

Testimony of:  
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Good afternoon Chairmen Camp and Boustany, Ranking Members Levin and Lewis, and other distinguished Members of the Subcommittee. I am Lewis Morris, Chief Counsel to the Inspector General for the U.S. Department of Health & Human Services (HHS or the Department). Thank you for the opportunity to testify about the progress the Office of Inspector General (OIG) and its partners are making to combat fraud, waste, and abuse in the Federal health care programs.

My testimony describes OIG's unique role in protecting the integrity of the Medicare and Medicaid programs; provides an overview of the nature and scope of health care fraud, waste, and abuse; and highlights three ongoing initiatives aimed at strengthening the integrity of these crucial programs. The three initiatives involve targeting fraud "hot spots" with Medicare Fraud Strike Force teams, strengthening our ability to protect the Federal health care programs from untrustworthy providers, and enhancing our collaboration with the private sector, including health care providers, insurers, and the public.

Our program integrity efforts, which are funded primarily through the Health Care Fraud and Abuse Control (HCFAC) Program, represent a prudent investment of taxpayer dollars. Over the past 3 years, for every \$1 spent on the HCFAC Program, an average of \$6.80 has been returned to the Government. That's an almost seven-to-one return on every dollar invested in HCFAC.

### **The Office of Inspector General Is Committed to Protecting HHS Programs and Beneficiaries**

OIG is an independent, nonpartisan agency within HHS. Our mission is to protect the integrity of more than 300 programs administered by the Department and the citizens served by those programs. Approximately 80 percent of OIG's resources are dedicated to promoting the efficiency and effectiveness of the Medicare and Medicaid programs and protecting these programs and their beneficiaries from fraud and abuse. OIG investigates suspected fraud and refers cases to the Department of Justice (DOJ) for criminal and civil actions. We impose administrative remedies, such as monetary penalties or exclusion from participation in Federal health care programs. We also evaluate and audit programs and providers and make life-saving and cost-saving recommendations to the Department on a wide variety of issues, including quality of care; recovery of improper payments; and reducing excessive payments for medical services, equipment, and prescription drugs.

Through this work, OIG helps to identify and recover billions of dollars in fraudulent, abusive, or wasteful payments and also raise awareness of these critical issues among policymakers, Government agencies, and the health care community at large. We engage the health care community and promote compliance with program rules and requirements. OIG has a strong track record of building on our successes, employing all oversight and enforcement tools

available to us, and maximizing our impact in protecting the integrity of Government health care programs and the health and welfare of people served by them.

### **Health Care Fraud, Waste, and Abuse Are Serious Problems Requiring Sustained Commitment To Fight Them**

Fraud, waste, and abuse in the health care system 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.

Although there is no precise measure 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. Since the inception of the HCFAC Program in 1997, audits and investigations under the Program have returned to the Federal Government \$18 billion in fraudulent or misspent funds. Over the past fiscal year (FY) alone, OIG has opened more than 1,700 health care fraud investigations. Additionally, OIG's enforcement efforts have resulted in more than 900 criminal and civil actions and over \$3 billion in expected investigative recoveries in FY 2010. The small number of providers who are intent on abusing the system can cost taxpayers billions of dollars.

In the fight against health care fraud, we work closely with DOJ; our Federal, State, and local law enforcement partners; and our colleagues at the Centers for Medicare & Medicaid Services (CMS) and the Food and Drug Administration (FDA). OIG conducts joint investigations with law enforcement agencies where there is concurrent jurisdiction and where sharing expertise or authority will lead to the best results possible. Additionally, commercial and private insurance entities and trade associations, such as the National Health Care Anti-Fraud Association (NHCAA), play pivotal roles in the identification and prevention of health care fraud.

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 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 bona fide 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, OIG investigators have found that criminals set up sham DME storefronts to masquerade as legitimate 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.

The Medicare program is increasingly being 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.

In this crime scheme, criminals allegedly stole 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 members of the syndicate allegedly leased office space, opened fraudulent clinics, and opened bank accounts to receive Medicare funds—often in the name of the doctor whose identity they had stolen. Upon becoming approved Medicare providers, the crooks allegedly billed Medicare for services never provided, using the stolen beneficiary information. The funds received from Medicare were quickly withdrawn and laundered; 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®. The company illegally marketed the drug for indications that, during the relevant time periods, had not been approved as safe and effective by FDA, including 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 OIG's successes, there is more to be done. Those intent on breaking the law are becoming more sophisticated and the schemes are becoming more difficult to detect. Some 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 in response to our enforcement efforts. To combat this fraud, the Government's response must be swift, agile, and well-organized.

### **Medicare Fraud Strike Forces Are a Proven Success in Fighting Fraud in “Hot Spots”**

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 fraud perpetrators; and enhance existing partnerships between HHS and DOJ.

Medicare Fraud Strike Forces are an essential component of HEAT and have achieved impressive enforcement results. Strike Forces are designed to identify, investigate, and prosecute fraud quickly. Strike Force teams are composed of dedicated DOJ prosecutors 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 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.

Strike Forces use 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 unusual billing patterns as they occur. To support this approach, OIG established a team of data experts composed of OIG special agents, statisticians, programmers, and auditors. Together, the team brings a wealth of experience in utilizing data analysis tools combined with criminal intelligence gathered directly from special agents in the field to identify more quickly 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.

OIG and DOJ first 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, the Strike Force has been expanded to eight additional locations—Los Angeles; Detroit; Houston; Brooklyn; Baton Rouge; Tampa; and, most recently, Dallas and Chicago.

The Strike Force model has proven highly successful. The majority of subjects in Strike Force cases are engaging in 100-percent fraud, i.e., not providing any legitimate services to beneficiaries. Since their inception in 2007, Strike Force operations in 9 cities have charged almost 1,000 individuals for fraud schemes involving more than \$2.3 billion in claims.

Just last month, HEAT Strike Forces engaged in the largest Federal health care fraud takedown in history. Teams across the country charged over 100 defendants in 9 cities, including doctors, nurses, health care company owners, and executives for their alleged participation in Medicare fraud schemes involving more than \$225 million in false billing. The defendants charged as a part of the operation 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 OIG special agents participated in partnership with other Federal and State agencies, including fellow Offices of Inspector General.

The effectiveness of the Strike Force model is enhanced by our use of several important tools. We work closely with CMS to suspend payments to the perpetrators of these schemes and in other cases where we have credible allegations of fraud. 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 by the investigation. The prompt action taken by OIG and CMS stopped the potential loss of over \$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 over 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.

Better access to, and use of, CMS claims data also is critical to the Strike Force model and for all health care fraud detection and enforcement activities. To be most effective, it is essential that law enforcement have access to robust, "real time" claims data—data that are available as soon as claims are submitted to Medicare. Timely data are 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. For example, we have obtained limited law enforcement access to real-time data, and OIG and DOJ are working with CMS to expand this access. Continued improvements in access to data, as well as creation of more robust data sets, are critical to OIG's ability to identify and investigate fraud.

### **Promoting Program Integrity by Removing Untrustworthy Individuals From the Health Care Programs**

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

There are many grounds for exclusion. Some are mandatory and imposed for a minimum of 5 years. These include a conviction related to the Medicare or Medicaid program and a conviction related to patient abuse. Other exclusions are imposed at OIG's discretion. There are a significant number of grounds for permissive exclusion, including actions based on a sanction taken by a State licensing authority or conduct that could trigger False Claims Act liability.

No program payment may be made for any item or service that an excluded person or entity furnishes, orders, or prescribes. This payment prohibition applies regardless of whether the excluded person is paid directly by the programs (like 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 the 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 they are “too big to fire” and thus OIG would never exclude them and thereby risk compromising the welfare of our beneficiaries. We are concerned that the providers that engage in health care fraud may consider civil penalties and criminal fines a cost of doing business. As long as the profit from fraud outweighs those costs, abusive corporate behavior is likely to continue. For example, some major pharmaceutical corporations that have been convicted of crimes and paid hundreds of millions of dollars in False Claims Act settlements continue to participate in the Federal health care programs, in part because of the potential patient harm that could result from an exclusion.

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. For example, in 2008, we excluded three former executive officers of the pharmaceutical company Purdue Frederick based on their convictions for misbranding of 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, officers, and managing employees of a sanctioned entity (i.e., an entity that has been convicted of certain offenses or excluded from participation in the 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 individuals accountable for corporate misconduct. OIG has used this exclusion authority in over 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 like a drug or device manufacturer.

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 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 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 underlying criminal misconduct of the organization, OIG will operate with a presumption in favor of exclusion of that executive. We have published guidance on our Web site that sets out factors we will consider when evaluating whether a section (b)(15) exclusion should be imposed in a particular case.<sup>1</sup> 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 interests of Federal

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<sup>1</sup> Available online at [http://oig.hhs.gov/fraud/exclusions/files/permissive\\_excl\\_under\\_1128b15\\_10192010.pdf](http://oig.hhs.gov/fraud/exclusions/files/permissive_excl_under_1128b15_10192010.pdf).

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 Strengthening Collaboration With the Private Sector, Health Care Providers, and the Public**

We recognize that the Federal health care programs can learn a great deal from how the private sector, including private insurers and the finance industry, combats fraud. OIG has increased its efforts both to learn from the private sector and to share information with its private sector counterparts. Collaboration with private health care insurers can be mutually beneficial, and we are increasing these efforts through our active participation in the NHCAA. Through NHCAA forums, we build relationships, share information, and learn about new fraud-fighting tools and techniques.

For example, we collaborate to identify fraud trends that target both Medicare and private insurers and share information on organized crime and medical identity theft. OIG agents have participated in joint investigations with private insurance companies and, subject to applicable legal restrictions, shared field intelligence. These joint investigative efforts can be very effective, and in an effort to replicate their success, OIG has started a public/private “best practices” initiative. In coordination with DOJ, we are surveying the U.S. Attorneys’ health care fraud working groups, Medicaid Fraud Control Units, and health insurers’ special investigative units to identify where public/private information sharing was most successful. The survey results will be translated into a series of “best practices” recommendations that promote a culture of information sharing between public and private partners working together to combat health care fraud.

We also recognize that the vast majority of health care providers are honest and well-intentioned. They are valuable partners in ensuring the integrity of Federal health care programs. OIG produces extensive resources to assist industry stakeholders in understanding the fraud and abuse laws and designing and implementing effective compliance programs. OIG also 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 the inappropriate payments.

Another example of OIG’s commitment to promoting compliance is our 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 speakers discuss fraud risk areas uncovered by OIG’s work and share compliance best practices. This will enable providers to strengthen their own compliance efforts and more effectively identify and avoid illegal schemes that may be targeting their communities. The first seminar took place in Houston last month, and we will be going to Tampa, Kansas City, Baton Rouge, Denver, and Washington, DC, during the spring of 2011. OIG also will provide a Webcast of the seminar for individuals who are unable to attend an in-person training session.

In response to requests for more guidance for physicians just beginning the practice of medicine, OIG recently published *A Roadmap for New Physicians: Avoiding Medicare and Medicaid Fraud and Abuse*.<sup>2</sup> The *Roadmap* summarizes the 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.

We also use the power of the Internet to enlist the public in the fight against health care fraud. Our internet site, <http://oig.hhs.gov>, offers a wealth of information to health care providers and patients about ways to reduce the risk of fraud and abuse, including OIG 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 which 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.<sup>3</sup>

We also have posted OIG's list of the most-wanted health care fraud fugitives, including photographs and details on the fugitives and their fraud schemes.<sup>4</sup> Our current most wanted list includes 10 individuals who have allegedly defrauded taxpayers 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 other stakeholders, we have achieved substantial results in the form of recovered funds, enforcement actions, and recommendations to remedy program vulnerabilities.

I would be happy to answer any questions.

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<sup>2</sup> Available online at <http://oig.hhs.gov/fraud/PhysicianEducation/>.

<sup>3</sup> Available online at <http://oig.hhs.gov/fraud/IDTheft/>.

<sup>4</sup> Available online at <http://oig.hhs.gov/fugitives/>.