

**Testimony to House Energy and Commerce Committee
Subcommittee on Oversight and Investigations**

**“Waste, Fraud and Abuse:
A Continuing Treat To Medicare and Medicaid”**

**Chairman Cliff Stearns (R-FL)
Ranking Member Diana DeGette (D-CO)**

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Chairman Stearns, Ranking Member DeGette and Members of the Committee, thank you for inviting me to testify today. My oral and written remarks reflect solely my own views and not necessarily those of my law firm (Hogan Lovells US LLP), any of our firm’s clients, or the Florida Agency for Health Care Administration, the public agency for which I previously served.

I was asked to share my views on effective ways to detect and prevent Medicare and Medicaid fraud, waste and abuse based principally on my prior experience serving as the General Counsel of Florida’s Agency for Health Care Administration, which operates one of the largest Medicaid programs in the nation. As you undoubtedly have read or heard, South Florida frequently has

been referred to as “Ground Zero” for health care fraud, and therefore enforcement authorities in Florida have a lot of experience dealing with this problem. The situation became so dire that the 2009 Florida Legislature took the virtually unprecedented step of designating Miami-Dade County “a healthcare fraud crisis area for purposes of implementing increased scrutiny of home health agencies, home medical equipment providers, healthcare clinics, and other healthcare providers” to prevent fraud, waste and abuse.¹

It is important to bear in mind that the focus of my remarks is on true fraud and abuse, as opposed to overpayments that occur as a result of honest mistakes. The overwhelming majority of healthcare providers serving Medicare and Medicaid beneficiaries are dedicated, honest, and high-quality caregivers who not only want to play by the rules, but also want enforcement authorities to apprehend and sanction those who do not. The best measures strike the proper balance between preventing waste, fraud and abuse while avoiding being so draconian and burdensome that honest providers and suppliers choose not to participate, thereby creating an access problem for program beneficiaries.

Unfortunately, there are enough criminals focusing their efforts on Medicare and Medicaid to create a significant fraud and abuse problem for this nation. The media have reported that the mafia and other organized crime rings have been drawn to Medicare fraud and as a result, federal investigators have been threatened, witnesses have been found “riddled with bullets, and a woman was discovered dead in a pharmacy under investigation, her throat slit with a piece of broken toilet seat.”² Perhaps even more alarming is the fact that some criminals have been willing to risk the health and safety of vulnerable Medicare and Medicaid beneficiaries in order

to reap their ill-gotten financial gains.³ Every taxpayer dollar wasted through fraud, abuse or other improper payments is a dollar that could have been used to provide a needed health care item or service to an eligible beneficiary. Accordingly, the Committee is right to focus on efforts to prevent Medicare and Medicaid waste, fraud and abuse.

On February 17, 2011, federal authorities announced that 111 doctors, nurses, company owners, “patient recruiters” and other individuals nationwide were arrested and charged with conspiring to loot more than \$225 million from Medicare.⁴ The Department of Justice announced that more than 700 federal and state enforcement authorities across the country participated in this operation, and arrests were made in Baton Rouge, Brooklyn, Chicago, Dallas, Detroit, Houston, Los Angeles, Miami, and Tampa.⁵ While certainly impressive in its size and scope, this enforcement operation highlights two very significant points: (1) many corrupt individuals continue to view Medicare and Medicaid fraud as a lucrative career path, and (2) at a rate of nearly seven enforcement agents needed to apprehend one criminal, the post-payment (i.e., “pay and chase”) approach to fraud and abuse detection and prevention is extremely expensive and highly inefficient.

What, then, can be done? In my view, the best techniques are those that prevent improper payments in the first place. With a greater emphasis on pre-payment fraud and abuse prevention, we can decrease significantly the loss of taxpayer dollars and make healthcare fraud a much less desirable career path. The best pre-payment prevention tactics seem to flow from a few guiding principles: limit the number of participating providers to those that are necessary to ensure access to quality care; trust but verify the claims submitted by participating providers; and expel

those providers, owners or other persons in control of provider organizations—and beneficiaries—who commit fraud or participate in fraud schemes. To some extent, the Medicare and Medicaid programs already do this. But the tactics employed are not always the best, and even the best tactics are not always utilized consistently. From experience, I believe the following five tactics are proven and effective ways of significantly reducing Medicare and Medicaid fraud and abuse that should be considered:

1. Maintain Better Control of the Provider Network. Despite the misconceptions of some, there is no constitutional right to be a Medicare or Medicaid provider. To the contrary, provider participation is based on an agreement between the provider and the government. Accordingly, Congress (with respect to Medicare and Medicaid) and state legislatures with respect to Medicaid) have the authority to limit their participating provider networks—much like commercial insurers and managed care organizations do—based not only on the criminal or professional disciplinary records of individuals but also on other legitimate factors, including without limitation the need (or lack thereof) for additional providers in the relevant geographic market and whether the provider is accredited or otherwise has a proven record of providing high-quality care.

Further, the Florida Medicaid program has chosen to include a “without cause” termination provision, as well as “for cause” termination provisions, in its Medicaid provider agreements. The “without cause” termination provision gives the Florida Medicaid program the ability to control its provider network and to act swiftly without the need to undergo lengthy administrative challenges or other litigation while being forced to continue paying the provider. In contrast, the Medicare program has not

historically exercised as much control over the scope of its provider network, and it has experienced difficulty in ousting certain providers it no longer wishes to have in its network. For example, when the Office of Inspector General (OIG) of the United States Department of Health and Human Services conducted unannounced site visits of 1,581 durable medical equipment (DME) suppliers in South Florida, the OIG found that 491 suppliers failed to maintain a physical facility or were not open and staffed during the unannounced site visits, which led the Centers for Medicare and Medicaid Services (CMS) to revoke all 491 suppliers' Medicare billing privileges.⁶ Incredibly, Medicare hearing officers later reinstated the billing privileges for 91 percent (222 of 243) of those suppliers. In 2008, the OIG reported that of the 222 DME suppliers that had their Medicare billing privileges reinstated, 111 subsequently had their privileges revoked again; 37 had their billing privileges inactivated; and the U.S. Attorney's Office indicted 18 individuals connected to 15 of the 222 reinstated suppliers.⁷

The waste of taxpayer dollars in this story is incredibly frustrating. First, the Medicare program failed to prevent individuals perpetrating fraud from obtaining Medicare DME supplier privileges and bilking the Medicare program. Second, long after the fraud was perpetrated and the taxpayer dollars were wasted, the suppliers' billing privileges were revoked. However, the OIG reported that the Medicare supplier appeals process was so flawed that 91 percent of the revoked suppliers were reinstated.⁸ The Justice Department ultimately obtained criminal convictions for a small percentage of the individual criminals, but the real problem is the significant amount of taxpayer dollars (improper Medicare payments, OIG investigation costs, Medicare appeals process costs, and

criminal prosecution costs) that was wasted along the way. If the Medicare program had exercised more control over its participating provider network, a significant portion of this problem could have been prevented before any taxpayer dollars were wasted.

2. Significantly Improve the Provider and Supplier Enrollment Screening Process. The Florida legislature in recent years has made it more difficult for bad actors to become enrolled as providers in the Medicaid program. But more can be done at the federal level to keep bad actors out of the Medicare program and, through cooperation with the states, the Medicaid program as well. The GAO issued a report in July 2008 after it performed covert testing to determine weaknesses in the DME supplier enrollment process.

According to the GAO:

Investigators easily set up two fictitious DMEPOS [Durable Medical Equipment, Prosthetics, Orthotics and Supplies] companies using undercover names and bank accounts. GAO's fictitious companies were approved for Medicare billing privileges despite having no clients and no inventory. CMS initially denied GAO's applications in part because of this lack of inventory, but undercover GAO investigators fabricated contracts with nonexistent wholesale suppliers to convince CMS and its contractor, the National Supplier Clearinghouse (NSC), that the companies had access to DMEPOS items. . . . As a result of such simple methods of deception, both fictitious DMEPOS companies obtained Medicare billing numbers. . . . However, if real fraudsters had been in charge of the fictitious companies, they would have been clear to bill Medicare from the Virginia office for potentially millions of dollars worth of nonexistent supplies.⁹

Another outrageous but unfortunately true example of the Medicare program failing to protect beneficiaries and taxpayer dollars involves the case of Guillermo Denis Gonzalez. According to reports, Mr. Gonzalez served 14 years in prison for murdering a man with a silencer-equipped handgun.¹⁰ After being released from prison, Mr. Gonzalez in 2006 purchased a Medicare-certified medical supply business for \$18,000, and within one year he had submitted \$586,953 in false claims for supplies never provided to patients.¹¹ Medicare reimbursed Mr. Gonzalez only \$31,442 before he was tracked down and arrested—but he also was charged again with murder: “this one for allegedly stabbing and dismembering an acquaintance during a monetary dispute.”¹² It goes without saying that the Medicare program, at a minimum, should be taking a closer look at individuals who have a violent criminal past before allowing them to have a controlling interest in a Medicare participating provider or supplier business.

Some county and city officials have adopted ordinances making it tougher for fraudsters to obtain occupational licenses and other local approvals that are required as part of the enrollment applications with Medicare and Medicaid. That type of local level enforcement, together with continuous communication and coordination among federal, state and local officials certainly is a good start, but more can be done. Medicare and many state Medicaid programs could make more effective use of the electronic data systems that have collected and organized otherwise disparate information pertaining the criminal records, professional licensure sanctions and discipline, and other concerning conduct to prevent bad actors from having any involvement in an approved Medicare or Medicaid provider or supplier.

3. Continue Shifting Reimbursement Methodologies Away from Fee-for-Service. One of the reasons that the overwhelming number of fraud and abuse incidents in Florida occurs in the Medicare program as opposed to Florida's Medicaid program is that Florida greatly has shifted away from the previous fee-for-service reimbursement system to capitated managed care systems. The capitated Medicaid managed care organizations (MCO) that contract with the Florida Medicaid program have a significant financial incentive to prevent fraud and abuse, and for the most part they are successful. Even if a Medicaid provider under contract with the MCO were to commit fraud, the MCO suffers the financial hit, not Florida's Medicaid program. Of course, a shift to managed care presents its own unique set of challenges from a fraud and abuse perspective, but there are significantly fewer MCOs than providers and suppliers for the government to monitor; further, many of the MCOs are operated either by publicly traded companies or by companies with sufficient access to capital to be held financially accountable should any improper payments occur.

4. Increase the Role of Physicians in Detecting and Preventing Fraud. Much of the intentional Medicare and Medicaid fraud and abuse is perpetrated by providers or suppliers—for example, pharmacies, DME suppliers, home health agencies—that first must rely on a physician's prescription in order to obtain government reimbursement. Although the Medicare and Medicaid programs have enhanced the requirements for such ancillary providers and suppliers to demonstrate that the items or services they furnish to beneficiaries are done so in connection with a valid physician's prescription, it remains too easy for bad actors to forge documents or otherwise fraudulently misrepresent that a

physician ordered the item or service. The GAO previously has recommended that CMS require that physicians receive a statement of Medicare home health services beneficiaries received based on the corresponding physicians' certification, which in turn the physicians would review to detect any potential misuse of their authorizations. This type of simple and relatively inexpensive approach potentially could detect and prevent significant fraud and abuse not only in home health but in other provider and supplier areas as well; however, the GAO reported last month that CMS has not implemented this recommendation.¹³

5. Use Predictive Modeling and Other Enhanced Technologies. Pre-payment predictive modeling has been used to analyze health care claims for some time, but historically its effectiveness has been hampered by an inability to limit false positives and produce focused, actionable results. In recent years, however, technology in this area has improved significantly. Just as the credit card industry is able contemporaneously to identify potentially fraudulent transactions and instantly alert cardholders through email and text message alerts, the Medicare and Medicaid programs should be able to use these technologies—with an appropriately prompt level of clinical confirmation—to detect and prevent fraudulent claims for reimbursement on a prepayment basis.

In conclusion, recent arrests across the nation for alleged Medicare fraud crimes underscore that our nation continues to face a significant problem that threatens taxpayer dollars and in some cases, the safety of program beneficiaries. Although criminal and administrative enforcement actions are an important part of the overall fight against Medicare and Medicaid fraud and abuse, the best way to prevent the waste of taxpayer dollars and to assure appropriate is available and

accessible for vulnerable populations is to detect and prevent fraud and abuse on a prepayment basis.

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Thank you Chairman Stearns and Ranking Member DeGette for holding this hearing and focusing on these very important issues. Upon request, I very much would look forward to working with members of the Subcommittee to develop proactive, innovative, and most importantly, effective ways to eliminate waste, fraud and abuse from Medicare and Medicaid.

¹ See CS/CS/CS Senate Bill (1986) (2009).

² E. Martinez, “Health Care Goodfellas: Mafia Turns to Medicare Fraud,” (Oct. 7, 2009), http://www.cbsnews.com/8301-504083_162-5368496-504083.html (last accessed on Feb. 25, 2011).

³ See, e.g., “Miami Clinic Owner Pleads Guilty to Fraud,” South Florida Business Journal, January 8, 2009 (reporting that as part of a plea agreement, the owner of two Miami-Dade medical clinics admitted that his “clinic employees intentionally manipulated patients’ blood samples so they would appear to need treatment, when in fact, they did not.”).

⁴ See Dept. of Justice Press Release, “Thirty-Two South Florida Residents Charged as Part of Nationwide Takedown by Medicare Fraud Strike Force Operations,” (Feb. 17, 2011), <http://miami.fbi.gov/dojpressrel/pressrel11/mm021711.htm> (last accessed on Feb. 26, 2011).

⁵ See http://www.washingtonpost.com/wp-dyn/content/article/2011/02/17/AR2011021703492_pf.html (last accessed on Feb. 26, 2011).

⁶ Department of Health and Human Services, Office of the Inspector General, South Florida Durable Medical Equipment Suppliers: Results of Appeals, at ii (October 2008).

⁷ *Id.* at ii, iii.

⁸ The OIG found that “[t]here are no criteria for hearing officers regarding the types of evidence required to reinstate a supplier’s billing privileges. For suppliers that request a hearing, hearing officers generally accept all documentation submitted as legitimate, unless they have reason to believe otherwise.” *Id.* at 10.

⁹ United States Government Accountability Office, *Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process*, (July 2008), available at <http://www.gao.gov/new.items/d08955.pdf> (last visited May 20, 2009).

¹⁰ C. Hiassen, “Medicare corruption gusher worsens,” Miami Herald (Jul. 17, 2010)

¹¹ *Id.*

¹² Id.

¹³ GAO High-Risk Series, An Update, GAO-11-278 at 157 (Feb. 16, 2011).