



FLORIDA INTERNATIONAL UNIVERSITY

STATEMENT OF

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FORMER U.S. ATTORNEY  
SOUTHERN DISTRICT OF FLORIDA

BEFORE THE

UNITED STATES CONGRESS  
ENERGY AND COMMERCE COMMITTEE  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

HEARING ENTITLED  
“WASTE, FRAUD AND ABUSE: A CONTINUING THREAT TO  
MEDICARE AND MEDICAID.”

MARCH 2, 2011

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OFFICE OF THE DEAN

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

I have been asked to provide testimony regarding (i) my efforts, as U.S. Attorney, to combat Medicare fraud and (ii) my thoughts, based on these experiences, on how we can reduce – and hopefully prevent – fraud in the future. I appreciate the opportunity to appear before you to address this critical issue.

I can think of few more pressing issues than that of health care fraud. Americans enjoy one of the world’s best health care systems. We hear often, however, of the skyrocketing cost of health care and we worry that one day we will be unable to afford quality care. Reducing fraud cuts costs without impacting quality. Reducing fraud is, in common parlance, “a no-brainer.”

I served as the United States Attorney for the Southern District of Florida (“SDFL”) from 2005 to June 2009. Early in my term, I made the prosecution of health care fraud a top priority in my District. The results were spectacular, yet sad. From FY2006 through May 2009, my District charged more than 700 individuals responsible for submitting more than \$2 billion in fraudulent bills to Medicare. Put differently, we prosecuted more than \$1,900 in Medicare fraud per senior citizen living in South Florida and the Treasure Coast.<sup>1</sup>

Admittedly, this \$1,900 per capita figure both underestimates and overestimates the scope of health care fraud. On the one hand, the actual per capita figure for South Florida is much higher, as only a small percentage of fraudulent billings are identified and prosecuted. On the other hand, this per capita fraud figure, when applied nationally, may be lower as South Florida’s popularity with Medicare beneficiaries makes it particularly vulnerable to fraud. (I reject the loose allegations, which I have sometimes heard, that label South Florida a “fraud capital.” Although fraud in South

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<sup>1</sup> The U.S. Census estimated the South Florida and Treasure Coast population, as of July 1, 2008, to be 6,114,069. The South Florida Regional Planning Council estimated that 17.2% of this population was 65 years or older, yielding 1,051,620 senior citizens, or \$1903 per capita. The Southern District of Florida also includes Okeechobee and Highlands Counties, which are excluded from these figures as they are not part of the South Florida / Treasure Coast Population Areas.

Florida is high, it is comparable to other major metropolitan areas with similar demographics.)<sup>2</sup>

Imagine the impact of saving even a fraction of \$1900 per Medicare beneficiary. This would go a long way toward improving Medicare without impacting the quality of care, and toward improving our budget deficit.

Despite our success prosecuting Medicare fraud in South Florida, I believe that increased prosecutions are not the answer to reducing Medicare waste, fraud and abuse. I want to make clear that I am proud of the work we did in South Florida, and want to thank the prosecutors, agents and staff of the Southern District of Florida law enforcement agencies for their incredible efforts to combat Medicare fraud. I want to thank, and to commend, in particular, my successors, my former First Assistant and later U.S. Attorney Jeffrey Sloman, and the now U.S. Attorney, Wilfredo Ferrer, for continuing and expanding the District's anti-fraud efforts. Nonetheless, prosecutions are not the solution.

We need to prevent fraud from happening in the first place. Prosecutions have limited deterrence. Prosecutions are resource intensive. Prosecutions rarely recover the taxpayer dollars wrongfully paid out to fraudsters. Prevention is the preferred approach. Think, if you will, of anti-fraud efforts as analogous to efforts to reduce traffic accidents at a busy intersection. What is a better way to reduce accidents at this intersection: to spend resources to station a police officer at that busy intersection to ticket cars (and prosecute drivers) that cause traffic accidents, or to place a traffic light at the intersection to prevent accidents in the first place?

I urge you to carefully review the various HHS Office of Inspector General ("HHS-OIG") recommendations regarding Medicare and Medicaid, and to investigate needed reforms to prevent fraud on these important public programs.

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<sup>2</sup> Media reports that reference South Florida as having the highest level of fraud overlook a simple fact. From 2006 until today, SDFL has prosecuted more cases than any other District in the nation. As a result, SDFL identifies and reports more fraud. This does not imply that there is substantially more fraud, any more than an increased incidence of speeding tickets implies that more drivers break traffic laws. Rather, the higher numbers are explained in part by our increased incidence of enforcement. Reference to pre-2006 figures supports this, as prior to our 2006 South Florida Health Care Fraud Initiative, reported measures of fraud in South Florida were substantially lower.

## I.

Early in my tenure as U.S. Attorney, the SDFL chief of economic crimes, Eric Bustillo, provided me data regarding the breadth and depth of the Medicare fraud problem. Subsequent investigations confirmed the concerns that he raised with me. For example:

- In 2006, HHS-OIG agents conducted site visits of all 1,581 durable medical suppliers (“DMEs”) registered in South Florida. They inspected the DMEs for compliance with five standards, including whether they: (i) maintained a physical facility and (ii) were opened and staffed during business hours. A total of 491 (31%) failed to maintain a physical facility or were not open during reasonable or posted business hours. Indeed, instead of medical equipment businesses, agents often found empty offices with “for rent” signs, abandoned offices with mail stacked outside the door, and sometimes even other businesses such as a florist shop, and a real estate company. These 491 suppliers billed Medicare approximately \$237 million (\$97 million paid) from January 1 to November 30, 2006.<sup>3</sup>
- In 2006, eight percent of Medicare beneficiaries with HIV / AIDS lived in South Florida. By contrast, South Florida providers accounted for 79% of the amount of drugs billed nationally by Medicare beneficiaries with HIV / AIDS. With respect to non-oral HIV / AIDS related drugs, South Florida providers submitted bills of more than \$2.2 billion (\$568 million paid), about 22 times the \$100 million submitted (\$42 million paid) in the rest of the nation.<sup>4</sup>
- In 2007, about two percent of Medicare beneficiaries lived in South Florida. Nonetheless, South Florida accounted for 17% of Medicare spending on inhalation drugs. On a per capita basis, Medicare spent approximately \$4400 per South Florida

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<sup>3</sup> See HHS Office of Inspector General, *South Florida Suppliers’ Compliance with Medicare Standards: Results from Unannounced Visit*.

<sup>4</sup> See HHS Office of Inspector General, *Aberrant Billing in South Florida for Beneficiaries with HIV / AIDS*.

beneficiary receiving inhalation drugs compared with a national average of \$815 per beneficiary.<sup>5</sup>

In 2006, in response to Mr. Bustillo's presentation, I organized the South Florida Health Care Fraud Initiative. Our initiative created more than a working group; it brought a different approach to health care fraud enforcement. First, to augment the cooperation between lawyers and investigators, we co-located SDFL prosecutors and federal agents in a fusion center modeled after similar arrangements more traditionally, and successfully, used in drug and organized crime prosecutions. To make clear that the agents and prosecutors must operate as a team, we cross-designated agents who held law degrees as Special Assistant United States Attorneys, to help with the prosecutions.

Second, the initiative streamlined criminal health care fraud prosecutions. Traditionally, white collar fraud cases rely on historical evidence of past billing records. Reconstructing years of records consumes time and resources. The South Florida quick-hit squad, and later the Strike Force, instead focused on present fraud, limiting criminal charges to the more recent fraudulent billings and thus avoiding the need to reconstruct years of data. Again, this resembled similar practices traditionally used in drug prosecutions: an individual found dealing illegal drugs is typically charged with that single, present act, and prosecutors do not spend additional resources recreating past history of drug sales absent a compelling reason.

Third, South Florida became the first District in which prosecutors worked with agents to review near real-time data to identify aberrant billing patterns. This use of advance data analysis techniques permitted our teams to identify and pro-actively investigate individuals while they were still engaged in fraudulent billing. Particular credit for these efforts goes to a licensed nurse, whom we employed, who reviewed and identified medically unrealistic data trends.

In 2007, our efforts were substantially energized as the Criminal Division's Fraud Section contributed its attorneys, expertise and resources through a Health Care Fraud Strike Force. Attorneys from Washington D.C. spent weeks co-located in our facilities. They integrated fairly seamlessly with SDFL prosecutors and agents, and they deserve credit for working to

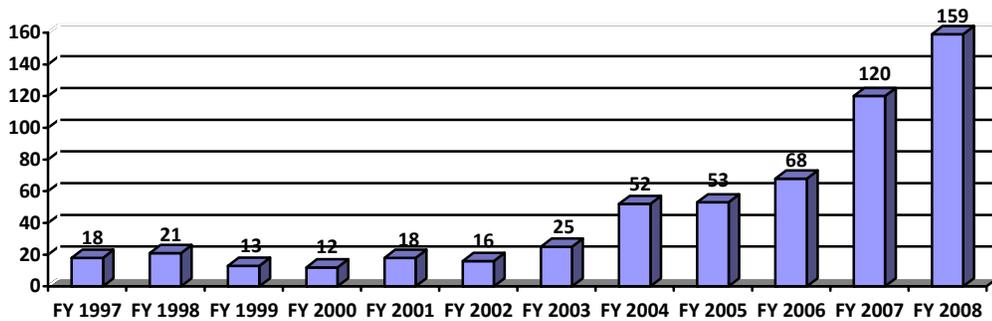
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<sup>5</sup> See HHS Office of Inspector General, *Aberrant Claim Patters for Inhalation Drugs in South Florida.*

avoid the bureaucratic squabbles that often impede these multi-office team approaches. South Florida owes much to their expertise, their contributions and their teamwork.

Our efforts resulted in a substantial increase in health care fraud prosecutions in South Florida. Indeed by FY 2008, SDFL was prosecuting 32% (159 of 502) of the nation's health care fraud matters.

Health Care Fraud Cases Prosecuted in SDFL



The fraudulent Medicare claims associated with these SDFL prosecutions are, as I said previously, both spectacular and sad:

- FY 2005 – data not available
- FY 2006 – \$138,000,000
- FY 2007 – \$638,000,000
- FY 2008 – \$793,448,162
- FY 2009 – \$951,575,415

The Southern District's efforts continue to this day. In 2008, the Southern District of Florida model was used to establish a Health Care Fraud Strike force in Los Angeles, and in 2009, a third Strike Force in Houston. Strike Forces now exist in Detroit, Brooklyn, Baton Rouge and Tampa as well, and the efforts have been elevated within the Justice Department, with the May 2009 creation of the HEAT (Health Care Fraud Prevention and Enforcement Action Teams).

## II.

Increased prosecutions, while commendable and important, are not the solution to Medicare fraud, waste and abuse. This may appear to be a surprising statement coming from a prosecutor. It is a belief based on my experience prosecuting health care fraud.

First, prosecutions are an insufficient deterrence. In FY 2010, federal court judges sentenced 146 defendants to terms of imprisonment averaging more than 40 months.<sup>6</sup> In the future, the average sentence will likely increase as, pursuant to a directive in the Patient Protection and Affordable Care Act, the U.S. Sentencing Commission implements a 2 to 4 level increase in Federal Sentencing Guidelines for crimes related to a government health program.<sup>7</sup> For a first time offender (likely a Level 22 under the Guidelines), these amendments would add 2 levels, resulting in a sentence of about 51 months.

These are serious sentences, yet they pale in comparison to the terms of imprisonment given for drug or other serious federal felonies. And, in my experience, they provide an insufficient deterrence. A quick thought experiment highlights some of the reasons why the deterrence is insufficient. Assume for example, that only 1 in 20 health care fraud criminals are identified and prosecuted. (Likely, a far lower percentage are prosecuted.) Would an individual, otherwise willing to commit crime, be willing to risk a five percent chance of a 51 month federal term of imprisonment in order to make an easy \$2 million (the figure most likely associated with a Level 22)? Few fraudsters think in such numerical terms, yet scholarship establishes that there is a basis to believe that the risk to reward ratio in these circumstances provides for insufficient deterrence.

Second, prosecutions are resource intensive. The Justice Department's prosecutions pay for themselves many times over in dollars recovered and fraud prevented. Nonetheless, they are expensive and drain prosecutorial and federal investigative resources. Courts and jails cost money too, and these expenses too often are ignored when calculating the cost of enforcement. Although Congress has appropriately increased

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<sup>6</sup> See <http://www.hhs.gov/news/press/2011pres/01/20110124a.html>.

<sup>7</sup> See [http://www.ussc.gov/Legal/Amendments/Reader-Friendly/20110119\\_RFP\\_Amendments.pdf](http://www.ussc.gov/Legal/Amendments/Reader-Friendly/20110119_RFP_Amendments.pdf) at 54 - 77.

funding for prosecutions (a funding increase that is clearly justified), prosecutions are not the most cost effective means of reducing fraud.

Third, prosecutions rarely recover the full taxpayer loss. Fraudsters tend to spend the money they illegally gain, or in some circumstances, to transfer the money overseas and beyond the reach of U.S. authorities. Even the wealthiest fraudsters often appear to have few assets by the time they are prosecuted.

Prevention is thus the preferred approach.

### III.

The Patient Protection and Affordable Care Act implements both enhanced prosecutorial funding and penalties, discussed *supra*, and enhanced oversight and screening measures, including licensure checks, background checks and site visits.<sup>8</sup> These are important new tools, and I was gratified to read that the HHS Secretary, on January 31, 2011, announced an implementing final rule that would create a more rigorous screening process for providers and suppliers enrolling in Medicare and Medicaid.<sup>9</sup>

Effective prevention, however, requires more than mere front-end screening. Effective prevention requires continuous and proactive efforts to identify and stop fraud as it happens. Businesses do this effectively. Most Americans have received calls from credit card companies asking whether a particular charge was theirs. Insurance companies do this effectively. Most insured Americans have received letters asking for additional information regarding a particular claim. Private business can serve as a model for Medicare anti-fraud efforts.

Among the most important changes that Medicare should consider, in my opinion, is assigning unique ID numbers to Medicare beneficiaries. Presently, a beneficiary's Medicare number is his or her social security number. This makes fraud simple, as anyone with a beneficiary's social security number can submit fraudulent claims in a beneficiary's name. This

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<sup>8</sup> Congressional Research Service, *Medicare Provisions in PPACA* at 15.

<sup>9</sup> <http://www.hhs.gov/news/press/2011pres/01/20110124a.html>

also makes stopping fraud difficult, as Medicare cannot cancel a number that is being wrongfully used by a third party to commit fraud.

Business long ago understood the importance of unique ID numbers on credit cards. Imagine, for example, if American Express used a social security number instead of a unique number. Imagine further that when a cardholder called to identify fraudulent billings, American Express responded by stating that they could not change the card number, and that the card holder should continue to monitor all bills and provide American Express notice of future fraud. American Express would likely be out of business, yet that is the system used by Medicare today. Biometric IDs, in lieu of paper Medicare cards, would be an additional step to ensure that the beneficiary is actually the person on whose behalf a claim is filed.

Effective predictive modeling is another tool that can assist with fraud prevention. I understand that Congress, in the Small Business Jobs Act of 2010, directed the Secretary to use predictive analytic technology to identify improper claims and to prevent the payment of these claims. I encourage the Secretary to use this authority aggressively.

The use of brand name inhalation drugs in South Florida shows the potential effectiveness of predictive modeling techniques. As U.S. Attorney, I prosecuted many cases involving fraudulent billing of inhalation drugs. Often, the claims submitted to Medicare were for fraudulent prescriptions that were not needed by beneficiaries, and in fact were not even filled. An April 2009 HHS-OIG Report revealed the scope of the problem. South Florida accounts for 17% of total Medicare reimbursements for inhalation drugs, even though South Florida accounts for only two percent of beneficiaries.<sup>10</sup> A very high incidence of claims for particularly expensive drugs explained this discrepancy. With respect to Budesonide (a steroid inhalation drug used to treat respiratory disorder), for example, providers in Miami-Dade County billed Medicare \$93.9 million (\$48.9 million paid). The next highest billing county in the nation was Cook County (Chicago) with \$2.7 million billed and \$1.8 million paid.<sup>11</sup>

This report made several observations. First, 74.5% of South Florida claims for Budesonide exceeded the 90 day maximum coverage quantity.

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<sup>10</sup> See Office of Inspector General, *Aberrant Claim Patterns for Inhalation Drugs in South Florida*.

<sup>11</sup> See Office of Inspector General, *Questionable Billing for Brand-Name Inhalation Drugs in South Florida*.

Other inhalation drugs similarly exceeded the coverage maximum. Second, 62% of beneficiaries that were supposedly receiving Budesonide treatment had not seen a prescribing physician in at least 3 years. Third, 10 South Florida physicians were each listed as ordering more than \$3.3 million in inhalation claims. In others words, each of these 10 physicians was responsible for more claims than all the physicians in Chicago combined. Such statistics represent “red flags” that would cause any private insurer to stop payment and begin an immediate investigation. Medicare should use predictive modeling and advanced data analysis to identify and investigate such obviously problematic claims pre-payment. Experience shows that pre-payment prevention is preferable to post payment pay-and-chase.

V.

Mr. Chairman, Ranking Member DeGette and distinguished Members of the Committee. I am gratified by your interest in this issue. As a prosecutor, I am prepared to answer questions regarding criminal matters. I note, as well, that during my term as U.S. Attorney, we brought several civil matters as well, including several average weighted price qui tams, and am prepared to address civil matters. As an American citizen, however, I hope that your focus remains on prevention. Thank you for your time and your leadership.