

Testimony of:
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Good afternoon Chairman Obey, Ranking Member Tiahrt, and other distinguished Members of the Subcommittee. I am Daniel Levinson, Inspector General for the U.S. Department of Health & Human Services (HHS). I thank you for the opportunity to appear before you today to discuss the Office of Inspector General's (OIG) efforts to combat health care fraud, waste, 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 against those who would divert resources that are vital to so many Americans.

Medicare and Medicaid fraud, waste, and abuse cost the taxpayers billions of dollars each year and put the programs' beneficiaries' health and welfare at risk. The growing numbers of people served by these programs and the increased strain on Federal and State budgets caused by the economic recession further exacerbate the impact of these losses. It is critical that we strengthen oversight of these essential programs and reduce their vulnerability to fraud, waste, and abuse.

My testimony today will describe the nature and scope of the health care fraud, waste, and abuse that we have identified; strategies and recommendations to fight these problems; and OIG's role in fraud prevention, detection, and enforcement, including our highly productive collaboration with our colleagues in HHS and the Department of Justice (DOJ). It will also describe how we have deployed our resources and the results we have achieved, as well as our plans for the new appropriations requested in the President's Budget for fiscal year (FY) 2011.

OIG's Mission to Protect the Medicare and Medicaid Programs and Beneficiaries

OIG fights health care fraud, waste, and abuse through a nationwide program of investigations, audits, evaluations, and enforcement and compliance activities. Our FY 2010 appropriation included approximately \$232 million in funding dedicated to protecting the integrity of Medicare and Medicaid.¹ In recognition of the value and impact of OIG's oversight and enforcement activities, the President's Budget for FY 2011 requests approximately \$272 million in Medicare and Medicaid integrity funding for OIG, a net increase of \$40 million. With this increased funding, OIG will expand its activities in support of the joint HHS-DOJ Health Care Fraud Prevention and Enforcement Action Team (known as HEAT and described in more detail below), including expanding the OIG-DOJ Medicare Fraud Strike Forces to 13 new locations.

OIG's funding is used to hire and support investigators, auditors, evaluators, attorneys, and management and support staff to carry out our mission and functions. OIG is comprised of more than 1,500 professionals who perform comprehensive oversight and enforcement activities for HHS programs, including:

¹ OIG's total appropriation for FY 2010 was approximately \$282 million, which also included \$50 million to oversee the more than 300 other HHS programs.

- Office of Investigations: conducts criminal, civil, and administrative investigations of health care fraud, which result in convictions, monetary recoveries, and exclusions of providers and suppliers from Federal health care programs;
- Office of Audit Services: conducts and oversees audits of Medicare and Medicaid payments and operations, identifies improper payments and program vulnerabilities, and recommends audit disallowances and program improvements;
- Office of Evaluation and Inspections: conducts evaluations of the Medicare and Medicaid programs to identify program integrity vulnerabilities and make recommendations to prevent fraud, waste, and abuse and to promote economy, efficiency, and effectiveness; and
- Office of Counsel to the Inspector General: represents OIG in all civil and administrative fraud cases and, in connection with these cases, negotiates and monitors corporate integrity agreements; provides guidance to the health care industry to promote compliance; and provides legal support to OIG operations.

OIG's program integrity activities are a sound investment.

In FY 2009, OIG investigations resulted in \$4 billion in settlements and court-ordered fines, penalties, and restitution, and in 671 criminal actions. OIG audits resulted in almost \$500 million in receivables through recommended disallowances. We also produced equally important but less quantifiable gains in deterrence and prevention of fraud, waste, and abuse. OIG has recommended numerous actions to address program integrity vulnerabilities. For example, we found 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. Many other recommendations to prevent and deter fraud, waste, and abuse are described in our annual *Compendium of Unimplemented OIG Recommendations*, the latest edition of which will be published later this month.

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 health care fraud, we know that it is a serious problem that demands an aggressive response. We must not lose sight of the fact that the vast majority of health care providers are honest and well-intentioned; nonetheless, a small minority of providers intent on abusing the system can cost billions of dollars. We believe that the \$4 billion in settlements and court-ordered returns in FY 2009 resulting from OIG fraud investigations is just the tip of the iceberg. More disturbing, even if the rate of fraud remains constant, as health care expenditures continue to rise, the financial impact of health care fraud will continue to increase.

OIG investigations uncover a range of fraudulent activity. Health care fraud schemes commonly include billing for services that were not provided or were not medically necessary, billing for a higher level of service than what was provided ("upcoding"), 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 scheme.

The Medicare program is increasingly infiltrated by violent criminals, and our investigations are also finding an increase in sophisticated and organized criminal networks. Some of these fraud schemes are viral, i.e., 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 shift 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 also be swift, agile, and organized.

Health care fraud is not limited to this blatant fraud among 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. 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 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 2009, 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 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 alone. 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 repeatedly demonstrated that Medicare and Medicaid pay too much for certain services and products and that 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. Likewise, in 2006, Medicare allowed approximately \$7,200 in rental payments over 36 months for an oxygen concentrator that cost approximately \$600 to purchase. Beneficiary coinsurance alone for renting an oxygen concentrator for 36 months exceeded \$1,400 (more than double the purchase price).

OIG's Strategy and Recommendations for Combating 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 developed five principles of an effective health care integrity strategy. OIG uses these principles in our strategic work planning to assist in focusing our audit, evaluation, investigative, enforcement, and compliance efforts most effectively.

1. Enrollment: Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment in the health care programs.

The first step in preventing health care fraud and abuse is to stop those who would defraud or abuse the programs from gaining entry to them. The concept is simple but the execution can be challenging. The Medicare program was designed to make it easy to enroll as a provider to encourage participation and ensure beneficiary access to services. However, this also makes it too easy for sham providers and suppliers to obtain Medicare billing numbers and bill for millions of dollars in fraudulent claims.

In 2006 and 2007, OIG conducted unannounced site visits to almost 2,500 Medicare DME suppliers in South Florida and Los Angeles and found that almost 600 of these suppliers (about 24 percent) did not maintain a physical facility or were not open and staffed during business hours, as required. OIG has recommended heightened enrollment screening and oversight for high-risk items and services. CMS has taken some important steps toward this end, particularly for DME providers in South Florida. Additional scrutiny for high risk areas through unannounced site visits, background checks, enhanced claims screening for new enrollees, and enhanced authorities (such as explicit authority to impose temporary enrollment moratoriums) could further discourage this type of fraud. OIG will continue to monitor the effectiveness of provider enrollment safeguards.

2. Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace and medical practice.

Establishing reasonable and responsive payment methodologies prevents the type of waste, described above, that results when payment methodologies are misaligned with costs and market prices. OIG has identified these misalignments for various health care services and products, and we have recommended fixes. For example, capping rental of oxygen concentrators at 13 months instead of 36 months would save Medicare billions of dollars.

Applying this principle can also deter fraud. For example, an OIG evaluation 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. Profit margins like these attract fraud. OIG has investigated numerous cases of fraudulent billing for power wheelchairs, and in some of these cases, the suppliers actually provide wheelchairs to beneficiaries who do not need them because the reimbursement – even after purchasing the wheelchair – is high enough to make this scam lucrative. CMS has the authority to make certain adjustments to payments for DME and other items or services, but for some changes (such as reducing the rental period for oxygen concentrators), legislative changes are needed.

3. *Compliance: Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.*

The vast majority of health care providers and suppliers are honest and well-intentioned. They are valuable partners in ensuring the integrity of Federal health care programs. OIG seeks to collaborate with health care industry stakeholders to foster voluntary compliance efforts. Toward this end, OIG has produced extensive resources (available on our Web site at <http://oig.hhs.gov>) to assist industry stakeholders in understanding the fraud and abuse laws and designing and implementing effective compliance programs. These resources include sector-specific Compliance Program Guidance documents that describe the elements of effective compliance programs and identify risk areas, advisory opinions, and fraud alerts and bulletins. We have a self-disclosure program that encourages providers to self-report fraud uncovered within their company and to work with OIG to resolve the problem fairly and efficiently. Effective compliance programs help make honest providers our partners in the fight against health care fraud. OIG recommends that providers and suppliers should be required to adopt compliance programs as a condition of participating in the Medicare and Medicaid programs.

4. *Oversight: Vigilantly monitor the programs for evidence of fraud, waste, and abuse.*

Rapid detection of fraud, waste, and abuse is essential to ensuring the integrity of health care dollars. This includes using data and technology to detect potential problems as claims are submitted and before they are paid. It also includes conducting advanced data analysis to identify, track, and monitor patterns of fraud to target enforcement efforts. With appropriate protections, identifying effective ways to share information across Federal and State agencies and with private insurers can leverage resources and improve our collective effectiveness in fighting fraud, waste, and abuse. Through HEAT, progress has been made in improving law enforcement's access to Medicare data, sharing information and intelligence, and conducting data analysis to prioritize and target our fraud-fighting efforts.

5. *Response: Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.*

Although it is ideal to prevent payments for fraudulent or improper claims, there will never be perfect prevention. An effective anti-fraud strategy must incorporate a strong enforcement component. Criminals balance the risk of detection and punishment against the benefits of the crime and have concluded that Medicare and Medicaid fraud are a good bet. It is imperative that

we change the calculation by increasing the risk of prompt detection and the certainty of punishment.

As part of this strategy, OIG is working closely with its partners in DOJ and in the States to accelerate and maximize the effectiveness of our law enforcement response to fraud. Medicare Fraud Strike Forces represent one very successful enforcement model. In addition, OIG investigates and DOJ prosecutes civil cases that return billions of dollars to the Medicare and Medicaid programs. OIG is also using our administrative authorities to hold responsible individuals accountable for fraud, including physicians who accept kickbacks and responsible corporate officials whose companies have committed fraud.

CMS and States must also respond swiftly to recoup misspent funds, take appropriate administrative actions (e.g., revoking billing privileges, suspending payments), and remedy program vulnerabilities. Through the HEAT initiative, described in more detail below, the Government is significantly accelerating and strengthening its response to fraud, waste, and abuse.

Resources and Tools for Health Care Oversight and Enforcement Activities

Adequate funding of the Health Care Fraud and Abuse Control (HCFAC) Program is vital to the fight against fraud, waste, and abuse.

The Health Care Fraud and Abuse Control (HCFAC) Program is a comprehensive program under the joint direction of the Attorney General and the Secretary of HHS, acting through our OIG, designed to coordinate Federal, state and local law enforcement activities with respect to health care fraud and abuse. The HCFAC Program draws funds from the Medicare Trust Fund to finance anti-fraud activities. Certain of these sums are to be used only for activities of OIG, with respect to the Medicare and Medicaid programs. The HCFAC Program is OIG's primary funding stream, and accounts for 73 percent of our FY 2010 appropriation.

From its inception in 1997 through 2008, HCFAC Program activities returned more than \$13.1 billion to the Federal Government. The HCFAC return-on-investment is \$6 for every \$1 invested in OIG, DOJ, and HHS activities through the HCFAC Account.² This return-on-investment calculation includes only actual recoveries, such as dollars returned to the Federal Government and redeposited in the Medicare Trust Fund, the Treasury or returned to other Federal "victim" agencies. Savings realized from implementation of OIG's recommendations to promote economy, efficiency, and effectiveness of Medicare and Medicaid operations create additional returns from OIG operations, but these are not captured in HCFAC return-on-investment calculations.

Thanks to this Subcommittee's support for investing in HCFAC activities, OIG's total HCFAC appropriation for FY 2010 is \$207 million, which includes \$177 million in mandatory funds and almost \$30 million in discretionary funding. OIG is directing these resources to conduct

² The \$6 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.

Medicare and Medicaid investigations, audits, evaluations, enforcement, and compliance activities to support our health care program integrity strategy described above. Examples of our HCFAC-funded activities include:

- Establishment of Strike Force teams in seven cities;
- Support of Civil False Claims Act investigations and enforcement;
- Support of administrative enforcement activities;
- Evaluations of Medicare contractor operations, services provided to nursing home residents, Medicare and Medicaid reimbursement for prescription drugs, and other issues;
- Audits of payments to hospitals, home health agencies, Medicare Advantage plans, and Medicare Part D plans, among other providers;
- Monitoring of providers under corporate integrity agreements; and
- Issuance of advisory opinions and other guidance to the health care industry.

In addition to the \$30 million in discretionary HCFAC funds in FY 2010 (which will continue into FY 2011), the President's FY 2011 Budget proposes an additional \$65 million increase in HCFAC discretionary funding. This represents a net increase of \$40 million in total funding for OIG's health care integrity activities.

The proposed \$65 million increase in HCFAC discretionary funding includes \$25 million to continue funding OIG's oversight and enforcement activities that were previously funded through the Deficit Reduction Act of 2005 (DRA). The DRA provided \$25 million each year in FYs 2006-2010 to fund OIG's Medicaid integrity activities. In recognition of the continued need for OIG oversight and enforcement beyond FY 2010, the Administration included \$25 million in its request for FY 2011 for OIG to sustain health care oversight activities. The proposed budget would enable us to continue fraud-fighting efforts that would otherwise necessarily dwindle as the DRA funding ceased. Further, providing these funds under HCFAC provides the advantages of consolidating funding streams with similar purposes and expanding the authorized use of these funds to include Medicare oversight as well as Medicaid oversight. Medicare and Medicaid program integrity activities are often related. For example, many of our investigations involve an individual or entity committing fraud against both programs.

The proposed \$65 million HCFAC increase also includes \$40 million in new funding for OIG's activities in support of the HEAT initiative, including establishing Strike Force teams in 13 new locations. We estimate that almost \$25 million of this funding would be needed to support the Strike Force expansions and the remaining \$15 million would support OIG's other HEAT activities, including audits, evaluations, civil and administrative enforcement, and compliance activities.

Through HEAT, OIG is enhancing the impact of our prevention, detection, and enforcement efforts.

OIG is a key member of HEAT; indeed, HEAT's fraud and abuse prevention, detection, and enforcement activities are our primary focus and core mission. The collaboration brought about by HCFAC and enhanced by HEAT has improved coordination and communication, which has in turn led to greater impact and effectiveness of our collective fraud-fighting efforts.

Prevention. Prevention of health care fraud, waste, and abuse was written into the legislation that created OIG – it is integral to our mission and activities. OIG makes recommendations to the Centers for Medicare & Medicaid Services (CMS) to remedy program vulnerabilities that we uncover through our evaluations and audits. OIG also provides CMS with intelligence gleaned from our investigations and data analysis to help CMS target its prevention efforts effectively. In addition, OIG’s guidance and outreach to the health care industry help the well-intended health care providers avoid fraudulent or abusive conduct and promote compliance with program requirements. Further, our enforcement activities prevent fraud by stopping ongoing schemes and deterring future fraud.

HEAT has strengthened these prevention efforts. It has provided a forum for advancing OIG’s recommendations to remedy program vulnerabilities in Medicare and Medicaid. For example, senior staff from OIG and CMS are working together to plan actions that CMS can take in the short term to address some of OIG’s outstanding recommendations. In addition, HEAT has increased interagency communication about fraud trends, new initiatives, and ideas through the creation of committees and work groups comprised of experts from across HHS and DOJ who meet regularly to collaborate and develop new strategies for preventing fraud, waste, and abuse. Also, in conjunction with HEAT, OIG is considering further outreach opportunities to engage health care providers in fraud prevention.

Detection. In support of HEAT, OIG has developed and leads a data analysis team, which includes DOJ and CMS, to identify fraud patterns and trends and strategically target all of our resources. This data analysis team identified geographic concentrations of fraud to help determine in what cities to establish new Strike Force teams and analyzes fraud indicators to provide specific investigative leads to Strike Force teams.

Collaborating with our partners through HEAT has also resulted in improved data access for law enforcement. Access to “real-time” claims data – that is, as soon as the claim is submitted to Medicare – is critical to identifying fraud as it is being committed. With “real time” knowledge, we would be better able to stop the fraud more quickly and to bring the perpetrator to justice and recoup the stolen funds before the criminal or the money disappears. Timely data is also essential to our agile response as criminals shift their schemes and locations to avoid detection. Although we do not yet have access to comprehensive real-time claims data, we have made important strides in obtaining data more quickly and efficiently. On a pilot basis, CMS recently provided several OIG investigators and analysts access to a Medicare data system that includes much of the real-time claims data that law enforcement needs. OIG, DOJ, and CMS have also worked together to develop a data request template so that CMS contractors can process our data requests faster and with more efficiency.

Enforcement. OIG and DOJ jointly lead the Medicare Fraud Strike Force teams, which have expanded through HEAT from two to seven locations. The successes of these Strike Forces are described in detail below. In addition, HEAT has also led OIG and DOJ to jointly reassess our resource allocation for our civil fraud cases, which have yielded billions of dollars in returns, to ensure that we are prioritizing these resources most effectively.

Medicare Fraud Strike Forces have proven to be successful in fighting health care fraud.

The Strike Forces are an essential component of HEAT and have achieved impressive enforcement results. Collectively, Strike Forces have resulted in approximately 270 convictions, indictments of more than 500 defendants, and more than \$240 million in court-ordered restitutions, fines, and penalties. Strike Forces also deter fraud. For example, during the first year of Strike Force operations in Miami, which focused on DME fraud, submissions of DME claims decreased by 63 percent, representing a decrease of \$1.75 billion, compared to the previous year. The Strike Force model is especially effective for investigating and prosecuting health care fraud cases involving sham Medicare providers and suppliers masquerading as legitimate health care providers and suppliers.

Strike Forces are designed to identify, investigate, and prosecute fraud quickly. Strike Force teams are comprised of dedicated DOJ prosecutors and Special Agents from OIG, the Federal Bureau of Investigation, and, in some cases, State and local law enforcement agencies. These “on the ground” enforcement teams are supported by the data analysis team (described above) and by CMS program experts and contractors. This coordination and collaboration has accelerated the Government’s response to criminal fraud, decreasing by roughly half the average time from an investigation’s start to the case’s prosecution.

Under HEAT, Strike Forces have expanded from two locations (Miami and Los Angeles) to seven. In May 2009, new Strike Forces were announced in Houston and Detroit. In December 2009, Strike Forces teams became operational in Brooklyn, Tampa, and Baton Rouge.

The President’s FY 2011 Budget proposal would expand Strike Forces to 13 new locations, bringing the total number of Strike Force locations to 20. The selection of Strike Force locations is based on data analysis of Medicare claims to determine fraud hot spots.

OIG estimates that it will require almost \$25 million to establish and operate Strike Forces in 13 new locations. This funding would support an estimated 130 full-time employees dedicated to Strike Force operations and support. These 130 employees would primarily be comprised of investigative staff, including criminal investigators, supervisory investigators, computer forensic specialists, and investigative operations trainers. Additional staff supporting the new Strike Forces would include auditors, evaluators, data analysts, attorneys, and administrative and information technology (IT) staff.

With this funding, OIG is committed to working with our DOJ partners to establish Strike Forces in 13 new locations. We anticipate that it will take us through 2012 to fully launch Strike Force teams in all 13 cities, consistent with the two-year time frame for which the money would be available under the President’s proposal. However, immediately upon receiving the funding, we will begin hiring and training staff and conducting the other preparatory work, such as leasing additional space and purchasing IT and other equipment, necessary to launch and support the new Strike Force teams.

Conclusion

Health care fraud, waste, and abuse are serious problems that cost taxpayers billions of dollars every year and require focused attention and commitment to solutions. Protecting Medicare and Medicaid beneficiaries and taxpayer dollars is integral to OIG's mission. Through the dedicated efforts of my staff and our collaboration with HHS and DOJ, 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 solutions to address program vulnerabilities and prevent fraud, waste, and abuse from occurring. Working together, we are maximizing our collective effectiveness and success in this endeavor. Health care fraud, waste, and abuse are long-standing problems that require sustained commitment to combat them. On behalf of OIG, I make that commitment to you. Thank you for your attention to and support for this mission. I welcome your questions.