

**U.S. Department of Health and Human Services
Office of Inspector General
National Health Care Fraud Take-Down
June 18, 2015**

Fact Sheet

Key Points

- Largest national health care fraud take-down to date with more than 200 subjects who defrauded the Medicare and Medicaid programs by more than \$700 million.
 - Almost twice the size of previous take-downs, including more than 900 Federal, State, and local law enforcement personnel in a three-day operation across 14 states culminating in a major press conference.
 - More than 325 agents, investigators, and analysts from the U.S. Department of Health and Human Services - Office of Inspector General (HHS-OIG) Office of Investigations will be participating in this operation. Accomplishments by OIG's Office of Investigations (OI) in the past three years include almost \$15 billion in investigative receivables and more than 2,700 criminal actions.
 - Effort includes OIG work with significant data analysis efforts, including proactive identification of post-operation areas of concern.

- This operation is unique in size and scope, and primarily focuses on fraud in three areas: (1) Medicare Part D prescription drugs, (2) Medicaid Personal Care Services (PCS), and (3) Medicare home health benefits.
 - Arrests cover geographical areas from Alaska to Florida, covering 14 states.
 - Other fraud schemes include Durable Medical Equipment (DME), behavioral health, and ambulance services.

- Partner agencies include the Department of Justice (DOJ); Federal Bureau of Investigation (FBI); the Internal Revenue Service-Criminal Investigations Division and several state Medicaid Fraud Control Units (MFCUs).
 - MFCUs include Alaska, California, Florida, Georgia, Illinois Louisiana, New York, North Carolina, Ohio, South Carolina, and Texas.
 - Law enforcement mutual assistance being provided within the Office of Inspector General (OIG) community including Department of Justice (DOJ-OIG), General Services Administration (GSA-OIG); Department of Homeland Security (DHS-OIG); Housing and Urban Development (HUD-OIG); Social Security (SSA-OIG); Department of Transportation (DOT-OIG); United States Postal Service (USPS-OIG); and Veteran's Affairs (VA-OIG).

Medicare Part D (Prescription Drug)

- The Medicare Part D program has seen notable cost increases. From 2006 to 2014, spending for Part D drugs increased by 136 percent, from \$51.3 billion to \$121.1 billion. In 2013, over 39 million beneficiaries were enrolled in the program.
 - OIG uses sophisticated data analytics combined with real-time field intelligence to identify fraud schemes within Medicare Part D.
- OIG has made Part D fraud a top priority.
 - During the last three years, Part D investigative efforts have resulted in 339 criminal actions, 31 civil actions, and over \$720 million in investigative receivables.
- Approximately one-third of the investigations focus on prescription drug fraud schemes.
 - Prescription drug abuse is a growing problem and in 2011 the Centers for Disease Control declared it an epidemic. Prescription drug diversion is the redirection of prescription drugs for illegitimate purposes.
- Prescription drug diversion is a serious problem and encompasses both controlled and non-controlled substances.
 - Controlled substances include opioids which have a potential for abuse and addiction.
 - Non-controlled substances include respiratory, HIV anti-retrovirals, anti-psychotics drugs and other types of medication. These are often diverted for their financial value, but can be combined with other prescription drugs for abuse purposes.
- Prescription drug fraud schemes are numerous and may include patient harm.
 - Prescription drug fraud schemes include billing for drugs that are not dispensed, illegal dispensing of expired and adulterated drugs, drug trafficking, doctor shopping, and diversion for recreational and other illegitimate use.
 - Prescription drug fraud often includes medical identity theft, kickbacks, and money laundering.
 - Prescription drug fraud may be committed by anyone, from trusted physicians to criminal enterprises, and often include Medicare and Medicaid patients involved in the fraud scheme.

Medicare Home Health Services

- Medicare home health services fraud is a priority of the Office of Investigations and represents a significant fraud scheme noted in today's operation.
- Home health fraud frequently involves criminal enterprises and cooperative beneficiaries.
 - Home health fraud schemes can include billing for services not rendered, misrepresentation of services, medically unnecessary services, and falsification of records and physician authorizations.

- Criminal enterprises often use patient recruiters to solicit Medicare beneficiaries who do not qualify for services. These patients often receive medically unnecessary physical therapy and other home health related services.
- Home health cases may also involve medical identity theft, money laundering, and kickbacks and bribes to providers to certify patients who are not qualified to receive home health care.
 - Some cases involve unlicensed or unqualified home health care providers.

Medicaid Personal Care Services

- In 2011, Medicaid costs for Personal Care Services (PCS) totaled approximately \$12.7 billion, a 35 percent increase since 2005.
- PCS fraud may include care rendered by unqualified health care providers and may result in patient harm and neglect, including identity theft and embezzlement.
- MFCUs across the nation are reporting PCS fraud as a top concern.
 - PCS schemes include billing for covered services not rendered and misrepresentation of daycare, housekeeping and other non-reimbursable services as covered health care services.
 - PCS fraud frequently includes care rendered or billed for patients who do not qualify for the services, and may include conspiracies between the patient and PCS caregiver.
- PCS fraud is a priority of the OIG, and this operation includes significant PCS investigations in Alaska and Southern Illinois.

Medicare Strike Force

- In May 2009, the Department of Health and Human Services and Department of Justice created the Health Care Fraud Prevention and Enforcement Action Team (HEAT). With its creation, the fight against Medicare fraud became a Cabinet-level priority.
- HEAT includes the Medicare Fraud Strike Force; a multi-agency group of investigators designed to fight Medicare fraud and has charged more than 2,097 defendants who collectively falsely billed the Medicare program more than \$6.5 billion.
 - There are Strike Forces in nine locations including Brooklyn, NY; Chicago, IL; Dallas, TX; Detroit, MI; Los Angeles, CA; Miami-Dade, FL; Southern Louisiana; Southern Texas, and Tampa, FL.

- The Strike Force was originally established in 2007 and utilizes sophisticated data analytics and leverages the combined resources of Federal, State, and local law enforcement entities to prevent and combat health care fraud, waste, and abuse.
- This operation is the largest health care fraud takedown since the inception of the Medicare Strike Force in terms of loss amount at over \$500 million, defendants charged at more than 200, and number of states involved at 14.