

Testimony of:
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Good morning, Chairman Baucus, Ranking Member Hatch, and other distinguished Members of the Committee. I am Daniel Levinson, Inspector General of the U.S. Department of Health & Human Services (HHS or the Department). Thank you for the opportunity to testify about the efforts of the Office of Inspector General (OIG) and our partners to combat waste, fraud, and abuse in Medicare and Medicaid. I also thank you for your continued commitment to furthering our shared goal of safeguarding the fiscal integrity of these programs.

Medicare and Medicaid fraud, waste, and abuse cost taxpayers billions of dollars each year and put beneficiaries' health and welfare at risk. The impact of these losses and risks is magnified by the growing number of people served by these programs and the increased strain on Federal and State budgets. Moreover, new and expanded programs under the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) further heighten the need for robust oversight.

My testimony today describes the nature and scope of health care fraud, waste, and abuse; OIG's ongoing initiatives to fight these problems, including our highly productive collaboration with our colleagues in HHS and the Department of Justice (DOJ); and new tools and initiatives to prevent and detect fraud, waste and abuse and hold accountable those who engage in it. OIG is committed to building on our successes, employing all oversight and enforcement tools available to us, and maximizing our impact on protecting the integrity of government health care programs and the health and welfare of the people they serve.

OIG Work Highlighting the Nature and Scope of Health Care Fraud, Waste, and Abuse

Fraud is a serious problem requiring a serious response.

Although there is no precise measure of the magnitude of health care fraud, we know that it is a serious problem that demands an aggressive response. OIG has been leading the fight against health care fraud, waste and abuse for more than 30 years. Although the majority of health care providers are honest and well-intentioned, a minority of providers who are intent on abusing the system cost taxpayers billions of dollars. Over the past fiscal year, OIG has opened more than 1,700 health care fraud investigations. Additionally, our enforcement efforts have resulted in more than 900 criminal and civil actions and more than \$3 billion in expected investigative recoveries in fiscal year (FY) 2010. OIG's total expected recoveries for FY 2010 also include more than \$1 billion in audit receivables.

OIG investigations uncover a range of fraudulent activity. Health care fraud schemes commonly include purposely billing for services that were not provided or were not medically necessary, billing for a higher level of service than what was provided, misreporting costs or other data to increase payments, paying or receiving kickbacks, illegally marketing products, and/or stealing

providers' or beneficiaries' identities. The perpetrators of these schemes range from street criminals, who believe it is safer and more profitable to steal from Medicare than to traffic in illegal drugs, to Fortune 500 companies that pay kickbacks to physicians in return for referrals.

Many OIG investigations target fraud committed by criminals who masquerade as Medicare providers and suppliers but who do not provide legitimate services or products. The rampant fraud among durable medical equipment (DME) suppliers in south Florida is a prime example. In these cases, our investigations have found that criminals set up sham DME storefronts to create the appearance that they are bona fide providers; fraudulently bill Medicare for millions of dollars; and then close up shop, only to reopen in a new location under a new name and continue the fraud. The criminals often pay kickbacks to physicians, nurses, and even patients to recruit them as participants in the fraud schemes. When their schemes are detected, some of these perpetrators flee with the stolen Medicare funds and become fugitives.

The Medicare program is increasingly infiltrated by violent and organized criminal networks. For example, the Government recently charged 73 defendants with various health-care-fraud-related crimes involving more than \$163 million in fraudulent billings. According to the indictments, the Armenian-American organized crime ring behind the scheme was the Mirzoyan-Terdjanian Organization, which has allegedly used violence and threats of violence to ensure payments to its leadership.

The scheme perpetrated by this crime ring involved subjects allegedly stealing the identities of thousands of Medicare beneficiaries from around the country, as well as the identities of doctors who were usually licensed to practice in more than one State. Other subjects leased office space and opened fraudulent clinics and bank accounts to receive Medicare funds—often in the name of the doctor whose identity they had stolen. Upon becoming approved Medicare providers, the subjects allegedly billed Medicare for services never provided, using the stolen beneficiary information. The funds they received from Medicare were quickly withdrawn and laundered, and sometimes sent overseas. Although Medicare identified and shut down some of the phony clinics, members of the criminal enterprise simply opened up more fraudulent clinics, usually in another State. The investigation uncovered at least 118 phony clinics in 25 States.

Health care fraud is not limited to blatant fraud by career criminals and sham providers. Major corporations, such as pharmaceutical and medical device manufacturers, and institutions, such as hospitals and nursing facilities, have also committed fraud, sometimes on a grand scale. For example, in August 2010, Allergan, Inc., agreed to plead guilty to misdemeanor misbranding and paid \$600 million (including a \$375 million criminal fine and forfeiture and a \$225 million civil settlement) to resolve criminal and civil liability arising from the company's promotion of Botox®. Our investigations found that the company illegally marketed the drug for indications that, during the relevant time periods, had not been approved as safe and effective by the Food and Drug Administration (FDA). These unapproved indications included headache, pain, spasticity and juvenile cerebral palsy. In addition, the settlement resolved allegations that Allergan misled doctors about the safety and efficacy of Botox®, instructed doctors to miscode claims to ensure payment by Government health care programs, and paid kickbacks to doctors.

Despite our successes, there is more to be done. Those intent on breaking the law are becoming more sophisticated, and the schemes are more difficult to detect. Some fraud schemes are viral,

i.e., schemes are replicated rapidly within communities. Health care fraud also migrates—as law enforcement cracks down on a particular scheme, the criminals may redesign the scheme (e.g., suppliers fraudulently billing for DME have shifted to fraudulent billing for home health services) or relocate to a new geographic area. To combat this fraud, the Government’s response must be swift, agile, and well organized.

Waste and abuse cost taxpayers billions of dollars and must be addressed.

Waste of funds and abuse of the health care programs also cost taxpayers billions of dollars. In FY 2010, the Centers for Medicare & Medicaid Services (CMS) estimated that overall, 10.5 percent of the Medicare fee-for-service claims it paid (\$34.3 billion) did not meet program requirements. Although these improper payments do not necessarily involve fraud, the claims should not have been paid. OIG’s analysis of the Medicare error rate found that insufficient documentation, miscoded claims, and medically unnecessary services accounted for almost all of these errors.

For our part, OIG reviews specific services, based on our assessments of risk, to identify improper payments. For example, OIG reviewed high-utilization claims for blood-glucose test strips and lancet supplies. Our audits identified an estimated \$270 million in improper Medicare payments for these supplies. OIG has also conducted a series of audits over the past decade identifying improper Federal Medicaid payments for school-based health services. Most recently, we found that Arizona was improperly reimbursed an estimated \$21.3 million in Federal Medicaid funds for school-based services.

OIG’s work has also demonstrated that Medicare and Medicaid pay too much for certain services and products and that better aligning payments with costs could produce substantial savings. For example, OIG reported that Medicare reimbursed suppliers for pumps used to treat pressure ulcers and wounds based on a purchase price of more than \$17,000, but that suppliers paid, on average, approximately \$3,600 for new models of these pumps.

OIG and its Partners Are Leading the Fight Against Health Care Fraud, Waste, and Abuse

Collaboration and innovation are essential in the fight against health care fraud. The collaborative antifraud efforts of HHS and DOJ are rooted in the Health Insurance Portability and Accountability Act of 1996, P. L. No. 104-191 (HIPAA), which established the Health Care Fraud and Abuse Control (HCFAC) Program. The HCFAC return-on-investment is at an all-time high. Over the past 3 years (FY 2008- FY 2010), for every \$1 spent on the HCFAC Program, the Government has returned an average of \$6.80. OIG’s, HHS’s and DOJ’s HCFAC activities returned \$4 billion in fraudulent and misspent funds to the Government in FY 2010 and have returned more than \$18 billion to the Medicare Trust Fund since 1997.

On May 20, 2009, the HHS Secretary and the Attorney General announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT). This initiative marshals significant resources across the Government to prevent health care waste, fraud, and abuse; crack down on those who commit fraud; and enhance existing partnerships between HHS and DOJ.

Medicare Fraud Strike Forces are a proven success in fighting fraud.

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

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

The Strike Force uses data analysis and a collaborative approach to focus enforcement resources in geographic areas at high risk for fraud. Strike Force cases are data driven to pinpoint fraud hot spots through the identification of suspicious billing patterns as they occur. To support this approach, OIG created a team of data experts composed of OIG special agents, statisticians, programmers, and auditors. Together, the team brings a wealth of experience in using sophisticated data analysis tools combined with criminal intelligence gathered directly from special agents in the field to identify more quickly ongoing health care fraud schemes and trends. To expand the coalition of data experts focused on this effort, OIG has garnered the support and participation of our law enforcement partners at DOJ and FBI. This model is particularly effective in detecting sham providers and suppliers who masquerade as bona fide providers and suppliers.

The Strike Force model has proven highly successful. Since their inception in 2007, Strike Force operations in nine cities have charged almost 1,000 individuals for fraud schemes involving more than \$2.3 billion in claims.

Just last month, Strike Forces engaged in the largest Federal health care fraud takedown in history. Teams across the country arrested more than 100 defendants in 9 cities, including doctors, nurses, health care company owners and executives, and others, for their alleged participation in Medicare fraud schemes involving more than \$225 million in false billing. The defendants are accused of various health-care-related crimes ranging from violating the anti-kickback statute to money laundering to aggravated identity theft. More than 300 special agents from OIG participated in partnership with other Federal and State agencies, including fellow Offices of Inspector General. With the approval of the Attorney General, the Council of the Inspectors General on Integrity and Efficiency (CIGIE) has established procedures to permit special agents from within the Inspector General community to work together on operations like the HEAT Strike Forces, thereby maximizing efficiency and reducing operational costs.

The effectiveness of the Strike Force model is enhanced by our use of important tools. We refer to CMS credible allegations of fraud so that CMS can suspend payments to the perpetrators of these schemes. For example, during a July 2010 Strike Force operation, OIG worked with CMS to initiate payment suspensions and pre-pay edits on 18 providers and suppliers targeted in the investigation. The prompt action taken by OIG and CMS stopped the potential loss of more than \$1.3 million in claims submitted by the defendants. During the February Strike Force operations discussed above, OIG and CMS worked to impose payment suspensions that immediately prevented a loss of more than a quarter million dollars in claims submitted by Strike Force targets.

OIG's work with CMS during these recent Strike Force operations reflects the multi-pronged, collaborative approach that is critical to success. OIG and our law enforcement partners investigate and prosecute those who steal from Medicare. Relying on our work, CMS "turns off the spigot" to prevent dollars from being paid for fraudulent claims.

OIG recommendations prevent fraud, waste, and abuse.

OIG has also recommended actions to remedy program integrity vulnerabilities and prevent fraud, waste, and abuse. We found, for example, that Medicare's average spending per beneficiary for inhalation drugs was five times higher in south Florida, an area rife with Medicare fraud, than in the rest of the country, and that a disproportionately high rate of these claims in south Florida exceeded the maximum dosage guidelines. OIG's recommendations included adding new claims edits to prevent fraudulent or excessive payments, including edits to detect dosages exceeding coverage guidelines. In another example, to prevent future improper payments for blood-glucose test strips and lancet supplies, we recommended that CMS contractors implement various payment edits, such as edits to identify claims with overlapping dates of service. We have also found that Medicare has paid for prescription drug and DME claims that did not include valid prescriber identifiers, and we have recommended that CMS verify the prescriber identifier on claims before they are paid. Many other recommendations to prevent fraud, waste, and abuse are described in our annual *Compendium of Unimplemented OIG Recommendations*; our latest edition will be published later this month.

Enhanced Tools and New Initiatives Further Support Our Mission

The Affordable Care Act enhances program integrity in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

The ACA, as amended by the Reconciliation Act, promotes program integrity by addressing program vulnerabilities, strengthening law enforcement resources and authorities, and encouraging greater coordination among Federal agencies. Consistent with OIG's recommended program integrity strategy, the ACA:

- strengthens provider enrollment standards;
- addresses payment vulnerabilities;
- promotes compliance with program requirements;
- enhances program oversight; and

- fortifies the Government's arsenal of fraud-fighting tools and penalties.

The ACA includes numerous provisions that address vulnerabilities in CMS program operations and payment methodologies. To address the need for more upfront oversight, the ACA authorizes more robust provider and supplier screening procedures, temporary enrollment moratoria when the Secretary identifies fraud "hot spots," provisional periods of enhanced payment oversight for newly enrolled providers and suppliers, heightened disclosure and transparency requirements, and mandatory compliance programs.

The ACA also addresses particular fraud, waste, and abuse risks by altering program requirements. The following examples are illustrative. The law requires physicians to document that the physician (or a designated health professional) has had a face-to-face encounter with a patient for whom the physician is certifying the need for DME or home health services. The law requires community mental health centers that provide partial hospitalization services to provide at least 40 percent of their services to non-Medicare beneficiaries, which should help reduce fraud by centers that set up shop to prey on Medicare. The ACA addresses misaligned payments by, for example, rebasing home health payments, and the law will produce cost savings by increasing the Federal Medicaid rebate for generic drugs. The ACA addresses quality-of-care vulnerabilities through provisions that create incentives for hospitals to reduce readmissions and prevent hospital-acquired conditions.

The ACA strengthens the Government's ability to respond rapidly to health care fraud and hold perpetrators accountable. Increased HCFAC funding will support important fraud-fighting resources, including new technology for detecting suspected fraud more effectively and "boots on the ground" for our vital oversight and enforcement efforts. The ACA provisions that strengthen cross-agency collaborations and information sharing will aid our program integrity efforts. Enhanced authority to suspend payments pending the investigation of credible allegations of fraud will help ensure that the Government can effectively stop perpetrators from absconding with ill-gotten program funds. Important changes to the False Claims Act, the Federal anti-kickback statute, OIG's administrative authorities, and the Federal Sentencing Guidelines, among others, will help the Government more effectively prosecute those who defraud or abuse Federal health care programs.

OIG promotes program integrity by removing untrustworthy individuals from Federal health care programs.

Once we determine that an individual or entity has engaged in fraud or abuse or provided substandard care, OIG can use one of the most powerful tools in our arsenal: the authority to exclude that provider from participating in Federal health care programs. Program exclusions bolster our fraud-fighting efforts by removing from Federal health care programs those who pose the greatest risk to our programs and their beneficiaries.

No program payment may be made for any item or service that an excluded person or entity furnishes, orders, or prescribes. This prohibition applies regardless of whether the excluded person is paid directly by the programs (such as a physician) or whether the payment is made from the program to another person (such as payments to a hospital for services by its employed

nurses and other staff or payments to a pharmacy for drugs manufactured by a pharmaceutical company). Those who employ the services of an excluded individual or entity for the provision of items or services reimbursable by Medicare or Medicaid may be subject to monetary penalties and program exclusion. Because of its scope and effect, the risk of exclusion creates a strong incentive to comply with the programs' rules and requirements.

In imposing discretionary exclusions, OIG must weigh the fraud and abuse risks to the programs and beneficiaries against the impact on patient access to care if the provider or entity is excluded from Federal health care programs. Some hospital systems, pharmaceutical manufacturers and other providers play such a critical role in the care-delivery system that they may believe that OIG would never exclude them and thereby risk compromising the welfare of our beneficiaries. We are concerned that these providers may consider engaging in fraud schemes, and paying civil penalties and criminal fines if caught, as a cost of doing business. As long as the profit from the fraud outweighs those costs, abusive corporate behavior is likely to continue. For example, some major pharmaceutical corporations have been convicted of crimes and paid hundreds of millions of dollars in False Claims Act settlements and continue to participate in Federal health care programs.

One way to address this problem is to attempt to alter the cost-benefit calculus of the corporate executives who run these companies. By excluding the individuals who are responsible for the fraud, either directly or because of their positions of responsibility in the company that engaged in fraud, we can influence corporate behavior without putting patient access to care at risk. To that end, in 2008, we excluded three executive officers of the pharmaceutical company Purdue Frederick based on their convictions for misbranding the painkiller OxyContin. Each of the executives was convicted based on his status as a responsible corporate officer.

OIG also has the discretionary authority to exclude certain owners and the officers and managing employees of a sanctioned entity (i.e., an entity that has been convicted of certain offenses or excluded from participation in Federal health care programs) even if the executive has not been convicted of a crime. This authority, section 1128(b)(15) of the Social Security Act, allows OIG to hold responsible those individuals who are accountable for corporate misconduct. OIG has used this exclusion authority in more than 30 cases since it was added to the statute in 1996. But until recently, we had typically applied this exclusion authority to individuals who controlled smaller companies, such as pharmacies, billing services, and DME companies and not to executives of large complex organizations such as a drug or device manufacturer.

Moving forward, we intend to use this essential fraud-fighting tool in a broader range of circumstances. For example, in addition to excluding the Purdue Frederick executives, we recently excluded an owner (and former executive) of Ethex Corporation Company under our section (b)(15) exclusion authority. Ethex operated manufacturing facilities in St. Louis. In March of last year, Ethex pled guilty to felony criminal charges after it failed to inform the FDA about manufacturing problems that led to the production of oversized tablets of two prescription drugs. The owner was excluded for a period of 20 years.

We are mindful of our obligation to exercise this authority judiciously, and we do not propose to exclude all officers and managing employees of a company that is convicted of a health care-

related offense. However, when there is evidence that an executive knew or should have known of the organization's underlying criminal misconduct, OIG will operate with a presumption in favor of exclusion of that executive. We have published on our Web site guidance that sets out factors that we consider when evaluating whether a section (b)(15) exclusion should be imposed. This guidance alerts health care providers and executives to the standards of ethical conduct and responsibility to which they will be held accountable by OIG. Even if we decide exclusion of a major health care entity is not in the best interest of Federal health care programs and their beneficiaries, we may decide that executives in positions of responsibility at the time of the fraud should no longer hold such positions with entities that do business with the programs.

OIG is engaging health care providers and the public in the fight against fraud.

We recognize that the vast majority of health care providers and suppliers are honest and well-intentioned. Health care providers and suppliers are valuable partners in ensuring the integrity of Federal health care programs and preventing fraud and abuse. OIG seeks to collaborate with health care industry stakeholders to foster voluntary compliance.

OIG is using the Internet to enlist the health care industry and the public in the fight against fraud. Our Web site, <http://oig.hhs.gov>, offers extensive information to health care providers and patients about ways to reduce the risk of fraud and abuse. These extensive resources include OIG's voluntary compliance program guidance, fraud alerts, and advisory opinions on the fraud and abuse laws. OIG also offers a guide for patients to avoid becoming the victim of medical identity theft, a growing problem that can disrupt lives, damage credit ratings, and waste taxpayer dollars. We offer tips to Medicare beneficiaries and their caregivers on how to avoid medical identity theft and where to report misuse of personal information.

The Web site also includes information about the OIG's self-disclosure protocol, which offers a way for providers that uncover fraudulent billings or other misconduct within their organizations to self-disclose the problem and to work with OIG to resolve the issue, including return of any inappropriate payments.

Another example of OIG's commitment to promoting compliance is the HEAT Provider Compliance Training Initiative. The initiative brings together representatives from a variety of Government agencies to provide free compliance training to local provider, legal, and compliance communities. The first of these seminars took place in Houston in February, and we have scheduled additional seminars in Tampa, Kansas City, Baton Rouge, Denver, and Washington, DC throughout the Spring of 2011. In May, OIG will provide a Webcast of the seminar for those unable to attend in-person training. Our aim is to educate providers about fraud risks uncovered by OIG and to share compliance best practices so that providers can strengthen their compliance efforts. We believe these efforts to educate provider communities will help foster a culture of compliance and protect Federal health care programs and beneficiaries.

In response to requests from physicians just beginning their practices, OIG recently published *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*. The *Roadmap* summarizes the five main Federal fraud and abuse laws and provides guidance on how

physicians should comply with these laws in their relationships with payers, vendors, and fellow providers.

Finally, we also have posted OIG's list of the 10 most-wanted health care fraud fugitives, including photographs and details about the fugitives and their schemes. Our current most-wanted list includes 10 individuals who have allegedly defrauded taxpayers of approximately \$136 million. We are asking the public to help us bring these fugitives to justice by reporting any information about their whereabouts to our Web site or fugitive hotline (1-888-476-4453).

Conclusion

Health care fraud, waste, and abuse cost taxpayers billions of dollars every year and require focused attention and commitment to solutions. Through the dedicated efforts of OIG professionals and our collaboration with HHS and DOJ partners, we have achieved substantial results in the form of recoveries of stolen and misspent funds, enforcement actions taken against fraud perpetrators, improved methods of detecting fraud and abuse, and recommendations to remedy program vulnerabilities. Finally, we have enhanced tools and authorities and have engaged in new initiatives aimed at achieving our mission. Thank you for your support of this mission. I would be happy to answer any questions that you may have.