medicare and Medicaid error, fraud,

waste or abuse simple inquiries were received, right here in Rhode Island; 4,223 people, it's estimated, have been reached by our community education events; 34 fraud, waste or abuse complex issues are pending further action; and, we have 40 active volunteers recruited and trained in 1 year with this new 1-year grant, and we really expect that to increase this year.

SMP volunteers are helping their peers get in the habit of carefully reviewing their Medicare summary notice each month, on the lookout for discrepancies, such as charges for services, equipment or medications never prescribed or provided. In fact, I saw a fellow that goes to my church, yesterday, who lives here in East Providence who said he didn't know he had a knee replacement until Medicare told him he'd had one.

[Laughter.]

Ms. TAYLOR. Charges for appointments that were never made, or with an unknown physician, or extraordinarily high bills. Other common Medicare scams include counterfeit prescription drugs, double billing both Medicare and a private insurance company for the same service, billing for individual counseling when group counseling was used, and medical identity theft.

One-on-one counseling and general education sessions are available in Rhode Island at six SMP partner locations—THE POINT at United Way, Tri-Town Community Action Agency, South County Community Action Agency, the East Bay Community Action Program, the West Bay Communication Action Program, and Child and Family Services of Newport County.

Volunteers help check paperwork, such as Medicare notices and billing, to identify those errors and discrepancies.

The greatest ally of any scam artist is silence. SMP volunteers teach their peers that stopping Medicare fraud is as easy as 1–2–3—protect your Medicare number, detect discrepancies on your Medicare summary notice, report your concerns.

Anyone who suspects they have been a victim of fraud or abuse can file a report with the Rhode Island SMP program by calling 462–0931.

It is exciting that Medicare beneficiaries are taking ownership of protecting the Medicare program from fraud. One of our newest volunteer recruits at West Bay CAP, 82-year-old Edla Fortin, sitting here, who Senator Whitehouse told us was here, a controller and accountant at Columbus Door, responded recently to an ad in December saying, "I started thinking how much older people can give back to their community." And Barbara Hackett, a retired project manager at AT&T and a resident of East Greenwich, says of the Medicare beneficiaries she assists, "I want to make them feel empowered."

It's also essential that we harness the volunteer power of Medicare beneficiaries themselves to do this work. No one is better positioned to recognize fraud or more invested in ensuring that Medicare dollars are there for them, not the scam artists.

Thank you, again, Senator Whitehouse, for allowing me to showcase what an excellent investment the Senior Medicare Patrol is.

[The prepared testimony of Ms. Taylor appears as a submission for the record.]

Senator WHITEHOUSE. Thank you very much, Director Taylor.

Our next witness is Mary Benway. She is a professional nurse, and she is President of the Rhode Island Partnership for Home Care. She has over 30 years' of experience in health care, specializing in long-term care.

Since 1985, she has been the owner and President of Community Care Nurses, a long-term home health care provider in Rhode Island. And since 1996, she has been the owner and Vice President of Capital Home Care, a Rhode Island Medicare skilled home care provider.

Ms. Benway has been a member of the Rhode Island Partnership for Home Care since 1990 and has twice headed the organization as its president.

She holds a bachelor's degree in business administration, and we are delighted to have her here today.

Ms. Benway.

STATEMENT OF MS. MARY BENWAY, PRESIDENT, RHODE ISLAND PARTNERSHIP FOR HOME CARE, NORTH KINGSTON, RI

Ms. BENWAY. Thank you, Senator. I appreciate the opportunity to speak with you today. And hello to you and members of your committee.

And as the Senator stated, I am currently the President of the Rhode Island Partnership for Home Care. So, obviously, I'm going to be speaking to fraud and abuse in home care today.

The Partnership for Home Care is a statewide trade association for licensed home nursing care, home care, and hospice agencies in Rhode Island, and this is nonprofit and proprietary organizations. So we are a very unusual organization, representing the broad spectrum of providers in home health care.

I'm also a registered nurse and owner and principal of both Medicare and Medicaid home care and long-term care providers, and, like many of you, as most of you, a taxpaying citizen of this country and this State.

Before I begin my formal remarks on behalf of the Partnership for Home Care, I want to take this opportunity to say that as a professional, a small business owner, and a taxpayer, I'm appalled, as well, by the horrendous behavior of unscrupulous health care providers and I support any effort to confront agencies that are abusing the Medicare and Medicaid system and the patients that they serve.

Both I and the Partnership for Home Care applaud the swift action of Federal agencies and State law enforcement after a Texas doctor and owners of five home health care agencies were charged earlier this month with $375 million in fraud against Medicare and Medicaid.

Home health care, non-medical care, and hospice agencies provide for thousands of Rhode Island citizens every day. Among our patients are those who have acute illnesses and need short-term care, older adults who need long-term support to remain living in the community, persons with disabilities who may have medical issues and need assistance with activities of daily living, and, also, children with special health care needs.

We're also a major employer here in the State. Our industry employs thousands of professionals and para-professionals.

The services home care provides are not only most preferred by patients and families, they are outcomes-based, patient-centered, and the least expensive alternative to costly institutional care. We help lower hospital admissions, help keep people living in their communities, and assist those at end of life, ensuring that their final days are comfortable and dignified, and that their families are also supported and cared for.

Many treatments that were once offered only in hospital or physician's office can now be safely, effectively, and efficiently provided in the patient's home. Chronic diseases, which are among the most costly of Medicare services, can be successfully managed by skilled home health care providers working with home care patients.

Every 13 seconds, another American turns 65 years old. This trend will continue for the next 20 years. In 2009, 3.3 million people received Medicare-funded home health care. With the onset of the aging baby-boom generations, millions more will join their ranks.

The time to repair the system is now. America's health care sector is rife with waste, fraud and abuse. The Government Accountability Office reported in January 2009 that 10 percent or $32.7 billion of Medicaid payments in 2007 were improper. Estimates of Medicare waste, fraud and abuse are even more staggering.

The home care industry and our National associations, the National Association for Home Care, the Visiting Nurse Association of America, have been champions for program integrity and have recommended to Congress, CMS, MedPAC, and other regulators various strategies to improve quality and payment integrity.

Before I explain some of them, I need to make clear the following. Medicare and Medicaid fraud and abuse in home care is a targeted problem which requires a targeted solution. MedPAC, the Medicare Payment Advisory Commission, has identified 25 counties in the United States with excessive home care utilization.

The home care problem is not nationwide. The percentage cost increase to Medicare of these 25 counties between the years of 2005 and 2009 was nearly 3.5 times the increase of the U.S. as a whole. The table which I've attached to this testimony identifies these 25 counties, which I will call the MedPAC 25, and these are located in the States of Texas, Louisiana, Oklahoma, Mississippi, and Florida.

When compared to the broader home health community, the growth in spending in these counties is totally out of line. The number of providers in the country grew by 7.3 percent 2005 to 2009, but the growth during that time period of these MedPAC 25 grew by 41.8 percent. Home health revenue growth in the U.S. during that same period averaged 11.75 percent. In the MedPAC 25, it was 40.8 percent.

It is crucial to eliminate fraud and abuse while also ensuring that beneficiaries maintain access to needed care. A current proposal to recoup lost Medicare revenue by charging beneficiaries a co-payment is not the right response to criminals' fraudulent billing. Rather than placing the financial burden on all recipients of

home care, the innocent, vulnerable and homebound seniors, our government needs to focus on and weed out the criminals.

That being said, there are some specific actions we think would go a long way to address the problem. Firstly, enact a moratorium on new certifications of Medicare participating home health agencies; cap outlier payments; require background and competency credentialing of home health agency owners, executives and managers; mandate that all home health agencies maintain a comprehensive compliance plan; require reporting of all financial relationships with patient referral sources; and, mandatory data transparency, make all claims data publicly available. We've already had a good discussion about the predictive modeling data analysis program.

There are other more detailed recommendations available from the National Association for Home Care, the Partnership for Home Health Integrity, the Visiting Nurse Association of America, and the Fight Fraud First Coalition. I urge you to review their expert reports, data and analysis.

On a smaller scale, the Rhode Island Partnership for Home Care has adopted a code of ethics to which each of our members must ascribe. The code is our pledge to conduct our business with integrity, treat our patients with dignity, and treat each other with respect. I've attached a copy of the code for your review.

We've also reminded our members to keep it legal and report any wrongdoing to Federal authorities. I've also attached a copy of a document identifying common practices that are prohibited. We invited the FBI and Interagency Health Care Fraud Program from Boston to meet with our members and acquaint them with fraud and abuse reporting processes.

I tell you this to demonstrate that we are taking steps, not just paying lip service, to our commitment to ethical business practices and compliance with Medicare and Medicaid requirements.

I close by reiterating a previous point. The home care industry is committed to quality, integrity and efficiency of the Medicare skilled home health benefit. The fraudsters are shining a negative light on us, and we want the HHS secretary, OIG and the Department of Justice to continue investigating abhorrent market practices and close the perpetrators down.

The expensive spending growth and over-utilization of services is not difficult to identify and with oversight from the committees like this, I'm confident that we can restore the public trust, save valuable resources, and provide exceptional care to those in the Medicare and Medicaid programs.

Thank you for this opportunity and for your attention, and I'd be happy to answer any questions you may have.

[The prepared testimony of Ms. Benway appears as a submission for the record.]

Senator WHITEHOUSE. Thank you, Ms. Benway.

It sounds as if the hot spot problem that we discussed with the first panel is equally, if not more acute, in the home health care agency. Is that your testimony?

Ms. BENWAY. Very much so, but as I said, in targeted areas of the country and may are repeat offenders, particularly in Texas and Louisiana and Florida.

Senator WHITEHOUSE. Let me ask both of you, starting with Director Taylor. The Senior Medicare Patrol is such a good idea. How do you recruit people for it? What can we do to be more helpful in your recruitment efforts?

I hope this hearing helps get the word out and brings volunteers to 462–0931.

Ms. TAYLOR. Thank you, Senator.

Senator WHITEHOUSE. And what advice do you have for seniors who might be considering volunteering for the senior Medicare patrol?

Ms. TAYLOR. Yes, sir. This hearing was enormously helpful. I know we got tremendous publicity around the program, and we have a booth here passing out information, as well, with our staff.

Part of the funding from our grant goes to publicity, and we've done a lot of work with radio ads and with print ads and going around giving events to try to recruit volunteers—I think that's what Ms. Fortin responded to is one of our ads in December—and to really broadcast that message that this is the way that we really can maintain the trust fund, that seniors need to be on the front lines.

Helping us with the grant money so that we can continue those recruitment efforts is important. We are on the third year of a $180,000 per year grant. We just hit the "send" button on our follow-on grant application a week ago Friday, and we have a 1-year grant now to ramp up the recruitment efforts, and we hope that that will continue.

I will say something about that grant, that CMS and AOA have a wonderful and very rigorous training module that has been put into place this time around and it's really going to be a model for other volunteer efforts.

So that support for our ability to continue with the outreach from the Federal Government is really, really helpful.

Senator WHITEHOUSE. And what would you tell a senior who was thinking about potentially joining the Senior Medicare Patrol? What is your advice to someone like that?

Ms. TAYLOR. Please join on! This is an opportunity to use your skills that you had in your professional life. For the actual counseling, we can use anybody who had a background in business or accounting, or even teachers who would give presentations to groups. We can use your skills now and you can help to save the program for other people.

I will also say, too, that the Corporation for National Service has asserted that for people over 65, there are actually strong, measurable health benefits to volunteering. Actually, you are doing as good a job as eating your vegetables or quitting smoking by volunteering once you hit the age of 65, and I'm not kidding about this.

So a program like this is actually a very valuable public health program, as well as an anti-fraud program. So I really encourage people to join it.

Senator WHITEHOUSE. Good and good for you.

Ms. TAYLOR. Exactly.

Senator WHITEHOUSE. Wonderful.

Well, Ms. Benway, what role do you see for senior volunteers in the home health care fraud industry?

Ms. BENWAY. Integral. I think it's very important that seniors advocate for themselves when they can, but when they can't, it's important that they have folks that can advocate for them. I think we welcome in home care. Certainly, one of our greatest roles as home care providers is as teachers to our patients, providing the services we need, but also fostering their learning about their diseases, particularly chronic diseases, and, also, the family members.

So we welcome and encourage volunteers or advocates for seniors. Oftentimes, it's a family member, but it could be someone from the community. I think the more—as they say, knowledge is power, and this could be a great help to us in our mission of teaching and helping folks to stay home and stay well.

Senator WHITEHOUSE. I encourage you two to work together.

Ms. BENWAY. Absolutely.

Ms. TAYLOR. And we do. We do.

Senator WHITEHOUSE. Ms. Benway, in your testimony, you said something that I thought was very important about home health care, "We help lower hospital admissions, help keep people living in their communities, and assist those at the end of life, ensuring that their final days are comfortable and dignified, and that their families are supported and cared for, as well.

I agree with all of that. I have seen it all in action. It is important to all of us to have the American health care system reduce hospital admissions where home care could provide the service at home, from a cost perspective.

It is certainly important to seniors who seek to be independent and to keep their lives out in their communities to be able to do that. It is one of the most important things that can be done for senior citizens. And, last, when the end of life comes, it is so important that those final days be comfortable and dignified and that families be supported through the difficulties of that change.

My father died at home and the reason that we could have that happen is because we had really wonderful home health care nurses who could help us with what was going to take place and help him remain comfortable and keep his dignity, and it just makes such a difference.

So all three of those things, I think, are important in terms of cost, in terms of people keeping their individual choices in their lives the way they have had them, and in terms of dealing with the most difficult and challenging of moments when we must lose a loved one.

And so it is really particularly infuriating when something that is so good as home health care services becomes an avenue for fraud.

Ms. BENWAY. Right.

Senator WHITEHOUSE. And I really applaud the specific recommendations you have made and I look forward to working with your organization to see what can be done by way of moving them into legislation.

We do two things in Congress. One is to legislate and create new laws. The other is to oversee the executive branch of government and its administration of laws that already exist. And, indeed, this week I will be putting out a report that I have done on the implementation of the Affordable Care Act, the health care reform bill's

delivery system reform provisions, the provisions that make health care better for people and lower the cost at the same time.

So I am very alert to the oversight functions of Congress of what we could from a regulatory and oversight perspective.

Do you have particular recommendations there, as well?

Ms. BENWAY. In terms of what could be done at CMS, I mean, one question I have to ask myself is that—when first I read about these atrocities in these States, the first thought that came to my mind was I had to wonder who was minding the store and why these obvious outliers didn't draw scrutiny and investigation sooner.

I think quick action is key. That was discussed here on the panel. I think whatever systems can be put in place to—we like to, call, scrub claims, make sure the claims are appropriate and proper before they're paid, because it's awfully difficult to chase folks once you've made the payment, because they know how to shut down shop and open somewhere else.

So I think speed and accuracy in scrutinizing claims, and I think claims transparency. Those would be the things that stand out, in my mind. I mean, we have——

Senator WHITEHOUSE. Tell me a little bit more what you mean by claims transparency and how do you protect patient privacy through that?

Ms. BENWAY. I guess that would be for them to figure out. I don't know. But I do know that the more providers know that people are watching what they're doing, the less chance you would have.

Good providers are not going to turn into bad providers. But I think when you look at these MedPAC statistics, you have to think, well, why the growth, why are these folks opening up shop.

We struggle every day as good providers who are playing by the rules really to pay our bills, to pay our staff, and to just make sure we keep open. And you have to wonder, why would—what would be so attractive to someone to open a shop in Florida and take on 50 patents. Something is wrong with someone that does that.

These types of things—one of the things I brought up in my solutions list was, again, to put a moratorium on this growth, this rapid growth, the signing on of "I want to be a Medicare provider."

It's not easy to do that and it shouldn't be easy, but I think however it can be done——

Senator WHITEHOUSE. And that is something CMS could do through regulation.

Ms. BENWAY. Absolutely. Absolutely. Let's slow this down. I mean, do we need all these providers? Why? Why is this happening? And CMS could certainly look at that. That could certainly be one thing they could do. Let's just hold the dam back and see what we've got for providers, see do we need all these new providers.

And then as I said, as providers are making claims for services, let's scrutinize these claims. Make it as transparent as possible. When people know they are being watched, they are going to behave.

Senator WHITEHOUSE. I think that is probably about as good a phrase to end this on as we could get.

[Laughter.]

Senator WHITEHOUSE. When people are being watched, they are going to know that they are going—when people know they are being watched, they are going to behave. And we are trying to watch them through our State and Federal law enforcement officials, as you saw in the first panel.

We are trying to bring new technologies that have proven themselves in other fields to bear, to watch the payment of claims, and we are counting on seniors who have done such an important job so far in reporting on fraud and abuse to also be the eyes and ears on the ground.

So let me thank you both for your testimony.

I would also like to add the news article about Edla Fortin into the record of these proceedings. And without objection, that record will be added.

[The article appears as a submission for the record.]

Senator WHITEHOUSE. And Nancy Roberts, who is the President and Chief Executive Officer, a VNA of CARE New England in Warwick, has provided written testimony that we will also add to the record of this proceeding.

[The information referred to appears as a submission for the record.]

Senator WHITEHOUSE. And the record of Congressional hearings remains open for 7 days after the gavel goes down at the end of the hearing. So if there is anything that anybody would like to contribute to the record of this hearing, you have 7 days to get it to my office and we will add it to the proceedings.

And with that, I will bring the hearing to a close, again, thanking Director Taylor and Ms. Benway for their testimony, and thanking our Attorney General, our U.S. Attorney, and Mr. Doolittle for their testimony. And thank you all very much for attending.

This has been interesting to me. I hope it has been interesting to you, as well.

[Whereupon, at 11:35 a.m., the hearing was concluded.]

[Submissions for the record follow.]

2012

SUBMISSIONS FOR THE RECORD

Testimony of Rhode Island Partnership for Home Care

Senate Judiciary Committee Subcommittee on Crime and Terrorism

Medicare and Medicaid fraud and abuse is a targeted problem. It needs a targeted solution.

Rhode Island Partnership
For Home Care, Inc

A unified voice for home care and hospice

Mary Benway, RN President
Rhode Island Partnership for Home Care
3/26/2012

Testimony of Rhode Island Partnership for Home Care

Senate Judiciary Committee Subcommittee on Crime and Terrorism

Monday March 26, 2012

Good morning Senator Whitehouse and members of the committee.

My name is Mary Benway and I am the president of the Rhode Island Partnership for Home Care.

The Partnership for Home Care is the statewide trade association for licensed home nursing care, home care and hospice agencies in RI.

I am also a registered Nurse, Owner and President of Community Care Nurses, a partner in Capitol Home Care Network and a tax paying citizen of this country and this state. Before I begin my formal remarks on behalf of the RI Partnership for Home Care I want to take this opportunity to say that as a professional, a small business owner and a tax payer I am appalled by the horrendous behavior of a few unscrupulous health care providers, and I support any effort to confront agencies that are abusing the Medicare and Medicaid system and the patients they serve.

Both I and the Partnership for Home Care applaud the swift action of federal agencies and state law enforcement after a Texas doctor and the owners of five home health care agencies were charged earlier this month with $375 million in fraud against Medicare and Medicaid.

Home health care, non medical home care and hospice agencies provide care for thousands of RI citizens every day. Among our patients are those who have acute illnesses and need short term care; older adults who need long term support to remain living in the community; persons with disabilities who may have medical issues or need assistance with activities of dialing living and children with special health care needs. We also are a major employer here in the state; our industry employs thousands of professionals and paraprofessionals.

The services home care provides are not only most preferred by patients and families; they are outcomes based, patient centered and the least expensive alternative to costly institutional care. We help lower hospital admissions, help keep people living in their communities and assist those at the end of life, ensuring that their final days are comfortable and dignified, and that their families are supported and cared for as well.

Many treatments that were once only offered in a hospital or physician's office can now be safely, effectively and efficiently provided in the patients' home. Chronic diseases, which are among the costliest of Medicare services, can be successfully managed by skilled home health care providers working with the patient.

Every 13 seconds, another American turns 65 years old. This trend will continue for the next 20 years. In 2009 3.3 million people received Medicare funded home health care. With the onset of the aging baby boom generation millions more will join their ranks. The time to repair the system is now.

America's health care sector is rife with waste, fraud and abuse. The Government Accountability Office reported in January 2009 that 10% or $32.7 billion of Medicaid payments made in 2007 were improper. Estimates of Medicare waste; fraud and abuse are even more staggering.

The Home Care industry and our national associations, the National Association for Home Care and the Visiting Nurse Association of America have been champions for program integrity and have recommended to Congress, CMS , MedPAC and other regulators various strategies to improve quality and payment integrity. Before I explain some of them I need to make clear the following:

Medicare and Medicaid fraud and abuse is a targeted problem which requires a targeted solution.

MedPAC has identified 25 counties in the US with excessive utilization. The problem is not nationwide.

The percentage cost increase to Medicare in these 25 counties, between the years of 2005 and 2009, was nearly 3.5 times the increase in the US as a whole. The table which I have attached to this testimony identifies those 25 counties, which I will call the "MedPAC 25".

When compared to the broader home health community, the growth and spending in these counties is totally out of line. The number of providers in the country grew by 7.3% in the 2005-2009 timeframe but the growth in the "MedPAC 25"grew by 41.8%. Home health revenue growth in the US during that same period averaged 11.75 % and in the "MedPAC 25" it was 40.8%.

You have to wonder who is minding the store and why these obvious outliers did not draw scrutiny and investigation.

It is crucial to eliminate fraud and abuse while also ensuring that beneficiaries maintain access to needed care. A current proposal to recoup lost Medicare revenue by charging beneficiaries a copayment is not the right response to criminals' fraudulent billing. Rather than placing the financial burden on all recipients of home care - the innocent, vulnerable and homebound seniors - our government needs to focus on and weed out the criminals.

That being said there are some specific actions we think would go a long way to address the problem:

1. Enact a moratorium on new certifications of Medicare participating home health agencies;
2. Cap outlier payments;
3. Require background and competency credentialing of home health agency owners, executives and managers;
4. Mandate that all home health agencies maintain a comprehensive compliance plan.
5. Require reporting of all financial relationships with patient referral sources
6. Mandatory Data Transparency- Make all claims data publicly available

There are other more detailed recommendations available from the National Association for Home Care, the Partnership for Home Health Integrity, the Visiting Nurse Association of America and the Fight Fraud First Coalition. I urge you to review their expert reports, data and analysis.

On a smaller scale, The Rhode Island Partnership for Home Care has adopted a code of ethics to which each of our members must ascribe. The code is our pledge to conduct our businesses with integrity, treat our patients with dignity and treat each other with respect. I have attached a copy of the code for your review. We have also reminded our members to "keep it legal" and report any wrong doing to federal authorities. I have also attached a copy of a document identifying common practices that are prohibited. We invited the FBI and interagency Health Care

Fraud Program from Boston to meet with our members and acquaint them with the fraud and abuse reporting process. I tell you this to demonstrate that we are taking steps, not just paying lip service to our commitment to ethical business practices and compliance with Medicare and Medicaid requirements.

I close by reiterating a previous point; the home care industry is committed to quality, integrity and efficiency of the Medicare skilled home health benefit. The fraudsters are shining a negative light on us and we want the HHS Secretary, OIG and the Department of Justice to continue investigating aberrant market practices and close the perpetrators down.

The expensive spending growth and overutilization of services is not difficult to identify and with oversight from committees like this, I am confident that we can restore the public trust, save valuable resources and provide exceptional care to those in the Medicare and Medicaid programs.

Thank you for your attention and I would be happy to answer any questions you might have for me.

Attachments:

US HH Program integrity

4 Reasons pdf

RIPHC Code of Ethics

STATEMENT OF

TED DOOLITTLE

DEPUTY DIRECTOR FOR POLICY

CENTER FOR PROGRAM INTEGRITY

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

PROTECTING MEDICARE AND MEDICAID:

EFFORTS TO PREVENT, INVESTIGATE, AND PROSECUTE HEALTH CARE FRAUD

BEFORE THE

UNITED STATES SENATE COMMITTEE ON THE JUDICIARY

SUBCOMMITTEE ON CRIME AND TERRORISM

MARCH 26, 2012

U.S. Senate Committee on the Judiciary
Subcommittee on Crime and Terrorism

Hearing on Protecting Medicare and Medicaid:
Efforts to Prevent, Investigate, and Prosecute Health Care Fraud

March 26, 2012

Chairman Whitehouse, thank you for the invitation to discuss how the Centers for Medicare & Medicaid Services (CMS) has improved program integrity and is continuing to reduce fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Fraud, waste, and abuse in our health care system is a problem that affects both public and private payers, draining critical resources from our health care system, and contributing to the rising cost of health care for all. Taxpayer dollars lost to fraud, waste, and abuse harm not just the Federal government, but everyone, and, particularly some of our most vulnerable citizens. While most health care providers and suppliers who work with Medicare, Medicaid, and CHIP are honest, we are targeting those who are not legitimate providers and suppliers that seek to defraud taxpayers and the Trust Funds. Thanks to recent legislation passed by Congress giving CMS new resources and tools to fight fraud, CMS is using new technology to make significant improvements to the twin pillars of CMS' program integrity efforts: fraud detection and provider enrollment.

CMS is using many of the new anti-fraud authorities provided in the Affordable Care Act (P.L. 111-148 and P.L. 111-152) and the Small Business Jobs Act of 2010 (P.L.111-240) to strategically combat fraud, waste, and abuse, and is integrating additional tools into our current program integrity efforts. This is part of our comprehensive strategy to prevent and detect fraud and abuse, and requires working closely with States, our law enforcement partners, the private sector, and health care providers. I am confident that the improvements we have put in place over the past year will provide increasingly greater protections to Medicare, Medicaid, and CHIP for a long time to come.

Preventing Fraud, Waste, and Abuse in Medicare and Medicaid

CMS processes about 4.5 million Medicare FFS claims every day, or more than $1.3 billion daily, and is statutorily required to pay claims promptly, usually within 14 to 30 days. In Medicare Parts C and D, all private plans are required to have programs in place to combat fraud, waste, and abuse. CMS is working closely with our Compliance and Enforcement Medicare Drug Integrity Contractor (MEDIC) to prevent fraud in Parts C and D and has recently taken steps to strengthen our efforts to combat prescription drug trafficking and diversion. However, preventing fraud in Medicare involves maintaining an important balance: carrying out our core responsibility to protect beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers, while identifying and thoroughly investigating suspect claims and reducing fraud, waste, and abuse.

Preventing fraud and abuse in Medicaid presents different challenges and requires a different approach. Medicaid is a shared Federal-State program. States design, implement, administer, and oversee their own Medicaid programs within broad Federal guidelines. The Federal government and States share in the cost of the program. Each State has a great deal of programmatic flexibility to tailor its Medicaid program to its unique health care, budgetary, and economic environment. As a result, there is variation among the States in eligibility, services, reimbursement rates to providers and health plans, and approaches to program integrity. CMS operates the Medicaid Integrity Program and administers the national Medicaid audit program in order to enhance Federal oversight of State Medicaid programs. The Medicaid Integrity Program accomplishes this by providing States with technical assistance and support that enhances the Federal-State Partnership.

The New "Twin Pillars" Strategy - Medicare

As we continue the traditional program integrity work of past years, our recent innovations on the Medicare side include a new twin-pillar strategy. The first pillar is our Fraud Prevention System (FPS), the predictive analytic technology mandated by the Small Business Jobs Act. It detects potential fraud, and can prevent potentially fraudulent claims from being paid. The FPS uses predictive 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 our new Automated Provider Screening (APS) system. The APS does rapid and automated screening of all providers and suppliers seeking to enroll or revalidate their enrollment in Medicare. These two systems are designed to constantly interact and feed information into one another regarding suspect providers or claims, creating a truly integrated data management and analysis capability. For example, by analyzing characteristics of known fraud, we are continuously improving the predictive algorithms in the FPS that are used to screen the providers in APS. Similarly, if a provider is flagged as risky by APS, we can watch this provider even closer in FPS. 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 in the first place, and knocking wrongdoers out of the program quickly once they are detected.

The Fraud Prevention System

The Small Business Jobs Act required CMS to adopt predictive modeling technology, similar to that used by credit card companies, to identify and prevent fraud, waste, and abuse in the Medicare fee-for-service program by July 1, 2011. 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 screen Medicare fee-for-service claims nationwide since June 30, 2011, putting CMS well ahead of the statutory schedule of phasing in the technology in an initial ten States over a three year period. 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 and train our anti-fraud contractors.

With the FPS, CMS is using our investigative resources to target suspect claims and providers before claims are paid and taking swift administrative action when warranted. The technology does this by identifying providers who exhibit the most egregious, suspect, or aberrant activity. Program integrity analysts begin swift and thorough investigations of such individuals almost as soon as the system generates the top-priority alerts. The FPS has enabled CMS and its program integrity contractors to stop, prevent, and/or 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. Since the inception of the FPS, 846 active Zone Program Integrity Contractor (ZPIC) investigations have resulted – 510 that are the direct result of the FPS and 336 existing investigations that are being supported by the real-time FPS data. ZPICs are local private investigators that CMS contracts with to investigate potential fraud.

The FPS has also led to 417 direct interviews with providers suspected of participating in potentially fraudulent activity, and over 1,200 interviews with beneficiaries to confirm they received the services for which the Medicare program had been billed. Information CMS learns from these beneficiary interviews is used along with historical claims data and beneficiary complaints submitted to 1-800-MEDICARE to help identify the characteristics of potentially bad actors, and that information is loaded directly into the 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 fee-for-service Medicare claims 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. 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.

Automated Provider Screening

The second pillar of our strategy is APS for providers and suppliers seeking to enroll or revalidate their enrollment in Medicare. The APS technology is complemented by 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 such 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 not one-size-fits-all, but rather is tailored to both categorical and individual provider risk.

The new APS technology was launched on December 31, 2011; it validates enrollment information against thousands of public and private data sources prior to enrollment and monitors for changes in information on a continuous basis. The APS has replaced the time- and resource-intensive manual review process of multiple data sources. 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.

Effective March 25, 2011, CMS promulgated final rules[1] pursuant to requirements of the Affordable Care Act, and established levels of risk for categories of providers and suppliers. Providers and suppliers designated at the lowest level, or "limited" risk, are subject to the same screening requirements for enrollment as they were prior to the Affordable Care Act. CMS established new requirements for categories of providers and suppliers designated as moderate or high risk, including home health agencies and durable medical equipment (DME) suppliers.

Providers and suppliers in the moderate level of risk are now required to undergo an onsite visit prior to enrolling or upon revalidation of their Medicare billing privileges. This new requirement expanded physical on-site inspections to many providers and suppliers that were previously not subject to such site visits as a condition of enrollment into the Medicare program. CMS has estimated that approximately 50,000 additional inspections will be conducted to ensure providers and suppliers are operational and meet all regulatory 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.

[1] http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf

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. Individuals with a five percent or more ownership interest in newly enrolling home health and DME companies and providers and suppliers that hit certain triggers (such as a prior Medicare or Medicaid payment suspension or termination from a State Medicaid program) will also be required to submit fingerprints for completion of a Federal Bureau of Investigation (FBI) criminal background check.

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 revalidation began in September 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 and the APS work in tandem with each other. 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 who do not meet Medicare enrollment requirements. CMS is also sharing information on revoked providers with State Medicaid programs.

The Affordable Care Act

While these efforts are already helping CMS to stop potentially fraudulent or otherwise inappropriate payments, we recognize that they cannot prevent every instance of fraud. In addition to the enrollment safeguards in the APS and data analytics in the FPS system, new tools included in the Affordable Care Act will also allow us to remove bad actors from our programs. 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. The Affordable Care Act requires States to terminate from Medicaid providers or suppliers who have been revoked by Medicare, or

terminated by another State's Medicaid or CHIP program. Similarly, Medicare may also revoke providers or suppliers who have been terminated by State Medicaid agencies.

The Affordable Care Act also enhances our authority to suspend Medicare payments to providers or suppliers during the investigation of a credible allegation of fraud. This allows CMS to halt claims payment before funds go out the door, and helps moves us beyond the old pay-and-chase paradigm to a more prevention-focused approach to fighting fraud. CMS suspended over $27 million in payments to suspect providers in calendar year (CY) 2011. In addition, States are now similarly required to suspend payments to Medicaid providers against whom there is a credible allegation of fraud.

It is important to remember that payment suspensions are just one of CMS' tools to prevent losses from fraud, waste, and abuse. We also use a variety of prepay edits that automatically deny claims when the submitted bills are implausible or inappropriate. In CY 2011, CMS saved $208 million in Medicare through the use of such edits. In addition to suspensions, CMS revoked billing privileges from thousands of Medicare providers and suppliers last year, cutting off fraudulent billing directly at its source. In CY 2011, CMS revoked or deactivated 19,139 providers and suppliers.

Engaging beneficiaries to combat fraud, waste, and abuse

Beneficiary involvement is a key component of all of CMS' anti-fraud efforts. Alert and vigilant beneficiaries, family members, and caregivers are some of our most valuable partners in stopping fraudulent activity. In CY 2011, over 49,000 beneficiaries reported complaints of fraud to 1-800-MEDICARE.

CMS also encourages our beneficiaries to review their Medicare billing statements and other medical reports in order to spot unusual or questionable charges. To that end, I am pleased to report that on March 7, 2012, Medicare announced the redesign of the quarterly Medicare Summary Notices (MSN) so that beneficiaries can more easily spot potential fraud or

irregularities on claims submitted for their care.[2] Beneficiaries are encouraged to report fraud to 1-800-MEDICARE, and this is promoted in the new MSN. This MSN redesign is part of a new CMS initiative, "Your Medicare Information: Clearer, Simpler, At Your Fingertips," which aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand. Starting in March, the redesigned MSN has been available to beneficiaries on www.mymedicare.gov, and starting in early 2013, paper copies of the redesigned MSN will replace the existing mailed version.

Additional educational resources, including tip sheets on protecting against fraud, are available on www.mymedicare.gov and www.stopmedicarefraud.gov.

Senior Medicare Patrols

In addition, CMS has been partnering with the Administration on Aging (AOA) to operate the Senior Medicare Patrol (SMP) program - groups of senior citizen volunteers that educate and empower their peers to identify, prevent, and report health care fraud. The SMP program empowers seniors through increased awareness and understanding of health care programs. SMP projects also work to resolve beneficiary complaints of potential fraud in partnership with State and national fraud control/consumer protection entities, including Medicare contractors, State Medicaid fraud control units, State attorneys general, the Department of Health & Human Services (HHS) Office of Inspector General (OIG) and the AOA. To support this work, CMS provided grant funding to SMP projects in recent years.[3] The increased funding levels have supported additional targeted strategies for collaboration, media outreach, and referrals for States identified with high-fraud areas.

The SMP has produced important results; since the SMP program's inception in 1997, more than 68,000 volunteers have been trained to educate their peers in local communities. Since inception, the program has educated over 3.84 million beneficiaries in group or one-on-one counseling sessions and has reached an estimated 24 million people through SMP-led community education outreach events. Over 267,000 Medicare, Medicaid and other complaints

[2] http://www.cms.gov/apps/media/press/release.asp?Counter=4298

[3] http://www.hhs.gov/news/press/2011pres/11/20111122b.html

of potential health care fraud have been resolved by SMPs or referred for further investigation. In Rhode Island, 49 volunteers provided education and assistance to 1,438 beneficiaries in 2010. Further, over the life of the program, the OIG has documented approximately $106 million in savings attributable to the SMP program resulting from beneficiary complaints.[4] However, this almost certainly understates the real impact of the program due to difficulties in quantifying the impact of the robust education and awareness efforts of the SMPs.

How Beneficiaries Can Report Fraud

If a beneficiary discovers a suspicious claim, there are a variety of places that Medicare and Medicaid fraud tips can be reported for further action: beneficiaries can contact the Medicare call center at 1-800-MEDICARE, call the OIG tip line at 1-800-HHS-TIPS, or call 1-877-808-2468 to find the SMP in their local area. As a reminder, any beneficiary whose tip leads to the uncovering of fraud is eligible for a reward of up to $1,000 of the recovered funds. To report a lost or stolen Medicare card, beneficiaries can call the Social Security Administration at 1-800-772-1213 for a replacement card. To report suspected misuse of personal information, beneficiaries can call the Federal Trade Commission at 1-877-ID-THEFT.

Engaging the Provider Community

As CMS implements many of the new tools in the Affordable Care Act, including the enrollment enhancements discussed above, we are working closely with our partners in the provider community to promote their active participation in efforts to cut fraud, waste, and abuse in Medicare. The American Medical Association and other organizations have participated in our periodic "Power Users Group" meetings designed to collect ongoing provider feedback from heavy users of our enrollment systems before and as those systems are developed, instead of after roll-out. This partnership has proven valuable, and because of CMS' proactive outreach to the provider community, we have been able to implement significant changes in our enrollment systems (such as an online enrollment option) with widespread provider acceptance. These groups also are collaborating with CMS to implement new methods to prevent and detect fraud, waste, and abuse.

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[4] Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011. Page 68

Engaging State Medicaid Programs in Program Integrity Efforts

The Medicaid Integrity Institute (MII) is one of CMS' most significant achievements in fighting Medicaid fraud, in partnership with our State colleagues. In its four years of operations, the MII has offered numerous courses and trained more than 2,464 State employees at no cost to the States. Courses have included teaching enhanced investigative and analytical skills, Medicaid program integrity fundamentals, and a symposium to exchange ideas, create best practice models, and identify emerging fraud trends. I encourage Rhode Island and all States to continue taking advantage of this opportunity to reduce fraud, waste, and abuse in Medicaid.

Fraud Summits

Building on the momentum generated by the National Health Care Fraud Summit in January 2010, regional health care fraud prevention summits have been held across the country in six cities since 2010. CMS and the OIG collaborated with the Department of Justice (DOJ), and the FBI to convene Regional Health Care Fraud Summits in Miami, Los Angeles, Brooklyn and Boston in 2010 and in Detroit and Philadelphia in 2011. These summits have brought together Federal and State officials, law enforcement experts, private insurers, beneficiaries, caregivers, and health care providers to discuss innovative ways to eliminate fraud within the nation's health care system. These summits have also featured educational panels that discussed best practices for providers, beneficiaries, government agencies, and law enforcement in preventing health care fraud. Our next Fraud Summit, scheduled for the spring of 2012, is intended to highlight our public-private partnership efforts, with presentations from the private sector on their efforts in predictive modeling.

CMS has hosted well-attended Provider Interaction Sessions at these regional health care fraud prevention summits, as well as multiple Open Door Forums and other professional outreach activities to discuss the impact of new Affordable Care Act requirements with physicians and other medical professionals. The responses received by CMS at these events have demonstrated physicians' and other practitioners' strong interest in working with CMS and the HHS in eliminating fraud, waste, and abuse in the federal health care programs. CMS has demonstrated its commitment to continuing and improving these conversations; the Center for Program

Integrity recently hired a Medical Officer to be a liaison for providers on program integrity issues and activities.

Collaboration with Law Enforcement and Public-Private Partnerships

CMS is working closely with key partners to reduce fraud. These partners include the OIG, the DOJ, State Medicaid offices, and partners from the health care sector of private industry. Sharing information and performance metrics broadly and engaging internal and external stakeholders requires establishing new partnerships with government and private sector groups. Because the public and private sectors have common challenges in fighting fraud and keeping fraudulent providers at bay, it makes sense that we work together to develop common solutions and share information about emerging and migrating scams, and we intend to highlight our strengthened public-private partnership at future summits.

Aligning with the HEAT Task Force

One of the most visible examples of increased collaboration is the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force, a joint effort between HHS (OIG and CMS) and DOJ to fight health care fraud. CMS has actively collaborated with DOJ and the OIG by providing improved access to Medicare data to help identify criminals and fight fraud while protecting patient privacy. CMS and the OIG have partnered to train more than 600 law enforcement agents in Medicare data analysis using CMS systems. The HEAT initiative has engaged law enforcement and professional staff at the highest levels of HHS and DOJ to increase coordination, intelligence sharing, and training among investigators, agents, prosecutors, analysts, and policymakers. A key component of HEAT is the Medicare Strike Force: interagency teams of analysts, investigators, and prosecutors who can target emerging or migrating fraud schemes in high fraud areas, including fraud by criminals masquerading as health care providers or suppliers. In FY 2011, the total number of cities with Strike Force prosecution teams increased to nine- Miami, Los Angeles, Houston, Detroit, Brooklyn, Baton Rouge, Tampa, Dallas and Chicago.

On February 28, 2012, the DOJ and HHS, and the Texas Attorney General's Office, announced the arrest of a Dallas physician and the office manager of his medical practice, along with five

owners of home health agencies, on charges related to their alleged participation in a nearly $375 million health care fraud scheme involving fraudulent claims for home health services. On the same day as the indictment, CMS also announced the suspension of payments to 78 home health agencies associated with the physician based on credible allegations of fraud against them. These enforcement actions were the direct result of collaborations with the HEAT Task Force and the Medicare Fraud Strike Force operations. We want to highlight the unprecedented scale of this civil-criminal coordination that occurred in the Texas case. The coordinated, simultaneous indictment and large-scale suspension of payments in last month's operation will be a template for future operations. Not only does such coordination between prosecutors and program administrators stop the flow of money simultaneously with criminal prosecution, but it also signals robust coordination among the States and federal government, and enhances the sentinel effect of the entire federal government's anti-fraud effort, by sending a strong warning to bad actors across the country that the government is willing and able to prosecute even the most sophisticated fraudsters.

CMS supports law enforcement activities from beginning to end: its Zone Program Integrity Contractors develop and refer cases to law enforcement, provide support throughout these investigations, and implement administrative actions such as payment suspensions, revocation of Medicare billing privileges, implementation of prepayment edits, review of medical records and computation of overpayments.

FY 2013 Budget Request

Demonstrating the Administration's commitment to combating fraud, waste, and abuse in Medicare, Medicaid, and CHIP, the President's FY 2013 Budget requests $610 million in discretionary program integrity resources, as part of a multi-year investment to enable HHS and DOJ to detect, prevent, and prosecute health care fraud. This investment will support efforts to reduce the Medicare fee-for-service (FFS) improper payment rate and initiatives of the HEAT task force. The investment also supports Strike Force teams in cities where intelligence and data analysis suggest high levels of fraud; more rigorous data analysis; and an increased focus on civil fraud. These targeted efforts, as part of a multi-year investment, will save an estimated $11.3 billion over 10 years. The Budget also proposes a series of new legislative authorities to

strengthen program integrity for Medicare, Medicaid, and CHIP. Our Program Integrity legislative proposals yield an estimated $3.6 billion in savings over 10 years.

Conclusion

Thank you, Chairman Whitehouse for the opportunity to outline CMS' efforts to cut fraud, waste, and abuse in Medicare, Medicaid, and CHIP. With the tools Congress has provided and the coordinated efforts that I have outlined above, the Administration and CMS have been successful in combating health care fraud, waste, and abuse. We look forward to working with beneficiaries, providers, community partners, and Congress to continue our efforts to prevent and identify health care fraud, waste, and abuse.

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SHARE

Fortin joins fight against Medicare fraud at age 82

Kim Kalunian

HELPING FELLOW SENIORS: Edla Fortin, age 82, has been bookkeeping for 65 years. When she saw a call for volunteers to help prevent Medicare fraud in the Beacon, she jumped at the chance to put her skills to good use.

"I was all excited when I saw this ad."

That's what Edla Fortin, age 82, said about a press release that ran in the Beacon at the beginning of December. The release called for volunteers to help prevent Medicare fraud in Rhode Island.

Fortin saw it as a great opportunity to help other seniors in the state, so she picked up the phone and signed up.

Fortin's background is in bookkeeping and accounting, so she's no stranger to numbers. But she admits that even with 65 years of experience under her belt, Medicare statements can still be confusing.

"I was scrutinized when I was sick," she said. "It's very difficult to understand."

The RI Department of Human Services, Division of Elderly Affairs, takes part in a national program called the Senior Medicare Patrol (SMP), which is funded in large part by the Administration on Aging. The RISMP works with six agencies throughout the state to protect beneficiaries from fraud or Medicare billing mistakes.

"There are 54 SMPs across the U.S.," said Aleatha Dickerson, the RISMP director. "We educate beneficiaries to be more mindful to protect their card and their personal identities. We advise them to detect problems and review their statements. It's also a means for them to report suspected fraud."

Although Dickerson said Medicare fraud is currently "not a big problem" in Rhode Island, a Centers for Medicare and Medicaid Services (CMS) fact sheet reported $5.6 billion in fraudulent payments were recovered nationally in FY 2011.

The CMS also reports that since the SMP's inception in 1997, the program has educated nearly 4 million beneficiaries and reached out to 25 million people.

Fortin hopes she'll be able to help raise that number, and looks forward to putting her years of bookkeeping and math skills to good use.

Today, Fortin works as a controller and accountant at Columbus Door, where she's been employed for 23 years. But her career began 65 years ago when she took her first job in 1946 after graduating from Central High School in Providence.

"In order to be a bookkeeper, we'd have to have Economics 101 and Commercial Law," she explained. Fortin never went to college.

"I was offered three jobs right out of high school because I had good marks," she explained.

Fortin learned most of what she needed to know from her high school curriculum.

"There's laws I learned then I'm still applying," she said.

At her first job at Rhode Island Dental Supply, Fortin teamed up with another young woman named Ina, who showed her the ropes of bookkeeping. When her boss was gone, Fortin would ask Ina to teach her about accounting.

"Ina, Mr. Silverman's gone, how do I do this entry?" she would ask, adding, "She was a peach."

Fortin said gender was never a factor when it came to math proficiency and crunching numbers. She thinks that young girls today should feel empowered to learn math and science, just like their male counterparts.

"I'm never embarrassed to say, 'Well, I don't know that answer.' I figure if somebody else can do it, there's no reason I can't do it," she said. "I love math."

When Fortin saw the call for volunteers, she thought her mathematical skills could lend nicely to the cause.

She called Westbay Community Action, one of six organizations in the state that partners with the SMP program, and spoke with Chris Murphy.

Murphy, the Elder and Family Services Director at Westbay, said the program at Westbay has been going on for several years, but the number of volunteers is small. Currently, they have three fully trained volunteers, and another four undergoing training sessions. Fortin is one of those four.

Volunteers have different tasks that range from checking billing statements, answering questions at senior centers, data entry and spreading Medicare fraud awareness through presentations.

Although volunteers can be any age, Murphy said it's nice when other seniors help their fellow beneficiaries.

"I started thinking how much older people can give back to their community," said Fortin, who is no stranger to volunteer work.

In 1967, Fortin trained to become a hairdresser, and started volunteering at a local hospital, giving haircuts to young girls with multiple sclerosis.

"Even though they were sick they still wanted to look nice," she said. "They were so excited just to get a haircut. We felt good that we were able to help someone."

Years later she teamed up with AARP to do income taxes for low-income and elderly clients.

"You get more out of something like that than you're actually giving," she said. "Even though I love my job, I want to give back to my community."

Fortin has been to a handful of training sessions for the SMP program, but won't be ready to field questions and give presentations until March. She's excited at the prospect of helping other people, especially seniors.

In addition to her new volunteer endeavors, Fortin will stay at Columbus Door; she has no plans to retire in the near future.

Instead, she'll continue putting her energy into doing what she does best, while using her skills to help others. She said she's always followed a key piece of advice her mother gave her:

"You give 110 percent to everything and that will carry out through your life," she recited. "My mother was a smart woman."

To learn more about volunteering for SMP programs at Westbay Community Action, call 732-4660 or visit www.smpresource.org for general information about SMP.

Attachments

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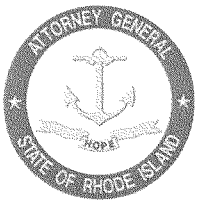

STATEMENT OF

PETER F. KILMARTIN

RHODE ISLAND ATTORNEY GENERAL

BEFORE THE

UNITED STATES SENATE

COMMITTEE ON THE JUDICIARY

SUBCOMMITTEE FIELD HEARING

HEARING ENTITLED

"PROTECTING MEDICARE AND MEDICAID: EFFORTS TO PREVENT, INVESTIGATE AND PROSECUTE HEALTH CARE FRAUD"

PRESENTED

MARCH 26, 2012

I. Introduction

Good morning, Chairman Whitehouse, and thank you for your invitation to address the Subcommittee. Thank you also for giving me the opportunity to discuss the efforts of the Rhode Island Office of Attorney General to combat Medicaid fraud.

According to U.S. Attorney General Eric Holder, health care fraud is a significant problem, estimated to cost the public and private sectors over $60 billion each year.[1] To put this figure into perspective, consider that the infamous Bernard Madoff Ponzi scheme defrauded investors of approximately $65 billion. Analyst Harry Markopolos has stated that healthcare fraud is so pervasive, "Wall Street is second fiddle to the health care industry."[2]

Each state (except North Dakota) has its own Medicaid Fraud Control Unit (MFCU) to investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. States administer the MFCUs, but they are jointly funded on a matching basis with the Federal Government. (The Federal Government pays 90 percent of a Unit's costs for the first three years of a Unit's operation and 75 percent for subsequent years; the States pay the remaining portion.) MFCUs operate on an interdisciplinary model and must employ investigators, auditors and attorneys. The MFCUs are required to have statewide authority to prosecute cases or to have formal procedures to refer suspected criminal violations to an office with such authority. The MFCUs' investigative authority extends to Medicaid-funded facilities and to "board and care" facilities that do not receive Medicaid funding. The U.S. Department of Health and Human Services Office of Inspector General, or another agency's Inspector General, may in some circumstances permit the Units to investigate fraud in Medicare or other Federal programs.[3]

In Rhode Island, the MFCU is housed in the Office of Attorney General. The Rhode Island Office of Attorney General Medicaid Fraud Control Unit is comprised of 11 staff members (including two attorneys, four fraud investigators, two patient abuse and neglect investigators, a nurse investigator and an auditor) who solely work on Medicaid fraud and patient abuse and neglect cases. The MFCU receives referrals from the Medicaid Single State Agency (Department of Health and Human Services Office of Health and Human Services – OHHS).

The State of Rhode Island's total unaudited Medicaid expenditures for fiscal year 2011 was nearly $1 billion. The MFCU's budget for FY2011 was approximately $1.3 million – or about one tenth of one percent of the total Medicaid budget.

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[1] Remarks by U.S. Attorney General Eric Holder, first National Summit on Health Care Fraud, January 28, 2010.
[2] CNN interview of financial analyst Harry Markopolos by Dr. Sanjay Gupta, July 3, 2010.
[3] United States Department of Health & Human Services – Office of Inspector General. Information available at http://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp (last visited March 21, 2012).

II. Prevention

My administration has made detecting and prosecuting Medicaid fraud a priority. As such, we aim to take several approaches toward the prevention, investigation and prosecution of fraud and abuse. I will first discuss ongoing prevention efforts. These efforts include collaboration and information sharing, background screenings for healthcare workers and fraud training for police officers and healthcare professionals.

The Rhode Island MFCU strives to maintain an extremely cooperative relationship with appropriate state and federal agencies, including local HHS investigators, the United States Attorney's Office and local FBI and DEA offices.

In addition, the MFCU participates on various task forces and committee memberships, which include the United States Attorney's Healthcare Supervisor's Task Force, the Lieutenant Governor's Long-Term Care Coordinating Council, the New England Law Enforcement Association Executive Board, Citizens Commission on Safety and Care of the Elderly, National White Collar Crime Center, National Association of Drug Diversion Investigators, Equal Employment Opportunity Commission and the American Nurses Association. The MFCU Director is on the National Association for Medicaid Fraud Control Units (NAMFCU) Qui Tam Subcommittee and is also the Northeast Regional Executive Committee Representative to NAMFCU.

The MFCU is working to combat Medicaid fraud by opening pathways to increase the amount of investigation referrals. In order to open lines of communication, this office has endeavored to hold regular meetings with the state OHHS, managed care organizations (MCOs) and the Rhode Island Department of Health so that the different entities may find common ground in the desire to combat fraud and increase referrals. In addition to investigation and criminal charges, the MFCU seeks to recoup monies that were fraudulently obtained by providers.

Beyond regular meetings with MCOs and the Rhode Island Department of Health, the MFCU meets quarterly with the Alliance for Better Long-Term Care and the State of Rhode Island Long-Term Care ombudsman, Kathy Heren. These meetings have incorporated members of the Rhode Island Department of Elderly Affairs, the Rhode Island Department of Health Legal Counsel, members of the Rhode Island Department of Health Facilities Regulation section, the United States Attorney's Office healthcare prosecutor and others in an effort to keep communications open on matters of joint interest in the healthcare community.

The MFCU has jointly conducted trainings of healthcare professionals in various venues throughout the state of Rhode Island. These trainings have included the U.S. Attorney's Office, the FBI, HHS, Office of Investigations and others to present a unified front in the battle against healthcare fraud and abuse. The Attorney General's Office has also recognized a need to train police officers to detect and recognize evidence of fraudulent healthcare activities. As a result,

the RI MFCU has conducted trainings at the Rhode Island Municipal Police Training Academy, as well as the most recent training class of the Rhode Island State Police. It is the hope that the "boots on the ground" will recognize fraudulent activity and investigate or refer cases to the MFCU.

In 2002, the Rhode Island General Assembly sent a joint resolution to Congress seeking national background checks for long-term healthcare employees. Congress took action: pilot programs have been established through an offering from the Centers for Medicare and Medicaid Services (CMS) to the states via grant funding to initiate national background check programs supported by fingerprints.

This effort was designed to weed out individuals with certain criminal histories from employment that would expose them to the patients most vulnerable to abuse in long-term care facilities. The Rhode Island Medicaid Agency sought and received a $1.3 million grant to establish a national background check pilot program in the state of Rhode Island. That grant is being implemented through the Rhode Island Office of Attorney General. We have authored enabling legislation to support the implementation of the national background check program; that legislation is in our state General Assembly this term. The passage of this legislation would require national background checks – supported by fingerprints – on all prospective employees in long-term care facilities where the employee has direct patient contact, as well as on personal care attendants in the homes of patients.

In addition to the enabling legislation for national background checks, we have also sought legislation to certify and require training of personal care attendants (PCAs) in an effort to educate and reduce fraud in this arena. The state of Rhode Island is employing advanced technology to root out fraud in this field and will continue to seek methods to allow us to find fraud while protecting Medicaid resources so that funding is available for those citizens most in need of these valuable services.

III. Investigation

Now I would like to pivot and discuss our efforts in investigation. Our investigations hinge upon data mining, referrals sent to the MFCU from other state agencies and collaboration with our federal partner agencies.

Hewlett Packard (HP) serves as fiscal intermediary under contract for OHHS. In this capacity, HP runs computer analytics and algorithms on all billing by providers of Medicaid services. This process is called data mining. The MFCU is federally prohibited from using federal matching funds to do data mining; as a result, the data mining is done through HP at the request of Medicaid single state agency and their Surveillance Utilization and Review (SUR)

unit. When outliers and anomalous activities are detected, those cases are referred to the MFCU for investigation.

The Rhode Island Secretary of Health and Human Services Steven Costantino oversees a Program Integrity Unit, which obtains the referrals sent to the MFCU for investigation. Secretary Costantino has expressed a desire to expand the Program Integrity Unit, so as to increase its productivity and obtain more referrals. An increase in referrals to the MFCU may require an addition to its investigative staff; an increase in staff would also increase recoveries to the Medicaid program, which would far exceed the cost of staffing.

The MFCU works closely with other state and federal agencies to combat fraud and abuse. Our investigators work with the United States Department of Health and Human Services Office of Investigations; we meet regularly with the supervisory agent from HHS to coordinate joint efforts, and currently have several ongoing joint investigations open. The MFCU has an investigator assigned on a part-time basis to the Food and Drug Administration (FDA) Task Force in Rhode Island. That investigator works solely on cases at the FDA that are related to Medicaid violations.

The area of personal care attendants (PCAs) and home health personnel in general is an area that, in this country, has seen an incredible amount of fraud. In several states, home health care fraud has comprised a majority of the caseload of some Medicaid fraud control units. We have gained a greater knowledge of the level of fraud involving PCAs through our investigatory efforts; this is why we have sought legislation to require background checks for PCAs to assist us in preventing fraud in this area.

IV. Prosecution

A number of these investigations will ultimately be prosecuted by the state and/or the federal government. Both civil and criminal prosecutions occur through collaboration with other governmental agencies.

The MFCU works closely with the U.S. Attorney's Office healthcare prosecutor. The director of the Rhode Island MFCU is cross-designated as a Special Assistant United States Attorney so that state cases with a federal component may be prosecuted jointly in the federal court of the District of Rhode Island.

The state of Rhode Island has a False Claims Act (FCA), which allows individuals, as well as the state, to pursue civil actions for false claims. The state has intervened in several cases involving Medicaid fraud which have been filed under the False Claims Act. These civil lawsuits

regularly result in recoveries to the state Medicaid program; in 2010, the recoveries totaled nearly $1.1 million from various global case settlements.[4]

In addition to the civil component, the RI MFCU has handled over 1,400 cases of patient abuse and neglect in the past year.

V. Conclusion

As you can see, the Rhode Island Attorney General's Office has a mechanism that works in conjunction with state agencies, the private sector, citizens and the federal government to prevent, investigate and ultimately prosecute cases of health care fraud, particularly in Medicaid. In 2011 this process led to the recovery of nearly $1.2 million, not including cases that are still under investigation.

But there is more to be done to prevent fraud and abuse. Additional steps that can be taken include staffing expansion, continued funding for background checks and required training of PCAs in fraud prevention.

Thank you very much for giving me the opportunity to provide you with an overview of the Rhode Island Medicaid Fraud Control Unit's mission. I look forward to continuing to work with the Committee to further the MFCU's efforts to combat Medicaid fraud, and I am happy to answer any questions.

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[4] Rhode Island Medicaid Fraud Control and Patient Abuse Unit 2011 Annual Report

Department of Justice

STATEMENT

OF

PETER F. NERONHA
UNITED STATES ATTORNEY
DISTRICT OF RHODE ISLAND

BEFORE THE

SUBCOMMITTEE ON CRIME AND TERRORISM
COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ENTITLED

"EFFORTS TO PREVENT, INVESTIGATE, AND PROSECUTE MEDICARE AND MEDICAID FRAUD"

PRESENTED ON

MARCH 26, 2012

Statement of
Peter F. Neronha
United States Attorney
District of Rhode Island

Before the
Subcommittee on Crime and Crime and Terrorism
Committee on the Judiciary
United States Senate

Entitled
"Efforts to Prevent, Investigate, and Prosecute Medicare and Medicaid Fraud"

Presented on
March 26, 2012

INTRODUCTION

Chairman Whitehouse, 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, along with my colleague Ted Doolittle, Deputy Director for Policy the Center for Program Integrity within the Centers for Medicare & Medicaid Services, and Peter F. Kilmartin, the Attorney General for the state of Rhode Island. The Department is grateful to the Subcommittee for its leadership in this area, and we appreciate the opportunity to appear before you here today.

Health care fraud is a serious law enforcement problem facing our country today. It threatens the long term 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. This fraud has the potential to corrupt the medical decisions made by these few health care providers, placing patients at risk of harm from unnecessary or unapproved treatments. With the rising cost of medical care, every dollar stolen from our health care programs is one dollar too many. For these reasons, fighting health care fraud is a priority of the Department of Justice. Together with our colleagues at the Department of Health and Human Services ("HHS"), we are fighting back. With HHS' assistance, 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. Through its United States Attorneys' Offices, Civil and Criminal Divisions, Civil Rights Division, and the Federal Bureau of Investigation ("FBI") – the entities responsible for enforcing laws against all forms of health care fraud – the Department has significantly enhanced its efforts to protect the public from health care fraud and to help ensure the integrity of patient care.

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

Because coordination across agencies 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 re-committed to making the fight against 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, the government's health care fraud and prevention efforts recovered nearly $4.1 billion in taxpayer dollars stolen from federal health care programs, and returned these funds to the Medicare Trust Funds, 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 Justice Department has a multi-faceted litigation approach to fighting health care fraud, with the U.S. Attorneys' Offices, the FBI, the Criminal Division, the Civil Rights Division, and the Civil Division all contributing substantial resources to the effort. Additionally, 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 in both criminal and civil cases in the federal courts in the 94 judicial districts across the country.

FEDERAL BUREAU OF INVESTIGATION

The Justice Department's primary investigative and enforcement arm in the area of health care fraud is the FBI. Working closely with U.S. Attorneys' Offices across the country and DOJ litigating components, the FBI serves to identify, investigate, and aid in the prosecution of health care fraud. With its large presence and extensive investigative authority, the FBI is uniquely positioned to investigate a broad spectrum of health care fraud activity. First, by leveraging its 798 FBI personnel dedicated to health care fraud investigations, the FBI is able to aggressively address fraud not only in Strike Force locations, but also in any of the 56 FBI field offices nationwide. Second, the FBI is the primary investigative agency involved in the fight against

health care fraud that has jurisdiction over both the federal and private health care programs. The FBI not only collaborates with HHS-OIG investigative personnel and other government agencies, but has built established partnerships with Special Investigative Units from many of the country's major private insurance companies. Third, the FBI leverages its intelligence across its multiple investigative programs to identify and attack criminal enterprises that are turning to health care fraud as a mechanism to fund additional activity. Some recent successes involving the FBI include:

- In November 2011, American pharmaceutical company Merck, Sharp & Dohme agreed to pay $950 million to resolve criminal charges and civil claims related to its promotion and marketing of the painkiller Vioxx® (rofecoxib).
- In September 2011, the Medicare Fraud Strike Force – a partnership between the Department of Justice and the Department of Health and Human Services – charged more than 91 defendants in eight cities, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving more than $295 million in false billing.
- Also in September 2011, Lawrence Duran and Marianella Valera, the owners of a mental health care company, American Therapeutic Corporation (ATC), were sentenced to 50 and 35 years in prison, respectively, for orchestrating a $205 million Medicare fraud scheme.

The FBI is a key component of the Justice Department's efforts to combat health care fraud and is a vital piece in the increasing return on investment to the Medicare Trust Funds and the Treasury.

U.S. ATTORNEYS' OFFICES' WORK WITH THE CIVIL DIVISION

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 tools. Through its Consumer Protection Branch, ("CPB"), the Civil Division also invokes the Food, Drug and Cosmetic Act ("FDCA"), which authorizes both civil and criminal actions. CPB pursues the unlawful marketing of drugs and medical devices, fraud on the Food & Drug Administration, and the distribution of adulterated products, among other violations. In FY 2011, CPB, working together with the U.S. Attorneys' Offices around the country, pursued cases under the FDCA that resulted in more than $1.5 billion in fines, forfeitures, restitution and disgorgement.

Since 2000, the U.S. Attorneys' Offices, working with our colleagues in the Civil Division, as well as with the FBI, HHS-Office of Inspector General ("OIG"), and Centers for Medicare & Medicaid Services (CMS), and other federal, state and local law enforcement agencies, have recovered over $1 billion nearly every year on behalf of defrauded federal health care programs. CMS has actively collaborated with DOJ and the OIG by providing improved access to Medicare data to help identify criminals and fight fraud while protecting patient privacy. CMS and the OIG have partnered to train more than 600 law enforcement agents in Medicare data analysis using CMS systems. In FY 2011, the Department secured approximately $2.4 billion in civil health care fraud recoveries. This marks two years in a row that more than $2 billion has been recovered in FCA health care matters, and since January 2009, the Department has used the FCA to recover more than $6.7 billion in federal health care dollars.

U.S. ATTORNEYS' OFFICES' WORK WITH THE CRIMINAL DIVISION

Working with our colleagues in the Criminal Division, the U.S. Attorneys' Offices' criminal health care fraud efforts have also been a tremendous success. Since 2009, the Departments of Justice and HHS have enhanced their coordination through HEAT, steadily increasing the number of Medicare Fraud Strike Force ("MFSF") teams, which supplement the Department's criminal health care fraud enforcement efforts. In FY 2011, the total number of cities with strike force prosecution teams was increased to nine, all of which have teams of investigators and prosecutors from the Justice Department, the FBI, HHS-OIG, and our state and local partners, dedicated to fighting fraud. Each United States Attorney's Office in the strike force cities has allocated several AUSAs and support personnel to this important initiative. The MFSFs use advanced data analysis techniques to identify high-billing levels 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 323 defendants, who allegedly collectively billed the Medicare program more than $1 billion. Strike force teams secured 172 guilty pleas, convicted 26 defendants at trial 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 identification information to providers so that those providers could submit false Medicare claims using the beneficiary identification information. Just last month, the Departments announced the arrest of a Dallas physician and the office manager of his medical practice, along with five owners of home health agencies, on charges related to their alleged participation in a nearly $375 million health care fraud scheme involving fraudulent claims for home health services. The conduct charged in this indictment represents the single largest fraud amount orchestrated by one doctor in the history of HEAT and the MFSF operations. In addition to the indictment, the Centers for Medicare & Medicaid Services ("CMS") announced the suspension of payments to 78 home health agencies ("HHA") associated with the physician, based on credible allegations of fraud against them. This enforcement action was made possible by the historic partnerships we've built to combat health care fraud, and sends a clear message that the government is serious about prosecuting health care fraud to the fullest extent of the law.

During FY 2011, HEAT and the MFSFs also helped educate Medicare beneficiaries about how to protect themselves against fraud. The Departments hosted a series of regional fraud prevention summits around the country, provided free compliance training for providers and other stakeholders and sent letters to state attorneys general urging them to work with HHS and federal, state and local law enforcement officials to mount a substantial outreach campaign to educate seniors and other Medicare beneficiaries about how to prevent scams and fraud.

U.S. ATTORNEYS' OFFICES' WORK WITH THE CIVIL RIGHTS DIVISION

The U.S. Attorney's Offices also work collaboratively with the Civil Rights Division to support their litigation activities related to health care fraud and abuse. The Civil Rights Division vigorously pursues the Department's goals of eliminating abuse and substandard care in public, residential health care facilities. The Civil Rights Division undertakes this work pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA.) CRIPA authorizes the investigation of conditions of confinement at state and local residential institutions, including facilities for persons with developmental disabilities or mental illness, and nursing homes. CRIPA also authorizes the Department to seek injunctive relief to remedy a pattern or practice of violations of the Constitution or Federal statutory rights. The Civil Rights Division also has established an initiative to eliminate abuse and grossly substandard care in public, Medicare and Medicaid funded nursing homes and other long-term care facilities.

Civil Rights Division staff conducted preliminary reviews of conditions and services at 16 health care facilities in 13 states during Fiscal Year 2011. The task in preliminary inquiries is to determine whether there is sufficient information supporting allegations of unlawful conditions to warrant formal investigation under CRIPA. The Civil Rights Division reviews information pertaining to areas such as abuse and neglect, medical and mental health care, use of restraints, fire and environmental safety, and placement in the most integrated setting appropriate to individual needs. Separately, in Fiscal Year 2011, the Civil Rights Division opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 79 health care facilities in 25 states, the District of Columbia, the Territory of Guam, and the Commonwealth of Puerto Rico.

For example, in Fiscal Year 2011, the Civil Rights Division: commenced investigations of 12 Mississippi facilities for persons with intellectual and developmental disabilities and/or mental illness, including the Boswell Regional Center, in Magee, Mississippi, and the Ellisville State School, in Ellisville, Mississippi; found that conditions and practices at the Delaware Psychiatric Center, in New Castle, Delaware, violated its residents' federal constitutional and statutory rights; entered settlement agreements to resolve its investigations of eight Georgia state-operated facilities for persons with mental illness, and of the William F. Green Veterans Nursing Home, in Bay Minette, Alabama; and monitored the implementation of remedial agreements for 20 facilities for persons with intellectual and developmental disabilities ,including the Clover Bottom Developmental Center, in Nashville, Tennessee, the Woodbridge Developmental Center, in Woodbridge, New Jersey, and the Lubbock State Developmental Center, in Lubbock, Texas.

U.S. ATTORNEY'S OFFICE FOR THE DISTRICT OF RHODE ISLAND

The attorneys in my own district, the District of Rhode Island, 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 are recent examples of the district's health care fraud efforts:

Rhode Island Hospital

In February 2011, Rhode Island Hospital agreed to reimburse federal health care programs approximately $2.6 million dollars and will pay the federal government approximately $2.7 million in double and triple damages for ordering medically unnecessary overnight patient

hospital stays and then submitting claims for payment to federally funded Medicare and Medicaid programs. An investigation by the United States Attorney's Office for the District of Rhode Island; Office of Inspector General of the U.S Department of Health and Human Services (OIG-HHS); and the Federal Bureau of Investigation determined that during the period from January 1, 2004, through December 31, 2009, medically unnecessary overnight hospital admissions were ordered for approximately 260 patients who underwent stereotactic radiosurgery, otherwise known as Gamma Knife treatment. The investigation also revealed that Rhode Island Hospital's claims for reimbursement for the overnight admissions to Medicare and Medicaid falsely represented that the admissions were medically necessary when, in fact, they were not.

Planned Eldercare

In February 2012, the owner of Planned Eldercare, a nationwide supplier of durable medical equipment was sentenced to 37 months in federal prison for defrauding the Medicare program of more than $2.2 million. The defendant pled guilty to two counts of health care fraud, and one count each of money laundering and the introduction of an adulterated and misbranded medical device into interstate commerce. The defendant admitted to targeting arthritic and/or diabetic Medicare beneficiaries through telemarketing, then ensuring that his company ordered and shipped medical equipment and supplies to the beneficiaries contacted that they did not order and/or were not medically necessary. The Court also ordered the payment of restitution in the amount of $2,210,152 to the Medicare Program.

At the time of his guilty plea, the defendant admitted to the Court that from 2005 through early 2009, he instructed Planned Eldercare employees, upon successfully reaching individuals as a result of unsolicited telemarketing calls, to inquire if they suffered from diabetes or arthritis.

Once call recipients identified themselves as suffering from either ailment, as an inducement for recipients to provide their Medicare and physician information, employees were instructed to inform recipients that Planned Eldercare could provide them with products to help with their ailments "at no cost to you." Once employees obtained Medicare beneficiaries' agreement to receive certain products, the defendant instructed employees to order as many products as possible, whether or not the beneficiaries requested them or had a medical need for the equipment. Medicare was billed for thousands of products that beneficiaries did not order.

Med Care Ambulance LLC

In November 2011, the owner and president of a Warwick, R.I. ambulance company was sentenced to 24 months in federal prison, three years supervised release and 1,000 hours of community service for defrauding health care programs administered by Medicare and Blue Cross Blue Shield of Rhode Island of more than $700,000. The owner and president of Med Care Ambulance LLC, was also ordered by the Court to make full restitution in the amount of $625,825.31 to the Medicare Program and $78,292.25 to Blue Cross Blue Shield.

The defendant pleaded guilty in June 2011 to two counts of health care fraud, and one count each of obstruction of a federal audit and making false statements. At the time of his guilty plea, he admitted to the Court that beginning in March 2008 and continuing until December 2010, he obtained payments in excess of $700,000 from Medicare and Blue Cross Blue Shield, by improperly submitting claims for reimbursement that falsely and fraudulently represented that Med Care had provided medically necessary Specialty Care ambulance transportation.

The defendant admitted that he routinely solicited Medicare beneficiaries to be transported on a routine basis to renal care facilities for dialysis treatments, the majority of which was routine in nature and did not require advanced or specialty care. He also admitted that he

actively solicited Medicare beneficiaries to agree to be transported for dialysis treatments by waiving the co-payment that the beneficiary would be liable for once Medicare or Blue Cross determined the amount that they would pay for services. By waiving co-payments, Med Care removed the monetary obstacle a patient might have had, and thus would agree to be transported by Med Care.

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 fifteenth year of operation, 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 and Criminal Divisions, the Civil Rights Division, FBI and HHS-OIG 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 and the Federal Treasury. 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.

Thanks you for the opportunity to provide this overview of the Department's health care fraud efforts and successes.

TESTIMONY
(for the record)

A field hearing of the
U.S. Senate Committee on Judiciary Subcommittee
on Crime and Terrorism

March 26, 2012
10:00 AM
East Providence Senior Center
610 Waterman Avenue
East Providence, Rhode Island

Submitted by:

Nancy Roberts
President and Chief Executive Officer
VNA of Care New England
51 Health Lane
Warwick, RI 02886

Good morning. My name is Nancy Roberts and I am the President and Chief Executive Officer of VNA of Care New England. I would like to thank Senator Sheldon Whitehouse and the Senate Committee on Judiciary Subcommittee on Crime and Terrorism for holding this special field hearing, "Protecting Medicare and Medicaid: Efforts to Prevent, Investigate, and Prosecute Health Care Fraud." It is both an honor and privilege to participate with colleagues and stakeholders in helping to solve this crisis.

While most home health agencies provide high-quality home healthcare and adhere to Medicare policy and regulations, fraudulent and abusive conduct by a minority of certified Medicare providers threatens the quality of care, drives up Medicare costs and undermines the perceived value of this vital care that is delivered to over 12 million Americans by 33,000 providers annually.

As the elder population grows, home health agencies offer a cost-effective alternative to institutional care by allowing these individuals to remain in their homes and communities, where they want to be, living safely and independently. Through the use of outcome driven care protocols and advanced technology, home health successfully meets the growing needs of Medicare beneficiaries with chronic conditions. In fact, in many instances, thanks to home healthcare, hospital stays are shortened and costly preventable hospitalizations are avoided.

Many home healthcare agencies, including most Visiting Nurse Associations (VNAs) existed before the 1965 inception of the Medicare and Medicaid program and have an exemplary record of service to Medicare beneficiaries and the communities they

serve. Not for profit VNAs that uphold the principles of high-quality and ethically rigorous care are deeply concerned about the reports of fraud, including the case of a Texas physician and five owners of home health care agencies. Recently they were indicted on charges of fraudulently billed Medicare and Medicaid nearly $375 million and illegally recruiting patients. While there has been no conviction, the facts are compelling; this appears to be a coordinated scheme to divert federal money into the pockets of individuals, money that is intended for care of the frail elderly.

VNA of Care New England commends the swift action of federal and state law enforcement agencies. However, this case, the largest in our nation's history involving home healthcare spotlights the need for change. We strongly support The Medicare Payment Advisory Commission's recommendation to the Secretary of Health and Human Services to suspend payment if fraud is suspected and to enact a moratorium on the enrollment of new home healthcare providers. In the interim, we urge the Centers for Medicare and Medicaid to utilize predictive and trend data to ensure that fraud efforts are targeted.

In summary, the Medicare home health benefit offers the best option to meet the needs of aging beneficiaries in a cost-effective manner. Abusive and fraudulent actions conducted by a small segment of the home health community serves to undermine its value. It is essential that we improve fiscal integrity and put controls in place to prevent waste, fraud and abuse.

I thank Senator Whitehouse for hosting this field hearing today. Efforts such as these must continue to bring about needed changes to safeguard home health care, a cost-

effective and vital service that for over a century has served the multiple needs of hundreds of thousands of Americans and preserved the integrity and health status of the frail elderly, members of our greatest generation.

State of Rhode Island and Providence Plantations

Department of Human Services
Division of Elderly Affairs

Testimony Submitted by
Catherine Taylor, Director, RI Division of Elderly Affairs
U.S. Senate Committee on Judiciary Subcommittee on Crime and Terrorism
field hearing on
Protecting Medicare and Medicaid: Efforts to Prevent, Investigate, and Prosecute Health Care Fraud

East Providence, Rhode Island
Monday, March 26, 2012

Senior Medicare Patrol (SMP) Activities in Rhode Island

Thank you, Senator Whitehouse, for this important opportunity to bring attention to the highly effective activities of the Senior Medicare Patrol, or SMP, in detecting Medicare fraud.

Several significant cases of suspected Medicare fraud have occurred in the last few years in Rhode Island. Between March, 2008 and December, 2010 a Warwick, RI ambulance company owner allegedly defrauded Medicare and Blue Cross Blue Shield of RI out of more than $700,000 by soliciting beneficiaries to receive medically unnecessary ambulance transportation. In 2010 a Massachusetts-based dermatologist agreed to repay $275,000 for Medicare payments for unnecessary pathology services. In April 2011, CVS Pharmacy paid the United States, Rhode Island and 9 other states a collective $17.5 million to resolve allegations of overbilling Medicaid for prescription claims. And in January, 2012, a Woonsocket, RI woman pleaded guilty to committing Medicare fraud by obtaining Medicare numbers from seniors at senior centers, senior housing facilities, and assisted living facilities, and ordering numerous diabetic shoes and arthritis equipment at no cost to the seniors and without their knowledge. Medicare was charged more than $70,000.

Rhode Island's 184,000 Medicare beneficiaries can play an active role in ensuring that the Medicare Trust Fund remains solvent, by working on the front lines to prevent the multi-billion dollar annual drain on the program nationwide attributable to fraud. The Senior Medicare Patrol – or SMP -- program keeps our RI Medicare beneficiaries alert to possible fraudulent activity, and, importantly, arms them with the knowledge and tools to combat it.

The Rhode Island Division of Elderly Affairs (DEA) DEA has administered the Senior Medicare Program since 2005, with funding from the U.S. Administration on Aging and the Centers for Medicare and Medicaid Services. The SMP program marshals the efforts of senior volunteers to teach their peers how to fight Medicare fraud.

This year, pursuant to the Affordable Care Act, the federal government is ramping up its anti-fraud effort, offering grants to the states to beef up volunteer recruitment and to provide rigorous training to volunteers. Rhode Island was fortunate to receive a one-year grant to engage a volunteer recruiter and trainer, Louanne Marcello, who is in the audience today, along with DEA's SMP program manager, Aleatha Dickerson.

The RI Division of Elderly Affairs and our SMP partners have worked diligently over the past three years to publicize the SMP message. In the 2011 RI-SMP funding year, we conducted the following activities that may have resulted in decreased Medicare fraud, waste, or abuse:

- 8,016 Medicare/Medicaid error, fraud, waste, or abuse *simple inquiries* received;
- 4,223 people estimated to have been reached by community education events;
- 34 fraud, waste, or abuse *complex issues* pending further action; and
- 40 active volunteers recruited and trained in one year.

SMP volunteers are helping their peers get in the habit of carefully reviewing their Medicare Summary Notice each month, on the lookout for discrepancies such as charges for services, equipment or medications never prescribed or provided, charges for medical appointments that were never made with an unknown physician, or extraordinarily high bills. Other common Medicare scams include counterfeit prescription drugs, double-billing both Medicare and a private insurance company for the same service, billing for individual counseling when group counseling is used, and medical identity theft.

One-on-one counseling and general education sessions are available in Rhode Island at six SMP Program partner locations: THE POINT at United Way; Tri-Town Community Action Agency; South County Community Action Agency; the East Bay Community Action Program; the West Bay Community Action Program; and Child and Family Services of Newport County, Inc.. Volunteers help check paperwork such as Medicare notices and billing to identify errors and discrepancies.

The greatest ally of any scam artist is silence. SMP volunteers teach their peers that stopping Medicare fraud is as easy as 1-2-3: 1. **Protect** Your Medicare Number. 2. **Detect** Discrepancies On Your Medicare Summary Notice. 3. **Report** Your Concerns. Anyone who suspects they have been a victim of fraud or abuse can file a report with the RI SMP Program by calling 401-462-0931.

It *exciting* that Medicare beneficiaries are taking ownership of protecting the Medicare program from fraud. One of our newest volunteer recruits at Westbay CAP, 82-year-old Edna Fortin, a controller and accountant at Columbus Door, responded to an ad in December, saying, "I started thinking how much older people can give back to their community." Barbara Hackett, a retired project manager at AT&T and resident of East Greenwich, says of the Medicare beneficiaries she assists, "I want to make them feel empowered."

It is also *essential* that we harness the volunteer power of Medicare beneficiaries themselves to do this work. No one is better positioned to recognize fraud, or more invested in ensuring that Medicare dollars are there for *them*, not the scam artists.

Thank you again, Senator Whitehouse, for allowing me to showcase what an excellent investment the Senior Medicare Patrol is.