STATEMENT OF

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ON

"Anatomy of a Fraud Bust: From Investigation to Conviction"

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Hearing on "Anatomy of a Fraud Bust: From Investigation to Conviction"

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

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

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

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

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

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

CMS Role in Detecting and Investigating Fraud Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The New "Twin Pillars" Strategy - Medicare

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

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

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

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

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

The First Pillar: The Fraud Prevention System

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

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

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

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

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

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

The Second Pillar: Enhanced Provider Enrollment and Automated Provider Screening

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

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

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

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

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

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

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

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

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

Supporting State Efforts to Combat Fraud, Waste, and Abuse

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

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

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

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

Looking Forward

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

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

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

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