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ENFORCEMENT OF THE CRIMINAL LAWS AGAINST MEDICARE AND MEDICAID FRAUD

HEARING

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY

OF THE

COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES

ONE HUNDRED ELEVENTH CONGRESS

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CONTENTS

MARCH 4, 2010

Page

OPENING STATEMENTS

The Honorable Robert C. "Bobby" Scott, a Representative in Congress from the State of Virginia, and Chairman, Subcommittee on Crime, Terrorism, and Homeland Security 1
The Honorable Louie Gohmert, a Representative in Congress from the State of Texas, and Ranking Member, Subcommittee on Crime, Terrorism, and Homeland Security 3
The Honorable John Conyers, Jr., a Representative in Congress from the State of Michigan, and Chairman, Committee on the Judiciar 5

WITNESSES

Mr. Greg Andres, Acting Deputy Assistant Attorney General, Criminal Division, U.S. Department of Justice, Washington, DC
Oral Testimony 7
Prepared Statement 9
Mr. Timothy J. Menke, Deputy Inspector General for Investigations, U.S. Department of Health and Human Services, Washington, DC
Oral Testimony 20
Prepared Statement 22
Mr. D. Mark Collins, Assistant Attorney General, Director of Nebraska Medicaid Fraud Control Unit, President of the National Association of Medicaid Fraud Control Units, Lincoln, NE
Oral Testimony 30
Prepared Statement 33
Mr. James Frogue, Vice President and Director of State Policy, Center for Health Transformation, Washington, DC
Oral Testimony 50
Prepared Statement 53

APPENDIX

Material Submitted for the Hearing Record 79

ENFORCEMENT OF THE CRIMINAL LAWS AGAINST MEDICARE AND MEDICAID FRAUD

THURSDAY, MARCH 4, 2010

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CRIME, TERRORISM,
AND HOMELAND SECURITY
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:05 a.m., in room 2141, Rayburn House Office Building, the Honorable Robert C. "Bobby" Scott (Chairman of the Subcommittee) presiding.

Present: Representatives Scott, Conyers, Pierluisi, Jackson Lee, Gohmert, Poe, and Goodlatte.

Staff present: (Majority) Bobby Vassar, Subcommittee Chief Counsel; Joe Graupensperger, Counsel; Veronica Eligan, Professional Staff Member; (Minority) Caroline Lynch, Counsel; Art Barker, FBI Detailee; and Kelsey Whitlock, Staff Assistant.

Mr. SCOTT. The Ranking Member has asked me to go on. He will be here in just a moment.

The Subcommittee will now come to order. I am pleased to welcome you today to the hearing before the Subcommittee on Crime, Terrorism, and Homeland Security. Today we will discuss enforcement strategies for fighting criminal fraud against Medicare and Medicaid programs.

These two programs have provided immeasurable benefits to the health of our Nation's citizens, particularly those who are often the most in need of assistance. It is the continuing responsibility of Congress to examine these programs to ensure that our government is making the best possible effort to reduce fraud, waste and abuse related to them.

Health care fraud, including fraud against Medicare and Medicaid, is a serious problem. It has been estimated that there is more than $60 billion of health care fraud against public and private plans each year.

Criminals have devised a number of ways of defrauding these programs, such as billing for services that were never rendered either by using genuine patient information, sometimes obtained through identity fraud, to fabricate entire claims or padding claims with charges for procedures that did not take place; billing for more expensive services or procedures than were actually provided or performed, commonly known as upcoding; performing medically unnecessary services solely for the purpose of generating insurance payments.

Now, we have been advised by some that that is a result of defensive medicine, but I think we are going to hear perhaps that some of these unnecessary services are just for the purposes of generating insurance payments.

Another is billing each step of the procedure as if it were a separate procedure, known as unbundling. In recent years, many of these schemes have been perpetrated in connection with the sale of durable medical equipment, the provision of home health, and infusion of certain expensive drugs for HIV therapy.

Federal law provides statutes that prosecutors use to bring charges against those who commit fraud against the Federal health care programs. Some are specific to health care fraud. Some are statutes with more general application such as the prohibition against false statements to the government, which are used by prosecutors to pursue many types of crimes.

I want to hear today how these statutory tools are being used as a basis for investigating and prosecuting those who defraud Medicare and Medicaid and how the statutes complement Federal civil remedies for these frauds.

And we also need to know whether or not there is a need for new laws—new criminal laws or whether the—we just need more resources to enforce the laws that are on the books. Frequently, our response to these kinds of situations are to increase the penalties.

Now, that obviously is irrelevant if there has been no investigation, no prosecution and no conviction. That is when the penalties would kick in. Sometimes if you just had the resources for the investigations and the prosecution, you could pursue these crimes much more efficiently, and that increased penalties would be irrelevant unless you would have done the investigation.

Federal effort against these crimes has evolved over the years in an effort to keep pace with the volume of these crimes and the increasing sophistication of the criminals committing them. For instance, irregularities in billing are more easily detectable now with the ability to examine billing records maintained in computer databases.

The Justice Department and HHS have increased monitoring of this information to detect suspicious patterns in claims data and adjust enforcement efforts accordingly. At the same time, these agencies have been able to better identify and focus on regional hot spots for this type of crime.

In 2007, DOJ and HHS established a Medicare strike force team in Miami-Dade County in Florida. Next year, the strike force—the next year, the strike force was established in Los Angeles. And over the past year, these two agencies under the HEAT program have expanded the use of task forces in Detroit, Houston, Tampa, Brooklyn and Baton Rouge.

I understand that further expansion of the strike task force concept is planned for later this year.

The pursuit of those who commit Medicaid—who defraud the Medicaid program involves both State and Federal law enforcement.

In 1977, Congress created a State Medicaid Fraud Control Units, which are usually located in the offices of the State attorneys general. They investigate and prosecute a variety of types of fraud

crimes primarily in connection with Medicaid programs. We will hear from the director of one of those control units today.

I hope this hearing will serve to highlight the continuing need to examine and adjust our efforts to combat fraud against Medicare and Medicaid. I look forward to hearing from all of our witnesses today concerning how we can better prevent, investigate and prosecute this time—this kind of fraud.

It is now my pleasure to recognize the Ranking Member of the Subcommittee, the gentleman from Texas, Judge Gohmert.

Mr. GOHMERT. Thank you. And I do appreciate us having this hearing. I appreciate your leadership on this, Chairman Scott. And appreciate the witnesses being here today.

One of the most famous bank robbers in history was William "Willie" Sutton. It is estimated Sutton robbed over 100 banks beginning in the late 1920's, stealing an estimated $2 million. He was one of the early faces on the FBI's Ten Most Wanted list, and when he was asked, famously, why he robbed banks, he said, "Because that is where the money is."

Well, whether Sutton really said that or not, if Sutton were in this room today he would likely agree Medicare or Medicaid systems are defrauded because that is where the money is—and, I would submit, apparently from what I have been reading of the testimony, easy money.

One individual convicted of health care fraud commented, "Wow. I just won the lottery." From making $20,000 to $40,000 a day cheating Medicare.

In fact, in some areas of the country, the Medicare fraud business is reported to have replaced the drug trade as the biggest crime problem. With little effort and with the odds of getting caught relatively low, the risk is—that criminal investigations and prosecutions are not serious enough deterrents to counter the relatively easy way that millions of taxpayer dollars are stolen.

There are witnesses here today from the Department of Justice, Department of Health and Human Services and Medicaid Fraud Control Unit, all who have success stories to tell.

I also want to thank my friend Jim Frogue for being here. And I appreciated getting and reading a copy of his book, "Stop Paying the Crooks: Solutions to End the Fraud that Threatens Your Healthcare." Newt Gingrich had a good forward in that book. But I appreciate his efforts and appreciate him being here today with the other witnesses.

In his testimony before the U.S. Senate on the topic of health care fraud deterrence, Professor Malcolm Sparrow of Harvard, the John Kennedy School of Government, identified the rule for criminals as it relates to these frauds. "If you want to steal from Medicare, Medicaid or any other health care insurance program, learn to bill your lies correctly. Then, for the most part, your claims will be paid in full and on time without a hiccup by a computer with no human involvement at all."

While the agencies represented by the witnesses before us today have implemented enforcement and prosecution strategies targeting regions that have been identified as high-risk areas for these types of frauds, one representative from an investigating agency

was quoted as saying that his "office finds fraud everywhere it looks."

In any event, to illustrate some of the topics that we will discuss here today, I would ask permission to have a brief—and it is actually cut down substantially from where "60 Minutes" played it, but with your permission, we would ask unanimous consent to view a small segment of the program that was produced by "60 Minutes" called "Medicare Fraud: A $60 Billion Crime."

Mr. SCOTT. All right. This "60 Minutes" story that provoked—it was partly responsible for provoking this hearing, so we would be, without objection, delighted to roll the tape.

[Begin videotape.]

Mr. KROFT. ["60 Minutes" Correspondent] FBI Special Agent Brian Waterman, who we rode with for several days, told us the only visible evidence of the crimes are the thousands of tiny clinics and pharmacies that dot the low-rent strip malls. You don't even know they are there because there is never anyone inside—no doctors, no nurses, and no patients.

Mr. WATERMAN. [FBI Special Agent] This office number should be manned and answered 24 hours a day.

Mr. KROFT. This tiny medical supply company billed Medicare almost $2 million in July and a half a million dollars while we were there in August. But we never found anybody in, and our phone calls were never returned.

Mr. WATERMAN. Say they are currently on the other line. Oh. Well, do they want you to hold?

Mr. KROFT. Sometimes they don't even have offices. We went looking for a pharmacy at 7511 Northwest 73rd Street that billed Medicare $300,000 in charges. It turned out to be in the middle of a public warehouse storage area.

Mr. WATERMAN. They have already told us that there is no offices here, there are no businesses here. In fact, they are not even allowed to have a business here.

Mr. KROFT. Waterman is the senior agent in the Miami office in charge of Medicare fraud. And Kirk Ogrosky, a top Justice Department prosecutor, oversees half a dozen Medicare Fraud Strike Forces that have been set up across the country.

This one operates out of a warehouse at a secret location in South Florida and includes investigators from the FBI, Health and Human Services and the IRS.

Mr. OGROSKY. [DOJ Prosecutor and Healthcare Fraud Strike Force Leader] There is a health care fraud industry where people do nothing but recruit patients, get patient lists, find doctors, look on the Internet, find different scams.

There are entire groups and entire organizations of people that are dedicated to nothing but committing fraud, finding a better way to steal from Medicare.

Mr. KROFT. Is the Medicare fraud business bigger than the drug business in Miami now?

Mr. OGROSKY. I think it is way bigger.

Mr. KROFT. What changed?

Mr. OGROSKY. The criminals changed.

Mr. WATERMAN. Sophistication.

Mr. OGROSKY. They figured out that rather than stealing $100,000 or $200,000, they can steal $100 million. We have seen cases in the last 6, 8 months that involve a couple of guys that, if they weren't stealing from Medicare, might be stealing your car.

TONY. You are waking up every day making $20,000, $30,000, $40,000, every day, almost literally, and you are like, "Wow, I mean, I just won the lottery."

Mr. KROFT. Let's call this guy "Tony." That is not his real name and obviously not his real face. But before he was ratted out by a friend and brought down by the FBI, he was making Wall Street money running a string of phony medical supply companies out of this building that were theoretically providing wheelchairs and other expensive equipment to Medicare patients.

How much money did you steal from Medicare?

TONY. About $20 million.

Mr. KROFT. $20 million?

TONY. Yes.

Mr. KROFT. Was it easy?

TONY. Real easy.

Mr. KROFT. And you are not exactly a criminal mastermind.

TONY. No. No, not really. It is more like common sense. That is all you need here.

Mr. KROFT. Did you actually ever sell any medical equipment?

TONY. No. No. Just have somebody in an office answering the phone like we are open for business, and wake up in the morning, check your bank account and see how much money you made today.

Mr. KROFT. So you didn't have any medical equipment. You didn't really have any clients either, did you?

TONY. No.

Mr. KROFT. All of it was fake.

TONY. All of it was fake, yes.

Mr. KROFT. And you would just fill out some invoices and some forms and send them to Medicare and——

TONY. Yeah, that is it. And 15 to 30 days you will have a direct deposit in your bank account. I mean, it is—it was ridiculous. It is more like taking candy from a baby.

[End videotape.]

Mr. GOHMERT. Thank you, Mr. Chairman. And again, appreciate the opportunity to have this hearing. Appreciate your calling it.

Mr. SCOTT. Thank you.

The Chairman of the full Committee is with us, the gentleman from Michigan.

Do you have a statement, comment?

Mr. CONYERS. Thanks, Chairman Scott, Judge Gohmert.

Now, this is an issue that everybody of every persuasion can come together on. And I congratulate you for having the hearing. And I would like to find out where the next step from the "60 Minutes" clip goes.

I mean, to whom did this enterprising young man send invoices to get the money? I mean, who sent the money to him? And they are the ones that ought to be sitting at the second panel here today to explain that, or removed from office, or at least discontinuing what they are doing.

That is the back story to this hearing.

Mr. SCOTT. Well, we have one inspector general from the HHS who might comment.

Mr. CONYERS. Well, he better make more than a comment. [Laughter.]

I will tell you that. No. No, this is simple. I mean, this is not complex crime. It is not international drug smuggling. This isn't undercover operations. I mean, this is just ordinary household criminal law violations.

And it is a little bit shocking it takes two Federal agencies at the top to combine to bust little guys like this who just say it is really just simple, you send in the invoices and then you check your bank account to see where the money comes from.

I mean, I want to ask the witnesses this in advance. Could you suggest a simpler crime that could be committed in the United States than what this young fellow just told "60 Minutes" and everybody in America?

To be honest, the one thing we have got to worry about is how many more people did he incentivize. I mean, people that are sitting at home that just got laid off, or their company moved out of the States, or their home is in foreclosure, and they see this program—I mean, he doesn't need a wake-up call.

They just told him what he might do, and that it might work, and that it—and it is working so successfully that we have two agencies at the Federal level—can I ask you why the Department of Justice can't get enough money from the Congress to bust this simple, ordinary kind of racket?

The second question that I am going to ask is what about the corporate crime that goes on here. We are talking about the little guys—if there is an element of corporate activity in—that we have to know about.

So I thank you, Mr. Chairman.

Mr. SCOTT. Thank you. And I thank you for your comments, Mr. Chairman.

And thank you, Mr. Gohmert, for bringing that piece to our attention.

Our first witness on the panel will be Mr. Greg Andres. He is appointed acting deputy assistant attorney general in the Criminal Division.

He is joined in the division on detail from the United States—U.S. Attorney's Office in the Eastern District of New York, where he has been an assistant U.S. attorney since 1999 and has served as chief of the Criminal Division since 2006. He has been involved in several high-profile prosecutions involving organized crime, terrorism and securities fraud offenses.

Our second witness will be Mr. Timothy Menke. He is the Department of Health and Human Services deputy inspector general for investigations. He has over 20 years of Federal law enforcement experience and has been with the Office of Inspector General since 1996.

Our third witness will be Mr. Mark Collins. He joined the Nebraska Attorney General's Office in September 2005 as director of the Nebraska Medicaid Fraud Control Unit which had just been created a year earlier. He also serves as the special assistant U.S.

attorney for the District of Nebraska for health care fraud matters and is president of the National Association of Medicaid Fraud Control Units.

And our final witness is Mr. Jim Frogue—did I pronounce that right?

Mr. FROGUE. Frogue.

Mr. SCOTT. Frogue, thank you—Mr. Jim Frogue, who is the vice president and director of State policy for the Center for Health Transformation. He is the center's chief liaison to the State policy projects—the primary areas of focus—including Medicare, Medicaid and fraud.

Previously, he was the director of Health and Human Services task force at the American Legislative Exchange Council, where he coordinated the development of market-oriented health policies among State legislators.

Now, each of our witnesses' written statements will be entered in the record in its entirety.

I would ask each of our witnesses to summarize your testimony in 5 minutes or less. To help stay within the time, there is a timing device at the table which will begin green and go to yellow when you have 1 minute left. And when it turns red, that signals that your 5 minutes has expired.

Mr. Andres.

TESTIMONY OF GREG ANDRES, ACTING DEPUTY ASSISTANT ATTORNEY GENERAL, CRIMINAL DIVISION, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Mr. ANDRES. Thank you, Chairman Conyers, Chairman Scott, Ranking Member Gohmert and distinguished Members of the Subcommittee.

Thank you for the invitation to be here today. Thank you for the opportunity to outline the Department of Justice's efforts to root out, prosecute and prevent health care fraud.

Every year the Federal Government devotes billions of dollars to provide health care services for our citizens, young and old alike. Sadly, between 3 and 10 percent of that money may be lost to waste, fraud or abuse.

We in the Department of Justice have a duty to protect against fraud and the obligation to make sure that money allocated for health care is not siphoned away by criminals. This is a responsibility that we embrace.

And the Department of Justice has used criminal and civil enforcement tools to prosecute health care fraud for more than a decade. Today we are doing it better. Most importantly, we are coordinating more effectively with our partners at the Department of Health and Human Services.

The Health Care Fraud Prevention and Enforcement Action Team, or HEAT initiative, is guiding this partnership in a smart, strategic and targeted way and it is producing results.

On the criminal side, we are identifying hot spots with unexplained billing patterns, and we are placing Medicare Fraud Strike Forces in those cities to catch the most egregious offenders.

We started in Miami and Los Angeles and expanded to Detroit and Houston. And later we expanded further, this time to Brook-

lyn, Baton Rouge and Tampa. Our strike force prosecutors and agents have made arrests and earned convictions in a wide variety of fraud schemes involving claims for services that were unnecessary or that were never provided.

For example, in June of 2009 Federal prosecutors charged 53 defendants in Detroit relating to fraudulent billing schemes involving physical, occupational and infusion therapy services. These scheme involved $50 million.

Days later, Federal prosecutors indicted eight Miami-area residents in connection with a $22 million scheme to submit false claims to Medicare for home health services.

And about a month after that, July of 2009, Federal prosecutors in Houston charged 32 defendants in schemes involving more than $16 million in fraudulent Medicare billing. Similar prosecutions have been brought in Los Angeles and Brooklyn alike.

In all, since its inception, strike force prosecutors and agents have charged more than 500 defendants who collectively billed the Medicare program for more than a billion dollars.

They have secured more than 260 guilty pleas to date, obtained prison sentences for 94 percent of defendants convicted. These efforts have a tangible result in terms of savings.

In the first year after strike force operations in Miami, there is an estimated reduction of $1.75 billion in durable medical equipment claims submitted.

The HEAT initiative also has a civil fraud enforcement component. Using the False Claims Act and the Anti-Kickback Act and Food, Drug and Cosmetic Act during fiscal year 2009, DOJ civil lawyers have secured $1.6 billion in civil settlements and judgments. They have opened 886 new civil health care fraud matters and filed complaints or intervened in 283 civil health care fraud matters.

The Civil Division's Office of Consumer Litigation prosecutes drug and device manufacturers and responsible individuals believed to be illegally promoting and distributing misbranded and adulterated drugs or devices in violation of the Food, Drug and Cosmetic Act.

The Civil Division also houses the Elder Justice and Nursing Home Initiative to coordinate and support law enforcement efforts to combat elder abuse, neglect and financial exploitation.

Finally, the Special Litigation Section of the Civil Rights Division ensures that the civil rights of persons who reside in public, State or locally run institutions are fully protected.

In conclusion, the Department of Justice has made the prosecution of health care fraud a priority. Resources are dedicated to these activities and the President's budget seeks additional funding to expand our enforcement efforts.

We look forward to working with Congress as we continue our important mission to prevent, deter and prosecute health care fraud. Thank you.

[The prepared statement of Mr. Andres follows:]

PREPARED STATEMENT OF GREG ANDRES

Department of Justice

STATEMENT OF

GREG ANDRES
ACTING DEPUTY ASSISTANT ATTORNEY GENERAL

BEFORE THE

SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY
COMMITTEE ON THE JUDICIARY
UNITED STATES HOUSE OF REPRESENTATIVES

ENTITLED

"ENFORCEMENT OF THE CRIMINAL LAWS AGAINST MEDICARE AND MEDICAID FRAUD"

PRESENTED

MARCH 4, 2010

INTRODUCTION

Chairman Scott, Ranking Member Gohmert, and distinguished Members of the Subcommittee, I appreciate the opportunity to appear before you to discuss the efforts of the Department of Justice to enforce laws against Medicare and Medicaid fraud, along with our partners in the Department of Health and Human Services and other federal and state law enforcement agencies. We are grateful for the Subcommittee's leadership on this important topic, and to the Chairman for inviting me to discuss the Department of Justice's enforcement efforts to combat Medicare and Medicaid fraud.

Every year, hundreds of billions of dollars are spent to provide health security for American seniors, children, and to the poor and disabled. We have a duty to ensure that taxpayer funds are well spent and that our citizens who receive treatment paid for by the Medicare, Medicaid, and other government programs are receiving proper medical care. While most medical providers and health care companies are doing the right thing, Medicare and Medicaid fraud cost the American taxpayer billions of dollars that could be spent on patient care. Medicare and Medicaid fraud also can corrupt the medical decisions health care providers make with respect to their patients and thereby put patients at risk of harm. For these reasons, the Department of Justice, through its Criminal, Civil, and Civil Rights divisions, along with the United States Attorneys' Offices and the FBI – the entities responsible for enforcing laws against all forms of health care fraud – has redoubled its efforts to protect the public from health care fraud and to help ensure the integrity of patient care.

FIGHTING MEDICARE AND MEDICAID FRAUD IS A PRIORITY OF THE DEPARTMENT OF JUSTICE

At the recent National Summit on Health Care Fraud, experts in both the public and private sectors concluded that a reliable measurement of fraud did not exist, and there was no evidence that fraud in Medicare and Medicaid was greater than that among private insurers. However, we believe health care fraud in this country constitutes billions of dollars in losses to taxpayers and private industry, that it drives up the cost of health care, and requires an urgent response from every level of government and the private sector. The Department of Justice, in coordination with the Department of Health and Human Services, and other federal and state law enforcement agencies, recognizes both the urgency in the need to recover those funds and the need to ensure that such fraud does not reoccur.

In 1997, Congress established the Health Care Fraud and Abuse Control (HCFAC) Program under the joint direction of the Attorney General and the Department of Health and Human Services, acting through HHS's Inspector General, to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. Since the inception of the program through fiscal year 2008, our Departments have returned more than $15 billion to the federal government, of which $13.1 billion went back to the Medicare Trust Fund. These efforts have resulted in more than 5,600 criminal convictions for health care fraud offenses. With $13.1 billion returned to the Medicare Trust Fund, the average return on investment to the Trust Fund for funding provided to law enforcement agencies by the 1996 law that created the program, HIPAA, is approximately $4 per dollar spent.

Because coordination across agencies is an integral part of preventing and prosecuting health care fraud, Attorney General Holder and Secretary Sebelius together have pledged to strengthen our fight against waste, fraud and abuse in Medicare and Medicaid. To improve that coordination, in May 2009, they announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) – a senior-level, joint task force, which the Deputy Attorney General oversees along with his counterpart, the Deputy Secretary of HHS, that is designed to marshal the combined resources of both agencies in new ways to combat all facets of the health care fraud problem. With the creation of the HEAT team, we re-committed to making fighting health care fraud a Cabinet-level priority for both DOJ and HHS.

We have had some remarkable successes thus far. In terms of enforcement, we expanded the Medicare Fraud Strike Force (Strike Force) last summer from two to four cities, and in December expanded to three more cities. The Strike Force is an example of the Department's recent strategic thinking about how to bolster our efforts to combat health care fraud. The Strike Force prosecution model involves analyzing Medicare data to identify hot spots of unexplained high-billing levels in concentrated areas that, combined with field intelligence from our law enforcement agents and investigators, help expedite health care fraud investigations and prosecutions. Strike Force teams are now operating in seven locations: South Florida, Los Angeles, Detroit, Houston, Brooklyn, Baton Rouge and Tampa. These expanded efforts have already produced substantial results, including several takedowns of numerous health care fraud perpetrators which I will discuss in more detail later in my testimony. In total, since the announcement of the HEAT Initiative last May, Strike Force prosecutors have filed over 60 cases charging more than 200 defendants, negotiated more than 50 guilty pleas, and litigated six jury trials obtaining convictions of six defendants. These enforcement actions have a significant deterrent effect. In the first 12 months following the announcement of Strike Force operations in the Miami area, there was an estimated reduction of $1.75 billion in durable medical equipment (DME) claim submissions and $334 million in DME claims paid by Medicare, compared to the preceding 12-month period.

In fiscal year 2009, federal prosecutors nationwide filed criminal charges in 481 health care fraud cases involving charges against 803 defendants and obtained 583 convictions for health care fraud offenses. In addition, they opened 1,014 new criminal health care fraud investigations involving 1,786 individuals or entities. During that same time period, the Department of Justice opened 886 new civil health care fraud matters and filed complaints in 283 civil health care fraud cases.

The HEAT initiative also has focused on civil fraud enforcement under the False Claims Act, the Anti-Kickback Act, and Food, Drug, and Cosmetic Act. During fiscal year 2009, the Department of Justice's vigorous efforts to combat health care fraud accounted for $1.6 billion in civil settlements and judgments. During that same time period, the Department opened 886 new civil health care fraud matters and filed complaints or intervened in 283 civil health care fraud matters. Last fall, Pfizer Inc. and its subsidiary Pharmacia & Upjohn Company Inc. agreed to pay $2.3 billion to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products. This is the largest health care fraud settlement in the history of the Department of Justice, the largest criminal fine of any kind imposed in the U.S., and the largest ever civil fraud settlement against a pharmaceutical company.

In fiscal year 2010, the federal government is devoting $1.48 billion for program integrity activities through the health care fraud and abuse control account, of which the Department of Justice litigating components will receive $85 million.[1] The President's 2011 Budget includes an additional $250 million in two-year funding to enhance program integrity and antifraud enforcement work of which $60 million is designated for the Department of Justice, including the Federal Bureau of Investigation, to continue to expand our criminal and civil health care fraud enforcement efforts, while working closely with the Department of Health and Human Services and other federal and state agencies.

In addition, the President has recently released a health insurance reform proposal that builds on provisions proposed by the House and the Senate health reform bills, as well as Republican bills, to crack down on fraud, waste, and abuse. These efforts include further authorities and initiatives at CMS and other federal agencies to provide proper oversight of Medicare. For example, the President's Proposal speeds access to claims data to identify potentially fraudulent payments more quickly. It also establishes a system for using technology to provide real-time data analysis of claims and payments under public programs to identify and stop fraud, waste, and abuse, among other efforts. It assists in reducing the number of individuals and agencies participating in Federal health programs who have a history of fraudulent activities. It improves coordination and information sharing in anti-fraud efforts. If adopted, we anticipate these efforts will improve our oversight efforts and stand ready to work with Congress to implement health insurance reform legislation.

The remainder of my testimony will describe the key activities of each Department component and highlight their recent accomplishments.

CRIMINAL DIVISION'S EFFORTS TO FIGHT HEALTH CARE FRAUD AND ABUSE

The Department of Justice's efforts to fight health care fraud have succeeded in part because of strategic thinking about how to respond to this growing problem. The Strike Force was launched by the Criminal Division in collaboration with the United States Attorney's Office in the Southern District of Florida in 2007 to target durable medical equipment (DME) and HIV infusion fraud in Miami. In March 2008, the Criminal Division expanded the Strike Force to a second phase, partnering with the United States Attorney's Office for the Central District of California and HHS to combat DME fraud in the Los Angeles metropolitan area. The Strike Force model for criminal health care fraud prosecutions has now become a permanent component of the United States Attorneys' Offices in both the Southern District of Florida and the Central District of California. In May 2009, we expanded the Strike Force to Houston and Detroit, and in December of last year we added three more cities – Brooklyn, Tampa, and Baton Rouge – bringing the total number of Strike Force locations to seven.

The Strike Force's mission is to supplement the criminal health care fraud enforcement activities of the United States Attorneys' Offices by targeting emerging or migrating schemes along with chronic fraud by criminals operating as health care providers or suppliers. Federal agents and analysts review Medicare data and then gather and develop additional investigative

[1] The allocation to the Department of Justice litigating components includes mandatory HCFAC funding of $55.3 million and discretionary funding of $29.8 million for fiscal year 2010.

intelligence to identify potential targets who are operating as health care providers or suppliers and may be billing for fictitious or medically unnecessary services. A key focus of the HEAT initiative is to make sure that investigators and prosecutors are getting real-time access to claims data in a useable format so that we can develop these cases quickly and effectively.

Typically in each Strike Force city, three to five teams of federal, state, and local investigators, work under the guidance of Criminal Division prosecutors and Assistant United States Attorneys, to investigate fraudulent activity and, where appropriate, bring criminal and civil cases against the most serious perpetrators. Our goal is to bring these cases as quickly and responsibly as possible once the fraud is identified to assure that viral fraud schemes do not spread between regions within our country. Strike Force prosecutors usually charge defendants for the total amount of fraudulent claims billed to the Medicare program, and where the facts merit, seek enhanced sentences for "relevant conduct" under the guidelines. After developing evidence to support arrests of individual targets and suspects, court processing of Strike Force cases from indictment to disposition and sentencing can occur within a matter of months. While variations in case processing time occur from district to district, the median time from indictment to sentencing for more than 200 defendants sentenced in Miami Strike Force cases to date has been about six months. Strike Force defendants are also more likely to receive prison sentences and longer terms of imprisonment than more traditional criminal health care fraud defendants. During the three fiscal years since the Strike Force's inception, over 94 percent of all Strike Force defendants were convicted and sentenced to terms of imprisonment compared to 64 percent of all criminal health care fraud defendants. The average prison term for Strike Force defendants was 45 months, which was about 10 percent longer than the overall national average for federal health care fraud defendants over this same period.

The HEAT Initiative has produced significant enforcement results since last May following our expansion of Strike Force locations and the scope of targeted schemes to include fraudulent physical and occupational therapy clinics, home health agencies, and enteral nutrition and feeding supplies, in addition to DME and HIV infusion:

- On June 24, 2009, the Criminal Division and United States Attorney's Office for the Eastern District of Michigan announced seven indictments charging 53 people in schemes involving physical, occupational, and infusion therapy to defraud Medicare of more than $50 million in the Detroit metropolitan area.
- On June 26, 2009, the Criminal Division and United States Attorney's Office for the Southern District of Florida indicted eight Miami-area residents in connection with a $22 million scheme to submit false claims to Medicare from two fraudulent providers for purported home health services.
- On July 29, 2009, the Criminal Division and United States Attorney's Office for the Southern District of Texas announced the unsealing of seven indictments charging 32 people in schemes involving false billing for "arthritis kits," which consist of sets of orthotic braces that are purportedly used for the treatment of arthritis-related conditions, power wheelchairs and enteral feeding supplies to defraud Medicare of more than $16 million in the Houston metropolitan areas.

- On October 21, 2009, Strike Force prosecutors in the Central District of California announced arrests of 20 defendants, most of them residing in the Los Angeles area, for participating in Medicare fraud schemes that resulted in more than $26 million in fraudulent billings to the Medicare program. The same day, Houston Strike Force prosecutors announced charges against six additional defendants in a new case and a superseding indictment involving fraudulent billings for "arthritis kits."
- On December 15, 2009, the Departments of Justice and HHS announced indictments of another 30 individuals charged by Strike Force prosecutors in Miami, Detroit, and Brooklyn with submitting more than $61 million in fraudulent billings to Medicare for various schemes involving unnecessary medical tests, durable medical equipment, home health services, and injection and infusion treatments. DOJ and HHS also announced plans to expand Strike Force operations to the Eastern District of New York, Middle District of Louisiana, and Middle District of Florida.
- On January 14, 2010, 13 defendants were indicted in Detroit for a home health care scheme to defraud the Medicare program of more than $14.5 million.

Typically, defendants in Strike Force indictments include physicians, nurses and other medical professionals, along with DME company or medical clinic owners, executives and/or employees, who are charged with participating in schemes to submit claims for services or products that were medically unnecessary and oftentimes, never provided. In many if not most cases, defendants paid kickbacks to medical professionals and beneficiaries for use of their Medicare information to support fictitious claims for items or services that were never provided. In other cases, defendants have been charged with aggravated identity theft for stealing physician or beneficiary information to support fraudulent claims. In some cases, indictments allege that beneficiaries were deceased at the time they allegedly received the items or services. Finally, a few cases have involved actions which put patients at risk of harm or injury by subjecting them to infusion or injection treatments that they did not need.

In addition to providing a leadership role in launching new Strike Force teams and training investigative agents and prosecutors, Criminal Division attorneys have litigated 17 of 20 trials in Strike Force cases located in four districts, obtaining guilty verdicts against 23 defendants over the past three years.[2] Division attorneys recently obtained jury trial convictions in the first trials held in Detroit and Houston cases, respectively, as part of the HEAT Initiative:

- On January 22, 2010 after a week-long trial, a federal jury convicted a Detroit-area physician of conspiracy to commit health care fraud. Trial evidence showed the physician worked at a Southfield, MI, clinic that purported to specialize in providing infusion therapy to Medicare beneficiaries and that he signed patient files ordering infusions and injections of corticosteroids and other medications, despite being aware that the patients did not need the drugs and that Medicare was being billed for the drugs. Patients were not referred to the clinic by their real physicians for any legitimate purpose, but rather were recruited to come to the clinic through the payment of kickbacks. Over a

[2] Assistant United States Attorneys and HHS Office of Inspector General attorneys detailed to the Strike Force have assisted in several of these trials. AUSAs in the Central District of California and Southern District of Florida have litigated the other three jury trials in Strike Force cases, to date.

six-month period, the physician and his co-conspirators caused approximately $4.2 million to be submitted to the Medicare program for unnecessary services that were never provided.

- On January 27, 2010 a Houston jury convicted a retired nurse of conspiracy to commit health care fraud and health care fraud. Trial evidence showed that a Houston-area durable medical equipment company owner entered into a kickback arrangement with the nurse to pay her a kickback of $300 per patient referred along with documentation to support false billings to Medicare for enteral nutrition supplies and for bundles of orthotics, referred to as "arthritis kits" in order to submit $747,258 in phony claims to Medicare.

Since its inception nearly three years ago, Strike Force prosecutors from the Criminal Division and United States Attorneys' Offices together have:

- filed more than 250 cases charging over 500 defendants who collectively billed the Medicare program more than one billion dollars;
- taken more than 260 guilty pleas;
- litigated 20 jury trials resulting in convictions of 25 defendants and only five acquittals;
- obtained sentences to imprisonment for 94% of defendants convicted, and
- imprisoned defendants received an average sentence of 45 months.

The Strike Force is just one tool designed to fight the most aggressive criminal schemes. The Division's Organized Crime and Racketeering Section also supports investigations and prosecutions of fraud and abuse targeting private sector health plans sponsored by employers and/or unions, including schemes by corrupt unauthorized insurers that fraudulently entice sponsoring employers and/or unions to purchase what appears to be valid group health coverage only to discover much later that the payment of health claims will not be made as promised. The Department's 93 United States Attorney's Offices throughout the nation bring many other significant Medicare and Medicaid fraud cases with criminal and civil prosecutors who work on health care fraud cases along with attorneys in the Department's Civil and Civil Rights Divisions, and are aided significantly by FBI field offices around the country.

THE DEPARTMENT'S CIVIL LITIGATING COMPONENTS' HEALTH CARE FRAUD EFFORTS

The primary enforcement tool possessed by the Department of Justice to pursue civil remedies in health care fraud matters is the False Claims Act (FCA), 31 U.S.C. §§ 3729-3733. In addition to the Department of Justice being able to go after false claims directly, lawsuits are often brought by private plaintiffs, known as "relators," under the *qui tam* provisions of the FCA. The *qui tam* provisions allow private citizens to sue, on the government's behalf, companies and others that defraud the government. The government then can intervene in appropriate cases to pursue the litigation and recovery against the defendant. Since the False Claims Act was

substantially amended in 1986 and through FY 2008, the Civil Division, working with United States Attorneys, has recovered $24 billion on behalf of the various victim federal agencies. Of that amount, $15.9 billion was the result of fraud against federal health care programs – primarily the Medicare program. Moreover, in FY 2009, False Claims Act health care fraud recoveries exceeded $1.6 billion, the eighth year that the Department obtained in excess of $1 billion in health care fraud recoveries.

That total does not include the Department's settlement with Pfizer, Inc., which was consummated in FY 2010. In that matter, Pfizer paid $2.3 billion, the largest health care fraud settlement in the history of the Department of Justice, to resolve criminal and civil liability arising from illegal promotion of certain pharmaceutical products. The civil settlement also resolved allegations that Pfizer paid kickbacks to health care providers to induce them to prescribe these, as well as other, drugs. The federal share of the civil settlement was $668.5 million and the state Medicaid share of the civil settlement was $331.5 million.

In addition to these matters, the Civil Division, as a part of our health care fraud enforcement efforts, investigates and pursues False Claims Act matters that are predicated on claims that doctors and others were paid kickbacks or other illegal remuneration to induce referrals of Medicare or Medicaid patients in violation of the Physician Self-Referral laws, commonly referred to as the "Stark" laws, the Anti-kickback Statute, and the civil monetary penalties statute. These statutes have been extremely important in protecting the integrity of our health care system and have proven useful in going after fraudsters.

The Department's civil enforcement efforts also focus on cases addressing substandard care delivered to federally insured beneficiaries. The most notable example is the recent $24 million recovery from FORBA, Inc., a dental management company that operates a nationwide chain of pediatric dental clinics known as Small Smiles. The government alleged that the clinics often performed unnecessary and painful dental procedures on their low-income pediatric patients in order to maximize Medicaid reimbursement.

Another way the Civil Division fights health care fraud is through the criminal prosecutions by the Office of Consumer Litigation (OCL). OCL, under the statutory authority of the Federal Food, Drug and Cosmetic Act, investigates and prosecutes drug and device manufacturers and responsible individuals believed to be illegally promoting and distributing misbranded and adulterated drugs or devices.

The Civil Division also houses the Elder Justice and Nursing Home Initiative to coordinate and support law enforcement efforts to combat elder abuse, neglect and financial exploitation of this population. When abuse and/or neglect is detected, the Elder Initiative coordinates the Department's litigation against long-term care providers, including nursing homes that fail to provide the quality of care to which our Medicare and Medicaid beneficiaries are entitled and for which the government pays.

The Civil Rights Division also plays a critical role in the Department's protection of the nation's health care system. The Special Litigation Section of the Civil Rights Division is the Department component responsible for the Civil Rights of Institutionalized Persons Act (CRIPA)

and its role is to ensure that the civil rights of residents in public, state or locally-run, institutions (including facilities for persons with developmental disabilities or mental illness, and nursing homes) are fully protected. The Department's CRIPA work goes hand-in-hand with the Civil Rights Divisions work under Title II of the Americans with Disabilities Act to uphold individuals' federal rights to receive adequate supports and services in the most integrated setting appropriate to their needs. The Department recognizes that unnecessary institutionalization is discrimination that diminishes individuals' ability to lead full and independent lives. As a result of our CRIPA and ADA enforcement activities, thousands of unnecessarily institutionalized individuals have been able to live safely in the community with adequate supports and services.

As part of the Department's Institutional Health Care Abuse and Neglect Initiative, the Civil Rights Division conducts reviews of conditions in health care facilities. In FY 2009, it pursued 19 investigations regarding conditions in 23 healthcare public facilities. Also in FY 2009, the Division addressed conditions and practices at 13 state facilities for persons with intellectual and developmental disabilities, eight state facilities for persons with mental illness, and three state operated nursing homes. The Division entered five settlement agreements regarding these 24 facilities. The Division was unable to settle one case involving a facility for persons with developmental disabilities, and that case is currently in contested litigation.

UNITED STATES ATTORNEYS' ENFORCEMENT EFFORTS

The 93 United States Attorneys and their AUSAs are the nation's principal prosecutors of federal crimes, including health care fraud (HCF). Each district has a designated Criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator charged with overseeing the United States Attorneys' Offices' (USAOs) commitment to fighting HCF wherever it occurs. The USAOs play a major role in this Department priority by investigating and litigating affirmative civil cases and criminal cases to recover funds wrongfully taken from the Medicare Trust Fund and other taxpayer-funded health care systems as a result of fraud. Civil and criminal AUSAs investigate and litigate a wide variety of HCF matters including, false billings by doctors and other providers of medical services, overcharges by hospitals, Medicaid fraud, kickbacks to induce referrals of Medicare or Medicaid patients, fraud by pharmaceutical and medical device companies, and failure of care allegations against nursing home and mental health facility owners. The USAOs partner with the Civil Division in investigating and resolving significant cases, including the Pfizer matter I mentioned earlier. In addition, the USAOs are partnering with the Criminal Division in the Medicare Fraud Strike Force Initiative.

Other notable health care fraud successes of U.S. Attorneys' Offices which are illustrative of the kinds of cases the USAOs handle across the nation include:

- In the Northern District of California, the former CEO of InterMune, Inc. was convicted of wire fraud for the creation and dissemination of false and misleading information about the efficacy of InterMune's Actimmune (Interferon gamma-1b) as a treatment for idiopathic pulmonary fibrosis ("IPF"). The CEO has not been sentenced yet, but faces a maximum sentence of 20 years.

- In the Southern District of Texas, a hospital group based in McAllen, Texas, has agreed to pay the United States $27.5 million to settle claims that it violated the False Claims

Act, the Anti-Kickback Statute and the Stark Statute between 1999 and 2006, by paying illegal compensation to doctors in order to induce them to refer patients to hospitals within the group.

- In the District of New Hampshire, four pharmaceutical companies, Mylan Pharmaceuticals, Inc., UDL Laboratories, Inc., AstraZeneca Pharmaceuticals LP, and OrthoMcNeil Pharmaceutical, Inc., entered into settlement agreements for a total of $124 million to resolve claims that they violated the False Claims Act by failing to pay appropriate rebates to state Medicaid programs for drugs paid for by those programs.

- In the Southern District of New York, the former senior manager of corporate benefits for Hitachi America Ltd. ("Hitachi America"), was sentenced to 57 months in prison for defrauding the Hitachi America Group Health and Welfare Plan (the "Plan") of more than $6 million. The defendant used the company's insurance plan funds to pay for personal and family expenses, including, at least $1 million in payments to defendant's credit cards; more than $2 million in checks made payable to the defendant; approximately $42,000 for a Lexus automobile registered to defendant; and approximately $625,000 to purchase a house in Vero Beach, Florida. In addition to the prison term, the court sentenced the defendant to three years of supervised release, and ordered restitution in the amount of $7,497,906.

- In the Central District of California, the former co-owner of City of Angels Medical Center (City of Angels) was sentenced to 37 months in federal prison for paying illegal kickbacks for referrals of "patients" who were recruited from Los Angeles' "Skid Row" and was ordered to pay $4.1 million in restitution for his role in the scheme that defrauded Medicare and Medicaid by recruiting homeless persons from Skid Row for unnecessary medical services. The medical center entered into sham contracts intended to conceal the illegal kickbacks paid, and billed Medicare and Medicaid for in-patient services to the recruited homeless beneficiaries, including those for whom hospitalization was not medically necessary.

- In the Eastern District of Pennsylvania, Willowcrest Nursing Home and Willow Terrace long-term nursing care residence settled allegations that arose from an investigation of Willowcrest's sub-standard pressure ulcer treatment and prevention, incontinence care, pain-management, nutrition, weight monitoring, infection control, and diabetic care. This quality-of-care settlement is the first in which a health care facility is required to hire a full-time physician assistant or nurse practitioner whose sole responsibility will be to regularly and continuously treat its residents. The settlement also provides that Willowcrest and Willow Terrace will, among other things, pay $305,072 to the Medicaid program.

FBI'S HEALTH CARE FRAUD INVESTIGATIONS

Health care fraud investigations are among the highest priority investigations within the FBI's White Collar Crime Program, along with Public Corruption and Corporate Fraud. Through national initiatives focusing on Internet pharmacy, durable medical equipment, and

infusion therapy fraud, the FBI is utilizing sophisticated investigative techniques—from undercover operations to wiretaps—not only to collect evidence for prosecution, but also to find and stop criminals before they take action.

The FBI is actively pursuing health care fraud in every region. It has local task forces and working groups to address health care fraud in every one of its 56 field offices, and it is shifting resources to regions where an increase in fraud schemes are detected. FBI's field office-level task forces and working groups are comprised of HHS-OIG, U.S. Attorneys' Offices, state and local law enforcement agencies and, in many districts, private insurance company special investigative units and Medicare contractors that refer suspected fraud activity that is investigated jointly by the law enforcement agencies that are involved in the task force or working group. These task forces and working groups, which meet regularly, provide a structure to address the unique health care fraud in each region.

In the past few years, the number of pending FBI health care fraud investigations has steadily increased to over 2,400. It should be noted that in FY 2009 alone, FBI-led investigations in federal and state health care fraud cases resulted in the filing of indictments and informations charging over 840 defendants, and 555 convictions for health care fraud.

CONCLUSION: LOOKING FORWARD

As I hope is clear from this discussion, the Department of Justice, together with our partners in HHS and other federal and state agencies, has made combating health care fraud a significant priority. The Department has devoted substantial resources and leadership from the highest levels of the Department to the HEAT initiative in order to be smarter and more effective about how we detect, deter and prosecute health care fraud. As we have seen time and time again, the only way we can be truly effective in protecting the integrity of our public health programs is by combining the full panoply of our federal resources, expertise, and information across agency and jurisdictional lines. The Department of Justice looks forward to working with Congress as we continue our important mission to prevent, deter, and prosecute health care fraud.

Mr. SCOTT. Thank you.
Mr. Menke.

TESTIMONY OF TIMOTHY J. MENKE, DEPUTY INSPECTOR GENERAL FOR INVESTIGATIONS, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. MENKE. Good morning, Chairman Conyers, Chairman Scott, Ranking Member Gohmert and distinguished Members of the Subcommittee. I am Timothy Menke. I am the deputy inspector general for investigations at the Department of Health and Human Services Office of Inspector General.

I thank you for the opportunity to discuss OIG's health care antifraud strategy, primarily focusing our law enforcement activities to combat Medicare and Medicaid fraud.

OIG is an independent nonpartisan agency committing to protecting the integrity of more than 300 programs administered by HHS.

OIG employs more than 1,500 dedicated professionals, including a cadre of nearly 400 highly skilled criminal investigators trained to conduct criminal, civil and administrative investigations.

Thanks to the hard work of our employees in fiscal year 2009, OIG's enforcement efforts resulted in 670 criminal actions, 362 civil actions and nearly $4 billion in monetary recoveries.

We work closely with the Department of Justice, our Federal, State and local law enforcement partners, to include State Medicaid Fraud Control Units with whom we are working over 980 joint investigations.

OIG's partnerships extend to one of the Administration's signature initiatives, the Health Care Fraud Prevention and Enforcement Action Team, known as HEAT.

The HEAT initiative, established by Secretary Sebelius and Attorney General Holder in 2009, brings together senior officials from both HHS and DOJ with the goals of sharing information, spotting fraud trends, coordinating prevention and enforcement strategies, and developing new fraud prevention tools.

OIG contributes its experience to HEAT by analyzing data for patterns of fraud, conducting investigations, supporting Federal prosecutions, as well as making recommendations to HHS to remedy program vulnerabilities.

One of the investigative strategies promulgated by HEAT is the Medicare Fraud Strike Force. The Medicare Fraud Strike Force 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. Strike force cases are data driven, using technology to pinpoint fraud hot spots through the identification of unexplainable billing patterns as they occur.

The majority of subjects in strike force cases are engaging in 100 percent fraudulent activity, not providing any legitimate services to program beneficiaries whatsoever.

Real-time access to data is critical to the success of the HEAT strike force initiative. Over the last several months, representatives from OIG, CMS and DOJ have explored ways to improve access to CMS claims data.

Much of our attention has been focused on obtaining real-time data. To date, we have established limited access to real-time

claims data, but we are continuing to work to improve our access to this data.

It is also important that we expand our access to CMS systems offering advanced analysis and query tools that can be employed in mining a comprehensive national Medicare claims database.

In addition to using data more efficiently, OIG is also using data to take a more strategic approach in identifying fraud. In 2009, OIG organized a cross-component data analysis team to support work of HEAT. The data team includes 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 from special agents to more quickly identify ongoing fraud schemes and trends.

OIG is also capitalizing on cutting-edge electronic discovery tools to maximize investigative efficiency in the processing and review of voluminous electronic evidence obtained during the course of our health care fraud investigations.

This technology is Web-based and has been made available to OIG investigators to increase investigative efficiency and effectiveness. OIG was the first Federal law enforcement agency to implement this technology. It enables OIG to analyze large quantities of mail or other electronic documents more efficiently and to associate or link e-mails contained in multiple accounts based on content or metadata.

Recently, OIG has expanded the use of this technology by making it available to our external law enforcement partners for use in joint investigations. This effort strengthens OIG's relationships with partner law enforcement agencies and allows for much greater collaboration.

Because the technology is Web-based and can be accessed securely over the Internet, investigators can use this tool from anywhere in the country.

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 suppliers will instead be available for legitimate businesses whose purpose is to serve the critical health care needs of our program beneficiaries.

And most importantly, we can assure that seniors and persons with disabilities receive the necessary supplies and care they need to stay healthy so as to enjoy enhanced well-being and quality of life.

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

And, Mr. Chairman, I would just like to add I brought a couple of exhibits along that may assist in our discussion a little bit later regarding fraud schemes. Thank you.

[The prepared statement of Mr. Menke follows:]

PREPARED STATEMENT OF TIMOTHY J. MENKE

Testimony before the Committee on the Judiciary
Subcommittee on Crime, Terrorism, and Homeland Security

U.S. House of Representatives

"Criminal Enforcement Against Medicare and Medicaid Fraud"

Testimony of
Timothy Menke
Deputy Inspector General for Investigations
Office of the Inspector General
Department of Health & Human Services

March 4, 2010
10:00AM
2141 Rayburn House Office Building

Testimony of:
Timothy J. Menke
Deputy Inspector General for Investigations
Office of Inspector General, U.S. Department of Health & Human Services

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

Good morning Chairman Scott, Ranking Member Gohmert, and distinguished Members of the Subcommittee. I am Timothy Menke, Deputy Inspector General for Investigations at the U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG). I 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 more than 300 programs administered by HHS. 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 program beneficiaries from fraud and abuse.

OIG employs more than 1,500 dedicated professionals, including a cadre of nearly 400 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 searches and making arrests. We utilize state-of-the-art technologies and a wide range of law enforcement tools in carrying out these important responsibilities.

Thanks to the hard work of our employees, in fiscal year (FY) 2009, OIG's enforcement efforts resulted in over 670 criminal actions, of which 515 involved heath care fraud; over 362 civil actions (355 involved health care fraud); and realized nearly $4 billion in settlements and court-ordered fines, penalties, and restitution, approximately 75 percent of which involved health care fraud. Additionally, OIG excluded over 2,500 providers from Federal health care programs.

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) and the Food and Drug Administration. Additionally, commercial and private insurance entities and trade associations, such as the National Health Care Anti-Fraud Association (NHCAA), 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. In FY 2009, OIG worked over 2,700 cases with our law enforcement partners on the Federal, State, and local levels, including over 980 cases with State Medicaid Fraud Control Units (MFCU).

OIG's partnerships extend to one of the Administration's signature initiatives, the Health Care Fraud Prevention and Enforcement Action Team (HEAT). This is a joint effort by HHS and DOJ to leverage resources, expertise, and authorities to prevent fraud and abuse in Medicare and Medicaid. The HEAT initiative, established by Secretary Sebelius and Attorney General 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, including program exclusions. OIG also makes recommendations to HHS to remedy program vulnerabilities and prevent fraud and abuse.

Overview of the Referral Process

OIG receives information about potential instances of fraud, waste and abuse through many sources. One source of information is the OIG Hotline. The Hotline receives and manages complaints of fraud, waste, abuse, and mismanagement related to HHS programs by way of phone, mail, fax, or email. In FY 2009, the OIG Hotline received approximately 5,000 complaints related to health care fraud. OIG also receives information in the form of correspondence from Congress, citizens, and a broad range of agencies. Information regarding health care fraud may also be received by our various offices directly from HHS operating divisions, as well as from other Federal, State and local law enforcement agencies.

A significant number of referrals come from official qui tam[1] notifications from DOJ. OIG also receives notification of Voluntary Self Disclosures sent from various health care related entities. OIG Regional Offices receive case referrals screened and prepared by the CMS Program Safeguard, Zone Program Integrity, and other integrity contractors and occasionally receive information obtained directly from CMS's Program Integrity staff. OIG is very active in internal working groups that target specific areas of health care issues, and has established liaisons with other agencies through health care fraud working groups sponsored by district-specific U.S. Attorneys Offices.

Additionally, OIG develops cases internally through its various components. The Office of Investigations (OI) through its outreach efforts with not only other law enforcement and government organizations, but also community contacts, develops investigative leads. Our Office of Audit Services refers complaints to OI based on its audit verification work. OI has initiated investigations based on the Office of Evaluation and Inspections identification of fraud trends.

Range of Investigations

From street gang members to corporate officers, our investigations are uncovering a wide range of individuals and entities committing health care fraud. The profitability, ease of entry, and

[1] The qui tam provisions of the Federal False Claims Act allow a private person, known as a "relator," to bring a lawsuit on behalf of the United States, where the private person has evidence of fraud against the Government, and to share in a portion of the funds recovered.

lower criminal penalties for health care related crimes attract criminals to health care fraud. Unfortunately, we also see some legitimate providers engaging in health care fraud. Below are examples of various fraud schemes we have encountered.

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 FDA 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 Corporate Integrity Agreement (CIA) with OIG, which requires procedures and reviews to be put in place to avoid and promptly detect fraud or misconduct. Two corporate officers were charged criminally for their role in this matter.

In Southern California, an individual set out to defraud the Medicare program by establishing multiple fraudulent durable medical equipment (DME) companies. The owner used primarily 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 the Medicare 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. To date, nine of the gang members and associates have been indicted for charges including health care fraud and providing false statements to government agencies. Not only is this investigation an example of one of the more prevalent fraud schemes that we are seeing, but also it 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 example of egregious health care fraud that OIG has investigated is the "Small Smiles" case. FORBA Holdings, LLC (FORBA), a management company operating Medicaid pediatric dental clinics, recently agreed to pay $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. FORBA manages 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/or sealants. This investigation involved OIG, the Federal Bureau of Investigation, and the National Association of MFCUs.

Our investigations have shown that there has been an increase in organized criminal enterprises within the health care fraud arena. Common elements of criminal enterprises include:

- use of consultants to start a company and obtain a Medicare billing number;

- use of "store fronts" – places made to look like legitimate medical companies;
- use of "false fronts" – billing for companies that do not exist or have a false address;
- use of straw or nominee owners and middlemen to protect the identities of real owners;
- association with medical identity theft rings to obtain stolen physician and patient identification numbers;
- use of "cappers," or recruiters, to recruit beneficiaries at rehabilitation facilities, soup kitchens, and senior centers for the use of their Medicare or Medicaid cards, and
- cooperation with other criminal enterprises, such as check cashing and money laundering rings.

Sham DME companies, home health companies, clinics and diagnostic laboratories are common schemes in criminal enterprises. Health care fraud is attractive to organized crime because: (1) the penalties are lower than those for other organized-crime-related offenses (e.g., offenses related to illegal drugs); (2) there are low barriers to entry (e.g., a criminal can obtain a supplier number, gather some beneficiary numbers and bill the program); (3) schemes are easily replicated; and (4) there is the perception of the low risk of detection.

An example of a criminal enterprise case involves Alain Amador who was sentenced to 52 months of incarceration and ordered to pay $3,928,552 in restitution following his guilty plea to conspiracy to commit health care fraud. Amador and his co-conspirators set up a series of fake medical clinics that existed in name only. Amador, who has a nursing degree, was instrumental in leasing space in the names of the companies, opening bank accounts, incorporating the companies, and obtaining Medicare billing numbers for the companies. The conspirators also improperly obtained identity information of legitimate doctors and Medicare patients. In fact, the investigation initiated with a complaint by a physician who had provided the conspirators with her Medicare provider number when applying for a medical director position at a clinic that they were allegedly opening. The stolen information was used to bill Medicare for infusion therapy services that were not rendered.

Criminal Statutes and Applicable Laws

There are a number of criminal laws that our agents and prosecutors have utilized successfully in strike force and other health care fraud cases. These include, most typically, Health Care Fraud (18 U.S.C. § 1347), which generally provides for prison sentences of up to 10 years, and can result in a sentence of up to 20 years for violations involving serious bodily injury and up to life if the action results in a death. Wherever possible, we have also supported criminal forfeiture of the stolen Medicare funds under the Criminal Forfeiture statute (18 U.S.C. § 982).

To attack more complicated schemes, in addition to the health care fraud statute cited above, our teams have utilized Conspiracy to Commit Health Care Fraud (18 U.S.C. § 1349), and Conspiracy (18 U.S.C. § 371) charged in combination with False, Fictitious, or Fraudulent Claims (18 U.S.C. § 287). For cases involving money laundering, we have on occasion pursued additional charges under Laundering of Monetary Instruments (18 U.S.C. § 1956). Many schemes also involve the solicitation or receipt of illegal kickbacks, which are charged under Criminal Penalties for Acts Involving Federal Health Care Programs (42 U.S.C. § 1320a-7b (b)).

Finally, in cases involving identity theft, we have occasionally pursued charges under 18 U.S.C. § 1028A (Aggravated Identity Theft), which provides for an additional term of imprisonment of 2 years that generally runs consecutively with any sentence imposed for any other related crimes.

In all of these cases, our agents work with prosecutors to develop facts supporting appropriate enhancements at sentencing.

Investigative Strategies

Strike Forces

The Medicare Fraud Strike Force, an antifraud effort in geographic areas at high risk for Medicare fraud, 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.

The typical Strike Force case differs from our traditional health care fraud investigations in the complexity and nature of the scheme. Our traditional health care fraud investigations often rely upon individuals with knowledge of the scheme, including corporate insiders. In contrast, Strike Force cases are data driven, using technology to pinpoint fraud hot spots through the identification of unexplainable billing patterns as they occur. Substantiating the allegation of fraud is more difficult when dealing with individuals as opposed to verifying the accuracy of evidence obtained directly from Medicare billing information. Also, 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 investigations are typically fully adjudicated in about 1 year, whereas traditional investigations can take up to 3 years.

OIG and DOJ first launched their Strike Force efforts in 2007 in South Florida using the expertise of staff from OIG, DOJ and the U.S. Attorney's Office for the Southern District of Florida, the FBI, and CMS 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 Los Angeles in March 2008. Today, Strike Force operations are in place in seven locations: South Florida, Los Angeles, Houston, Detroit, Brooklyn, Tampa, and Baton Rouge.

We believe that our Strike Forces have had a marked sentinel effect. Though deterrence is difficult to quantify, we have empirical evidence that our Strike Force model for investigating and prosecuting health care fraud has resulted in reductions in improper claims to Medicare. Claims data showed that during the first 12 months of the Strike Force (March 1, 2007, to February 29, 2008), claim amounts submitted for DME in South Florida, a particularly hot spot of DME fraudulent activities, decreased by 63 percent to just over $1 billion from nearly $2.76 billion during the preceding 12 months.

As of January 30, 2010, our Strike Force efforts nationwide have charged over 500 defendants, obtained over 270 convictions, resulted in the sentencing of over 200 defendants, and secured over $240 million in court-ordered restitutions, fines, and penalties.

In one Miami Strike Force case, two brothers were indicted for conspiring to submit approximately $110 million in false and fraudulent claims to the Medicare program for HIV infusion services allegedly provided at 11 corrupt HIV infusion clinics that they owned and controlled. As part of the scheme, the defendants referred Medicare beneficiaries to the clinics and directed that the beneficiaries be paid kickbacks to induce them to claim they received legitimate services at the clinics when in fact the HIV infusion services either were not provided or were not medically necessary.

The Strike Force model is especially effective for investigating and prosecuting fraud committed by sham providers masquerading as legitimate providers. This fraud is viral and migratory. However, that is only one model of health care fraud. Major corporations and institutions, such as pharmaceutical 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.

Importance of Real-Time Data Access

The Strike Forces are designed to target fraud in areas identified as being at high risk for and having high concentrations of health care fraud. OIG is implementing a new paradigm in fighting fraud by using data analysis to swiftly identify, investigate, and prosecute health care fraud perpetrators. Strike Force investigations are data driven and target individuals and groups that are actively involved in ongoing Medicare fraud schemes.

Real-time access to data is critical to the success of the HEAT Strike Force initiative. Over the last several months, representatives from OIG, CMS, and DOJ have explored ways to improve access to CMS claims data. Much of our attention has been focused on obtaining real-time data. To date, we have established limited access to real-time claims data but we are continuing to work to improve our access to these data, increase the number of investigators who have access, and expand access across all parts of the Medicare program. In addition to having access to real-time data, it is also important that we expand our access to CMS systems offering advanced analysis and query tools that can be employed in mining a comprehensive national Medicare claims database. Since the start of HEAT, OIG has sent more than 130 investigators and analysts to

claims database training and we anticipate each of them having access to the database by mid-March 2010. Other projects that are in progress at this time include:

- developing standardized summary reports for claim dollars submitted for payment, denied for payment, and allowed by Part A and B providers;
- improving investigators' access and ability to analyze Medicare Part D prescription drug event data;
- developing a more efficient and less timely process for obtaining access to CMS contractor support for trials; and
- establishing a cross-government data intelligence sharing workgroup to share ideas and success stories.

Real-time data access is also important in our traditional health care fraud investigations. There are many investigative activities performed throughout an investigation that require the agent to gather all available information to effectively plan and conduct the operation. In an effort to keep up with the criminals, immediate access to the most current claims information gives law enforcement an important advantage when interviewing witnesses and efficiently identifying subjects for investigation.

Additionally, real-time data access would enable us to more efficiently conduct field surveillance, electronic monitoring, and issue search and arrest warrants. The more current the data, the more effective our agents can be when:

- confronting a witness who may be lying or withholding information;
- identifying relevant parties, locations, and times to conduct surveillance or electronic monitoring operations in order to have the best chance to observe an ongoing criminal operation;
- planning a search warrant so that we can quickly and accurately locate evidence of a crime (including evidence that no service was provided) before perpetrators destroy, alter, or manufacture information; and
- planning an arrest warrant so that we can quickly determine the location of a subject before the subject is alerted to our investigation and has an opportunity to flee or prepare for our arrival if the subject does not intend to cooperate.

The more effective we are when conducting these operations, the less likely there will be any surprises. This helps to ensure the safety of our agents and others whom we encounter during these operations. It also increases the likelihood that our cases will succeed at prosecution.

In addition to using data to more efficiently conduct our investigations, OIG is also using data to take a more strategic approach to identifying fraud. In 2009, OIG organized the cross-component Advanced Data Intelligence and Analytics Team (Data Team) to support the work of HEAT. The Data Team includes 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 more quickly identify ongoing health care fraud schemes and trends.

The selection of Strike Force city locations is also data driven. To support this, OIG's Data Team analyzes Medicare claims data and the prevalence of unusual Medicare billing patterns in

various metropolitan areas across the United States. Specifically, the team identifies Medicare fraud "hot spots" on a national level, narrowing those results to regional trends, and then reducing those selections to specific metropolitan areas. Utilizing the findings of the Data Team, the HEAT Operations Committee was able to more effectively strategize in determining the next locations for Strike Force operations.

OIG is also capitalizing on cutting-edge electronic discovery tools to maximize investigative efficiency in the processing and review of voluminous electronic evidence obtained during the course of our health care fraud investigations. This technology is Web-based and has been made available to OIG investigators throughout the organization to increase investigative efficiency and effectiveness. OIG was the first Federal law enforcement agency to implement this technology. It enables OIG to analyze large quantities of email or other electronic documents more efficiently, and to associate or link emails contained in multiple accounts based on content and metadata. Recently, OIG has expanded the use of this technology by making it available to our external law enforcement partners for use in joint investigations. This effort strengthens OIG's relationships with partner law enforcement agencies and allows for much greater collaboration. Because the technology is Web-based and can be accessed securely over the internet, investigators can use this tool from anywhere in the country.

Conclusion

The examples that I have discussed today are critical aspects of a multi-departmental effort to protect the health, vitality, and integrity of Federal health programs, as well as protect the finite resources dedicated to pay for these services and programs. OIG is committed to investing in program integrity efforts in order to send a clear message that criminal 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 suppliers will instead be available for legitimate businesses whose purpose is to serve the critical health care needs of our program beneficiaries. And most importantly, we can ensure that seniors and persons with disabilities receive the necessary supplies and care they need to stay healthy, so as to enjoy enhanced wellbeing and quality of life.

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

Mr. SCOTT. Thank you.
Mr. Collins.

TESTIMONY OF D. MARK COLLINS, ASSISTANT ATTORNEY GENERAL, DIRECTOR OF NEBRASKA MEDICAID FRAUD CONTROL UNIT, PRESIDENT OF THE NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS, LINCOLN, NE

Mr. COLLINS. Thank you, Chairman Scott, Chairman Conyers, Ranking Member Gohmert, Members of the Committee. I am Mark

Collins. I am director of the Nebraska Medicaid Fraud Control Unit in the Nebraska Attorney General's Office and also president of the National Association of Medicaid Fraud Control Units.

As you all know, Medicaid is financed by both Federal and State funds and administered by each State. And although most taxpayer dollars go directly toward providing essential medical care to the intended beneficiaries of the program, there is a tremendous amount of money that is lost to fraud, waste and abuse.

The Medicare and Medicaid antifraud and abuse amendments enacted by Congress in the 1970's established the State Medicaid Fraud Control Unit program and provided the States with the incentive funding to investigate and prosecute Medicaid provider fraud, and also to prosecute abuse and neglect of patients in Medicaid-funded residential health facilities, and to investigate fraud in the administration of the Medicaid program.

Medicaid Fraud Control Units are law enforcement agencies, and they are primarily responsible for monitoring each State's Medicaid program. MFCUs have investigated and prosecuted some of the largest and most sophisticated frauds ever committed against the program.

And they also work to identify and implement systemic reform initiatives in the administration of the Medicaid program by advocating for legislation, exposing emerging trends of abusive practices, and collaborating on technological solutions and safeguards against fraud.

Since the inception of the National MFCU program in 1978, the 50 Medicaid Fraud Control Units have obtained thousands of criminal convictions and recovered hundreds of millions of dollars in restitution.

Perhaps even more importantly, and more important than any specific prosecution, these units have demonstrably deterred the loss of many more hundreds of millions of dollars in Medicaid overpayment.

The National Association of Medicaid Fraud Control Units, which we call NAMFCU, was established in 1978 to provide a forum for nationwide sharing of information concerning the challenges of Medicaid fraud control.

NAMFCU fosters interstate cooperation on law enforcement and Federal issues regarding MFCUs, conducts training programs to improve the quality of Medicaid fraud investigations and prosecutions, gives technical assistance to our association members, and provides the public with information about the MFCU program.

Beginning with the first global settlement case in 1992, NAMFCU has effectively coordinated State-Federal investigations of settlements, primarily involving pharmaceutical companies.

In the past decade, State MFCUs have seen a rapid increase in both the number of fraudulent schemes targeting Medicaid dollars and the degree of sophistication with which they are perpetrated.

Typical fraud schemes included—will include billing for services never rendered, double billing, misrepresenting the nature of services provide, providing unnecessary services, submitting false cost reports, and paying illegal kickbacks.

MFCUs continually adapt their investigative and prosecutorial techniques to curtail and to anticipate new and innovative methods of thievery.

The Office of Inspector General at the U.S. Department of Health and Human Services provides oversight to State MFCUs. One important feature of the MFCU oversight program is to cultivate close and effective working relationships between State and Federal agencies to combat fraud and abuse in the Medicaid programs of all the various States.

All MFCUs work closely with the Offices of the United States Attorney in their respective districts and with Federal law enforcement agencies such as the U.S. Department of Justice, the FBI, HHS OIG, the IRS and the Postal Service.

MFCUs actively participate in State-Federal health care fraud task forces and working groups that operate in virtually every State in the Nation.

The Federal False Claims Act contains qui tam provisions that provide the authority and financial incentive for private individuals or relators to enforce the act on behalf of the government. Qui tam relators are often called whistleblowers, and they are generally current or former employees of target entities.

Twenty-five States currently have false claims statutes with qui tam provisions. An increasing number of relators are filing their cases with the States as well as with the Federal Government, and this development has fostered a significant increase in State-Federal investigative partnerships.

The National Association of Medicaid Fraud Control Units encourages States to look beyond their individual State perspectives and to participate in global cases. NAMFCU coordinates these multistate investigations, often appointing NAMFCU investigative and settlement teams.

And if settlements are reached, per NAMFCU protocol, then all State recoveries are allocated to each State based upon their actual damages. Multistate cases in which the MFCUs have played a role have resulted in the recovery of over $5 billion to the Medicaid program.

In an historic 2009 case against Pfizer, Pfizer and its subsidiaries agreed to pay Medicaid and Medicare and other Federal programs a total of $2.3 billion to resolve civil and criminal allegations against kickback and illegal off-label marketing campaigns.

As we have done for the past 30 years, State Medicaid Fraud Control Units continue to play a national leadership role in investigating and prosecuting health care fraud and resident abuse and will continue to do so in the future.

Thank you for your time today and allowing me to testify and would look forward to any questions that you may have.

[The prepared statement of Mr. Collins follows:]

PREPARED STATEMENT OF D. MARK COLLINS

TESTIMONY
OF
D. MARK COLLINS

ASSISTANT ATTORNEY GENERAL
DIRECTOR, NEBRASKA, MEDICAID FRAUD CONTROL UNIT AND
PRESIDENT, NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS

BEFORE

U.S. HOUSE JUDICIARY SUBCOMMITTEE ON
CRIME, TERRORISM AND HOMELAND SECURITY

"Enforcement of the Criminal Laws Against Medicare and Medicaid Fraud"

MARCH 4, 2010

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you today to discuss the role of the states in investigating and prosecuting Medicaid fraud. I am Mark Collins, Director of the Nebraska Medicaid Fraud Control Unit in the Nebraska Attorney General's Office. I am very pleased to speak to you today as the representative of the National Association of Medicaid Fraud Control Units, of which I currently serve as President.

INTRODUCTION

The Medicare-Medicaid Anti-Fraud and Abuse Amendments, enacted by Congress in the 1970s, established the state Medicaid Fraud Control Unit Program and provided the states with incentive funding to investigate and prosecute Medicaid provider fraud, to prosecute the abuse and neglect of patients in all Medicaid-funded residential health care facilities and to investigate fraud in the administration of the Medicaid program. The Ticket to Work and Work Incentives Improvement Act of 1999 authorizes Medicaid Fraud Control Units (MFCUs), with the approval of the Inspector General of the relevant federal agency, to investigate fraud in other federally-funded health care programs if the case is primarily related to Medicaid. This law authorizes MFCUs, on an optional basis, to investigate and prosecute resident abuse or neglect in non-Medicaid board and care facilities and emphasizes the necessity of having an integrated multi-disciplinary team of attorneys, investigators and auditors working full-time on Medicaid fraud cases in order to successfully prosecute these complex financial crimes. MFCUs are required to be separate and distinct from the state Medicaid programs to avoid institutional conflicts of interest.

MFCUs are usually located in the state Attorney General's office, although some Units are located in other state agencies with law enforcement responsibilities, such as the state police or the state Bureau of Investigation. Since the inception of the national MFCU program in 1978, the fifty Medicaid Fraud Control Units have obtained thousands of convictions and recovered hundreds of millions of dollars in restitution. Perhaps even more important than any specific prosecution or recovery, these Units have demonstrably deterred the loss of many more hundreds of millions of dollars in Medicaid overpayments.

Because the federal government provides 75 percent of each Unit's costs, with the remaining 25 percent funded by the state, each MFCU operates under the administrative oversight of the Inspector General of the U.S. Department of Health and Human Services (HHS-OIG) and each Unit must be annually recertified. This funding formula allows the federal government to ensure that each Unit's activities are directed exclusively at provider fraud, fraud in the administration of the program and resident abuse or neglect, rather than at crimes lacking an appropriate Medicaid nexus.

HISTORY OF THE MFCU PROGRAM

Medicaid was enacted by Congress in 1965 to provide a comprehensive range of medical services to people with disabilities and America's poorest citizens. It is sometimes confused with Medicare, the federal health insurance program for people sixty-five years of age and older and their eligible dependents. However, unlike Medicare, which is federally-funded and provides the

same benefit coverage nationwide, Medicaid is financed by both federal and state funds and is administered by each state. In addition to all fifty states, the District of Columbia and the territories participate in the Medicaid program.

Although Medicaid benefits might differ from state to state, a common problem plaguing the program since the mid-1960s has been its skyrocketing costs. The reasons are many; they include pay and chase claims processing, increased enrollment, the rising cost of medical care and prescription drugs, the frequency with which services are used and the lack of explanation of benefit forms sent to Medicaid recipients. Although most taxpayer dollars go directly toward providing essential medical care for the intended beneficiaries of the program, a tremendous amount of money is lost to fraud, waste and abuse.

The lack of comprehensive safeguards in the initial Medicaid legislation gave a small but greedy group of individuals free rein to steal millions of taxpayer dollars during Medicaid's first decade of operation. Additionally, Medicaid's costs began their upward spiral shortly after the program was begun. Congressional hearings confirmed that widespread misappropriation of taxpayer funds by a handful of unscrupulous health care providers was partly to blame for this rapid cost increase.

While numerous Congressional hearings were bringing such abuses to light, it became clear that states such as New York, where a separate statewide investigative entity had been established, were able to substantially increase the rate of prosecutions and convictions and the recovery of taxpayer dollars.

Medicaid Fraud Control Units are the law enforcement agencies primarily responsible for monitoring each state's Medicaid program. The MFCUs have uncovered some of the largest and most sophisticated frauds ever committed against the program. The Units have seen wave after wave of fraud sweeping through nursing homes and hospitals, clinics and pharmacies, podiatrists, labs, home health care providers and durable medical equipment vendors and, more recently, pharmaceutical companies. Each surge has brought its own special brand of profiteer in search of the next great loophole in the Medicaid program.

In addition to fulfilling their primary investigative and prosecutorial functions, the MFCUs work to identify and implement systemic reform initiatives in the administration of the Medicaid program. In an effort to maximize their effectiveness, the MFCUs have:

- Identified pharmaceutical products not subject to federal upper limit pricing, leading to the imposition of state upper limits on the pricing of many high-volume and high-cost prescription drugs;

- Developed and implemented changes in the approval process for Medicaid payments for durable medical equipment (including wheelchairs, specialty beds and therapeutic footwear) to ensure that expenditures for these goods are made only when they are medically necessary and accurately coded;

- Identified, investigated and remedied abusive or fraudulent patterns and practices in the submission of expenses in the nursing home cost reporting system;
- Implemented computer edits and controls in the automated Medicaid payment process to safeguard against improper disbursements;
- Redefined program integrity protocols;
- Identified computer software problems in Medicaid pharmacy billing programs;
- Provided training and technical assistance to improve fraud detection methods utilized by medical peer review organizations employed by the Medicaid program;
- Recommended and implemented changes in Medicaid provider enrollment screening processes to provide for effective background checks;
- Identified improper billing for clinical laboratory testing that was not medically necessary;
- Developed a computerized tracking system to identify and prevent perpetrators of resident abuse from being rehired;
- Worked with the HHS-OIG to develop protocols and procedures for a voluntary disclosure program that provides ongoing guidance to the health care industry and encourages providers to evaluate themselves, promptly report overpayments and voluntarily disclose improper conduct;
- Drafted and successfully advocated for passage of legislation requiring background checks of home health aides and nursing home employees; and
- Assisted the Offices of the State Auditor and the United States Attorney in the investigation of mental health counseling corporations.

NATIONAL ASSOCIATION OF MEDICAID FRAUD CONTROL UNITS (NAMFCU)

The National Association of Medicaid Fraud Control Units (NAMFCU) was established in 1978 to provide a forum for the nationwide sharing of information concerning the challenges of Medicaid fraud control. NAMFCU fosters interstate cooperation on law enforcement and federal issues affecting the MFCUs, conducts training programs to improve the quality of Medicaid fraud investigations and prosecutions, gives technical assistance to Association members and provides the public with information about the MFCU program. The Association also gathers, coordinates and disseminates information to the various MFCUs, maintains a library of resource materials and provides informal advice and assistance to its member Units.

Of the 50 MFCUs that comprise the Association, 43 are located in state the Offices of the Attorney General and seven are located in other state agencies.

NAMFCU is called upon regularly to supply speakers for numerous health care fraud seminars. The Association's newsletter, the *Medicaid Fraud Report*, is published six times a year and contains information concerning prosecutions by various states and reports of legal decisions affecting fraud control. Beginning with the first global settlement case in 1992, NAMFCU has effectively coordinated multistate/federal investigations and settlements, primarily involving pharmaceutical companies.

PROVIDER FRAUD SCHEMES

In the past decade, state MFCUs have seen a rapid increase in both the number of fraudulent schemes targeting Medicaid dollars and the degree of sophistication with which they are perpetrated. Although the typical fraud schemes – billing for services never rendered, double-billing, misrepresenting the nature of services provided, providing unnecessary services, submitting false cost reports and paying illegal kickbacks – still regularly occur, new and often innovative methods of thievery continue to appear.

Perpetrators of Medicaid fraud run the gamut from the solo practitioner who submits claims for services never rendered to large institutions that exaggerate the level of care provided to their patients and then alter patient records in order to conceal the resulting lack of care. MFCUs have prosecuted psychiatrists who demanded sexual favors from their patients in exchange for prescription drugs, nursing home owners who stole money from residents and even funeral directors who billed the estates of Medicaid patients for funerals they did not perform.

SELECTED STATE MEDICAID FRAUD INVESTIGATIONS, PROSECUTIONS AND SETTLEMENTS

MFCUs have identified serious incidents of fraud in numerous sectors of the health care industry, including hospitals, home health care agencies, medical transportation and durable medical equipment companies, pharmacies and medical clinics. They have prosecuted individual providers such as physicians, dentists and mental health professionals.

Examples of recent Medicaid Fraud cases follow:

PHYSICIANS

- In Arizona, a physician was charged with 14 felony crimes related to his health care practice, including conspiracy, assisting a criminal syndicate, money laundering and illegally administering narcotic drugs.

In addition, the investigation determined that the physician filed more than 31,900 claims for insurance reimbursement between 2004 and 2009, far in excess of what could be possible to comply with appropriate medical standards during the hours he saw patients. Claims submitted to the Arizona Medicaid program totaled nearly $8 million. Medicaid paid the physician $2.5 million. In addition, more than $1 million was paid to the physician for claims submitted to Medicare and other insurance companies. The Arizona Attorney General's Office has seized over $2 million of the physician's assets as part of this joint state/federal case.

- Following a two week trial, a physician in the District of Columbia was found guilty of one count of Health Care Fraud and sixteen counts of false statements in a health care matter for billing Medicaid over $700,000 for procedures and office visits that never occurred.

- A Nevada pediatric group was accused of submitting claims for multiple dates of service and for tests and services that were either not performed or were improperly billed. The corporation pled guilty to one count of felony Medicaid Fraud and entered into a civil settlement agreement, without admission of liability, in which it agreed to pay $475,000 ($350,000 in restitution and $125,000 in costs).

- In Pennsylvania, a physician who was board certified in neonatal medicine submitted hundreds of false claims for an expensive procedure that he did not perform. He defrauded the South Carolina and Pennsylvania Medicaid programs, the TriCare program and several private insurance programs for a total of more than $8 million. He is expected to plead guilty, be sentenced to 96 months in a federal prison and pay the remaining restitution of $7,116,423.

- Two Washington state providers, one a physician, maintained a medical practice where they treated patients for pain management. They were indicted for unlawfully billing several governmental health care benefit programs and prescribing Methadone, Oxycontin and Oxycodone for improper purposes, resulting in at least one death. The physician was sentenced to nine months in prison and ordered to pay restitution and fees.

- A South Dakota physician reached a civil settlement to resolve allegations that he employed unlicensed personnel as nurses. The $57,000 settlement includes reimbursement to the Medicaid and Medicare programs.

MEDICAL TRANSPORTATION

- An investigation in North Carolina revealed that a Medicaid provider of medical transportation services had routinely transported approximately fifteen Medicare and Medicaid recipients to their dialysis treatments by wheelchair vans, but billed the government programs as if ambulance transport was necessary and provided.

Hours of surveillance and consensual monitoring provided evidence that the company was falsifying medical records to disguise wheelchair transports as ambulance transports. The owner of the company was sentenced to 24 months in prison and ordered to pay full restitution of $948,542.36 to the Medicare and Medicaid programs.

- In Rhode Island, surveillance of a medical transportation company showed that elderly individuals were transported in vehicles that were not equipped with wheel chair lifts, as required by state Medicaid policy. An audit of the company's billing revealed that the company billed $303,984 for services in unauthorized vehicles. The company entered into a settlement agreement with the state for the full amount along with $10,000 in investigative costs.

MENTAL HEALTH PROVIDERS

- A MFCU investigation established that a Florida psychiatrist submitted claims to both Medicaid and Medicare for treating up to 78 patients a day and billing up to 58.8 hours a day over a period of 18 months. He was paid $317,286.63 by Medicare and $313,170.71 by private insurance during this period. A civil action filed by the MFCU resulted in a settlement in the amount of $720,000 to resolve allegations of Medicaid fraud.

NURSING HOMES

- Following an audit of a Tennessee nursing home, questions were raised about possible misappropriation of funds relating to bonuses paid to the administrators and other staff. An agreement directed that the two former administrators and the nursing home collectively pay a total of $200,000 in fines and restitution.

PHARMACIES

- Eleven individuals and corporations, including three pharmacies, were indicted in connection with New Jersey's Operation PharmScam. The PharmScam investigation revealed a group of health care providers and pharmacists defrauding the state in connection with expensive HIV and AIDS drugs. The pharmacies would pay cash, usually $40 to $50, for prescriptions for HIV/AIDS drugs, then bill Medicaid as though the medication was dispensed to the patient. However, no medication was ever dispensed.

- A South Carolina pharmacist who operated a family-owned independent pharmacy allegedly billed for medications that were not dispensed. The South Carolina MFCU obtained records to verify that the pharmacist billed for more units of two antibiotics than he actually dispensed. The pharmacist was arrested and charged with two counts of filing false claims. The overall exposure to the Medicaid program over the 15-month period of the scheme was approximately

$145,000. The pharmacist pled guilty and the state Medicaid program was fully reimbursed.

DENTISTS

- A dentist in Kentucky engaged in a pattern of pulling patients' teeth, generally one at a time, and prescribing 16 doses of hydrocodone each time. Most patients had all of their teeth extracted by the dentist. He billed Medicaid for the extractions, many of which were medically unnecessary. Additionally, he made more money from Medicaid by extracting the teeth one at a time. The dentist entered an "Alford" plea and received concurrent sentences of five years on one count of Medicaid fraud and three counts of drug trafficking. Additionally, he was ordered to pay restitution of $4,900 and investigative costs of $3,000.

- In Missouri, a dentist was charged with 13 felony counts of Medicaid fraud. The dentist engaged in upcoding, unbundling services and billing for x-rays, root canals and fillings that were not performed. During the investigation, the dentist withheld records, created false dental records and even cut off portions of the records to conceal his fraud.

HOME HEALTH

- In Alaska's largest Medicaid fraud case, the owner of a home health care agency pled guilty to a felony count for defrauding the Alaska Medicaid program of over $1.3 million. There were several different schemes involved, including billing for services never rendered and billing for Medicaid recipients who did not qualify for the personal care attendant program. The owner was sentenced to three years in jail with 28 months suspended, ten years of suspended probation and was ordered to pay $800,000 in restitution.

- A Minnesota personal care provider agency that provided private duty nursing services and personal care assistant services was owned and operated by a licensed practical nurse. The nurse was providing LPN services without a current registration with the state Board of Nursing. A MFCU investigation revealed that the owner submitted claims for RN services when the services were provided by an LPN. The provider pleaded guilty to theft and was ordered to serve 364 days in jail, to pay Medicaid restitution of $57,185.56 and to be on supervised probation for five years.

- The New York MFCU and the federal government reached a $24 million settlement with three home health agencies, alleging that the agencies defrauded the Medicaid program. This is the largest settlement that the New York MFCU has reached with the home health industry.

During the course of its industry-wide investigation, the MFCU discovered that one of the agencies employed hundreds of home health aides who had fraudulent certifications obtained from corrupt training schools. These improperly-trained aides were subsequently assigned to work for the other two home health agencies, which sent them daily into the homes of New York's elderly, frail and indigent to provide care. As a result, these aides caused Medicaid to be billed millions of dollars for services they were not qualified to provide.

The settlement resolved allegations that the home health agencies knowingly presented, or caused to be presented, false claims to Medicaid. In addition to the payment of the settlement amount, all three agencies will be subject to the terms of a corporate integrity agreement.

- A family of four was convicted of masterminding an eight-year fraud in Oregon. The four received more than $230,000 in Social Security disability and Medicaid in-home care payments. Although the state conducted annual in-home assessments, the husband and wife were able to fool investigators into believing that the husband needed around-the-clock care. Surveillance by the MFCU revealed that the husband was not disabled.

DURABLE MEDICAL EQUIPMENT

- The California MFCU and HHS-OIG conducted an expansive joint-investigation of a durable medical equipment (DME) provider. Investigators identified over 1,400 persons of interest, pursued approximately 100 leads across the United States and executed searches of established DME locations, banks and co-conspirators.

  One family linked to the operation of this criminal enterprise lived in a million-dollar home and drove luxury vehicles, yet they also took advantage of Medi-Cal and county assistance, including school lunch programs and rent programs to cover their residential loan payments. To date, over $6.3 million has been seized from bank accounts related to the DME provider

OTHER PROVIDERS

- Two Idaho denturists billed Medicaid for dentures that were never made. When a Medicaid patient came to the clinic, the denturists obtained the patient's Medicaid card and immediately billed Medicaid. This forced the patient to return to those denturists, thus cutting out competitors. In some instances, the denturists even billed for people who still had teeth in their mouths.

- An investigation in Illinois alleged that an optometrist and his corporation operated a scheme to fraudulently bill Medicare and Medicaid for optometry services as rural health services and to use unqualified personnel to conduct the

eye exams over a five-year period. Undercover visits confirmed the fraud. The defendant entered a negotiated plea of guilty to misdemeanor Health Care Fraud and a negotiated plea of guilty to felony Health Care Fraud for his corporation in federal district court. As part of the plea, the optometrist immediately paid approximately $325,000 in restitution for fraud committed against the Illinois Medicaid program and the federal Medicare program.

- The owner of an Oklahoma respiratory services company was renting oxygen concentrators to Medicaid recipients. The concentrators were supposed to come with all the tubing, cannulas and other supplies. However, the owner devised a scheme to unbundle the accessories and bill for them separately. A jury trial was held and the owner was found guilty and ordered to pay a fine of $95,222.

- A West Virginia physician assistant wrote medically unnecessary prescriptions to patients in exchange for money or cocaine. He falsified patient records in an attempt to show medical necessity for the fraudulent prescriptions. He pled guilty to Intent to Distribute Hydrocodone and was sentenced to one year in prison.

- A community-based drug and alcohol abuse treatment provider in Kansas billed and was paid by the state Medicaid program for substance abuse treatment services reportedly provided to 81 Medicaid beneficiaries, all of whom were younger than 12 years old. As a result of these fraudulent claims, the provider was paid in excess of $3.76 million.

  A federal grand jury indicted the provider on 81 counts of Health Care Fraud for billing services that were not medically necessary and were never provided. On the eve of trial, the defendant pled guilty to one count of Health Care Fraud. She was ordered to serve two years in a federal penitentiary, followed by three years supervised probation. She was also ordered to pay full restitution to the Medicaid agency. A forfeiture judgment in the amount of $3.76 million was also entered against the provider.

- A Maryland podiatrist fraudulently billed both the Medicaid and Medicare programs for podiatry services allegedly provided to residents in nursing homes and at senior centers. However, those services either were not necessary, not documented or not provided. The podiatrist billed for invasive surgical procedures such as an incision and drainage, when in fact all he did was cut the patients' toe nails.

  Following an extensive joint investigation by the MFCU and HHS-OIG, the podiatrist pled guilty to Medicaid fraud and theft from the Medicare program. He was sentenced to five years incarceration, with all but 14 months suspended, with the 14 months to be served on home detention. He was also ordered to pay restitution and penalties of $400,000, placed on five years unsupervised probation

and ordered to perform 200 hours community service. The podiatrist paid $50,000 in restitution to the Medicaid program on the day of sentencing.

- In Vermont, a provider who owned and operated a traumatic brain injury program agreed to pay $201,043 in Medicaid restitution pursuant to a civil agreement with the Vermont Medicaid Fraud and Resident Abuse Unit. The agreement resolved allegations that the provider billed Medicaid for more than the maximum allowable number of days in the month and for more overnight charges than were possible. In other instances, the same provider billed for services when a client was hospitalized or had died.

- A husband and wife operated a therapy center in Arkansas and contracted with therapists to perform services for Medicaid recipients. The owners submitted false claims to Medicaid, including claims for services that recipients could not have received because they were in the hospital, out of town or involved in an activity that would have prevented them from receiving therapy. In addition, the therapy center made fraudulent claims by overstating the number of hours the therapists worked. The owners pled guilty to felony Medicaid fraud and were excluded from participating in the Medicaid program.

- A settlement was reached in a Medicaid quality of care case involving a profoundly disabled resident of a group home in Nebraska. The group home was not equipped to properly care for her and as a result she was severely neglected. Medicaid paid the group home owners more than $75,000 to care for the resident. The owners agreed to settle the matter with the Medicaid Fraud Control Unit for $175,000, including restitution, additional damages and costs.

MFCU GLOBAL INVESTIGATIONS AND SETTLEMENTS

One important feature of the MFCU program is to cultivate close and effective working relationships between state and federal agencies to combat fraud and abuse in the Medicaid programs of the various states. These cooperative efforts have grown out of the relationship between MFCUs and HHS-OIG, which has oversight over the MFCU program. Medicaid fraud is a crime under both state and federal statutes and may be prosecuted in both state and federal courts. Consequently, all MFCUs work closely with the Offices of the United States Attorneys in their respective states and with federal law enforcement agencies such as the U.S. Department of Justice, the FBI, HHS-OIG, the Internal Revenue Service and the U.S. Postal Service. MFCUs actively participate in state-federal health care fraud task forces and working groups that operate in virtually every state in the nation.

Cooperative efforts between state and federal authorities are very effective in protecting the Medicaid and Medicare programs from health care providers or vendors who defraud both programs and whose misconduct occurs in multiple states. Multi-state cases in which the MFCUs played a role have resulted in the recovery of over $5 billion to the Medicaid program. Defense

attorneys recognize that settling an investigation brought by one state Medicaid program does not resolve Medicaid claims in other states and that most states, like the federal government, have the authority to exclude a convicted provider from their health care programs. Accordingly, resolution of these cases would be difficult or impossible if the targets were required to negotiate separate terms and obtain separate settlement agreements from each state.

The National Association of Medicaid Fraud Control Units encourages states to look beyond their individual state perspective and to participate in global cases. These cases succeed only with the cooperation of all state MFCUs, whose goal is to protect the integrity of the entire state Medicaid program.

The federal False Claims Act (FCA) includes *qui tam* provisions that provide the authority and financial incentive for private individuals or "relators" to enforce the Act on behalf of the government. *Qui tam* relators, often called "whistleblowers," generally are current or former employees of target entities. The FCA protects relators from retaliatory actions by their employers. A *qui tam* complaint is filed under seal in federal district court and remains under seal for at least 60 days (and often much longer) to allow the government to conduct a thorough investigation. In addition, twenty-five states currently have state false claims statutes with *qui tam* provisions, and an increasing number of relators are filing their cases with the states as well as the federal government. This development has fostered a significant increase in state/federal investigative partnerships.

The state MFCUs are generally notified about an ongoing investigation when the United States Department of Justice or a United States Attorney's Office, relator's counsel, defense attorney, or other source, contacts the National Association of Medicaid Fraud Control Units and requests the assistance of the MFCUs. NAMFCU obtains relevant information and then prepares a list of states affected by the suspected wrongdoing. The NAMFCU President then determines if it is appropriate for the states to participate and whether a NAMFCU investigative team should be appointed.

If the investigation reaches the settlement stage, the NAMFCU team contacts the defendant to set out basic ground rules, including the framework for negotiations (exclusion/ non-exclusion, criminal pleas and/or civil settlement, the payment of the team's expenses attributable to the negotiations, etc.). In joint state-federal cases, this process takes place in cooperation with federal attorneys assigned to the matter.

There are other crucial factors to consider in a settlement. These include the provider's ongoing economic viability, the effect on shareholders, potential employment impact on specific communities and the effect that exclusion from Medicaid, Medicare and other state and federal health care payment programs will have upon a Medicaid beneficiaries' access to adequate and convenient medical care. Settlements may include additional terms such as incarceration of employees or officers, corporate reorganization and compliance or corporate integrity agreements. The negotiations are highly confidential and often are governed by grand jury secrecy requirements, *qui tam* provisions, privilege issues and Securities and Exchange Commission statutes and regulations.

Per NAMFCU protocols, all state recoveries are allocated based upon a state's actual damages. The participating states usually supply state-specific data regarding the defendant's billings, although it is sometimes possible to calculate state losses from information supplied by the federal government or through discovery from the defendant. Each NAMFCU settlement team, in conjunction with its partners in the federal government, is committed to negotiating for the best settlement possible for its member states and will, in appropriate circumstances, seek penalties as well as damages.

Examples of recent state-federal global settlements follow:

PFIZER

Pfizer, Inc. agreed to settle civil and criminal allegations that the company and its subsidiaries paid kickbacks and engaged in off-labeling marketing campaigns that improperly promoted numerous drugs that Pfizer manufactures. This is the largest settlement in history in a health care fraud matter. Pfizer paid the states and the federal government a total of $1 billion in civil damages and penalties to compensate Medicaid, Medicare and various federal healthcare programs for harm suffered as a result of its conduct.

The state and federal governments alleged that Pfizer, the largest pharmaceutical manufacturer in the world, engaged in a pattern of unlawful marketing activity to promote multiple drugs for uses that were not approved by the Food and Drug Administration (FDA). While it is not illegal for a physician to prescribe a drug for an unapproved use, federal law prohibits a manufacturer from promoting a drug for uses not approved by the FDA. This promotional activity included:

- Marketing Bextra for conditions and dosages other than those for which it was approved;
- Promoting the use of the antipsychotic drug Geodon for a variety of off-label conditions such as attention deficit disorder, autism, dementia and depression for patients that included children and adolescents;
- Selling the pain medication Lyrica for unapproved conditions;
- Making false representations about the safety and efficacy of Zyvox, an antibiotic only approved to treat certain drug resistant infections.

Pfizer was also alleged to have illegally paid health care professionals to induce them to promote and prescribe thirteen different drugs. These payments allegedly took many forms, including entertainment, cash, travel and meals. Federal law prohibits payment of anything of value in exchange for prescribing a product paid for by a federal health care program.

As a condition of the settlement, Pfizer entered into a corporate integrity agreement with HHS-OIG, which will closely monitor the company's future marketing and sales practices.

In addition, a Pfizer subsidiary, Pharmacia & Upjohn Company, Inc., pled guilty to a felony violation of the Food, Drug, and Cosmetic Act for engaging in the illegal marketing and promotion of Bextra, an anti-inflammatory drug that Pfizer pulled from the market in 2005. The subsidiary paid a criminal fine and forfeiture of $1.3 billion.

This settlement was based on nine federal and state *qui tam* cases that were filed in the United States District Court for the Districts of Massachusetts, the Eastern District of Pennsylvania and the Eastern District of Kentucky.

FORBA HOLDINGS, LLC

Twenty-two states and the federal government settled allegations against FORBA Holdings LLC, a dental management company that provided management services to a national chain c pediatric dental clinics operating under the name of "Small Smiles." It was alleged that thes services were either medically unnecessary or performed in a manner that failed to mee professionally-recognized standards of care. These services included performing pulpotomies (bab root canals), placing crowns, administering anesthesia (including nitrous oxide), performin extractions, providing unneeded fillings and/or sealants and using inappropriate behavic management techniques to restrain pediatric patients.

To resolve these allegations, FORBA agreed to pay $24 million plus interest. In addition, FORBA agreed to enter into a five-year corporate integrity agreement with HHS-OIG. The agreement establishes procedures and reviews to avoid and promptly detect any further inappropriate conduct. Specifically, FORBA must engage external reviewers to monitor its quality of care and reimbursement. In addition, the Chief Dental Officer must develop and implement policies and procedures to ensure that the Small Smiles clinics provide services consistent with professionally-recognized standards of care.

This investigation was initiated by three whistleblower lawsuits filed under the *qui tam* provisions of the federal False Claims Act pending in the United States District Court for the District of Maryland, the Western District of Virginia and the District of South Carolina.

OMNICARE AND IVAX

Omnicare, Inc. is a Delaware corporation headquartered in Covington, Kentucky that specializes in providing pharmacy services to long term care facilities. IVAX Pharmaceuticals, Inc. is a Florida corporation headquartered in Weston, Florida that manufactures generic drugs.

State and federal governments alleged that Omnicare and other entities engaged in several unlawful kickback schemes including the following:

- Omnicare solicited and received $8 million in exchange for agreeing to purchase $50 million in generic drugs from IVAX Pharmaceuticals and to drive utilization of the generic drugs for their nursing home patients;

- Omnicare paid $50 million to certain nursing home chains in exchange for 15-year contracts with each company to refer residents to Omnicare for their drug purchases;

- Omnicare provided pharmacy consultants to long term care facilities throughout the country at below market rates in exchange for the facilities' agreement to exclusively use the company's pharmacy services for their patients; and

- Omnicare solicited and received kickback payments in exchange for the company's agreement to convince physicians to prescribe the antipsychotic drug Risperdal as an initial drug or in place of competitors' antipsychotic drugs.

Omnicare and IVAX agreed to settle allegations that they engaged in unlawful kickback schemes that defrauded federal and state healthcare programs. The states and the federal government received a total of $112 million in civil damages to compensate the Medicaid and Medicare programs for harm suffered as a result of the kickbacks. Omnicare and IVAX also entered into corporate integrity agreements with HHS-OIG, which will closely monitor the companies' practices.

These settlements were based on five separate *qui tam* lawsuits filed by private individuals and consolidated in the United States District Court for the District of Massachusetts under state and federal false claims statutes.

MYLAN, UDL LABORATORIES, ASTRAZENECA AND ORTHO McNEIL

Four pharmaceutical companies agreed to pay a total of $124 million to resolve claims that they violated the federal False Claims Act by failing to pay appropriate rebates for drugs paid for by Medicaid.

Mylan Pharmaceuticals, Inc., UDL Laboratories, Inc., AstraZeneca Pharmaceuticals LP and Ortho McNeil Pharmaceutical, Inc. are participants in the Medicaid Rebate Program and executed Rebate Agreements with the United States. By agreeing to participate in the Medicaid Rebate Program and signing these Rebate Agreements, the companies agreed to pay quarterly rebates to Medicaid based upon the amount of money that Medicaid paid for each company's drugs. The precise amount of a rebate is determined in part by whether a drug is considered an "innovator" drug or a "non-innovator" drug. The rebate that must be paid for innovator drugs is higher than the rebate for non-innovator drugs.

Each of the companies agreed to pay a settlement to resolve allegations that it had sold innovator drugs that were manufactured by other companies and classified those drugs as non-

innovator drugs for Medicaid rebate purposes. As a result of the improper classification of these drugs, the companies underpaid their rebate obligations to the Medicaid program.

Mylan and UDL paid $118 million to resolve allegations that they underpaid their rebate obligations with respect to twelve Mylan drugs and ten UDL drugs AstraZeneca paid $2.6 million to resolve allegations that it underpaid its rebate obligations with respect to Albuterol. Ortho McNeil paid $3.4 million to resolve allegations that it underpaid its rebate obligations with respect to Dermatop. From the total, $7,279,135 was paid to entities that participated in the Public Health Service's Drug Pricing Program.

QUEST DIAGNOSTICS

A $12.4 million national Medicaid civil settlement was reached with Quest Diagnostics, Inc. and its former subsidiary Nichols Institute Diagnostics.

This settlement followed the April 2009 resolution of federal allegations involving the same conduct. The federal and state cases stemmed from a *qui tam* lawsuit which alleged that certain test kits manufactured by Nichols and used by laboratories to measure parathyroid levels in blood samples produced an unacceptable level of elevated results. The test kits at issue were generally used by medical practitioners to determine if patients suffering from End Stage Renal Disease also had overactive parathyroid glands. The government also alleged that there were problems with the accuracy of certain additional Nichols tests during specified limited time periods. Quest Diagnostics denied the government's civil allegations but agreed to the settlement. The test kits at issue were disproportionately billed to Medicare, meaning the payments by state Medicaid programs for these tests were limited.

In April 2009, Nichols pled guilty in federal court to misbranding charges under the Food, Drug and Cosmetic Act. Quest voluntarily closed Nichols in April 2006, before the federal criminal case was brought.

The $12.4 million civil recovery for the state Medicaid programs correlates with the amount the state Medicaid programs paid for all of the allegedly inaccurate Nichols tests. As part of the federal and state settlements, Quest entered into a corporate integrity agreement that, among other things, requires it to retain an expert to review how compliance concerns are communicated to senior management and the Quest Board of Directors.

CONCLUSION

As they have done for the past thirty years, state Medicaid Fraud Control Units continue to play a national leadership role in investigating and prosecuting health care fraud and resident abuse, and will continue to do so in the future. MFCUs aggressively identify and prosecute, both civilly and criminally, those who seek financial gain at the expense of the Medicaid program. By doing so, MFCUs deter health care fraud, identify program savings, and remove incompetent practitioners from the health care system. Equally important, the MFCUs protect our nation's

most vulnerable citizens – the poor and the frail elderly – by prosecuting those who abuse and neglect them in our nation's nursing homes, thereby ensuring that our nursing homes are safe places to live.

Thank you again for giving me the opportunity to testify today.

Mr. SCOTT. Thank you.
Mr. Frogue. Thank you.

TESTIMONY OF JAMES FROGUE, VICE PRESIDENT AND DIRECTOR OF STATE POLICY, CENTER FOR HEALTH TRANSFORMATION, WASHINGTON, DC

Mr. FROGUE. Thank you, Chairman Scott, Chairman Conyers and Ranking Member Gohmert. My name is Jim Frogue. I am vice president of the Center for Health Transformation here in town.

Chairman Conyers, I would like to associate something you said in your opening statement about who should be sitting up here at perhaps your next hearing. People with street-level knowledge of how easy it is to steal from Medicare and Medicaid would make for a fantastic hearing at some point down the road. I think you are exactly right with that point.

President Obama said in his speech to the joint session of Congress on September 9th that there are hundreds of billions of dollars in waste and fraud in our health care system.

Secretary Sebelius said at the National Summit on Health Care Fraud on January 28th, "We believe the problem of health care fraud is bigger than government, law enforcement or private industry can handle alone." And she is certainly right about that.

Congressman Ron Klein of South Florida, which is a hot spot for health care fraud, said at the same summit, "Constituents come to me repeatedly with fake billings and stories of solicitations for their Medicare I.D. number."

Senator Tom Coburn said at the White House Health Summit last week he believes 20 percent of government health programs are fraud. Senator Schumer from New York a few minutes later associated himself with those remarks.

The scope of health care fraud is certainly vast. A Thomson Reuters study in October of last year said it could be as much as $175 billion a year.

The Government Accountability Office and HHS OIG have literally issued hundreds of reports over the years warning how big and how serious the problem is.

Law enforcement—the HEAT program, for example—does an excellent job, but they are up against an unwinnable battle. They are much like the mythical character Sisyphus trying to push the rock up to the top of the hill, only to have it collapse at the last minute. Law enforcement can't do it alone.

James Mehmet, who is the former inspector general of New York Medicaid, said in 2005 that he thinks 40 percent—that is four zero—40 percent of Medicaid claims in New York State might be fraudulent or at least questionable. Now, that would be up to $20 billion in one State's Medicaid program in 1 year.

Keep in mind that 1 percent of Medicare spending is $5 billion. So identification and prosecution of fraud schemes in the tens or even hundreds of millions of dollars are very significant and very worthy, but they barely scratch the surface of how serious the problem is.

It should be worth nothing that the credit card industry is a great example of pre-screening of payments, something that Medicare and Medicaid don't do in any significant degree.

They actually check and make sure the vendor is legitimate and the claims are legitimate before they pay the money. That is a huge step in the right direction for Medicare and Medicaid, and

adopting that technology would be hugely—would be hugely important.

One-tenth of credit card spending is fraud—one-tenth of 1 percent, I should say. And for an industry that is over $2 trillion, that is more money than Medicare and Medicaid, so that would be an industry to learn from.

A few quick bullet points on what can be done to make the difference. For one, although this sounds a little strange, there is no constitutional right to be a Medicare supplier.

There is this attitude out there that if you fill out the application properly you have the right to supply Medicare, whether your services are needed or not. And I think there needs to be significantly better screening.

One very easy solution is add the term—add the phrase "under penalty of perjury" to the CMS 855 form, which would give prosecutors a much more important tool to go after people for committing crimes.

Medicare and Medicaid should use private-sector standards for establishing how many suppliers should be in a defined area. California Medicaid has done this for almost a decade now and it has worked very well.

Reduce the administrative red tape and lengthy appeals process that suppliers get to exploit. Often supplies can drag out for months their appeals process when they are trying to get kicked out of the program.

The OIG identified 15—they did 1,500 unannounced site visits back in 2008, found 491 either didn't have an actual facility or were not staffed accordingly, so they revoked billing privileges of 491.

Two hundred and forty-three of them appealed. Two hundred and twenty-two, or 91 percent, were reinstated. And 111 of those had their billing privileges revoked again.

Authorize demonstration projects whereby authentication of new suppliers to Medicare fee-for-service is outsourced by and to an entity not CMS. Perhaps OPM would be a good place to try that.

Data-sharing across departmental jurisdictions, which has been successful with the HEAT program, should be done with the vigor that it has been done with the national security agencies post-9/11.

Another one is open up Medicare claims data to audits conducted by contingency-fee-based companies beyond the standard four recovery audit collection companies. I think that would bring a new set of eyes, a new set of techniques and some fresh ideas to that particular—those series of investigations.

Create a Web site where payments to all Medicare suppliers are posted for public access. We all have a right to know, as taxpayers, where these dollars are going. If you are billing Medicare, what you bill Medicare should be available to anyone to see as soon as possible.

Perhaps more radical is consider a way to post claims before they are even paid. In the spirit of President Obama's idea that all legislation should be posted for 72 hours before it is voted on, taxpayers should have a right to see what kind of claims are being paid before they are actually paid.

This need not interfere with Medicare's prompt payment promise already for providers, but it would be an interesting way to take a look at some of the money being sent out.

And hold hearings about the governance of CMS and its ability to be truly effective in fighting fraud and abuse. And I think Chairqman Conyers' opening statement made a lot of sense.

And it would be my privilege, Mr. Chairman, to work with you and your staff to help identify some people who could testify that would give you stories that would be quite shocking.

With that, thank you very much. I look forward to your questions.

[The prepared statement of Mr. Frogue follows:]

PREPARED STATEMENT OF JAMES FROGUE

Testimony to the House of Representatives Committee on the Judiciary

Subcommittee on Crime, Terrorism and Homeland Security

"The Enforcement of Criminal Laws Against Medicare and Medicaid Fraud"

Chairman Bobby Scott (D-VA)
Ranking Member Louie Gohmert (R-TX)

By
James Frogue
Vice President
Center for Health Transformation

March 4th, 2010

Chairman Scott, Ranking Member Gohmert and Members of the Subcommittee, thank you for holding this hearing today and inviting me to share a few thoughts. This is a topic of great importance that affects access to healthcare services for every American. I want to emphasize my willingness to work with all of you following this hearing to develop and implement policies that will ensure our precious healthcare dollars do not end up in the hands of criminals.

I must begin by emphasizing that my oral and written remarks are solely my own. They do not necessarily reflect the views of my employer the Center for Health Transformation or any of its staff or members.

The problem of healthcare fraud is far bigger than most Americans can imagine. But fortunately leaders from both political parties have started speaking up on this critical topic. That is the first step toward creating a climate where real solutions can be offered and implemented.

During his address to a joint session of Congress on September 9, 2009, President Barack Obama accurately spoke of the "hundreds of billions of dollars of waste and fraud" in our healthcare system. This was surprising news to a lot of people.

Health and Human Services Secretary Kathleen Sebelius said at the "National Summit on Health Care Fraud" on January 28, 2010, "We believe the problem of healthcare fraud is bigger than government, law enforcement or private industry can handle alone." She was correct about that. Later in her speech she said, "Today, Medicare, Medicaid and private insurance companies pay out billions of dollars in fraudulent claims, and charge taxpayers higher premiums for it."

Congressman Ron Klein of South Florida, a hot spot for healthcare fraud, also spoke at the "National Summit on Health Care Fraud." He said, "Constituents come to me repeatedly with fake billings and stories of solicitations for their Medicare ID number."

Senator Tom Coburn suggested that, "Twenty percent of the cost of government healthcare is fraud," at the White House Health Summit on February 25, 2010. Senator Charles Schumer later associated himself with those comments, "I was glad to hear my friend Tom Coburn's remarks. I think we agree with most of them, and particularly the point that about a third of all of the spending that's done in Medicare and Medicaid, I would imagine a lot of it's in the private sector as well, doesn't go to really good health care, goes to other things."

Across the political spectrum there is emerging consensus that the amount of fraud in our healthcare system is very significant and totally unacceptable. Yet efforts thus far have failed to make a major dent in the problem.

The Government Accountability Office (GAO) has produced literally hundreds of reports over the last 30 years outlining waste, fraud and abuse in Medicare and Medicaid. A simple visit to GAO.gov and use of their search engine confirms this fact.

GAO designated Medicare a "high-risk" program in 1990 and Medicaid in 2003. The two programs combined will total $1 trillion in 2010 and their "high risk" status perseveres. An April 2009 report on the "High-Risk Series" estimated that the improper payment rate in Medicaid in 2008 was 10.5 percent with home health care administration and durable medical equipment being disproportionate contributors.[1] By contrast, the improper payment rate for non-health government agencies in 2008 was 3.9 percent.[2]

Secretary Sebelius sent a letter to Senator John Cornyn last week that outlined the first ever state-by-state breakdowns of improper payment rates. There were two notable takeaways – the improper payments are indeed excessive across a sampling of over half the states, but they are heavily concentrated in fee-for-service Medicaid and not in managed care.[3]

The Office of the Inspector General at the Department of Health and Human Services is equally dire in its reports and warnings. In just one example, on August 26, 2009 they sent a letter to CMS Director of State Operations Cindy Mann essentially saying that the Medicaid's data collection is so poor they cannot even accurately measure how bad the fraud is.[4]

Thomson Reuters released a comprehensive study in October 2009 showing that between $600 and $850 billion of what we spend on healthcare each year is wasted. That is approximately one-third of our entire national health spending. The report suggested that between $125 and $175 billion of that is pure fraud, with the remainder mostly made up of administrative waste, provider errors and waste largely characterized by unnecessary and duplicative diagnostic testing.[5]

The CBS news magazine show *60 Minutes* had a segment hosted by Steve Kroft on October 25, 2009 on Medicare fraud. It started with Kroft warning viewers that the following piece, "might make your blood boil." He asserted that $60 billion a year is stolen from Medicare by criminals like one they profiled.[6] Other news outlets confirm that organized crime in particular is rapidly moving into Medicare fraud because the risk is so low and the payoff so high.[7]

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[1] Government Accountability Office, "Progress Made but Challenges Remain in Estimating and Reducing Improper Payments," April 22, 2009. http://www.gao.gov/highlights/d09628thigh.pdf.
[2] Garret Hatch & Virginia McMurtry, "Improper Payments Information Act of 2002: Background, Implementation, and Assessment," Congressional Research Service, October 8, 2009. http://assets.openers.com/rpts/RL34164_20091008.pdf.
[3] Letter from Secretary Kathleen Sebelius to Senator John Cornyn, February 25, 2009.
[4] Stuart Wright, "Memorandum Report: 'MSIS Data Usefulness for Detecting Fraud, Waste, and Abuse,' OEI-04-07-00240," Office of Inspector General, Department of Health & Human Services, August 26, 2009. http://oig.hhs.gov/oei/reports/oei-04-07-00240.pdf.
[5] Thomson Reuters, "Healthcare Reform Starts with the Facts," October 27, 2009. http://thomsonreuters.com/content/corporate/articles/healthcare_reform.
[6] 60 Minutes, "The $60 Billion Fraud," October 25, 2009. http://www.cbsnews.com/video/watch/?id=5419844n.
[7] Kelli Kennedy, "Mafia, violent criminals turn to Medicare fraud," Newsvine.com, October 6, 2009. http://www.newsvine.com/_news/2009/10/06/3354515-mafia-violent-criminals-turn-to-medicare-fraud.

The American people are becoming aware of how bad the problem is. In a poll conducted last summer by Insider Advantage, the American people by a margin of 61-27 said Congress should eliminate fraud in existing public programs before creating another one.[8]
A Zogby poll from around the same time asked Americans what is their preferred way to pay for modernizing our healthcare system. Eighty-eight percent said "eliminate fraud" placing well ahead of the second place finished "standardize administrative forms" at 77 percent and "reduce medical errors" at 72 percent.[9] In other words, Americans prefer going after criminals before ensuring their own personal safety from medical mistakes!

More broadly speaking, Americans believe that 50 cents of every dollar spent by the federal government is wasted according to a September 2009 Gallup poll. Democrats pegged it at 41 cents, Republicans at 54 cents and independents at 55 cents.[10] This is a startling lack of faith in the ability of the federal government to spend tax dollars efficiently.

Prior to getting into specific, workable solutions however, it is important to mention third-party payer as the root cause of excessive waste, fraud and abuse in our healthcare sector. I appreciate that this is well beyond the scope of today's hearing. But it must be acknowledged that third-party payer arrangements dominate all of Medicare and Medicaid and nearly all of what we call "private insurance." They encourage patients and healthcare providers to be less than vigilant about dollars being spent and billed. Consumers of health care services are simply more mindful of their spending when they have skin in the game as shown by the classic Rand Health Insurance Experiment[11] and more recently by the experience of Indiana state employees.[12]

Absent confronting the inherent perverse incentives of third-party payer, the next best solutions are exponentially better use of available information technology, better data sharing, metrics-based management and more transparency. Fortunately, these cost relatively little, should have few partisan boundaries and done properly would have a massively positive effect on rooting out waste, fraud and abuse.

Consider the example of the credit card industry. There are over $2 trillion in credit card transactions annually in the United States which makes it more than twice as large as

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[8] Insider Advantage poll of 636 registered voters, July 15, 2009. http://www.healthtransformation.net/cs/IAPollJul09.
[9] Zogby International/University of Texas Health Science Center poll of 3,862 adults, June 2009. http://www.zogby.com/news/ReadNews.cfm?ID=1722.
[10] Gallup, "Americans: Uncle Sam Wastes 50 Cents on the Dollar," September 15, 2009. http://www.gallup.com/poll/122951/Americans-Uncle-Sam-Wastes-50-Cents-Dollar.aspx.
[11] RAND Health Insurance Experiment. http://www.rand.org/health/projects/hie
[12] Mitch Daniels, "Hoosiers and Health Savings Accounts," Wall Street Journal, March 1, 2010. http://online.wsj.com/article/SB10001424052748704231304575091600470293066.html?mod=WSJ_Opinion_LEFTTopOpinion.

Medicare and Medicaid combined. There are roughly 800 million cards in circulation, millions of vendors and countless products available for purchase. Yet, fraud in the credit card industry is less than one-tenth of one percent. It is perhaps 100 times worse in Medicare and Medicaid.

Why is this true? For one, the credit card industry does a much better job at screening out bad vendors in the first place. Medicare fee-for-service consistently fails at that. The *60 Minutes* segment referenced earlier gives a flavor for that.

Second, the credit card industry uses advanced information technology that flags suspicious purchases in real time. All of us know that if we traveled to Fargo, North Dakota, tomorrow and tried to buy three plasma televisions, our credit card company would signal the store clerk to ask for us for identification in the space of seconds. Most of us have had similar experiences with seemingly more routine purchases. Medicare fee-for-service is light years behind the credit card industry in its ability to identify criminals and deny their payments.

It is worth noting that there are not thousands of federal and state law enforcement officials assigned to police rampant and ongoing credit card fraud. The problem is almost entirely nipped in the bud by proper pre-screening of vendors and advanced algorithms that spot outliers instantly.

Law enforcement plays a critical role in combating healthcare fraud but it is by definition reactive. The cost in time and money of indicting, prosecuting and imprisoning a criminal is significant and unfortunately the deterrent effect appears to be minimal as organized crime continues its march into Medicare and Medicaid fraud. Keeping up with and stopping the latest scams in a third-party payer system with poor use of information technology is like the mythical character Sisyphus trying to push the rock up to the top of the hill only to have it crash to the bottom every time he seems to be making progress.

That said, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) has been a successful joint effort between the Justice Department and Health and Human Services. The level of cooperation and data sharing has been extensive and they notched up several significant successes in 2009. Aggressive, innovative United States Attorneys like Luis Perez in South Florida are making important contributions.

But the fact is, these efforts simply do not have and will never have the amount of resources and manpower to try and convict all the criminals guilty of Medicare and Medicaid fraud. James Mehmet, the former chief state investigator for Medicaid fraud in New York said in 2005, "40 percent of all claims are questionable."[13] In a Medicaid program the size of New York's that is in the neighborhood of $20 billion annually in questionable claims. To re-emphasize - that is *one state's* Medicaid program in *one year*. With all due respect to the honorable and hardworking men and women in law

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[13] Clifford J Levy and Michael Luo, "New York Medicaid Fraud May Reach Into Billions," *The New York Times*, July 18, 2005. http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?pagewanted=print

enforcement, a number of this magnitude makes the busting of $50 million dollar fraud rings seem like a drop in the ocean especially when factoring in all costs associated with the investigation, prosecution and eventual jail time for those convicted. One percent of annual Medicare spending is $5 billion.

Many of the attorneys and investigators I have spoken with off the record say that prosecutions focus almost exclusively on very large cases where convictions are a virtual slam dunk. The message criminals hear is that they should just not get too greedy. So long as their theft remains in the tens of thousands of dollars, they need not fear prosecution. Those smaller activities multiplied across the country thousands of times likely add up to far more dollars than the marquee indictments, prosecutions and convictions.

So because law enforcement cannot reach these smaller and vastly more numerous crimes, we must think of innovative and low cost ways to prevent and deter fraud that utilize the all-hands-on-deck approach as suggested by Secretary Sebelius.

There is no Constitutional right to become and remain a supplier to the Medicare program. This may sound obvious. But there is a mentality among too many that simply because an application is filled out properly and various token requirements are met, everyone can supply Medicare patients. This leads to ridiculous situations where there are 897 licensed home health agencies in Miami-Dade County (as of April 2009) which was more than in the entire state of California.[14] There is simply not a need for that many home health providers in such a small geographic area. The Medicare fee-for-service program essentially accepts all eligible applicants regardless of patient need or demand. By contrast, commercial insurers don't have 40 suppliers in a region when five are sufficient.

Here are nine action items that would significantly reduce fraud and abuse:

1). Add the phrase, "under penalty of perjury" to CMS form 855 and its various subforms. These are the applications used by people wanting to become suppliers to Medicare. This very minor tweak would be a big asset to prosecutors going after bad actors because perjury is a more serious offense.

2). Medicare and Medicaid should use private sector standards for establishing the number of suppliers for a product or service in a defined area. California's Medicaid program has been doing this for the better part of a decade now in the durable medical equipment space. While there was some pushback from frustrated potential providers, there were no reports of access to care issues from beneficiaries.

In a related experiment last year, the South Carolina Medicaid program told its 48 Medicaid beneficiaries with the most number of prescriptions that they could select any pharmacy. That one pharmacy would be their sole provider of needed medications. After

[14] Craig Smith, "South Florida: Ground Zero for Healthcare Fraud," *Stop Paying the Crooks*, ed. James Frogue (Washington, DC: Center for Health Transformation Press) 47

eight months those 48 individuals had 40 percent fewer prescriptions which translated into a savings of $320,000 for the Medicaid program.

3). Reduce the administrative red tape and lengthy appeals that suppliers too often exploit. Currently, suppliers can drag out the process for months and usually get reinstated. In 2007 and 2008 the OIG conducted 1,581 unannounced site visits of durable medical equipment providers in South Florida and found 491 either didn't have an actual facility or were not staffed accordingly. All 491 billing privileges were revoked. 243 of them appealed and 222 (or 91 percent) of those were reinstated. Of the 222 reinstated, 111 had their billing privileges revoked again.[15]

The Florida Medicaid program requires suppliers to sign contracts that the state has the right to terminate a supplier at any time, "without cause." This has been effective in Florida without harming access to care. Any public or private purchaser of a service should retain the right to stop buying that service whenever they see fit.

4). Authorize demonstration projects whereby the authentication of new suppliers to Medicare fee-for-service is outsourced by and to an entity *not* CMS. Congress could identify a handful of counties with a history of Medicare fraud and designate an agency that is not CMS to conduct the bidding. Perhaps the Office of Personnel Management could run a small handful of these initial experiments as OPM has experience in this area. Entities such as credit card companies, financial institutions or health insurers among others would be free to bid.

5). Data sharing across departmental jurisdictions and with state and local governments should be done with the same seriousness as in national security. Prior to 9/11 the CIA and FBI rarely communicated. Now they compare intelligence frequently. There are multiple databases of Medicare and Medicaid providers and suppliers along with their disciplinary records.[16] But these databases are not as universally comprehensive or as accessible as say the National Instant Criminal Background Check System (NICS) used to keep guns out of the hands of people with criminal records. The National Crime Information Center is another law enforcement tool that allows a local officer to have instant access to a suspect criminal background across the country. These systems are not perfect, but they represent good examples of how individuals with criminal records and/or disciplinary actions in the healthcare field can at least be flagged early. This concept was part of President Obama's revised health proposal unveiled on February 22nd and based on legislation introduced by Congressman Mark Kirk so it has bipartisan support. Utilize data from the Social Security Administration and IRS as well.

6). Open up Medicare claims data to audits conducted by contingency-fee based companies beyond the standard four recovery audit collection companies. The status quo is not working. Higher contingency fees of perhaps 20 percent and new eyes would

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[15] Ibid

[16] The National Supplier Clearinghouse, the Healthcare Integrity and Protection Data Bank, the OIG Exclusion List, and CMS's Medicare Exclusion Database, etc

introduce more powerful incentives, fresh ideas and modern research techniques to the fraud hunt. The same could be done by governors with their Medicaid programs to stir up new lines of inquiry beyond what is produced by the Medicaid Fraud Control Units.

7). Create a website where payments to Medicare providers and suppliers are posted for public access. This would allow for better identification of outlier billing practices, particularly among providers with similar geography and patient demographics.

The South Carolina Medicaid program has three years of claims data available broken out by provider name, county, number of patients treated, number of patient visits, total payments for billed claims, and average cost per billed claim.[17] Future iterations could have increasing granularity around specific treatments per patient, outcomes and how those compare with peer providers around the state. A version for Medicare would be most useful if complete patient data were posted and not made available only in Part A, Part B and Part D silos (with Medicaid data for the very expensive "dual eligibles" in still another silo). It must be clearly emphasized that all "patient data" be devoid of any individual identifiers that could compromise patient privacy. Fortunately, Medicare has successfully shared its claims data with academic institutions for decades without breaching patient privacy.

8). Consider the feasibility of having all Medicare suppliers and providers publicly post their requests for payment *before* they are reimbursed by taxpayers. Again, it would have to be scrambled appropriately to guarantee patient privacy. The volume of that raw data would no doubt be massive and few people would comprehend it initially. But eventually sense would be made of the seeming chaos and patterns would emerge, some of them unflattering. This need not interfere with Medicare's existing requirement for prompt payment. President Obama spoke of the need to post legislation on the Internet for 72 hours before it is voted on by Congress. This suggestion is in that spirit of transparency.

9). Hold hearings about the governance of CMS and its ability to be truly effective iu fighting fraud and abuse. But instead of having CMS political appointees and senior bureaucrats as witnesses as is nearly always the case, invite current and former Medicare contractors for example and others who could testify about how impactful CMS policies really are at the street level. Those witnesses would be most effective if they were not in positions where they feared retribution from CMS. Some of their ideas would shock.

The fraud, waste and abuse in Medicare and Medicaid are vast but it is possible to fix the problems. Law enforcement will always play a key role in prosecution and deterrence. But our best hope for solving the problem is far more aggressive use of technology, better management of the programs and more transparency. Taxpayers have the right to know where and how their dollars are being spent.

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[17] South Carolina Department of Health and Human Services, Transparency Reporting of Medicaid. http://www.scdhhs.gov/Transparency.asp

Mr. SCOTT. Thank you. Thank you very much.

And I thank all of our witnesses for their testimony. We will now ask questions under the 5-minute rule. And I would like to start with Mr. Frogue.

Is there a difference in the public and private sector in terms of processes to prevent fraud? I mean, is Medicaid and Medicare getting ripped off any more than private insurance companies?

Mr. FROGUE. Yes, they are, and I think when you look at Medicare and Medicaid specifically, I think a really important distinction is the fact that un-managed fee-for-service, particularly in Medicare and Medicaid, is much, much worse than it is where there is some sort of managed care involved.

Secretary Sebelius sent a letter to Senator Cornyn just last week where they identified that the fraud in managed care was far, far less than it is where you have un-managed fee-for-service. I mean, it is several times higher.

But the answer to your question is absolutely yes. Where the right incentives are in place, fraud is a lot less.

Mr. SCOTT. Mr. Menke, one of the problems that—one of the concerns that I have had addressed to me is that when you start going after Medicaid fraud, there is a difference between fraud and honest mistakes.

In the inner city where the doctors have an error rate just the same as everybody else but their population is much more likely to be Medicaid, they get targeted for audits. And if you audit enough, you are going to find something. Many of these are minority physicians, and it has an unfortunate pattern to it.

Can we be satisfied that when you target looking for Medicaid and Medicare fraud that you are not targeting—essentially targeting minority physicians?

Mr. MENKE. Well, we have a body of work with our office of audit that takes a look at error rates across the board. And to my knowledge, they don't focus in on any particular group or group of physicians——

Mr. SCOTT. And you don't look at volume?

Mr. MENKE. Yes, we look at volume.

Mr. SCOTT. So that would end up disproportionately affecting people that practice in the inner cities.

Mr. MENKE. That could happen, yes.

Mr. SCOTT. Well, that is not fair.

Mr. MENKE. Congressman, we have our Office of Audit Services, and I am—I have to admit that I am from the investigation side, not the audit side, and we would be happy to get you any information from our Office of Audit Services regarding error rates.

Mr. SCOTT. And following through on that, we have—I have heard from this panel that unnecessary—medically unnecessary services being performed are performed for the purposes, effectively, of defrauding insurance companies.

Mr. MENKE. Yes.

Mr. SCOTT. We have been told that those unnecessary services are there for some kind of defensive medicine or something like that. Can you comment on that? Is most of this just insurance fraud when people say that unnecessary services are being provided?

Mr. MENKE. Well, Mr. Chairman, I can give you an example. One is regarding wheelchairs. A prescription will be written for a power wheelchair for a person who has no need, medically unnecessary. And sometimes the wheelchair is delivered. Sometimes a substandard scooter is delivered instead.

And the bottom line is the beneficiary doesn't need it because it is medically unnecessary, will never use it, and it basically sits in their apartment with clothes hanging over it until our agents show up and they basically say, "You can take it."

Mr. SCOTT. And limiting attorneys' fees or capping damages on liability suits wouldn't affect the frequency of that kind of fraud.

Mr. MENKE. I wouldn't have expertise in that area, sir.

Mr. SCOTT. Now, the cost of audits—I mean, it costs money to audit and do these investigations. Do you think you save more money than you spend on audits by saving money and reducing fraud and billing problems?

Mr. MENKE. Well, Mr. Chairman, I can refer to my specific budget in the Office of Investigations. I have a $92 million budget, and last year we recovered $4 billion in recoveries, so our return on investment is pretty high.

Mr. SCOTT. Now, by recovering this, it seems that you don't need any new laws, no new criminal statutes. You just need new—more resources for investigations?

Mr. MENKE. That is a fair characterization, sir.

Mr. SCOTT. We have heard practices where people go out and try to recruit and get people identification numbers that they can fraudulently bill. Is there any reward system for people to snitch on people who have made those kinds of contacts?

Mr. ANDRES. Chairman, there is certainly instances where if someone comes forward with respect to information that is used for a prosecution there are different—there are certainly different rewards within the criminal justice system for people that come forward, whether it be judicial consideration at the time of sentencing or it be some sort of agreement with the prosecuting U.S. Attorney's Office for working proactively, for wearing a wire, for helping us uncover a greater degree of fraud or unveiling the other co-conspirators involved.

Mr. SCOTT. I mean, with the widespread fraud, it looks like encouraging people to come forward would certainly have an effect.

Let me just ask a general question to whoever wants to answer it. What are we doing now that we weren't doing before the "60 Minutes" report? Are we doing anything different now than when the "60 Minutes" report was describing widespread fraud where people are making tens of thousands of dollars a day without much resistance? Are we doing something different?

Mr. MENKE. Well, Mr. Chairman, if I could answer that, we are doing some things, and basically we are working with the Centers for Medicare and Medicaid Services to improve upon real-time access for law enforcement. That has improved. We have a long way to go in that area.

In the bottom line, the importance of the real-time data access is to get the information pre-payment rather than post-payment, which puts us—post-payment puts us behind the crooks. They have already been paid. That is the pay and chase method.

What we are trying to do is get ahead of the curve. Within 48 hours after it is submitted to the Medicare administrative contractor, they have about 15 to 30 days, by law, to pay the claim.

And we are trying to get in 48 hours after that claim is submitted to flag any type of questionable provider numbers or beneficiary numbers, to throw red flags up, to hold payment before the money goes out the door. That has improved since the "60 Minutes" piece.

Mr. SCOTT. If you have made a payment, why can't you chase after it? You have got a money trail all the way to whoever is getting the money.

Mr. MENKE. We do that.

Mr. SCOTT. I mean, just because you have paid the money doesn't mean—is there a problem—once you have paid the money, you can't track down people who have cheated you out of some money?

Mr. MENKE. Absolutely not. And we are the best at doing that. We are chasing them very well. But it is still a pay and chase. And what is important, I think, is prevention on the front side because, as Mr. Frogue had mentioned, law enforcement catching up after the fact is a daunting task.

And if we can put preventative measures in on the front side, pre-payment, it can really make a difference in the amount of money going out the door.

Mr. SCOTT. Okay. Now, do you have enough in resources to do what you need to do to reduce fraud? Or have you asked for money that Congress has not provided?

Mr. MENKE. This afternoon at 2 o'clock my boss, the inspector general, will be testifying with the deputy secretary on resource needs. There is a request for additional resources to expand strike force locations to a total of 20 cities.

What I can tell you is last year in fiscal year 2009 we referred over 1,400 cases elsewhere because I didn't have the resources or the bodies to work them. And that amount of case work could have resulted in an additional billion dollars in recoveries.

Mr. SCOTT. And so it is your testimony that if we give you more resources you will be able to save us much more money in—through fraud reduction than we spend in the resources for your office.

Mr. MENKE. I would have to defer to my boss and chain of command—the inspector general, the secretary and the President's budget.

Mr. SCOTT. But I mean, I think you have suggested that it is not even close. We will save a lot more money.

Mr. MENKE. We have a very good return on investment, sir.

Mr. SCOTT. Mr. Gohmert?

Mr. GOHMERT. Chairman, if I could, Judge Poe has got to go to another hearing. With the votes, could I allow him to——

Mr. SCOTT. Judge Poe?

Mr. GOHMERT [continuing]. Go in my place right now?

Mr. POE. Appreciate my friend the Ranking Member for yielding time.

Thank you for being here.

As Mr. Gohmert has mentioned, I used to be a judge in my other life, tried felons for 22 years, saw about 25,000 outlaws work their way to the courthouse, or the "Palace of Perjury," as I refer to it.

These are just among the worst. And people who steal from people who are sick or people who won't get medical attention are the worst of the lot. And I don't care whether it is a doctor, a nurse, an insurance company or another recipient of Federal aid, either Medicare or Medicaid.

How many recipients illegally have received Medicare and have gone to jail for that, Mr. Menke?

Mr. MENKE. Well, I would actually have to defer to Department of Justice on the prosecution stats.

Mr. ANDRES. I believe in my written testimony I speak about that, but there have been more than 500 individuals that have been convicted for these schemes. And certainly, there are a number of schemes that involve the beneficiaries themselves.

Mr. POE. Excuse me, because my time is limited. How many recipients who have claimed they want—they need Medicare—a patient, citizen—and they are lying, they are stealing from the system—how many people went to jail, like, last year?

Give me a statistic that I can—because we got millions of people on the system. How many are going to jail for stealing from it?

Mr. ANDRES. I can get back to you with a specific number. I know 94 percent of the defendants who are being tried are now receiving jail terms.

Mr. POE. Are you talking about the recipients? I am not talking about the providers. I am talking about the person who gets it.

Mr. ANDRES. Again, I can get back to you, Congressman, with the specific numbers about that.

Mr. POE. Okay. I would appreciate that.

Mr. Frogue, you mentioned some good ideas on how we could make the system better. Two things. What do you think about—rather than—that we deal with some of these violations with an administrative process more than running them through the criminal justice system, that we restructure Medicare, Medicaid—that if you are going to come in the system, there are administrative penalties that will be administered to you?

That would make it, it seems to me, a lot quicker, more effective. You are kicked off the list. Whatever. What do you think about that?

Mr. FROGUE. Well, getting in the system is exactly—that is the biggest problem. It is too easy to get in the system. And that is why it is important for someone other than CMS—maybe a credit card company, or a financial institution or insurance company; it could be anyone—to do some demonstration projects on authenticating some of these new suppliers, because once you are in the system, you can bill and bill and bill, and law enforcement will catch up with a couple of them, but the vast majority go undetected.

But I think you are exactly making the right point. But I think the real key—and I think everyone on this panel has mentioned this—is it has got to be switched from a system—Medicare and Medicaid—from reactive to proactive, where the payments are screened before they go out the door.

Trying to capture them after they leave is—the horse is already out of the barn. You might be able to get some of it back, but you are not going to get all of it. The credit card industry does this extremely well, and we all know this.

If we went to Fargo, North Dakota tomorrow and tried to buy a plasma screen TV, they would ask you for your I.D. It is not a real burden on you, but it—they check, and within seconds, if this is a legitimate purchase. There is none of that in Medicare fee-for-service.

Mr. POE. Well, I guess my real question is assuming there are violations in the system—somebody cheats—do you think that we could restructure Medicare and Medicaid to make the penalties—not all of them, but some of the penalties administrative, where you are cut off a list, you are not allowed to reapply for a period of time?

I mean, not neglect due process, but readapt the whole model of Medicare and Medicaid to have administrative penalties where possible.

Mr. FROGUE. Yes, I think that is a fantastic idea, and I think there needs to be much better data-sharing between the agencies and the Federal, State and local in order to flag people.

You know, it is like if a local police officer in Oregon pulls someone over for a speeding violation, they know if they have a criminal conviction in Virginia. There is not enough of that in the health care space. There needs to be a lot more.

Mr. POE. Well, I have never heard of anybody with a criminal record of Medicare fraud coming through the courthouse charged with something else. But there are those thieves out there.

$60 billion is a lot of money of fraud. And I think if we had people, whether they are a hospital administrator, or an accountant, or a doctor or a nurse, or a citizen who applies for Medicare or Medicaid, carted off to jail in handcuffs, that might get the attention—because now it is just a cost of doing business.

Last question, organized crime, how predominant is that in this whole system?

Mr. MENKE. Yes, sir. Organized crime is a problem. We are starting to see an increase in the infiltration because of the ease of getting into it. Why sell drugs and risk getting shot when you can click a mouse when you are an organized criminal?

And we have seen different groups with similar schemes, but different groups, across the country. It is becoming more and more viral. And unfortunately, our agents are seeing—we are coming across more and more guns at every single search and arrest warrant. So they are bringing the tricks of the trade with them into health care fraud.

We investigate health care fraud, and lo and behold, we come across organized crime. We don't do it the other way around.

Mr. POE. Thank you very much.

Appreciate the gentleman for yielding.

Mr. SCOTT. Thank you. We have just a minute and a half before the—run out of time on the floor. But the gentleman from Michigan wanted to ask a brief question. And then we will come back after the votes.

Mr. CONYERS. And I will try to come back, too, Mr. Chairman. Thank you.

How many of you here know about or have been in touch with the Center for Health Transformation, between the Department of Justice and HHS? Have you ever heard of them?

Mr. MENKE. No.

Mr. CONYERS. You?

Mr. ANDRES. No, sir.

Mr. CONYERS. How come we haven't talked about corporate crime here? We talked about individuals. Corporate crime sounds more serious and more criminal to me than individual hustlers.

Mr. COLLINS. Mr. Chairman, I did mention in my remarks the—what had happened with Pfizer as far as the illegal marketing that they had engaged in. And that was pursued both civilly and criminally.

Pfizer paid about a billion dollars in civil penalties and then——

Mr. CONYERS. A billion?

Mr. COLLINS. Billion. And then $1.3 billion was paid by two—Pfizer——

Mr. CONYERS. What did they do?

Mr. COLLINS [continuing]. Subsidiaries. They were engaged in illegal—what we call off-label marketing, where they were marketing drugs for a purpose that had not been approved by the Food and Drug Administration. And there was a criminal component to that case as well. Pharmacia and Upjohn, which are——

Mr. CONYERS. Okay.

Mr. COLLINS.—Pfizer subsidiaries——

Mr. CONYERS. What other corporate crime investigations have you checked into?

Mr. ANDRES. Mr. Chairman, the Pfizer case that was referenced is one that was handled by the Department of Justice both on the civil and criminal fronts. There are other cases as well.

Mr. CONYERS. Like what?

Mr. ANDRES. Well, sir, I can provide the specifics—I think there are specifics in my written testimony, but I am happy to get back to the Committee with——

Mr. CONYERS. Well, what about the names? Name me some nice famous pharmaceutical names.

Mr. COLLINS. Eli Lilly.

Mr. CONYERS. Right.

Mr. COLLINS. Merck.

Mr. CONYERS. Merck?

Mr. COLLINS. Yes.

Mr. CONYERS. Okay.

Mr. COLLINS. And Ely Lilly are a couple more examples.

Mr. CONYERS. All right. More.

Mr. ANDRES. There is a medical device manufacturer, Norian Corp, that was prosecuted in the Eastern District of Pennsylvania. That involved individuals who pled guilty to misdemeanor offenses as responsible corporate officers in July, and they are awaiting sentence.

There is also the Serono Laboratories, a subsidiary of a Swiss drug manufacturer.

Purdue Pharma was a case that was handled in the Western District of Virginia. And there are others.

Mr. CONYERS. Mr. Collins, did that cover what you had in mind?

Mr. COLLINS. It is. I think if you would look at it, Mr. Chairman, most of the pharmaceutical companies in some way or another have, at one point or another, run afoul either of the criminal law or, more likely, of the Federal False Claims Act and been prosecuted civilly for those types of violations.

Mr. CONYERS. Please keep our Committee Chair and this Committee advised of these.

Now, last, why do I keep seeing ads on television that say you can get a power wheelchair or scooter free and it will be paid for by the government?

Mr. MENKE. I believe you are talking about The SCOOTER Store, and we had a case and entered into a settlement with that particular——

Mr. CONYERS. They are still——

Mr. MENKE [continuing]. Company.

Mr. CONYERS [continuing]. Advertising.

Mr. MENKE. Yes, they are, sir.

Mr. CONYERS. Why?

Mr. SCOTT. The time on the floor has expired some time ago, so there—I think we need to recess at this time, and we will come back right after the votes, so it will be about 15 minutes.

[Recess.]

Mr. PIERLUISI. [Presiding.] So the Subcommittee is back and in order, and we will continue with the hearing.

Chairman Conyers was asking the panelists some questions before we went on our recess, so now it is your turn, Judge Gohmert.

Mr. GOHMERT. Thank you so much.

And again, thanks for being here and particularly for your patience. I know the money we pay witnesses is not that good.

People at home or whoever may not know that you don't get paid anything, so we know it is a sacrifice to be here and especially put up with questions from us. But we appreciate that.

Let me start with my right, Mr. Frogue. And from a personal standpoint, I really appreciate all the insights that you had given me as I put together a bill and filed for health care reform.

And I even appreciate the President last week and this week acknowledging that we have some Republican bills out there.

But it was very clear to me from working with you in trying to craft effective health care options that you know your stuff, and you have seen and studied where the fraud is, what can be done about it, how it could be corrected.

Let me go to the issue of the Center for Medicare and Medicaid Services. It appeared or it occurs to me from things that you have said here today and previously that that may be the weakest link in the process for detecting and preventing fraud. So would you elaborate on that, if that is, indeed, your feeling?

Mr. FROGUE. Sure, Congressman. Thank you for the nice compliment and the question.

As I mentioned in one of my bullet points, I think it would be a very valuable experiment at the very least to outsource the authentication of new Medicare suppliers to someone other than

CMS, because the weakest point is how easy it is to become a supplier.

And as I said, there is no constitutional right to become a Medicare supplier, but that is how most people treat it. You fill out the application, you get to be a supplier, and you get to start billing away.

And if you said, you know, Miami-Dade County, or Houston or Dallas, or Los Angeles or anywhere else—if you just said in this particular county, we are going to say, "All right, someone other than CMS is both going to run a bidding process and win the contract," there is no way they could do worse.

There is no way they could do worse, to see why it is that we have, as I said in my opening, 897 home health agencies in South Florida when there is fewer than that in the entire State of California. I mean, that kind of stuff is just crazy, and it happens all the time.

The number of HIV infusion therapy centers in South Florida was just way disproportionate to the rest of the country. And these kind of things just aren't detected very often until well, well after the fact.

Mr. GOHMERT. Well, and you bring up infusion therapy.

Mr. Menke, my understanding was that infusion therapy is not that widely used anymore, but from the information seen historically it has been a significant item for which Medicare still gets billed.

Can you comment on that and how you deal with—how we should go about dealing with treatments that possibly should not be very frequently paid for?

Mr. MENKE. Thank you, Congressman. We have seen a reduction in the Medicare billing, in Part B billing, for HIV infusion in Miami. But these crimes are viral. We address it in Miami, and then all of a sudden HIV infusion starts increasing in Detroit.

One other disturbing thing that we have seen recently is that beneficiaries that were getting HIV infusion which were not getting any infusion at all—it was outright fraud—are being de-enrolled from the Part B side, slid over to the Part C side in managed care, and the same scheme is going on.

What I could suggest is the private sector has an opportunity to work with CMS in order to put appropriate technology so that edits can go across the board, from Part A right through Part D, instead of targeting one particular part of Medicare, and then only for high-volume fraud areas, because we shouldn't punish the people in Wyoming for delayed payments just because there is a hot spot—and I am just picking States out here—because there is a hot spot in Houston or Los Angeles or Miami.

Mr. GOHMERT. Well, and Mr. Collins, the shifting that Mr. Menke is talking about is something I understood you had seen. How do we deal with entities who are caught moving from one place to another, setting up shop? What is the best way, in your opinion, to deal with that?

Mr. COLLINS. It can be kind of catch as catch can, especially if you have——

Mr. GOHMERT. But we got to get beyond that.

Mr. COLLINS. That is true, and especially—it can be especially problematic in towns that straddle a State line, for example—Omaha, Nebraska, Council Bluffs, Iowa—something like that, where you have got a provider who might be excluded on one side in Iowa, and we might not know of an exclusion on the other. Now there is a national exclusion database that takes care of those issues.

But as far as being involved in fraud on the civil side, which is handled as a civil matter, it is difficult to track those, except that—unless there is something put into the provider agreement when they first enroll in the State Medicaid program so that they can be screened and so that you can check to see what had happened in other States where they had operated.

But what you have to understand is, especially if these are operating as corporations or as shells—you know, you can call it ABC Corporation in one place, and 123 Corporation in another, and it is run by the same folks who run the same scam, and it can be difficult to catch that way if they have just been pursued civilly.

So it provides—excuse me—a really difficult situation when they move from State to State.

Now, our national association keeps track of these things. When we see a trend where a certain company or a certain group of individuals has been engaging in improper conduct, that is something that we can kind of send out amongst all the Medicaid fraud directors in 50 States.

But that is a more informal process. For example, we have had a situation where we had a provider in Colorado who the Colorado MFCU had basically run out of town, and it was thought that they would be headed to Nebraska. And when that was about to occur, the Colorado MFCU called us and said, "Be on the lookout."

And so just like any State law enforcement agency or local law enforcement agency does, you cooperate that way and try and share information.

Mr. GOHMERT. Well, it seems like that has been a shortcoming when it comes to Medicare fraud. There hasn't been as much sharing.

And I appreciate the indulgence of the Chair. My time has expired. But let me just remind the witnesses that they—there is so little time in this hearing. You have so much knowledge and information.

And as the Chair pointed out earlier, this is really a bipartisan effort, and we want to get to the bottom in dealing with this widespread fraud. So any thoughts you have that you haven't been able to get out, that is not in your written testimony, things that you think of, "You know what? Congress ought to do this. They ought to do that. You know, this might be able to stop this." Please get that to us.

Don't think when the hearing is over we don't want to hear from you anymore. We need to hear from you. Thank you.

Thank you, Chair.

Mr. PIERLUISI. Thank you.

I will ask some questions myself. Actually, I have to say that the timeliness of this hearing is—it couldn't be better.

At a time when we are all trying to improve the health care system in America, we should be looking at existing programs and making sure that there is no abuse, there is no waste, no fraud. And that is precisely what you all are doing. And I commend you for that and for appearing here before us.

I want to ask a couple of questions about the statistics. I saw that Chairman Scott gave an estimate of about $60 billion being lost to fraud in both the public and private health sector.

And then I believe Mr. Frogue mentioned—or used the figure of $70 billion at some point. I might get that wrong. Could you help me in understanding the size of this problem?

I know that we are talking about estimates. But still, what is the size, maybe splitting it between or among Medicaid, Medicare and the private health plans?

Mr. FROGUE. Sure, Congressman. It is a great question, and the scope of it is bigger than most people can get their head around. Like I said in my opening, the Thompson Reuters study said up to $175 billion is just flat-out fraud, across the system.

"60 Minutes" had asserted $60 billion a year just in Medicare fraud.

And New York Medicaid—if 40 percent of all claims are questionable, that is $20 billion a year in one State's Medicaid program that might be going to places where it shouldn't go.

But the biggest problem is that nobody actually knows, because the data collection is so non-transparent. I think that is the biggest issue.

And I will let the other witnesses speak from their points of view, but all the data is out there but just not shared with the right agencies. It is just not shared with the general public.

And it is shared with academics in some regard, like the Dartmouth Health Atlas and a bunch of others, so it can be shared in a way that protects patient privacy, which is very, very, very important.

But the data is siloed between Medicare Part A and Part B and Part D, between Medicare and Medicaid. You can't get full pictures. And the fact that—I mean, this is actually stuff that really shouldn't cost very much, if anything at all, to solve.

Just let CMS—force them to share data better so that you are not paying people that bill, you know, 500 wheelchairs in an area where there is not even 500 people who need wheelchairs.

Mr. PIERLUISI. Yes? Mr. Menke, yes.

Mr. MENKE. Thank you. Looking at some of the midrange estimates out there—and I know the $60 billion figure came from the National Health Care Anti-Fraud Association.

If we take that midrange number and we take a look at Hurricane Katrina, we have had three Hurricane Katrinas in health care fraud in the past 5 years, looking at the payouts, if that puts it into perspective.

And I know the numbers are all over the place. I think what I have seen personally, if you want to cut to the chase here, the biggest impact I have seen recently is cabinet-level attention to the fraud effort that has really brought CMS around to start focusing in on antifraud efforts and program integrity more than they have done so in the past.

They are paid to cut checks. And if I am a legitimate provider, I would like to be paid on time, between 15 and 30 days. What I have seen with Secretary Sebelius and Attorney General Holder making this a cabinet-level priority, we have seen people basically fall into line and change their attitude about how they look at fraud.

I have seen much more cooperation from CMS in the past 9 months than in all the previous time I have dealt with CMS. That is making a difference.

Mr. ANDRES. If I——

Mr. PIERLUISI. That is good to hear.

Mr. ANDRES. If I could just follow up on that because we are seeing that many of the fraud schemes are, in fact, viral: they moved from an area in Miami to an area in Detroit when enforcement in Miami was ramped up. This is one of the reasons why it is important that we continue the strike force model and why we have asked for additional money so that we can increase the number of strike forces up to 20, so that when a group of fraudsters moves from one area of the country to another and are, in effect, perpetrating the exact same fraud scheme—whether it is the HIV infusion, or it is the DMEs—we are ahead of the game. We have learned that is an issue, that is an area that is going to be exploited within the system, and we need be prepared to move forward with prosecution.

Mr. PIERLUISI. Yes. On the enforcement side of this, I am intrigued about—how are you picking these new 20 cities in which you will have this strike force working?

Mr. MENKE. We have put together a data analysis team, and they take a look at trends nationwide. They do mapping on—we see spikes in some areas of the country where it is 2,000 percent above the national average. We call that a clue.

And what we start doing then is narrowing down the region, the city and even a zip code, and we do mapping, and we work with our partners at the Department of Justice who are also involved in this process, as well as analysts from Centers for Medicare and Medicaid Services.

And we can narrow down hot spots not only regionally but also in particular billing areas. And that helps us in our conversations in the HEAT operations subcommittee on identifying future cities to put strike forces in.

Mr. PIERLUISI. And on the prevention side, Mr. Frogue came up with a good list of ideas, initiatives. I particularly like the prescreening of claims and adding the "under penalty of perjury" to a lot of this paperwork that is submitted by the suppliers.

I wonder, though, whether any of you, the other three panelists, can add to that conversation—prevention side. What can we do better prevention-wise?

Mr. MENKE. Thank you, Congressman. Vetting on the front end is absolutely essential for prevention to keep the crooks out from getting in.

Even though it doesn't specifically address perjury, I have got an enrollment claim form here that I would be happy to provide to the Subcommittee. In section 14, it doesn't address perjury, but it has

multiple different areas where the person, if they are committing false statements on the form, is subject to criminal penalty.

But prevention is absolutely key, in vetting with CMS' implementing surety bonds as well as accreditation processes on the front end to keep the crooks out.

We have two different types of patterns here. We have the outright 100 percent fraud. Crooks come into health care because it is easy. And then we have legitimate providers who cross over the line and put their hand in the cookie jar type of a deal. Those are the two different types that we are seeing.

We need to keep the outright crooks out from the beginning, and that is—that is what the strike force is addressing.

Mr. PIERLUISI. Well, I have exceeded my time, and I am afraid Judge Gohmert will start overruling me. So I will let you take over, Judge—or, I am sorry, Mr. Goodlatte, if you would like to question the witnesses, you are welcome.

Mr. GOODLATTE. Well, thank you, Mr. Chairman.

Mr. Menke, I would like to follow up with your conversation with Chairman Scott about the wheelchairs and the scooters. Can you tell me some more about that?

Are you actively investigating fraud? Are you taking any measures? Have you recommended to CMS that they take any measures to tighten up their screening process for who gets those?

Mr. MENKE. Yes, Congressman, we have. We entered into a civil settlement with The SCOOTER Store specifically regarding the scooters and wheelchairs.

Mr. GOODLATTE. Is The SCOOTER Store a manufacturer or do they sell a variety of products manufactured by other entities?

Mr. MENKE. I am not sure. We can get back to you on that, sir.

Mr. GOODLATTE. All right.

Mr. MENKE. The SCOOTER Store did enter into a corporate integrity agreement for establishing a compliance monitoring within as well as training, and our Office of Counsel at the Office of Inspector General worked on that corporate integrity agreement.

The commercials continue. And I think sophistication with language and how they say certain things in the commercials—sometimes you can dance around corporate integrity agreements and still be in compliance. So we are monitoring the situation very closely.

Mr. GOODLATTE. And how do they get people who are not eligible medically for these devices to get them? Don't they have to have the cooperation of some physicians, or——

Mr. MENKE. Yes, sir. We see a combination, either forged prescriptions through identity theft, where someone purports to be a physician, or they pay a physician kickbacks in order to write prescriptions for medically unnecessary equipment such as a power wheelchair.

A power wheelchair runs around $5,000. The scooter runs around $1,900. But the power wheelchair is almost like a car. You can get a stripped-down version of it, and then they add all the extras, the balancing equipment, inflatable chair—inflatable seat, all kinds of extra things that they can bill on top of the basic model.

And their profit margin—if they do deliver something, their profit margin, even if they deliver the power wheelchair, sometimes $2,500. Some areas——

Mr. GOODLATTE. Do you get involved in that aspect of it at all, the pricing of it, or is that strictly something made by regulators at CMS, the decisions about what is Medicare going to pay for these devices?

Mr. MENKE. Those are decisions made by CMS.

Mr. GOODLATTE. All right. And what about the repairs? I had a constituent dealing with the Hoveround Corporation who was charged $2,114 for repairs, which were mostly related to, like, replacing an arm and fixing the seat. It wasn't even the mechanical aspects of it.

And the breakdown of these charges were astonishing—several hundred dollars to replace the arm or fix the—one of the arms on the chair, almost half the price of the device, based upon what you just told me.

And we are getting kind of vague responses from CMS on that. Have you looked into that area at all, what the companies are charging? Some of these people have had these chairs for a long time now. Obviously, they are going to wear. They are going to need repairs.

But in this instance, $2,114 was charged. Medicare approved $1,553 of that and paid $1,227. My constituent was billed $306 of that.

And we have written letters—Congressman Camp, who is the Ranking Member of the Ways and Means Committee, has written letters—and not gotten really any definitive response on anybody looking into whether these repair items are not a scam in themselves.

Mr. MENKE. I am not familiar with the repair angle. We may have ongoing cases in that area. We have about 5,000 open cases a year. But once again, I would suggest to the American public, if it doesn't pass the smell test, let us know about it.

Mr. GOODLATTE. Yes.

Mr. MENKE. There is common sense involved with this.

Mr. GOODLATTE. We will let you know, but I think we are writing to CMS. But I will send you this information as well. If you could look into it, and if you would let the Committee know not about this specific case, but about what your experience is in general, I would appreciate it.

And then, Mr. Chairman, with a little forbearance, if I might ask each of the other panelists if they have any experience with this issue of fraud either in the purchase, in the approval process, or in the repair of these devices.

Mr. Andres?

Mr. ANDRES. Sadly, we are more often dealing with the people that are given wheelchairs that have no medical necessity for them, so most of the fraud schemes either involve cases where the beneficiaries and the doctors are themselves complicit in the fraud and the devices are simply not medically necessary, or the instances where there is identity fraud, where individuals' and doctors' information is being stolen for a different scam.

And obviously, in those cases as well, the services are never rendered.

Mr. GOODLATTE. And you are prosecuting people for that type of fraud?

Mr. ANDRES. Absolutely.

Mr. GOODLATTE. Is a physician getting a kickback? Is that the——

Mr. ANDRES. That is correct. Those individuals, the physicians, the nurses, are being prosecuted for those crimes.

Mr. GOODLATTE. And when you answer your questions to Congressman Poe, who asked you earlier about those who had receive jail time, would you let us know if there are any who have actually been imprisoned for fraud related to these power devices?

Mr. ANDRES. To the repair or to the——

Mr. GOODLATTE. Either one.

Mr. ANDRES. Okay.

Mr. GOODLATTE. I am as interested in the sale as in the repair, but I just wondered whether there was anything being done about these repair charges.

Mr. ANDRES. Certainly.

Mr. GOODLATTE. Mr. Collins? Mr. Frogue?

Mr. COLLINS. I do know that in the District of Nebraska that one of the scooter stores was the subject of a criminal prosecution federally in the last couple of years.

Due to, you know, the rural nature of our State, that is the only case that I am aware of that we have had to deal with the scooter issue.

Mr. FROGUE. Congressman Goodlatte, I would just make two broader points. One is this article that someone sent me this morning from the South Florida Business Journal. It says, "Like bugs scurrying out from under an overturned rock, the perpetrators of health care fraud in South Florida are finding new schemes to hide behind to siphon off public dollars."

So even if you ended all fraud in wheelchairs tomorrow, they would be off to something else before you even know it. And I am happy to give this to anyone who wants to see it. But it was HIV infusion therapy, which is still a problem, but home health now is a huge, huge issue.

The other quick comment I would like to make is so much of this flies under the radar screen. You hear about the large, you know, pharmaceutical settlements and all that, and that is very significant.

But as long as it is under a certain threshold, whether it is a few hundred thousand dollars or a few million dollars, law enforcement just doesn't have the resources and time to go after the small guys. And so if you are—as long as you keep your crimes to $50,000, $80,000 a year, you are probably going to get left alone.

So the signal to criminals is just don't get too greedy and you won't have a problem. And "Tony" in the "60 Minutes" piece made the point, "There are thousands of people like me." He just got a little too greedy and a little bit unlucky. But if you keep it under a certain level, you can—these things will go on forever.

And that multiplied by all the people doing it across the country is actually much, much bigger that the marquee settlements you hear about.

Mr. GOODLATTE. What is the solution to that?

Mr. FROGUE. The solution is to have the data out there—the biggest solution of all, and I think I speak for everyone on the panel, but please correct me if I don't. The biggest solution is to prescreen the payments before they go out the door.

And that is what the credit card industry does. And the credit card industry is bigger and arguably as complex as Medicare and Medicaid, and they do it, because we all know it. If you travel somewhere and make a big purchase, they ask you for I.D. There is nothing like that in Medicare fee-for-service. That is the biggest problem.

It is very simple. We all understand it, because it has all happened to us, and it is not a big deal. If we would add that to Medicare, the potential savings are easily into the billions.

Mr. GOODLATTE. I agree, and I would just add that I also agree with Congressman Poe that we would like to see some of these folks, large and small, serving some jail time and a lot of other people hearing about the fact that they are in prison for these outrageous ripoffs of the public.

Mr. PIERLUISI. Okay. Chairman——

Mr. GOODLATTE. Thank you, Mr. Chairman.

Mr. PIERLUISI.—Chairman Scott is back with us, so he will probably want to continue his line of questions.

Mr. SCOTT. [Presiding.] Let me just ask a question on recommendations. We have had a lot—what we would like to hear from you are specific recommendations on how to do audits, policies and procedures, fraud detection, and whether or not we need legislation to do that or whether it can be done administratively, and also what—whether or not we are providing the Administration sufficient resources for investigations and prosecutions.

And if the ball is in our court, put the specifics in our court so we know what we are dealing with. And I think the testimony is clear that if we put more money into investigations and prosecutions, we would get more back than we are spending.

So we should not be shy—with the level of fraud and crime going on, we should not be shy in going after it and curing the problem.

Mr. ANDRES. The Department of Justice is asking for additional resources so that we can increase the number of strike forces in different cities.

As I explained, since some of these schemes are viral and they move from one city to another, we need to be in a position to anticipate that and to be in the areas where they are—where the fraud will occur so that we can deal with those prosecutions and have the deterrent effect of these people going to jail and serving significant jail sentences.

That in and of itself will serve some deterrent effect after the fraud has happened.

Mr. SCOTT. And if there is some procedures we can go through, research or best practices that we can disseminate in the private sector that could apply to the Medicaid and Medicare, if you could help—if any of the panelists can help us on that—and if it costs

money to try to implement them that Medicare and Medicaid presently doesn't have, perhaps we need to authorize expenditures in those areas.

But whatever we need to do. I think after the Ranking Member showed the clip from "60 Minutes," obviously, we are in an embarrassing situation that we want to cure.

Mr. COLLINS. Well, one thing, Congressman, that is an issue on the Medicaid side of the house and provides an obstacle to Medicaid fraud units being able to pursue some of these providers is Federal regulation that prohibits Medicaid fraud units from engaging in data mining.

We have been in discussion with folks from the U.S. Department of Health and Human Services and with the Justice Department concerning this prohibition. But the current rules break down the process so that data mining is to be done by the program integrity unit of each State's Medicaid program, which is kind of the State equivalent of CMS.

But a lot of times, those program integrity units in State Medicaid programs are understaffed and don't have the time and the resources to do the data mining. Medicaid fraud units would love to be involved in data mining, but the the Code of Federal Regulations——

Mr. SCOTT. Who funds the——

Mr. COLLINS [continuing]. Prohibits us from doing that.

Mr. SCOTT [continuing]. State offices—fraud detection offices? Who funds these State fraud detection—you are in Nebraska, right?

Mr. COLLINS. Yes, sir.

Mr. SCOTT. Who funds your office?

Mr. COLLINS. In the MFCUs?

Mr. SCOTT. Yes.

Mr. COLLINS. Okay. Medicaid fraud units across the country are funded 75 percent with Federal dollars and 25 percent with State dollars throughout the duration of their operation.

Mr. SCOTT. And I suspect that with the budgets that States have, there is not going to be much increase in the 25 percent.

Mr. COLLINS. I would be surprised, sir.

Mr. SCOTT. So if we want to do something, we might have to do it with no match or a better match than that. And Medicaid will do—would save more money than we spend in that area.

Mr. COLLINS. I think so, Congressman, but I don't even know that it is necessarily an issue where resources have to be expended.

But I think it is—if we were—if we would be allowed to engage in data mining ourselves rather than relying upon Medicaid agencies doing the data mining for us, I think that we would reap the benefits of that for both the State governments and the Federal Government.

Mr. SCOTT. Wait, wait a minute. The data mining that you are talking about is being done but by doing—somebody else, so we are not talking about new invasions of privacy. That is not the issue?

Mr. COLLINS. No.

Mr. SCOTT. It is who does it.

Mr. COLLINS. It is who does it. The way the rules are written now, the folks in the Medicaid program have a program integrity

unit that does the data mining. Medicaid Fraud Control Units are not inside of the Medicaid program. Most of us who have an MFCU operate within a State attorney general's office.

The rules do not allow us to be involved in data mining, in what they call random statistical analysis. If we were able to do that ourselves, we would have more cases that we could pursue.

Mr. FROGUE. Mr. Chairman, if I might just emphasize his point even more, that is exactly right. That wouldn't necessarily cost a penny to let them do data mining.

And I talked to one State attorney general who said, "I would go even one better than that—is allow for contingency-fee-based outsiders to come in at, say, 20 percent and also look at the data," with full protections for patient privacy, of course, which can absolutely be built in, and should be.

But the more eyes that are looking at this, the better. No one program integrity unit is going to be as good as all the other people who could look at this and find better ideas.

Mr. PIERLUISI. [Presiding.] I believe Ranking Member Gohmert has a couple of questions.

You may proceed.

Mr. GOHMERT. Thank you.

And it really is just a follow up of what Chairman Scott was talking about, what you have each been alluding to, but this discussion about CMS sharing information—I was staggered to find out by virtue of this hearing that CMS just has not been good about sharing information.

And I understand, as Mr. Frogue was just saying, we have to ensure patient confidentiality so that someone's medical records are not just all over the place. But that can surely be done—that information could be protected. We do that—DOJ does—I mean, that is done in so many areas. It doesn't seem like it would be a problem.

For Mr. Menke to find out that HHS I.G. has trouble getting information from CMS in the past is just staggering to me. If there is anybody that should have been able to just say, "We need to see this," have adequate protection for patient protection and get it, my goodness, it ought to be you.

So we need to know what we need to do to help you do your job. And of course, I think people on both sides of the aisle, when it comes to DOJ, we recognize the balance that there is between protecting society and not being too much—too invasive into society, like—was thinking about—while there was talk here about, you know, if we can anticipate.

You don't want to get to the point that that Tom Cruise movie did, where you arrest people because you figure they are going to commit a crime in the future, so arrest them now. We don't want to get there.

But it seems that if CMS could share information with HHS I.G., and then when you see these patterns, man, that stuff ought to be going to DOJ. We don't want you out there actively recruiting, you know, in case somebody might commit a crime.

But when there is patterns that could just be provided—and of course, that is what we have seen from a law enforcement standpoint when it comes to the courts having said that a pen register,

for example, is not protected and you don't necessarily have to get a warrant for a pen register.

But for any information that goes with it, whose it is, you know, all that kind of stuff, that is when we require a warrant. But it seems like there ought to be a way to data mine without getting into personal information that picks up when you have got somebody that is, you know, billing for five chairs out of the same house, or whatever it is.

Those things ought to be able to be picked up. So any thoughts you may have—you will think about it after the hearing—ways that we can effectively pass not regulation, but just a law saying, "This is what you got to do."

We are going to protect personal data, but we have got to do a better job of sharing information with the people that can use it and do something about it. So please keep that in mind. Forward us any information you have.

I know Chairman Scott—I know all of us would like to see that and try to craft something to make your job not only easier but far more effective than you—it just seems like you got your hands tied. And we have got to unburden you so that you can do your jobs.

So thank you very much.

Mr. PIERLUISI. On behalf of Chairman Scott and all the Members of the Committee or the Subcommittee, I would like to thank the witnesses for their testimony today.

Members may have additional written questions which we will forward to you and ask that you answer as promptly as you can so that they may be made part of the hearing record.

The record will remain open for 1 week for submission of additional material.

Without objection, the Subcommittee stands adjourned. Thank you.

[Whereupon, at 12:24 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Statement by the Honorable Chairman John Conyers, Jr.
for the Hearing on the

Enforcement of Criminal Laws Against Medicare
and Medicaid Fraud

Before the Subcommittee on Crime, Terrorism,
and Homeland Security

Thursday, March 4, 2010, at 10:00 a.m.
2141 Rayburn House Office Building

With regard to the subject of criminal law, the Judiciary Committee typically focuses much of its attention on how the basic and critical government function of protecting our citizens from crime can be improved. Another essential function of our Nation's government is to help ensure our citizens have the basic health care they need and deserve.

Today's hearing combines the discussion of these two roles of government. To that end, I want to raise several points about the effort to fight Medicare and Medicaid fraud.

First, I want to emphasize the importance of the Medicare and Medicaid programs. For more than 40 years, Medicare and Medicaid have helped pay the medical bills of millions of older and low-income Americans.

Today, Medicare is a critical lifeline to 46 million Americans, and Medicaid enrollment is over 54 million this year.

These programs have played a major role in helping to maintain the health and well-being of many millions of Americans and their families. They are as important as ever, providing a necessary safety net in a time of economic uncertainty.

Second, we must protect the integrity of these programs so that they are able to fulfill their fundamental roles, and we must ensure that monies appropriated to fund these programs are, in fact, used to provide health care.

Those who defraud these programs harm the integrity of the programs, and impede the legitimate delivery of health care services to those in need.

Especially in these times of fiscal belt-tightening, we must strengthen efforts to identify all sources of Medicare and Medicaid fraud and undertake measures to counteract them.

Finally, I want to commend the Justice Department, the Department of Health and Human Services, and the state Medicaid Fraud Control Units for their enhanced commitment to prioritizing the need to combat fraud, waste, and abuse in Medicare and Medicaid.

In particular, I welcome the establishment of the Health Care Fraud Prevention and Action Task Force, which expanded the joint task forces that were already operating in Miami and Los Angeles into five more cities last year, including Detroit.

Each task force includes participation by the local U.S. Attorney, the FBI, the Inspector General of HHS, the State Medicaid Fraud Control Units, and local police.

As a result of their collaborative efforts, these task forces have been extremely effective in identifying and prosecuting criminals who commit these types of fraud.

Last year, for example, the Department of Justice charged more than 800 defendants in health care fraud cases, including Medicare and Medicaid fraud, and obtained more than 580 convictions. These are record high numbers of criminal health care prosecutions.

And civil enforcement under the False Claims Act led to recoveries exceeding $2.2 billion in 2009.

Together, criminal and civil enforcement efforts against these types of fraud have been a very worthwhile investment that saves taxpayer money in several respects.

They also serve to prevent even more fraud from occurring, and to return the proceeds of crime to the government.

I hope the witnesses today will focus on ways we can do even more to combat fraud against these programs.

I thank the witnesses for appearing here today and I look forward to their testimony.

Office of Investigations

Fact Book

Department of Health & Human Services
Office of Inspector General

Office of Investigations
Mission Statement

The mission of the Office of Investigations (OI) is to protect the integrity of the programs administered by the United States Department of Health & Human Services (HHS). OI conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and employees, utilizing state-of-the-art technologies and law enforcement tools. Additionally, OI provides protective services to the Secretary and participates in the Department's continuity of operations program as well as a full range of public safety and security incident management activities. OI fulfills its mission through its dedication to integrity, innovation, and excellence.

Message From the Deputy Inspector General for Investigations

Greetings:

I am pleased to introduce the Office of Investigations (OI), Office of Inspector General (OIG), Department of Health & Human Services (HHS). This resource provides an overview of OI's mission, operations, resources, goals, and accomplishments.

OI conducts and coordinates criminal, civil, and administrative investigations of fraud, waste, abuse, and misconduct related to more than 300 HHS programs and operations. The investigations include Medicare and Medicaid fraud, failure-of-care cases, child support enforcement violations, grant and contract fraud, computer intrusions, and employee misconduct. In addition to carrying out our investigative responsibilities, OI agents provide protective services to the Secretary of HHS.

OI conducts investigations in all 50 States, Puerto Rico, the District of Columbia, and all U.S. territories. We maximize our resources by actively coordinating with HHS and the Department of Justice (DOJ); other Federal, State, and local law enforcement authorities; and various health-care-related agencies to investigate fraudulent activities within our jurisdiction.

From fiscal years (FY) 2005 through 2009, OI efforts resulted in approximately $10.7 billion in monetary receivables. OI has successfully accomplished its Congressional and Executive mandates and has carried out its responsibilities to the American people by employing a mission-focused approach to effectively counter fraudulent schemes perpetrated against HHS programs and operations. We are proud that OI employees have received numerous internal and external awards for their outstanding investigative efforts.

Thank you for your interest in our activities. We look forward to working with you.

Sincerely,

Timothy J. Menke
Depnty Inspector General
for Investigations

OFFICE OF INSPECTOR GENERAL COMPONENTS

OIG protects the integrity of HHS programs, as well as the health and welfare of program beneficiaries by engaging in audits, evaluations, investigations, and a variety of law-related activities. OI works closely with other OIG components to plan and execute OIG's mission. Below is a brief description of the OIG components.

Office of Audit Services

The Office of Audit Services provides auditing services for HHS, either by conducting audits with its own resources or by overseeing work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their responsibilities. They also provide independent assessments of HHS programs and operations. The assessments help reduce fraud, waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. As do audits, evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. OEI reports also present practical recommendations for improving program operations.

Office of Investigations

OI conducts criminal, civil, and administrative investigations of fraud, waste, abuse, and misconduct related to HHS programs, operations, and beneficiaries. OI conducts investigations in all 50 States, Puerto Rico, the District of Columbia and all U.S. territories. It also maximizes resource use by actively coordinating with DOJ and other Federal, State, and local law enforcement authorities. OI's investigative efforts often lead to criminal convictions, civil actions, administrative sanctions, and civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, renders advice and opinions on HHS programs and operations, and provides legal support for OIG's internal operations. OCIG represents OIG in civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act (FCA), program exclusion, and civil monetary penalty (CMP) cases. OCIG negotiates and monitors corporate integrity agreements (CIA), renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

OFFICE OF INVESTIGATIONS
KEY CONTACT INFORMATION

Headquarters	(202) 619-3210
Boston Regional Office	(617) 565-2664
New York Regional Office	(212) 264-1691
Philadelphia Regional Office	(215) 861-4586
Atlanta Regional Office	(404) 562-7603
Miami Regional Office	(305) 530-7756
Chicago Regional Office	(312) 353-2740
Dallas Regional Office	(214) 767-8406
Kansas City Regional Office	(816) 426-4000
San Francisco Regional Office	(415) 437-7961
Los Angeles Regional Office	(714) 246-8302

Web site	http://www.oig.hhs.gov/organization/oi/

HHS OIG Hotline (for reporting fraud)

Phone	1-800-HHS-TIPS (1-800-447-8477)
TTY (for hearing impaired)	1-800-377-4950
Fax	1-800-223-8164
Email	HHSTips@oig.hhs.gov
Mail	Office of Inspector General Department of Health & Human Services Attn: HOTLINE P.O. Box 23489 Washington, DC 20026

TABLE OF CONTENTS

Welcome Letter

OIG Component Descriptions

Key Contact Information

I. MISSION AND ACCOMPLISHMENTS

Office of Investigations Overview	1
Map of OI Regional Office Boundaries	2
OIG's Five Principles of an Effective Health Care Integrity Strategy	3
Accomplishments – OI Actions	4
Use of Investigative Technology	5
Joint Investigations	6
Strike Force Initiatives – Health Care Fraud Prevention and Enforcement Action Team	7
American Recovery and Reinvestment Act of 2009	8

II. PROGRAM INVESTIGATIONS – HEALTH CARE

Medicare – Part A	9
Medicare – Part B	11
Medicare – Part C	13
Medicare – Part D	15
Medicaid	17
Medical Identity Theft	19
Food and Drug Administration	20

III. PROGRAM INVESTIGATIONS – OTHER

Child Support Enforcement	22
Indian Health Service	23
Bioterrorism	24
Employee Fraud and Misconduct	25

List of Acronyms Used in This Publication

I. MISSION AND ACCOMPLISHMENTS

OFFICE OF INVESTIGATIONS OVERVIEW

OI's mission is to conduct and coordinate criminal, civil, and administrative investigations of fraud, waste, abuse, and misconduct related to more than 300 HHS programs and operations.

Specifically, OI:

- investigates allegations of Medicare and Medicaid fraud, failure-of-care cases, Federal and State child support enforcement violations, and grant and contract fraud;
- investigates allegations of misconduct and breaches of integrity affecting and involving more than 65,000 OIG and Department employees;
- investigates cybercrime incidents affecting HHS information systems;
- exercises a wide range of mandatory and permissive authorities to exclude individuals and entities from participation in Medicare, Medicaid, and all other Federal health care programs;
- administers OIG's Hotline, which receives and manages complaints of fraud, waste, abuse, and mismanagement related to HHS programs;
- manages OIG's emergency response plan, including Continuity of Operations, and provides emergency services support to other HHS operating divisions and Federal agencies as needed; and
- provides executive protection for the Secretary, the Deputy Secretary, the Surgeon General, and other high-ranking Department officials.

In 2002, the Homeland Security Act increased the law enforcement authorities of Presidentially appointed, Senate-confirmed OIGs, including the HHS OIG, by amending the Inspector General Act and granting full law enforcement authority. Therefore, when engaged in official duties, OI agents may carry firearms and make arrests.

OI has more than 500 employees nationwide, including nearly 400 criminal investigators and other mission support staff, such as general investigators, forensic computer examiners (FCE), investigations analysts, investigations assistants, and administrative staff. OI is divided into 10 Regions as shown on the following map.

MAP OF OI REGIONAL OFFICE BOUNDARIES

OIG'S FIVE PRINCIPLES OF AN EFFECTIVE HEALTH CARE INTEGRITY STRATEGY

OIG has identified five principles of an effective strategy for combating fraud, waste, and abuse in Medicare and Medicaid. In essence, OIG believes that to protect the integrity of Medicare and Medicaid, the Federal Government should:

1. scrutinize individuals and entities wanting to participate as providers and suppliers prior to their enrollment in the programs;

2. establish payment methodologies that are reasonable and responsive to changes in the marketplace;

3. assist health care providers and suppliers in adopting practices, including quality and safety standards, which promote compliance with program requirements;

4. vigilantly monitor HHS programs for evidence of fraud, waste, and abuse; and

5. respond swiftly to detected frauds, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

Through coordinated and strategic planning, OI effectively uses the five-principle framework to maximize its impact in fighting fraud, waste, and abuse.

ACCOMPLISHMENTS

OI ACTIONS

FISCAL YEARS 2005 THROUGH 2009

	CRIMINAL ACTIONS			CIVIL ACTIONS			EXCLUSIONS
Year	**Health Care**	**Other**	**Total**	**Health Care**	**Other**	**Total**	**Total**
2005	384	153	537	211	13	224	3,806
2006	310	162	472	222	15	237	3,425
2007	302	145	447	229	7	236	3,308
2008	455	120	575	286	5	291	3,129
2009	515	156	671	355	7	362	2,556
Total	**1,966**	**736**	**2,702**	**1,303**	**47**	**1,350**	**16,224**

OI MONETARY IMPOSITIONS

(in millions)

FISCAL YEARS 2005 THROUGH 2009

	HEALTH CARE			OTHER			ALL
Year	**HHS**	**Non-HHS**	**Total**	**HHS**	**Non-HHS**	**Total**	**Total**
2005	$1,651.7	$309.3	$1,961.0	$21.2	$8.8	$30.0	$1,991.0
2006	$1,590.4	$520.9	$2,111.3	$3.8	$17.1	$20.9	$2,132.2
2007	$2,175.8	$892.5	$3,068.3	$4.9	$10.2	$15.0	$3,083.4
2008	$2,320.1	$798.9	$3,119.0	$2.3	$7.5	$9.8	$3,128.8
2009	$2,936.0	$979.1	$3,915.1	$14.0	$15.8	$29.8	$3,944.9
Total	**$10,674.00**	**$3,500.70**	**$14,174.70**	**$46.20**	**$59.40**	**$105.50**	**$14,280.30**

USE OF INVESTIGATIVE TECHNOLOGY

The Seized Computer Evidence Recovery Staff (SCERS) is composed of FCEs located in OI Regional Offices across the country. Their principal duty is acquiring and analyzing electronic evidence obtained through voluntary submissions, search warrants, and subpoenas.

The majority of evidence acquired involves on-scene support during execution of search warrants. On average, SCERS helps execute more than 90 search warrants annually. FCEs represent part of the search warrant team and either seize or copy electronic evidence. Once obtained, all evidence is transported to an OI office where FCEs analyze it and extract all relevant material for review by the case agent and prosecuting attorneys. Additionally, FCEs serve as subject matter experts and provide testimony for grand jury and court proceedings.

OI is constantly utilizing new technology and creatively leveraging existing technology to more efficiently process and provide usable evidence. One recent addition to the SCERS tool chest is an email analysis software program. It enables OI to efficiently and more quickly analyze large quantities of email or other electronic documents and to associate or link emails contained in multiple accounts based on content and metadata.

As one of the first Federal agencies to utilize this technology, OI is setting a new standard of technology use within the Inspector General community.

JOINT INVESTIGATIONS

OI conducts joint investigations with Federal, State, and local law enforcement agencies where there is concurrent jurisdiction and where sharing expertise or authority will lead to the best results possible.

OIG conducts joint investigations with other investigative agencies when HHS program violations are covered by Federal, State, or local statutes and may be prosecuted under these jurisdictions. OI works with State agencies, such as the Medicaid Fraud Control Units (MFCU) and the State police. Additionally, OI often works with local investigative agencies, such as a county sheriff's office or a municipal police department.

Joint investigations conducted with State investigative agencies are typically prosecuted through the State prosecutorial agency, such as an Attorney General's Office. Investigations conducted with local investigative agencies are typically prosecuted with the local prosecutorial agency, such as a District Attorney's Office.

In FY 2009, OI worked 1,421 cases with the Federal Bureau of Investigation (FBI), 982 cases with State MFCUs, 201cases with other State law enforcement agencies, and 147 cases with local law enforcement agencies.

Strike Force Initiatives

In an effort to reduce health care fraud, OI, in collaboration with the Criminal Division of DOJ, U.S. Attorneys' Offices (USAO), State and local law enforcement agencies, and the Centers for Medicare & Medicaid Services (CMS), launched the Medicare Fraud Strike Force in South Florida in March 2007. As of September 2009, the Miami Strike Force had achieved 182 convictions and $224 million in criminal receivables.

Strike Force teams conduct real-time data analysis to quickly and efficiently detect ongoing fraud schemes. The Strike Force then rapidly investigates and prosecutes individuals and entities that do not provide legitimate health care services but exist for the sole purpose of defrauding Medicare and other Government health care programs.

Targeted providers have been associated with hundreds of millions of dollars in fraudulent claims submitted to Medicare through a variety of schemes. They include claims made for durable medical equipment (DME) supplies, compounded medicatious for use with DME supplies (such as inhalers and nebulizers), human immunodeficiency virus infusion clinics, and fraudulent billing companies.

Strike Force teams have expanded the scope of targeted schemes to include fraudulent home health agencies (HHA), independent diagnostic testing facilities, and physical aud occupational therapy clinics. DOJ and HHS expanded the Strike Force in March 2008 by rolling out a second phase in the Los Angeles metro area. As of September 2009, the Los Angeles Strike Force has achieved 45 indictments for criminal health care fraud offenses.

Health Care Fraud Prevention and Enforcement Action Team

On May 20, 2009, HHS Secretary Kathleen Sebelius and Attorney General Eric Holder announced a renewed effort between HHS and DOJ to collaboratively focus efforts on preventing health care fraud and enforcing current anti-fraud laws around the country. They pledged that senior officials from HHS and DOJ will work together on the Health Care Fraud Prevention and Enforcement Action Team (HEAT).

The HEAT task force consists of top-level law enforcement agents, prosecutors, and staff from both Departments and their operating divisions. During the May announcement, the third phase of the Strike Force expansion into Houston and Detroit was revealed. By September 2009, the Houston Strike Force had arrested 32 individuals and executed 12 search warrants while the Detroit Strike Force efforts had resulted in 50 indictments.

The creation of HEAT reaffirms the collaborative efforts of HHS and DOJ to combat health care fraud through a visible and unified partnership, expansion of Strike Force teams to new geographical locations, identification of additional types of fraud schemes, and a commitment to providing more resources to prevent fraud and abuse.

AMERICAN RECOVERY AND REINVESTMENT ACT

On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (Recovery Act). The Recovery Act's goal is to stimulate the economy in the short term and invest in essential public services to ensure the long-term economic health of our Nation.

Stimulus funding appropriated through the Recovery Act is subject to enhanced levels of transparency and accountability. The Act provides the HHS OIG funding for oversight and review.

OIG will assess whether HHS is using the $135 billion it received in Recovery Act funds in accordance with legal and administrative requirements. OIG will also assess whether HHS is meeting the accountability objectives defined by the Office of Management and Budget.

As part of this effort, OI will:

- evaluate and investigate allegations of fraud relating to the expenditure of Recovery Act funds,
- implement procedures for identifying and monitoring all Recovery Act-related investigations to ensure that it meets mandatory timelines for reporting on such activities, and
- implement a process for screening potential HHS grant recipients to help ensure that grants are not awarded to individuals or entities under investigation by OIG.

In addition to providing economic stimulus funding, the Recovery Act extends "whistleblower protection" to employees who reasonably believe they are being retaliated against for reporting misuse of Recovery Act funds received by their non-Federal employers. Specifically, an employee of any non-Federal employer, including grantees, contractors, subcontractors, and subgrantees, who reports waste, fraud, or abuse may not be discharged, demoted or "otherwise discriminated against" because of the disclosure.

OI has primary responsibility for investigating whistleblower reprisals regarding HHS-based Recovery Act funds. It must investigate allegations of reprisal under the whistleblower protection provided by the Recovery Act within 180 days of complaint receipt. The Inspector General (IG) may authorize a 180-day extension or an agreed-upon-time through the mutual consent of the IG and the whistleblower.

II. PROGAM INVESTIGATIONS – HEALTH CARE

MEDICARE – PART A

Medicare Part A covers medically necessary services for inpatient hospital care, skilled nursing facilities, home health, and hospice.

Hospitals

OI will continue its ongoing probes into illegal schemes designed to defraud Medicare, including investigations of hospitals that have billed the Medicare Part A program for services that were not rendered or manipulated diagnosis-related group codes in an effort to inflate reimbursement. Other areas anticipated to draw heavily on OI resources are investigations into business arrangements violating the anti-kickback statutes and unnecessary invasive services and procedures provided by hospitals.

Nursing Homes/Quality of Care

Residents of nursing facilities are commonly targeted for fraudulent Medicare schemes. Common fraudulent schemes include billing Medicare for services not rendered, services not rendered as claimed, or unnecessary services provided to nursing home residents.

Home Health Agencies

HHAs are one of the fastest growing segments of the health care industry because they enable patients to remain in their homes at less expense than at a hospital or other institution. Medicare, which formerly reimbursed HHAs under a fee-for-service system, now reimburses them under the Prospective Payment System (PPS). Under PPS, HHAs receive predetermined base payments for services provided. Payments are adjusted for the health conditions and care needs of the beneficiaries. To identify fraud and abuse, OI monitors claims submitted under PPS.

Accomplishments

In FY 2009, OI's accomplishments related to Part A included 30 criminal actions or convictions; 142 civil actions; and $1.6 billion in restitution, fines, penalties, settlements, and recoveries. Over the same period, OI received 1,003 complaints related to alleged Medicare Part A fraud.

Case Examples

- Tenet Healthcare Corporation (Tenet), operator of the Nation's second largest hospital chain, agreed to pay the Federal Government $900 million plus interest and entered into a 5-year CIA to resolve its liability under the FCA and related authorities. Of the settlement amount, more than $788 million was intended to resolve claims related to outlier payments Tenet received based on inflated charges for inpatient and outpatient care.

- Grant Park Care Center, the owners and operators of a 296-bed skilled nursing facility in DC, agreed to pay $2 million to settle allegations regarding fraudulent billings to Medicare and Medicaid between 1998 and 2007. The allegations involved providing compromised care to residents, reducing staffing levels to inadequate levels, and seeking reimbursement for services that were not provided or were of a quality that failed to meet professionally recognized standards of health care. Grant Park Care Center and its management company, Grant Park Management, LLC, entered into a 5-year CIA with OIG that required them to establish a detailed compliance program and retain an independent monitor to assess their quality assurance and quality improvement systems.

- In California, a licensed vocational nurse was sentenced to 78 months in prison and ordered to pay $4.2 million in restitution. A review of records showed that the nurse, employed by multiple HHAs, submitted records falsely claiming that she saw 58 patients on a single day, personally made visits that lasted from 30 to 45 minutes each, saw patients every day during a 2-year period, and saw multiple patients in different locations at the same time.

- In Pennsylvania, a nursing home and its owner/operator were convicted of health care fraud and false statements. The judge ordered the nursing home, now defunct, to pay a $490,000 fine and sentenced the owner/operator to serve 5 years in jail and to pay a $50,000 fine.

  Trial evidence showed that the owner/operator directed employees to falsify medical records to conceal the nursing home's deficiencies. As a result of the scheme, the nursing home billed Medicare and Medicaid for substandard services or services not actually provided to residents, most of whom suffered from Alzheimer's disease.

MEDICARE – PART B

Medicare Supplemental Insurance, called Medicare Part B, helps beneficiaries pay for physician services, outpatient hospital care, diagnostic tests, DME, ambulance services, and many other health services and supplies not covered under Medicare Part A. The most common Medicare Part B fraud schemes that OI investigates include filing false claims, paying kickbacks in return for patient referrals, and buying and selling beneficiary health insurance numbers that will be used to submit false claims.

Durable Medical Equipment Supplier Fraud

The DME industry has fallen victim to waves of fraudulent schemes in which companies bill Federal health care programs for equipment and supplies never delivered, delivered to patients who did not meet medical necessity guidelines, or billed at rates higher than appropriate for the equipment actually delivered.

Transportation Fraud

Common Medicare Part B schemes associated with transportation and ambulance companies involve submission of claims for charges of advanced life support services when patients required or received basic life support services. Other schemes include submitting claims for medically unnecessary transportation by qualifying patients as nonambulatory or bed-bound when they are actually ambulatory.

Clinical Laboratory Fraud

A common scheme for laboratory services involves submitting individual claims to the Medicare and Medicaid programs for separate components of automated blood chemistry tests actually ordered as a group panel and performed simultaneously. Other schemes involve individuals selling beneficiary health insurance numbers to, or sharing them with, laboratories throughout the country and using the numbers to bill for tests that were never rendered, never ordered, and medically unnecessary.

Accomplishments

In FY 2009, OI's accomplishments included 312 criminal actions or convictions; 136 civil actions; and $1.1 billion in restitution, fines, penalties, settlements, and recoveries related to Medicare Part B. Over the same period, OI received 2,559 complaints related to alleged Part B fraud.

Case Examples

- In Ohio, a pain management physician was convicted in a jury trial for health care fraud that resulted in the deaths of two patients. The physician received a life prison sentence and was ordered to pay $14.3 million in restitution. The investigation revealed that patients allowed the doctor to bill for and conduct unnecessary and painful procedures in

exchange for narcotic drug prescriptions. He then submitted claims falsely indicating that he performed multiple complex procedures, such as nerve block or epidural injections.

- In Florida, a DME company owner was sentenced to more than 12 years in prison and ordered to pay $3.4 million in restitution. A Federal jury convicted the owner of writing fraudulent prescriptions for non-commercially-available aerosol medications so that pharmacists could illegally "compound" them. He then billed Medicare for the nonapproved medications. Pharmacy owners involved in the scheme returned to the owner half of the Medicare reimbursement they received for each fraudulent prescription. The owner also paid cash kickbacks to patients and physicians involved in the fraud scheme. The South Florida Medicare Fraud Strike Force carried out the investigation and prosecution.

- Also in Florida, a court ordered a former dermatologist to serve 22 years in prison, pay $3.7 million in restitution, forfeit an additional $3.7 million, and pay a $25,000 fine for performing 3,086 medically unnecessary surgeries on 865 Medicare beneficiaries. The dermatologist falsely diagnosed patients with skin cancer so he could bill Medicare for the expensive surgeries.

MEDICARE – PART C

Medicare Part C provides health benefits coverage under a policy or contract offered by a Medicare Advantage (MA) plan, formerly known as Medicare+Choice, under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the plan. MA plans include:

- Medicare managed care plans,
- Medicare preferred provider organization plans,
- Medicare private fee-for-service plans,
- Medicare specialty plans, and
- prescription drug benefits (under Part D).

OI is working with CMS to continue to heighten its awareness of fraud in this area. In addition, OI continues to work with DOJ to ascertain what types of violations are prevalent among MA plans, and how these types of violations should be investigated and prosecuted.

Accomplishments

From October 1, 2007, through September 30, 2009, OI's accomplishments included one civil settlement and $100,000 in restitutions, settlements, or penalties related to Part C. Additionally, over the same time period, OI received 98 complaints related to alleged Medicare Part C fraud.

Case Examples

- In Florida, the Medical Management Director of America's Health Choice (AHC) had provided false information about her qualifications and credentials to CMS. This information was provided to CMS on at least two applications in support of an expansion of AHC's service area. A settlement agreement was entered into by AHC and OCIG in which AHC agreed to pay $100,000 in exchange for OIG's release from any additional action related to the covered conduct.

- Keystone Health Plan East, Inc. (Keystone), a managed care organization, entered into a settlement agreement after it allegedly failed to take appropriate steps to verify the credentials of providers billing for services provided by Keystone's mental health subcontractor. As a result, a man pretending to be a psychiatrist treated approximately 600 Keystone health maintenance organization patients. In the agreement, Keystone agreed to ensure that only qualified health care providers treat patients. Through a model credentialing policy, Keystone will not only initially verify providers' licenses, education, and board certifications but will also perform numerous audits to ensure that

appropriate verification procedures are followed. This model addresses credentialing and recredentialing criteria for Keystone's health care providers, as well as the monitoring of credentialing processes at its delegated entities and its organizational providers.

MEDICARE – PART D

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) established a Medicare outpatient prescription drug benefit known as Medicare Part D. This voluntary benefit, which took effect on January 1, 2006, is available to all Medicare beneficiaries.

According to CMS, as of January 2009, nearly 26.7 million beneficiaries had enrolled in Part D. The magnitude of expenditures and impact of this benefit on beneficiaries make it critical that Part D operate efficiently and effectively and be protected from fraud and abuse.

OI works jointly with FBI, the Drug Enforcement Administration (DEA), and State and local authorities to identify and investigate illegal schemes related to Part D. By investigating these schemes, OI deters the illegal use of prescription drugs, curbs the danger associated with street distribution of highly addictive medications, and protects the Medicare program from making improper payments.

The structure and operation of the Part D benefit contains features that present significant management challenges. Within HHS, CMS bears the primary responsibility for implementing and administering Part D. Private entities, known as drug plan sponsors, contract with CMS to provide Part D coverage. Administration of Medicare Part D requires extensive coordination and information sharing among Federal and State Government agencies, drug plan sponsors, contractors, health care providers, and third-party payers.

To date, OI has received allegations of Part D fraud related to:

- telemarketing scams;
- enrollment violations, including forged signatures on benefits applications and false or misleading statements by insurance agents;
- unnecessarily enrolling beneficiaries in plans with high reimbursement rates; and
- diversion of controlled substances involving patients who see several physicians in order to obtain multiple prescriptions for controlled substances (doctor shopping) and doctors, clinics, or pharmacies that prescribe or dispense powerful narcotics inappropriately or for nonmedical reasons (pill mills).

Accomplishments

In FY 2009, OI's accomplishments related to Medicare Part D included 23 criminal actions or convictions; 2 civil settlements; and $1.5 million in restitution, fines, penalties, settlements, and recoveries. During the same period, OI received 245 complaints related to alleged Part D fraud.

Case Examples

- In Virginia, a man received a sentence of 32 years in prison, which was suspended, provided that he serve 10 days in jail, for obtaining prescription drugs through fraud and identity theft. The court also ordered the man to pay Medicare $1,177 in restitution. The investigation showed that the man had illegally obtained a CIGNA Medicare Part D prescription card number that belonged to a Virginia beneficiary. On 15 separate instances, he used the victim's card number at Virginia and Tennessee pharmacies to obtain Schedule III and IV prescription drugs at no cost to him.

- In Pennsylvania, a woman was sentenced to 2 years' probation for knowingly, intentionally, and fraudulently obtaining controlled substances. The woman, who is both a Medicaid recipient and a Medicare beneficiary, utilized her Medicare Part D benefits to obtain prescription drugs, which she, in turn, sold on the street for cash.

MEDICAID

Medicaid is a joint Federal-State program that provides medical assistance to an estimated 50 million Americans with low incomes or disabilities. In 2007, the Medicaid program accounted for nearly $350 billion in health care spending. That year, the Federal share was nearly $191 billion, up from $91 billion in 1997. In the same period, Medicaid enrollment grew from 40.6 million to 49.1 million beneficiaries.

Section 6034 of the Deficit Reduction Act of 2005 (DRA) facilitated OI's ability to exert leadership in Medicaid integrity efforts. The DRA allowed OI to accomplish objectives and goals that enhanced collaborative relationships with other Federal and State agencies.

At the Federal level, CMS administers the Medicaid program. However, Medicaid's structure gives States the flexibility to design and administer their programs within Federal parameters. The Federal Government pays the States a statutorily determined matching rate for Medicaid payments, ranging between 50 and 83 percent.

The Children's Health Insurance Program (CHIP) provides coverage to uninsured low-income children who do not qualify for Medicaid. CHIP provides an allotment of Federal matching funds to help States expand health care coverage to uninsured children. In 2007, the program assisted about 7.5 million low-income children at a Federal cost of $6 billion. In a manner similar to the way in which it designs and administers Medicaid, States design and administer their CHIP programs within Federal parameters.

OI closely coordinates with multiple Federal and State entities regarding Medicaid oversight and enforcement. These entities include CMS; State Medicaid agencies; State MFCUs; and other Federal, State, and local law enforcement and prosecutive agencies.

OI has investigated numerous joint cases with individual State MFCUs and has taken part in several multi-State and national Medicaid investigations. Major fraud vulnerability areas for Medicaid include long-term care, skilled nursing care, and home and community-based services. Investigations in these program areas cover billing fraud, patient harm, abuse, and neglect. Also of note are large civil settlements with major pharmaceutical companies and an increase in the number of qui tams (a suit brought by a private citizen on behalf of the Government) filed at both the Federal and State levels.

Accomplishments

In FY 2009, OI's accomplishments related to Medicaid included 147 criminal actions or convictions; 56 civil actions; and $139 million in restitution, fines, penalties, settlements, and recoveries. Over the same period, OI received 505 complaints related to alleged Medicaid fraud.

Case Examples

- In Pennsylvania and Louisiana, Merck and Company, Inc. (Merck), agreed to pay more than $650 million to resolve allegations that it failed to pay proper rebates to Medicaid

and other Federal and State Government health care programs and paid illegal remuneration to health care providers to induce them to prescribe the company's products. Whistleblowers filed two separate lawsuits under the qui tam provisions of the FCA containing the allegations. According to the allegations, Merck offered hospitals deep discounts on some of its products and then overcharged Federal and State Government programs. The investigation involved OIG and individual State MFCUs.

- In Indiana, the owner and operator of a practice, purportedly a mental health counseling agency employing psychologists and counselors, was convicted of health care fraud. He was sentenced to 120 months in prison and ordered to pay $3.2 million in restitution. An investigation revealed that the owner billed Medicaid for 84,000 psychotherapy services that were never rendered. He also used 2,500 separate Medicaid recipients' identities and benefits to defraud the Medicaid program. The investigation involved OIG, the FBI, and the Indiana MFCU.

- In Oregon, a woman was sentenced to 39 months' imprisonment and ordered to pay $108,225 in restitution and fines after being convicted of making false Medicaid claims and theft. A trial revealed that the woman, an in-home caregiver paid with Medicaid funds, and her co-defendant, a Medicaid recipient, engaged in a 7-year fraud scheme. In the scheme, the Medicaid recipient pretended to be disabled and the defendant falsely claimed to be providing covered caregiver services. The investigation involved OIG, the Social Security Administration, and the Oregon MFCU.

MEDICAL IDENTITY THEFT

OI recognizes the increased vulnerabilities identity theft can cause to the Medicare and Medicaid programs. OI will continue to engage in activities that show a nexus between identity theft and health care fraud.

OI has investigated numerous cases of identity theft relating to Medicare and Medicaid fraud. The cases have included beneficiary and physician identity theft as well as business providers' use of false identities to bill Medicare and Medicaid.

In addition to performing the casework described below, since FY 2008, OI has been an active participant on the Criminal Law Enforcement Subgroup of the President's Identity Theft Task Force, which discusses multiple issues, including medical identity theft.

Case Examples

- In California, a DME company owner who pled guilty to health care fraud and aggravated identity theft was sentenced to 54 months of incarceration and ordered to pay $807,000 in restitution to Medicare. The owner submitted false claims to Medicare for medical equipment he did not deliver to beneficiaries, that physicians listed on the claims did not prescribe, or that were not medically necessary. The owner also used the stolen identities of Medicare beneficiaries to submit false claims to Medicare. This case was investigated under Strike Force operations that began in Los Angeles in March 2008.

- In Utah, three defendants received prison sentences ranging from 12 to 42 months for aggravated identity theft, health care fraud, and other violations. The court ordered these defendants, along with two other co-defendants, to pay a total of $25,601 in restitution. The defendants obtained physicians' names and DEA numbers to write fraudulent prescriptions without the physicians' knowledge or consent. They billed many of the prescriptions to Medicaid and private insurance companies. OIG and the Utah MFCU conducted the investigation.

- In Maine, a woman was sentenced to 44 months in prison and 5 years of probation and was ordered to pay restitution totaling $13,632 for aggravated identity theft and other offenses. She had assumed a family friend's identity by obtaining a duplicate copy of her Social Security card and then used the victim's identity to obtain medical treatment.

FOOD AND DRUG ADMINISTRATION

Unlike other agencies within HHS, the Food and Drug Administration (FDA) maintains its own investigative component, the Office of Criminal Investigations (OCI). OI conducts joint investigations with OCI in areas of mutual jurisdiction, such as companies that manufacture, market, and distribute products causing harm to Medicare and Medicaid beneficiaries and the Medicare program.

OCI has primary responsibility for all criminal investigations FDA conducts, including investigations into suspected tampering incidents and suspected counterfeit products. OCI also investigates entities that have dealings with FDA, such as pharmaceutical companies and food importers.

Accomplishments

In FY 2009, joint OI and OCI accomplishments included 36 criminal actions or convictions; 5 civil actions; and over $1 billion in restitution, fines, penalties, settlements, and recoveries. During the same period, OI received 126 complaints involving FDA programs and employees.

Case Examples

- Pfizer Inc, a drug manufacturer, and its subsidiary, Pharmacia & Upjohn Company Inc. (collectively, Pfizer), entered a $2.3 billion global resolution with the Federal Government and participating States, one of the largest Federal Government settlements in history. The agreement settled charges that Pfizer promoted four drugs, including its pain drug Bextra, for uses not approved by FDA and that the company paid kickbacks to health care professionals to induce them to prescribe Pfizer drugs. In its plea agreement, Pfizer admitted that it promoted Bextra and other drugs for unapproved uses and at unapproved dosage levels. Pfizer also entered into a comprehensive 5-year CIA.

- In Pennsylvania, Eli Lilly and Company (Lilly) agreed to plead guilty and pay up to $1.4 billion for promoting its atypical antipsychotic drug Zyprexa for uses FDA did not approve. The global resolution includes an $800 million civil FCA settlement, a criminal fine of $515 million, and the forfeiture of $100 million in assets. In the plea agreement, Lilly admitted that it promoted Zyprexa in elderly populations as treatment for dementia, including Alzheimer's dementia. Lilly also entered into a comprehensive 5-year CIA.

- In Virginia, as part of a global criminal, civil, and administrative settlement agreement, the Purdue Frederick Company, Inc.; Purdue Pharma L.P. (collectively the Purdue Companies); and three top executives agreed to pay nearly $635 million to resolve a variety of Federal, State, and private liabilities. The agreement resolved allegations that the Purdue Companies waged a fraudulent and deceptive marketing campaign. The companies' goal was to convince doctors nationwide that OxyContin, because of its time-release formula, was less prone to abuse and less likely to cause addiction or to produce other narcotic side effects than competing immediate-release opioids. The Purdue

Frederick Company, Inc., is subject to a 25-year exclusion; Purdue Pharma L.P. agreed to enter a 5-year CIA with OIG.

- In Massachusetts, Bristol-Myers Squibb Co. and its wholly owned subsidiary, Apothecon, Inc., agreed to pay $499 million plus interest and to enter into a 5-year CIA to resolve allegations made in seven qui tam actions. The allegations involved FCA violations associated with drug marketing and pricing practices.

  The investigation revealed that Bristol-Myers and Apothecon devised and implemented fraudulent marketing and pricing schemes aimed at inducing providers to purchase and prescribe their drugs. For example, Bristol-Myers allegedly violated requirements of the Federal Medicaid drug rebate statute by failing to accurately report the "best price" at which it sold its antidepressant drug Serzone.

III. PROGRAM INVESTIGATIONS - OTHER

CHILD SUPPORT ENFORCEMENT

The 1992 Child Support Recovery Act made it a Federal offense for a noncustodial parent residing in a different State than the child(ren) to willfully avoid paying his/her court-ordered child support obligations. Since the enactment of this act, OI has dedicated resources to investigate child support enforcement violations.

Child Support Task Force Model

In 1998 OI, in conjunction with the HHS Administration for Children and Families, Office of Child Support Enforcement, created a multiagency task force to identify, investigate, and prosecute the most egregious criminal nonsupport matters at Federal and State levels. This model began as a pilot program in Michigan, Ohio, and Illinois, which were selected because they had the highest number of outstanding child support cases.

By 2003, the program, now known as Project Save Our Children, grew to 10 task force screening units covering 50 States and the District of Columbia. These task forces bring together law enforcement officials who work together to establish the most efficient methodology to enforce the Federal and State crininal child support statutes. Organizations can include OI, U.S. Marshals Services offices, USAOs, State and local law enforcement agencies, local prosecutors, State child support agencies, and other interested parties.

Accomplishments

In FY 2009, OI's accomplishments included 102 criminal actions or convictions and $6.6 million in restitution, fines, penalties, settlements, and recoveries. Over the same period, OI received 266 child support enforcement complaints.

Case Examples

- In Texas, the most egregious child support evader, a former professional major league baseball player, pled guilty to nonpayment of child support in excess of $763,000. In December 2008, he was arrested while trying to enter the United States after leaving his $1.5 million resort island in the Republic of Vanuatu. As part of a 1998 divorce decree, he was ordered to pay $5,000 per month in child support for his two children, both with serious medical conditions. His guilty plea was the culmination of a 6-year multiagency international investigation.

- In Maryland, a former U.S. professional basketball player was sentenced to 12 months in prison and 12 months of supervised release for failure to pay child support. During his release, he was ordered to remain current on his court-ordered support payments as well as to pay $2,000 a month toward his back child support of $128,000. His sentencing was the culmination of a 5-year investigation during which he lived in Spain.

INDIAN HEALTH SERVICE

Members of the 564 federally recognized American Indian and Alaska Native tribes are eligible for services provided by HHS's Indian Health Service (IHS). IHS employs approximately 15,500 people and administers a comprehensive health service delivery system for approximately 1.9 million of the Nation's American Indians and Alaska Natives. Its annual appropriation is approximately $3.58 billion.

IHS provides its services directly through tribally contracted and operated health programs. Health services also include health care purchased from more than 9,000 private providers annually. The Federal system consists of 31 hospitals, 63 health centers, and 30 health stations. In addition, 34 urban Indian health projects provide a variety of health and referral services. Through P.L. 93-638 self-determination contracts, American Indian tribes and Alaska Native corporations administer 14 hospitals, 240 health centers, 9 residential treatment centers, 102 health stations, and 166 Alaskan village clinics. Additional information can be found at http://info.ihs.gov/.

OI investigations have addressed various issues, including theft, grant fraud, diversion of drugs, improper transfer of IHS funds, and dispensing of Federal discount drug program pharmaceuticals to ineligible non-Indian employees.

Accomplishments

In FY 2009, OI's accomplishments included 6 criminal actions or convictions; 1 civil settlement; and more than $1 million in restitution, fines, penalties, settlements, and recoveries. Over the same period, OI received 56 complaints related to IHS.

Case Examples

- In New Mexico, a court sentenced the former chief financial officer for an HHS and IHS grantee to 57 months in prison and ordered $218,000 in restitution to the grantee's insurance provider for theft or bribery from programs receiving Federal funds. During his employment, the officer embezzled funds by charging improper and unauthorized expenses to an official credit card.

- In Arizona, a former IHS employee was sentenced to concurrent terms of 5 years in prison for theft and 3 years in prison for forgery and ordered to pay $770,000 in restitution. Over 5 years, the Federal employee deposited State Medicaid program insurance checks made payable to IHS into his personal bank account.

- In New Mexico, a former nurse at an IHS hospital was sentenced for unlawful possession of a controlled substance. She removed narcotics from the hospital's emergency room without physician orders on numerous occasions.

BIOTERRORISM

The tragic events of September 11, 2001, resulted in the passage of the Public Health and Security and Bioterrorism Preparedness and Response Act of 2002. In 2005, HHS issued the final rule for Possession, Use, and Transfer of Select Agents and Toxins, codified in 42 CFR § 73.

The regulation grants dual authority to HHS and the U.S. Department of Agriculture to oversee registration to possess, use, and transfer select agents and toxins. OIG is authorized to impose CMPs up to $250,000 against individuals and up to $500,000 against any entities that violate the regulations.

OIG has worked with the Centers for Disease Control and Prevention (CDC) to establish referral protocols to effectively address potential violations of the regulations. OIG has established preliminary procedures to accept such referrals and is developing procedures for regional staff to assist in completing CMP matters that violate these regulations.

Case Example

- A Texas university agreed to pay $1 million to resolve its liability for violating select agent regulations. OIG's allegations included failure of the university's responsible official to ensure that deficiencies identified during annual inspections were corrected and to ensure compliance with select agent regulations. Additional allegations included the university's failures to obtain CDC approval to conduct restricted experiments with a select agent and to report occupational exposures to select agents.

EMPLOYEE FRAUD AND MISCONDUCT

OI is responsible for investigating employee criminal violations and egregious noncriminal misconduct matters, where fraud or misconduct relates to HHS programs or operations.

OI refers matters involving employee safety to the Federal Protective Service, the FBI, or the local police department as appropriate.

OI refers issues concerning equal employment opportunity, Civil Rights Act violations, or personnel matters to the HHS operating division or other components with jurisdiction. In all cases, OI is responsible for protecting the identity of Department employees who report allegations of wrongdoing.

Case Examples

- In Maryland, a former National Institutes of Health (NIH) senior researcher received a 4-year prison sentence followed by supervised release for life, was fined $12,500, and was ordered to register as a sex offender for possession of child pornography. The investigation revealed that the subject used his NIH email account to order child pornography videos. A search of his home found child pornography videos and a home computer containing more than 600 child pornographic images.

- In Washington, DC, a former FDA Commissioner was sentenced to 3 years of supervised release plus 50 hours of community service and was ordered to pay nearly $90,000 in fines for conflict-of-interest and false writing violations. The investigation found that the former Commissioner filed false financial reports with Government officials in which he failed to disclose holdings in companies FDA regulated.

- In Maryland, an NIH scientist was sentenced to 2 years of probation for a conflict-of-interest violation. The scientist provided consulting services for a drug company without the required prior approval of and disclosure to NIH officials. As part of his sentencing, the scientist was ordered to pay $300,000, the amount of income and expenses he received for his consulting services.

LIST OF ACRONYMS USED IN THIS PUBLICATION

AHC	American Health Choice
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CIA	corporate integrity agreement
CMP	civil monetary penalty
CMS	Centers for Medicare & Medicaid Services
DEA	Drug Enforcement Administration
DME	durable medical equipment
DOJ	Department of Justice
DRA	Deficit Reduction Act
FBI	Federal Bureau of Investigation
FCA	False Claims Act
FCE	forensic computer examiner
FDA	Food and Drug Administration
FY	fiscal year
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHA	home health agency
HHS	U.S. Department of Health & Human Services
IG	Inspector General
IHS	Indian Health Service
MFCU	Medicaid Fraud Control Unit
NIH	National Institutes of Health
OCI	Office of Criminal Investigations
OCIG	Office of Counsel to the Inspector General
OEI	Office of Evaluation and Inspections
OI	Office of Investigations
OIG	Office of Inspector General
PPS	Prospective Payment System
SCERS	Seized Computer Evidence Recovery Staff
USAO	United States Attorney's Office

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Follow Up Answer Provided by HHS OIG:

How does OIG select the physicians/providers/claims included in its audits and evaluations?

In recent years, OIG has not audited individual physicians; however, we have begun performing more audits of other types of Medicaid providers. Our focus has been primarily on home health agencies, transportation providers, and providers of personal care services. For some of these audits, we need to contact a physician to validate the need for a service. For example, for an audit of a non-emergency medical transportation provider, we have contacted physicians to validate that the company transported the beneficiary to the doctor's office. We generally select providers for review based on (a) discussions with State Medicaid agency officials or (b) analysis of Medicaid claims data that identified abnormalities, patterns or trends which could be a sign of potential abuse.

The majority of OIG's Medicaid audit work focuses on ensuring that Federal Medicaid funding claimed by a State is allowable. Some of these audits involve sampling claims and contacting providers to obtain information and records to support the sampled claims. These samples are generally selected randomly so that we can project our results to the universe (e.g., all State Medicaid claims for a particular service and time period). These audit reports are issued to the State Medicaid agency with recommendations on how the program could be improved.

The majority our evaluations assess Federal health care programs at a national level. When selecting claims or providers for a national review, we do not target geographic areas based on the number of program beneficiaries who reside or receive services there. Rather, our evaluations generally draw a random sample of all claims for analysis.

Although most studies are national in scope, we do occasionally conduct evaluations focusing on specific geographic areas. These areas are not chosen based on the numbers of providers, beneficiaries, or claims from that area, but on broader billing patterns suggestive of fraud. For example, we might analyze data nationally and find that a given county is home to a small percentage of total program beneficiaries, yet the proportion of total payments is disproportionately high. This type of mismatch is often associated with fraud and might lead us to conduct a focused review of claims from that county.

Our evaluations rarely involve site visits to or contact with providers' offices. Most commonly, we select a sample of claims from centralized national or State-level data to review. In most cases, unless we identify an inappropriate payment, providers are never aware that their claims have been sampled for review. An exception would the small number of studies we conduct each year that require medical record review. For these studies, we first identify a random sample of claims. For each claim, we then contact the provider and request only those records associated with the sampled claim. We do not conduct evaluations that involve wholesale review of providers' entire practices or records.

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