



Testimony Before the United States House of Representatives

Committee on Oversight and Government Reform:
Subcommittee on Government Organization, Efficiency and
Financial Management; and Subcommittee on Health Care, District
of Columbia, Census and the National Archives

“A Medicaid Fraud Victim Speaks Out: What’s Going Wrong and Why?”

Testimony of:

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INTRODUCTION

Good morning Chairmen, Ranking Members, and other distinguished Members of the Subcommittees. I am Gary Cantrell, Assistant Inspector General for Investigations with the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG). Thank you for the opportunity to testify about OIG's efforts to combat Medicaid fraud. My testimony will provide an overview of certain areas of Medicaid fraud, describe our law enforcement efforts and investigative challenges, and make recommendations to improve Medicaid oversight.

BACKGROUND

OIG's mission is to protect the integrity of over 300 HHS programs, as well as the health and welfare of program beneficiaries. In fulfillment of this mission, we investigate and hold accountable those who defraud and abuse the Department's programs, promote provider compliance, and recommend program safeguards.

OIG has a robust program of audits, evaluations, and investigations directed towards identifying, preventing, and stopping Medicaid fraud, waste, and abuse. OIG employs more than 1,700 dedicated professionals, including a cadre of over 480 highly skilled criminal investigators, trained to conduct criminal, civil, and administrative investigations of fraud related to HHS programs and operations. Our special agents have full law enforcement authority to effect a broad range of actions, including the execution of search and arrest warrants. We use state-of-the-art technologies and a wide range of tools in carrying out these important responsibilities. We are the Nation's premiere health care fraud law enforcement agency.

Our constituents are the American taxpayers, and we work hard to ensure that their money is not stolen or misused. In fiscal year 2011, OIG opened over 2,000 investigations. Enforcement efforts for the same fiscal year resulted in record numbers that included over 1,100 criminal and

civil actions and \$4.6 billion in expected recoveries. Of this, nearly 400 criminal and civil actions are related to Medicaid and over \$1.1 billion in restitutions or recoveries are to be returned to Federal and State Medicaid programs.

MEDICAID FRAUD OVERVIEW

Medicaid is an important health care benefit for approximately 56 million Americans with limited incomes or disabilities that rely on the program for medical care. The program is funded jointly by Federal and State governments. Generally speaking, the Federal Government sets broad guidelines for Medicaid, and the States have flexibility to administer the program within those guidelines. The scope and composition of each Medicaid program vary significantly across States. In fiscal year 2011, the program accounted for nearly \$275 billion in Federal spending. Medicaid fraud drains vital Federal and State program dollars, in turn, harming both recipients and the American taxpayers.

OIG is leading the fight against health care fraud

OIG brings a formidable combination of cutting edge techniques and traditional investigative skills to the fight against Medicaid fraud. This has been useful in uncovering a range of schemes, especially those relating to home health and personal care services, prescription drug diversion, durable medical equipment, and ambulance transportation. These schemes have involved many types of fraud, including billing for equipment not provided or for services not rendered, medical identity theft, false statements, bribery, and kickbacks.

We receive information related to these schemes through a variety of sources, including the Centers for Medicare & Medicaid Services (CMS) as well as qui tam referrals from the Department of Justice (DOJ).

One such example is our recent investigation of Maxim Healthcare Services, Inc. (Maxim), which was initiated on the basis of Mr. Richard West's qui tam complaint against the company. Mr. West was a patient of Maxim, one of the Nation's leading providers of home health services. The settlement resolved allegations that between 1998 and 2009, Maxim filed false claims with State Medicaid programs and the Department of Veterans Affairs for services either not provided, not sufficiently documented to show they were provided, or delivered from unlicensed offices. Our investigation resulted in a settlement in which Maxim agreed to pay more than \$150 million to resolve civil and criminal charges. The settlement represents the largest-ever involving home health services. The company has also entered into a 5-year Corporate Integrity Agreement (CIA) with OIG, which requires additional reforms and monitoring under our supervision.

In addition, nine individuals--eight former Maxim employees, including three senior managers, and the parent of a former Maxim patient--have pleaded guilty to felony charges arising from the submission of fraudulent billings to government health care programs, the creation of fraudulent documentation associated with government program billings, or false statements to government health care program officials regarding Maxim's activities.

The Maxim case is also an example of a recent increase in fraud cases involving home health and personal care providers. According to data obtained from the Medicaid Fraud Control Units (MFCUs), as of the fourth quarter of 2010, we are now seeing more Medicaid fraud cases involving home health services than any other single program area. The vast majority involve personal care services, which are nonmedical services provided by unskilled aides who assist recipients with activities of daily living, such as bathing, meal preparation, and feeding.

As stated above, we are also witnessing persistent fraud trends surrounding misuse of prescription drugs. These cases are among the most deplorable because they involve the over-prescribing of dangerous narcotics and sometimes the diversion of dangerous narcotics to street drugs, often causing harmful or deadly results to those who abuse them. We saw a particularly

egregious example of this in the State of Washington, which resulted in the death of a patient from an overdose of Oxycodone prescribed by the patient's physician. The physician had established relationships in the local heroin-user community and was writing medically unnecessary prescriptions to patients for narcotics, including Oxycodone and Vicodin. In this case, the physician was incarcerated and ordered to pay \$700,000 in restitution. The physician also lost her medical license and was excluded from all Federal health care programs.

OIG is collaborating with Medicaid Fraud Control Units

State MFCUs have played a significant role in helping us identify the fraudulent activities discussed above and other fraud trends in Medicaid. The number of our joint investigations with MFCUs nearly doubled in the past 5 years from 621 to over 1,100. The collaboration with MFCUs and other law enforcement partners has been critical, as many of the providers defrauding Medicaid have operations throughout the United States.

For nationwide investigations, the National Association of Medicaid Fraud Control Units (NAMFCU) plays a coordinating role in marshaling the investigative efforts of the many individual States affected by fraud. In a recent nationwide investigation, OIG collaborated with the MFCUs, through a NAMFCU committee, as well as other law enforcement partners, to investigate the pediatric dental clinic Small Smiles, managed by FORBA Holdings, LLC (FORBA). The investigation revealed that FORBA, among other things, allegedly caused the submission of claims to Medicaid for dental services that either were not medically necessary or did not meet professionally recognized standards of care. These unnecessary services included pulpotomies (baby root canals), placing multiple crowns, administering anesthesia, performing extractions, and providing fillings and/or sealants. This investigation resulted in an agreement from FORBA to pay over \$24 million plus interest and enter into a 5-year quality-of-care CIA to settle allegations that it performed unnecessary and often painful services on children to maximize Medicaid reimbursement.

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

OIG is using a variety of tools to engage all our stakeholders in our efforts to prevent, detect, and combat health care fraud. OIG is extensively using the Internet to enlist the health care industry and the public in the fight against fraud. Our Web site, www.oig.hhs.gov, offers a wide range of information to health care providers and patients about ways to reduce the risk of fraud and abuse. These resources include OIG's provider compliance training, voluntary compliance program guidance, fraud alerts, self-disclosure protocol, and advisory opinions on fraud and abuse laws.¹ OIG also offers a guide to prevent medical identity theft.² And we recently published *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*,³ which summarizes 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.

The OIG Hotline is another valuable fraud-fighting tool, which allows individuals to contact OIG directly through our Web site or by calling 1-800-HHS-TIPS to provide information regarding these and other types of fraud, waste, and abuse schemes in HHS programs.⁴

We have also posted OIG's list of the 10 most wanted health care fraud fugitives, including photographs and details about the individuals and their schemes.⁵ One of our top most wanted fugitives, Dr. Gautam Gupta, is wanted for allegedly defrauding Medicaid and private insurance companies of millions of dollars. Gupta owned and operated several weight loss nutrition clinics in northern Illinois and the Chicago metropolitan area. According to the arrest warrant, the clinic defrauded Medicaid and private insurance companies of as much as \$24 million from unwarranted medical tests and false billings for doctor visits.

¹ Available at <http://oig.hhs.gov/compliance/>.

² Available at <http://oig.hhs.gov/fraud/medical-id-theft/index.asp>.

³ Available at <http://oig.hhs.gov/compliance/physician-education/index.asp>.

⁴ Information about the OIG Hotline can be found at <http://oig.hhs.gov/fraud/report-fraud/index.asp>.

⁵ Available at <http://oig.hhs.gov/fraud/fugitives/index.asp>.

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). A recent call to the Hotline led to the capture of one of OIG's top 10 most wanted fugitives; we hope, with the public's help, to also bring Gupta to justice in the near future.

RECOMMENDATIONS TO IMPROVE MEDICAID OVERSIGHT

OIG uses data to detect possible fraudulent billing at the earliest possible stage. In combating Medicare fraud, OIG has worked closely with its partners, including CMS, to provide our special agents with access to more data sources and real-time access to Medicare claims data. This has been critical in our enforcement efforts and has enabled us to develop a consolidated data analysis center, which integrates business intelligence tools and develops new data analytics to enhance our fraud detection efforts. This has improved OIG's ability to access, analyze, and share data with our law enforcement partners and accomplish this in a manner consistent with applicable privacy, security, and disclosure requirements. The centralized data analysis center has already enhanced the efficiency and coordination of our collective efforts by enabling law enforcement to identify a broader range of potentially fraudulent activities and more efficiently use our investigative resources. Much of our Medicare enforcement success can be attributed to our timely access to useful data, which has played a pivotal role in our recent enforcement results.

Inability to access useful, timely Medicaid data hinders oversight efforts

In contrast to Medicare, our efforts to use data analytics to oversee Medicaid have been impeded by the lack of national-level, timely Medicaid data. Medicaid presents unique data challenges because key program operations occur across 50 States, the District of Columbia, and U.S. territories, rather than on a national level. The Medicaid Statistical Information System (MSIS) is the only source of nationwide Medicaid claims information, and weaknesses in MSIS data limit its usefulness for oversight and monitoring of the program. In a 2009 report, OIG

determined that MSIS data were an average of 1 1/2 years old when released by CMS to users for data analysis purposes.⁶ In law enforcement, a 1 1/2-year timelag is an eternity, especially when dealing with astute criminals who cash out quickly and move on to the next scheme. Moreover, MSIS was not designed for anti-fraud efforts and lacks many basic data elements that can assist in fraud, waste, and abuse detection. Additionally, MSIS does not include complete data received through managed care plans, despite the fact that the majority of Medicaid beneficiaries received their health care services through Medicaid managed care.⁷

Our investigation of Maxim illustrates challenges faced in conducting nationwide investigations involving Medicaid fraud. Maxim is a nationwide conglomerate providing home health services in over 40 States, which made it difficult to collect comprehensive Medicaid claims data in support of our investigation. We understand that CMS is working to address these and other data issues. We hope that CMS moves forward expeditiously to systematically collect comprehensive data and make the data available to us.

We further recommend that MFCUs' abilities to access data be enhanced. Our goal is to help them establish their own analytic capabilities with regard to their respective State Medicaid data. To support this, OIG issued a notice of proposed rulemaking to permit MFCUs, under certain conditions, to use Federal matching funds to identify fraud through screening and analyzing State Medicaid claims data.⁸ We believe this will enhance our enforcement efforts and improve Medicaid oversight.

CONCLUSION

The need to protect Medicaid from fraud has never been more important. The Congressional Budget Office estimates that in 2014, 16 million new recipients will join the Medicaid program.

⁶ "MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse," OEI-04-07-00240, August 2009, available at <http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf>.

⁷ "Medicaid Managed Care Encounter Data: Collection and Use," OEI-07-06-00540, May 2009, available at <http://oig.hhs.gov/oei/reports/oei-07-06-00540.pdf>.

⁸ 76 Fed. Reg. 52 (March 17, 2011), pp. 14637–14641.

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States and the Federal Government alike must work to eliminate vulnerabilities and ensure that we are positioned to effectively oversee the program in the years to come. It is critical that OIG have access to timely and accurate Medicaid data to protect program recipients and expenditures. As shown through our accomplishments in Medicare, data analysis is vital to fighting health care fraud. We believe comparable access to Medicaid data will yield similar successes.

To that end, OIG will continue moving forward to implement mechanisms to protect the integrity and vitality of Medicaid and punish those who defraud the program. We will continue partnering with those who share our objectives to safeguard the programs that protect the health of all Americans and provide essential health care to those in need.

Thank you for your support of OIG's mission. I would be happy to answer any questions.