



Testimony before the United States House of Representatives

Committee on Energy and Commerce

Subcommittee on Oversight & Investigations

“Waste, Fraud and Abuse: A Continuing Threat to Medicare and Medicaid”

Testimony of:

Gerald T. Roy

**Deputy Inspector General for Investigations
U.S. Department of Health & Human Services**

March 2, 2011

10:00AM

2322 Rayburn House Office Building



OIG'S LAW ENFORCEMENT ACTIVITIES TO COMBAT MEDICARE AND MEDICAID FRAUD

Good morning Chairman Stearns, Ranking Member DeGette, and distinguished Members of the Subcommittee. I am Gerald Roy, Deputy Inspector General for Investigations at the U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG). Today, I am privileged to have with me OIG Assistant Special Agent in Charge Omar Perez who has served in the Miami Regional Office since 2007. We thank you for the opportunity to discuss OIG's health care anti-fraud strategy, focusing primarily on our law enforcement activities to combat Medicare and Medicaid fraud.

OIG's Role and Partners in Protecting the Integrity of Medicare and Medicaid

OIG is an independent, nonpartisan agency committed to protecting the integrity of the more than 300 programs administered by HHS. Approximately 80 percent of OIG's resources are dedicated to promoting the efficiency and effectiveness of federally funded health care programs and protecting these programs and our beneficiaries from fraud, waste, and abuse.

OIG employs more than 1,700 dedicated professionals, including a cadre of over 450 highly skilled criminal investigators trained to conduct criminal, civil, and administrative investigations of fraud, waste, and abuse related to HHS programs and operations. Our special agents have full law enforcement authority to effectuate the broad range of available law enforcement actions, including the execution of search and arrest warrants. We utilize state-of-the-art technologies and a wide range of law enforcement tools in carrying out these important responsibilities. We are the Nation's premiere health care fraud law enforcement agency.

Our constituents are the American tax payers and we work hard to ensure that their money is not stolen or misspent. Thanks to the work of our dedicated professionals, over the past fiscal year OIG opened over 1,700 health care investigations and obtained over 900 criminal convictions and civil actions. OIG investigations also have resulted in over \$3.7 billion in expected criminal and civil recoveries.

Range of Investigations

Fraud, waste, and abuse in the Medicare and Medicaid programs 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. 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 stealing providers' or beneficiaries' identities. From street gang members to corporate officers, our investigations are uncovering a wide range of individuals and entities committing health care fraud. Below are examples of fraud schemes we that have encountered.

In southern California, an individual set out to defraud the Medicare program by establishing multiple fraudulent durable medical equipment (DME) companies. The owner used members of a street gang as nominee owners of his DME companies. He paid the gang members approximately \$5,000 each to establish bank accounts and fill out Medicare enrollment 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. Nine of the gang members and associates were indicted for charges including health care fraud and providing false statements to Government agents. Of the nine defendants, eight have pled guilty and are currently serving or have completed serving jail time for their crimes. Not only is this investigation an example of one of the more prevalent fraud schemes that OIG is seeing, but it also highlights the increasing number of violent criminals entering the health care fraud arena. The criminal records for the gang members involved in this fraud ranged from assault on a peace officer to drug trafficking.

Another recent case involving violent criminals and organized criminal networks involved 73 defendants charged with various health care fraud-related crimes with 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, set up 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 several 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 sham clinics in 25 States.

Our agents also work on investigations involving fraud committed by large corporate entities. For instance, OIG investigated the “Small Smiles” case, a horrific example of egregious health care fraud. FORBA Holdings, LLC (FORBA), a management company operating Medicaid pediatric dental clinics, recently agreed to pay \$24 million plus interest and entered into a 5-year quality-of-care Corporate Integrity Agreement (CIA) to settle allegations that it performed unnecessary and often painful services on children to maximize Medicaid reimbursement. FORBA managed a chain of 68 pediatric dental clinics in 22 States and the District of Columbia commonly known as “Small Smiles Centers.” The investigation revealed that among other things, FORBA allegedly caused the submission of claims for reimbursement for dental services

that either were not medically necessary or did not meet professionally recognized standards of care. Such services billed to the Medicaid programs included performing pulpotomies (baby root canals), placing multiple crowns, administering anesthesia, performing extractions, and providing fillings and sealants. This investigation involved OIG, the Federal Bureau of Investigation (FBI), and the National Association of Medicaid Fraud Control Units.

In 2009, OIG, along with our law enforcement partners, successfully completed one of the largest Federal Government settlements in history. Pfizer Inc., a drug manufacturer, and its subsidiary, Pharmacia & Upjohn Company, Inc., entered a \$2.3 billion global resolution with the Federal Government and participating States. The agreement settled charges that Pfizer promoted four drugs, including its pain drug Bextra, for uses not approved by Food and Drug Administration and that the company paid kickbacks to health care professionals to induce them to prescribe Pfizer drugs. In its plea agreement, Pfizer's subsidiary admitted that it promoted Bextra for unapproved uses and at unapproved dosage levels. Pfizer also entered into a comprehensive 5-year CIA with OIG, which requires procedures and reviews to be put in place to avoid and promptly detect fraud or misconduct. Two corporate managers were charged criminally for their role in this matter.

OIG is not alone in the fight to combat fraud and protect the integrity of Federal health care programs. We work closely with the Department of Justice (DOJ); our Federal, State, and local law enforcement partners; and our colleagues at the Centers for Medicare & Medicaid Services (CMS). Additionally, commercial and private insurance entities and trade associations, such as the National Health Care Anti-Fraud Association are also involved in the identification and prevention of health care fraud. 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.

OIG's partnerships extend to one of the Administration's signature initiatives, the Health Care Fraud Prevention and Enforcement Action Team (HEAT). HEAT is a joint effort by HHS and DOJ to leverage resources, expertise, and authorities to prevent fraud, waste, and abuse in Medicare and Medicaid. The HEAT initiative, established by Secretary Kathleen Sebelius and Attorney General Eric Holder in May 2009, is an unprecedented partnership that brings together senior officials from both Departments with the stated goals of sharing information, spotting fraud trends, coordinating prevention and enforcement strategies, and developing new fraud prevention tools. OIG contributes its expertise to HEAT by analyzing data for patterns of fraud; conducting investigations; supporting Federal prosecutions of providers who commit criminal and civil fraud; and pursuing administrative remedies, such as excluding providers from billing Federal health care programs. OIG also makes recommendations to HHS to remedy program vulnerabilities and prevent fraud and abuse.

Investigative Strategies

Strike Forces

A critical component of HEAT is the Medicare Fraud Strike Force. Strike Forces are collaborative efforts, combining OIG's law enforcement skills and resources with those of our partners in the FBI, Medicaid Fraud Control Units, and other State and local law enforcement agencies. The Medicare Fraud Strike Force concentrates its antifraud efforts in geographic areas at high risk for Medicare fraud and has changed the way health care fraud cases are investigated and prosecuted. Strike Force cases focus on the development and implementation of a technologically sophisticated and collaborative approach to combat fraud.

The typical Strike Force case differs from traditional health care fraud investigations. Traditional health care fraud investigations are often initiated months after the fraud has been perpetrated and rely heavily on information from individuals and dated evidence gathered by contract program integrity entities. It is often difficult to identify the perpetrator, who has dropped the "business" under investigation, and is on to the next.

In contrast, Strike Force cases are data driven to pinpoint fraud "hot spots" through the identification of unexplainable billing patterns—as they occur. Further, in traditional health care cases, the subjects of the investigations often provide some level of legitimate services. The majority of subjects in Strike Force cases are engaging in 100 percent fraud, i.e., not providing any legitimate services to beneficiaries. These differences allow Strike Force cases to be completed more quickly. Strike Force coordination 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.

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 South Florida, the Strike Force model was expanded to eight additional locations—Los Angeles, Houston, Detroit, Brooklyn, Tampa, Baton Rouge, and most recently, Chicago and Dallas.

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. More than 300 OIG special agents participated in partnership with other Federal and State agencies. 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.

As of February 28, 2011, OIG's Strike Force efforts nationwide have charged over 800 defendants, of which 390 have been convicted and sentenced, resulting in over \$376 million in court-ordered restitutions, fines, and penalties.

Corporate Fraud

Health care fraud is not limited to blatant fraud by career criminals and sham providers. Major corporations and institutions, such as pharmaceutical and device manufacturers, hospitals and nursing facilities also commit fraud, often on a grand scale. These corporate and institutional frauds often involve complex kickbacks, accounting schemes, illegal marketing, and physician self-referral schemes. These cases necessitate different, and often more laborious, investigative techniques to unravel the complex fraud schemes and build strong cases.

Investigations of large corporations are often initiated after a “whistleblower” files a law suit on behalf of the Government, known as a “qui tam,” alleging wrongdoing by the company. The allegations include information that the company engaged in illegal activities that violated the False Claims Act. In doing so, the companies cause false claims to be submitted to Federal health care programs for payment. The investigations involve coordination among many Federal Government departments and agencies whose programs are alleged to have been harmed.

Investigative techniques utilized in these multi-year, complex corporate investigations include reviewing voluminous paper and electronic documents obtained via subpoenas, interviewing witnesses, and analyzing diagnosis and claims data. We now use cutting-edge electronic discovery tools to maximize investigative efficiency in the processing and review of voluminous electronic evidence. Notably, our office was the first Federal law enforcement agency to implement such technology. This technology enables OIG to analyze large quantities of email or other electronic documents quickly, and to associate or link emails contained in multiple accounts based on content and data.

OIG often negotiates compliance obligations, known as CIAs, such as those discussed earlier in the FORBA and Pfizer investigations, with health care providers and other corporate entities as part of the settlement of Federal health care program investigations arising under a variety of civil false claims statutes. The typical term of a comprehensive CIA is 5 years. This compliance measure seeks to ensure the integrity of corporate activities and the Federal health care program claims submitted by providers. While many CIAs have common elements, each agreement addresses, in part, the specific facts of the conduct at issue.

I will now address OIG’s strategy to counter through our exclusion authority the fraud schemes discussed above and discuss additional high impact tools we employ in our fight against health care fraud.

Employing Effective Fraud-Fighting Tools

The effectiveness of our fraud-fighting efforts is enhanced by our use of several tools. We continuously implement and evaluate these new tools to ensure we are maximizing our impact on health care fraud.

Exclusion

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 such exclusions, 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 have been convicted of crimes and paid hundreds of millions of dollars in False Claims Act settlements and yet continue to participate in the Federal health care programs.

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 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 the 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.¹ 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 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.

Payment Suspension

We work closely with CMS to suspend payments to the perpetrators of these schemes and in other cases where we have credible evidence 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.

¹ Available online at http://oig.hhs.gov/fraud/exclusions/files/permissive_excl_under_1128b15_10192010.pdf.

Data Access

Better access to, and use of, CMS claims data 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 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. We have obtained limited law enforcement access to real-time data, and OIG and DOJ are working with CMS to expand this access.

The Strike Force approach also uses 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 suspicious billing patterns as they occur. To support this approach, OIG established a team of data experts comprised of OIG special agents, statisticians, programmers, and auditors. Together, the team brings a wealth of experience in utilizing sophisticated data analysis tools combined with criminal intelligence gathered directly from special agents in the field to identify more quickly ongoing 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.

Mutual Assistance

OIG recently worked with the Council of the Inspectors General on Integrity and Efficiency and the U.S. Department of Justice to establish assistance agreements within the Inspector General community to leverage law enforcement resources, maximize efficiency, and reduce operational costs. As a result, special agents in the IG community can assist each other on law enforcement operations, limited in time and scope. Before, when a local OIG office lacked the resources to serve multiple search and arrest warrants, special agents traveled from other locations at considerable cost to assist. Now, OIG special agents from various OIG offices can assist each other. This mutual assistance agreement was used with great success during last month's major Strike Force operation. Special agents from seven OIG offices assisted us in our historic takedown. In Miami, for example, those agents knew the geographic areas and were familiar with the local communities and customs. Most of those who assisted us spoke Spanish, they language spoken almost exclusively in many South Florida communities. Knowledge of local environment, ability to speak a common language, and familiarity of local customs results in a safer environment in which OIG special agents can operate and conduct law enforcement activities. As a result of leveraging the resources of the IG community, we saved in excess of \$40,000. These funds will be put towards future operations and investigations.

Interpol

Recently, we assigned a special agent to INTERPOL Washington, the U.S. National Central Bureau (USNCB). USNCB is the official U.S. representative to the International Criminal Police Organization (INTERPOL) as designated by the U.S. Attorney General. The USNCB

serves as the national point of contact for INTERPOL matters and coordinates international investigative cooperation between INTERPOL's 188 member countries and the more than 18,000 Federal, State, local and tribal law enforcement agencies in the United States. HHS OIG is the first in the Inspector General community to have a special agent detailed to INTERPOL. We have over 200 fugitives from our investigative efforts, more than 170 of which are the result of health care fraud investigations. We will leverage the resources and relationships of INTERPOL's, 18,000 law enforcement partners worldwide to bring perpetrators of health care fraud to justice.

OIG's Fugitive Web site

Recently, OIG established a fugitive Web site to assist in locating fugitives running from health care fraud charges. We have posted on our website the list of the most-wanted health care fraud fugitives, including photographs and details on the fugitives and their fraud schemes.² Our current most-wanted list includes 10 individuals who have allegedly defrauded taxpayers of approximately \$136 million. We have partnered with "America's Most Wanted" and INTERPOL to feature our Web site and actively engaged the media to spread the word that we are searching for these fugitives. 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

OIG's efforts that I have discussed today are critical aspects of a multi-agency effort to protect the vitality, integrity and finite resources of the Federal health care programs. We are committed to investing in program integrity efforts in order to send a clear message that fraud in our Federal health care programs will not be tolerated.

By attacking fraud vigorously, wherever it exists, we all stand to benefit. Medicare Trust Fund resources will be protected and remain available for their intended purposes. Medicare dollars that have gone to fraudulent providers will instead be available to serve the critical health care needs of our program beneficiaries. And most importantly, we can ensure that our seniors and persons with disabilities receive the necessary services and care they need to stay healthy, so as to enjoy enhanced well-being and quality of life.

Finally, our anti-fraud efforts represent a prudent investment of taxpayer dollars. Over the past 3 years, for every \$1 spent on the health care fraud and abuse control program, an average of \$6.80 has been returned to the Government.

Thank you for the opportunity to discuss our law enforcement efforts and strategies used to protect the integrity of Federal health care programs.

² Available at <http://oig.hhs.gov/fugitives/>.