

Good morning, Chairmen Waxman and Pallone, Ranking Members Barton and Shimkus, and other distinguished Members of the Subcommittee. 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 discuss new tools in the recently enacted Patient Protection and Affordable Care Act (Affordable Care Act or ACA) that will help to combat fraud, waste, and abuse in the health care system. My testimony will describe OIG's strategy for strengthening the integrity of the health care system and ways in which the Affordable Care Act significantly bolsters that effort.

**Health Care Fraud, Waste, and Abuse: Serious Issues That Must Be Addressed Through Concentrated and Sustained Efforts**

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 exacerbated by the growing number of people served by these programs and the increased strain on Federal and State budgets. With new and expanded programs under the Affordable Care Act, it is critical that we strengthen oversight of these essential health care programs.

Although there is no precise measure of health care fraud, we know that it is a serious problem that demands an aggressive response. For example, over the past fiscal year, OIG has opened over 1,300 health care fraud investigations and obtained over 500 convictions. OIG investigations also have resulted in nearly \$3 billion in expected civil and criminal recoveries. While the majority of health care providers are honest and well-intentioned, a minority of providers who are intent on abusing the system can cost taxpayers billions of dollars.

Health care fraud schemes commonly include billing for services that were not provided or were not medically necessary, purposely billing for a higher level of service than what was provided, misreporting costs or other data to increase payments, paying kickbacks, 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 trafficking 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 appear to be legitimate providers, fraudulently bill Medicare for millions of dollars, and then close up shop and reopen in a new location under a new name and repeat the fraud. The criminals often pay kickbacks to physicians, nurses, and even patients to recruit them as participants in the fraud schemes.

The Medicare program is increasingly infiltrated by violent and organized criminal networks. For example, an individual in southern California led a Medicare DME fraud ring that established various fraudulent DME companies, primarily using street gang members to pose as nominee owners of his sham companies. He paid each gang member \$5,000 to establish bank accounts and to fill out the Medicare paperwork. The nominee owners submitted claims for reimbursement to Medicare for power wheelchairs and orthotic devices that were not medically necessary or legitimately prescribed by a physician. To date, nine of the gang members and associates have been indicted for charges including health care fraud and providing false statements to Government agencies. The gang members involved in this fraud had previously been convicted of charges ranging from assault on a peace officer to numerous narcotics violations.

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

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. OIG has a strong record of investigating these corporate and institutional frauds, which often involve complex billing frauds, kickbacks, accounting schemes, illegal marketing, and physician self-referral arrangements. In addition, we are seeing an increase in quality of care cases involving allegations of substandard care.

Waste of funds and abuse of the health care programs also cost taxpayers billions of dollars. In fiscal year (FY) 2009, the Centers for Medicare & Medicaid Services (CMS) estimated that overall, 7.8 percent of the Medicare fee-for-service claims it paid (\$24.1 billion) did not meet program requirements. Although these improper payments do not necessarily involve fraud, the claims should not have been paid. For our part, OIG reviews claims for specific services, based on our assessments of risk, to identify improper payments. For example, an OIG audit uncovered \$275.3 million in improper Medicaid payments (Federal share) from 2004 to 2006 for personal care services in New York City. As another example, an OIG evaluation of payments for facet joint injections (a pain management treatment) found that 63 percent of these services allowed by Medicare in 2006 did not meet program requirements, resulting in \$96 million in improper payments.

OIG’s work has also demonstrated that Medicare and Medicaid pay too much for certain services and products and that aligning payments with market costs could produce substantial savings. For example, in 2007, 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. Similarly, we found that in 2007, Medicare allowed, on average, about \$4,000 for standard power wheelchairs that cost suppliers, on average, about \$1,000 to acquire. These pricing disparities also affect

beneficiaries, who are responsible for 20 percent copayments on items and services covered under Medicare Part B.

### **OIG's Five-Principle Strategy Combats Health Care Fraud, Waste, and Abuse**

Combating health care fraud requires a comprehensive strategy of prevention, detection, and enforcement. OIG has been engaged in the fight against health care fraud, waste, and abuse for more than 30 years. Based on this experience and our extensive body of work, we have identified five principles of an effective health care integrity strategy.

1. Enrollment: Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment or reenrollment in the health care programs.
2. Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace and medical practice.
3. Compliance: Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.
4. Oversight: Vigilantly monitor the programs for evidence of fraud, waste, and abuse.
5. Response: Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

OIG uses these five principles in our strategic work planning to assist in focusing our audit, evaluation, investigative, enforcement, and compliance efforts most effectively. These broad principles also underlie the specific recommendations that OIG makes to HHS and Congress. The Affordable Care Act includes provisions that reflect these principles and that we believe will support the fight against fraud, waste, and abuse in Medicare and Medicaid.

### **The Affordable Care Act Enhances Health Care Oversight and Enforcement Activities**

The breadth and scope of health care reform alter the oversight landscape in many critical respects, and as a result OIG will assume a range of expanded oversight responsibilities. The ACA provides us with expanded law enforcement authorities, opportunities for greater coordination among Federal agencies, and enhanced funding for the Health Care Fraud and Abuse Control (HCFAC) program. In addition, new authorities for the Secretary and new requirements for health care providers, suppliers, and other entities will promote the integrity of the Medicare, Medicaid, and other Federal health care programs. The following examples illustrate how the ACA will strengthen our oversight and enforcement efforts.

*Effective use of reliable data is critical to the Government's anti-fraud efforts.*

Section 6402 of the Affordable Care Act will enhance OIG's effectiveness in detecting fraud, waste, and abuse by expanding OIG's access to and uses of data for conducting oversight and law enforcement activities. For example, section 6402 exempts OIG from the administrative

requirements of matching data across programs in the Computer Matching and Privacy Protection Act and authorizes OIG to enter into data-sharing agreements with the Social Security Administration (SSA).

The law also requires the Department to expand CMS's integrated data repository (IDR) to include claims and payment data from Medicaid, the Departments of Defense and Veterans Affairs, SSA, and the Indian Health Service and fosters data-matching agreements between Federal agencies. These agreements will make it easier for the Federal Government to help identify fraud, waste, and abuse.

Further, the ACA recognizes the importance of law enforcement access to data. Access to "real-time" claims data – that is, as soon as the claim is submitted to Medicare – is especially critical to identifying fraud as it is being committed. Timely data is also essential to our ability to respond with agility as criminals shift their schemes and locations to avoid detection. We have made important strides in obtaining data more quickly and efficiently, and the Affordable Care Act will further those efforts.

In addition to claims data, access to records and other information is of critical importance to our mission. Pursuant to section 6402 of the ACA, OIG may, for purposes of protecting Medicare and Medicaid integrity, obtain information from additional entities, such as providers, contractors, subcontractors, grant recipients, and suppliers, directly or indirectly involved in the provision of medical items or services payable by any Federal program. This expanded authority will enable OIG to enhance Medicare and Medicaid oversight. For example, OIG audits of Part D payments can now more effectively follow the documentation supporting claims all the way back to the prescribing physicians.

Ensuring the integrity of information is also crucial, and the Affordable Care Act provides new accountability measures toward this end. For example, section 6402 authorizes OIG to exclude from the Federal health care programs entities that provide false information on any application to enroll or participate in a Federal health care program. The ACA also provides new civil monetary penalties for making false statements on enrollment applications; knowingly failing to repay an overpayment; and failing to grant timely access to OIG for investigations, audits, or evaluations.

*The Affordable Care Act provides the Secretary with new authorities and imposes new requirements that are consistent with OIG's recommendations.*

In addition to promoting data access and integrity, health care reform includes numerous program integrity provisions that support an effective health care integrity strategy. Consistent with OIG's five-principle strategy, these include authorities and requirements to strengthen provider enrollment standards; promote compliance with program requirements; enhance program oversight, including requiring greater reporting and transparency; and strengthen the Government's response to health care fraud and abuse.

Section 6401 of ACA requires the Secretary to establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and the Children's Health Insurance Program

(CHIP). The Secretary is to determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier. At a minimum, providers and suppliers will be subject to licensure checks. The ACA also authorizes the Secretary to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State database inquiries, and random or unannounced site visits. These statutory provisions address significant vulnerabilities that OIG has identified in Medicare's enrollment standards and screening of providers and are consistent with recommendations that we have made to prevent unscrupulous providers and suppliers from participating in Medicare.

Health care providers and suppliers must be our partners in ensuring the integrity of Federal health care programs and should adopt internal controls and other measures that promote compliance and prevent, detect, and respond to health care fraud, waste, and abuse. OIG dedicates significant resources to promoting the adoption of compliance programs and providing guidance to health care providers on incorporating integrity safeguards into their organizations as an essential component of a comprehensive antifraud strategy. For example, OIG is planning a Provider Compliance Training Initiative to bring together representatives from a variety of government agencies to provide compliance training at no cost to local provider, legal, and compliance communities. The training sessions are scheduled to roll out in 2011 in several locations across the country. We aim to educate communities about fraud risk areas uncovered by OIG's work and to share compliance best practices so that providers can strengthen their own compliance efforts and more effectively identify and avoid illegal schemes that may be targeting their communities. This initiative will supplement OIG's extensive written guidance that is available on our Web site. We believe these efforts to educate provider communities can help foster a culture of compliance and protect the Federal health care programs and beneficiaries.

The Affordable Care Act require providers and suppliers to adopt, as a condition of enrollment, compliance programs that meet a core set of requirements, to be developed in consultation with OIG. In addition, the ACA separately requires skilled nursing facilities and nursing facilities to implement compliance and ethics programs, also in consultation with OIG. These new requirements are consistent with OIG's longstanding view that well-designed compliance programs can be an effective tool for promoting compliance and preventing fraud and abuse. These provisions are also consistent with recent developments in States that have made compliance programs mandatory for Medicaid providers.

Consistent with OIG recommendations, the ACA also facilitates and strengthens program oversight by increasing transparency. The new transparency requirements will shine light on financial relationships and potential conflicts of interest between health care companies and the physicians who prescribe their products and services.

Specifically, section 6002 requires all U.S. manufacturers of drugs, devices, biologics, and medical supplies covered under Medicare, Medicaid, or CHIP to report information related to payments and other transfers of value to physicians and teaching hospitals. This information will be made available on a public web site. The types of payments subject to disclosure have been the source of conflicts of interest and, in some cases, part of illegal kickback schemes in many of OIG's enforcement cases. OIG already includes similar disclosure requirements in our corporate

integrity agreements with pharmaceutical manufacturers as part of the settlement of these cases. The requirement of public disclosure of these payments will help the Government, as well as the health care industry and the public, to monitor relationships and should have a sentinel effect to deter kickbacks and other inappropriate payment relationships.

The quality of care in nursing homes also may improve with the increased transparency required by the Affordable Care Act. Section 6101 requires nursing facilities and skilled nursing facilities to report ownership and control relationships. Disclosure of these relationships is critical to facilitating better oversight of and response to quality-of-care and other issues. Historically, law enforcement has struggled to determine responsibility within an organization's management structure. We have had to resort to resource intensive and time-consuming investigative and auditing techniques to determine the roles and responsibilities of various management companies that are affiliated with a single nursing facility. Establishing accountability is challenging in part because corporations sometimes intentionally construct byzantine structures that obscure responsible parties from view. OIG has seen a variety of methods used to conceal true ownership, including establishing shell corporations, creating limited liability companies (LLC) to manage operations of individual homes, creating LLCs for real estate holdings, and creating affiliated corporations to lease and sublease among the various inter-owned corporations. The new requirements for disclosure of ownership and control interests will help ensure that corporate owners and investment companies that own nursing homes will no longer be able to provide substandard care, deny responsibility, and leave underfunded shell companies to take the blame.

Additional transparency provisions in the ACA will shine light on the administration of the Medicare and Medicaid programs. Section 6402 will require Medicare and Medicaid program integrity contractors to provide performance statistics, including the number and amount of overpayments recovered, number of fraud referrals, and the return on investment (ROI) of such activities, to the Inspector General and the Secretary. This latter requirement is consistent with OIG's call for greater accountability in the performance and oversight of CMS's program integrity contractors.

In addition to strengthening the Government's ability to detect fraud and abuse, the Affordable Care Act strengthens the Government's ability to respond rapidly to health care fraud and hold perpetrators accountable. For example, it expressly authorizes the Secretary, in consultation with OIG, to suspend payments to providers based on credible allegations of fraud. Significantly, the ACA also increases criminal penalties under the Federal Sentencing Guidelines for Federal health care offenses and expands the types of conduct constituting Federal health care fraud offenses under Title 18 of the United States Code. Put simply, criminals who commit health care fraud are going to be cut off from the Medicare Trust Funds faster, face longer prison terms, and be subject to larger criminal fines.

Each of these integrity provisions advances the fight against fraud, waste, and abuse. Further, we expect that the combined impacts of these new program integrity measures will be greater than the sum of the parts. Preventing unscrupulous providers and suppliers from gaining access to the health care programs and beneficiaries is the first step in an integrated integrity strategy. Requiring compliance programs and providing guidance helps to ensure that those permitted to

participate in the programs do not run afoul of the law or program requirements. Expanded oversight and reporting requirements will help the Government, industry, and the public monitor the programs and identify potential fraud, waste, and abuse more quickly and effectively. In combination, the ACA's new enforcement authorities and tools will help change the calculus undertaken by criminals when deciding whether to target Medicare and Medicaid by increasing the risk of prompt detection and the certainty of punishment.

*Funding of the Health Care Fraud and Abuse Control Program is vital to the fight against fraud, waste, and abuse.*

In addition to providing new authorities and enforcement tools, the Affordable Care Act provides critical new funding that will enable OIG to expand and strengthen current enforcement and oversight efforts to combat fraud, waste, and abuse.

The HCFAC program is a comprehensive effort, under the joint direction of the Attorney General and the Secretary of HHS, acting through OIG, designed to coordinate Federal, state and local law enforcement activities with respect to health care fraud and abuse. The HCFAC program provides OIG's primary funding stream to finance anti-fraud activities such as:

- Support of Criminal and Civil False Claims Act investigations and enforcement;
- Support of administrative enforcement activities;
- Evaluations of Medicare contractor operations, Medicare and Medicaid reimbursement for prescription drugs and DME, and other issues;
- Audits of payments to hospitals, home health agencies, Medicare Advantage plans, and Medicare Part D plans;
- Expansion of our use of technology and innovative data analysis to enhance our oversight and enforcement activities;
- Monitoring of providers under corporate integrity agreements;
- Issuance of advisory opinions and other guidance to the health care industry; and
- Establishment of Medicare Fraud Strike Force teams.<sup>1</sup>

From its inception in 1997 through 2009, HCFAC Program activities have returned more than \$15.6 billion to the Federal Government through audit and investigative recoveries, with a ROI of more than \$4 for every \$1 invested in OIG, DOJ, and FBI investigations, enforcement, and audits.<sup>2</sup> HCFAC-funded activities have a further sentinel effect, which is not captured in this ROI calculation. HCFAC-funded activities are a sound investment, and HHS and DOJ are receiving vital new HCFAC funding – \$10 million per year for 10 years in FYs 2011–2020 under the ACA, and an additional \$250 million total allocated across FYs 2011–2016 under the Health Care and Education Reconciliation Act of 2010. With our share of this new funding, OIG will expand our Medicare and Medicaid investigations, audits, evaluations, enforcement, and compliance activities to support our efforts toward improving health care program integrity.

---

<sup>1</sup> Medicare Fraud Strike Forces are a joint OIG-Department of Justice (DOJ) initiative used to fight concentrations of Medicare fraud in specific geographic “hot spots.” Strike Force teams include special agents from OIG and the Federal Bureau of Investigation (FBI), DOJ prosecutors, and oftentimes State and local law enforcement officials.

<sup>2</sup> The \$4 to \$1 return on investment is a 3-year rolling average from 2006-2008, which is used to help account for the natural fluctuation in returns from investigative, enforcement, and audit activities.

## **Innovative Uses of Data Are Central to OIG's Program Integrity Efforts**

Health care fraud schemes have become more sophisticated and better able to morph quickly in response to anti-fraud initiatives. Innovative uses of information technology have dramatically enhanced OIG's ability to respond to this challenge. For example, OIG is capitalizing on technology to process and review voluminous electronic evidence obtained during our health care fraud investigations. Using Web-based investigative software, OIG can efficiently analyze large quantities of email or other electronic documents and identify associations among emails contained in multiple accounts based on content and metadata. This technology is enabling investigators to complete in a matter of days analysis that used to take months with traditional investigative tools. Recently, OIG expanded the impact of this cutting-edge technology by making it available to our law enforcement partners for use in joint investigations.

Efficient and effective analysis of claims data to detect fraud indicators also is shaping how we deploy our law enforcement resources. OIG is using data to take a more proactive approach to identifying suspected fraud. In 2009, OIG organized the multidisciplinary, multiagency Advanced Data Intelligence and Analytics Team (Data Team) to support the work of the Health Care Fraud Enforcement and Prevention Action Team (HEAT). The Data Team, composed of experienced OIG special agents, statisticians, programmers, and auditors and DOJ analysts, combines sophisticated data analysis with criminal intelligence gathered from special agents in the field to more quickly identify health care fraud schemes, trends, and geographic "hot spots." For example, the Data Team has identified locations where billing for certain services is more than 10 times the national average. The Data Team's analyses inform the deployment of Strike Force resources and selection of new locations to focus and leverage Government resources in the areas with concentrations of health care fraud. Medicare Fraud Strike Forces have been established in seven fraud hot spots – Miami, Los Angeles, Detroit, Houston, Brooklyn, Tampa, and Baton Rouge.

We are committed to enhancing existing data analysis and mining capabilities and employing advanced techniques, such as predictive analytics and social network analysis, to counter new and existing fraud schemes. As part of that commitment, we are developing a consolidated data access center, which will integrate business intelligence tools and data analytics into our fraud detection efforts. It will also provide the opportunity to access, analyze, and share data – consistent with applicable privacy, security, and disclosure requirements – with our law enforcement partners. This will enhance the efficiency and coordination of our collective efforts by giving law enforcement agents an opportunity to put the pieces together and see the totality of the fraud scheme.

Through this data-enhanced collaboration, law enforcement will be able to increase the numbers of credible investigative leads, recoveries, and avoidances of improper Medicare and Medicaid payments and detect emerging fraud and abuse schemes and trends. In addition, these tools will support our effective targeting of audits and evaluations to identify program vulnerabilities and recommend systemic solutions.

## **Conclusion**

Health care fraud, waste, and abuse cost taxpayers billions of dollars every year and require focused attention and commitment to solutions. The Affordable Care Act provides additional



authorities and resources that will significantly enhance our effectiveness in fighting health care waste, fraud, and abuse in the Medicare and Medicaid programs. 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. Thank you for your support of this mission. I would be happy to answer any questions that you may have.