

Good morning, Chairman Baucus, Ranking Member Hatch, and other distinguished Members of the Committee. Thank you for the opportunity to testify about the Office of Inspector General's (OIG) role in the prevention, investigation, and prosecution of fraud, waste, and abuse in the Federal health care programs.

In September 2011, the Department of Health & Human Services (HHS) and the Department of Justice (DOJ) announced indictments against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$295 million in false billing. At that time, this coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history. My testimony provides an inside view of how OIG conducts health care fraud investigations and coordinates on national Strike Force takedowns.

### **OIG and Its Partners Are Leading the Fight Against Health Care Fraud**

#### *Record Breaking Recoveries Through the Health Care Fraud and Abuse Control Program (HCFAC)*

In Fiscal Year (FY) 2011, the work of OIG, the Centers for Medicare & Medicaid Services (CMS), and DOJ resulted in criminal health care fraud charges against more than 1,430 defendants, 743 criminal convictions, 977 new investigations of civil health care fraud, and recoveries of nearly \$4.1 billion in taxpayer dollars. This is the highest annual amount ever recovered from individuals and companies through the Health Care Fraud and Abuse Control (HCFAC) Program.

Accomplishments such as this are the result of collaboration and innovation in the fight against health care fraud. HHS-DOJ collaborative efforts are rooted in the HCFAC Program. The HCFAC return-on-investment is at an all-time high. Over the past 3 years, for every \$1 spent on the HCFAC Program, the Government has returned an average of \$7.20. From 1997 to 2011, HCFAC activities have returned more than \$20.6 billion to the Medicare Trust Funds. In FY 2011, for the second consecutive year, coordinated interdepartmental anti-fraud efforts have resulted in more than \$4 billion in recoveries.

The Health Care Fraud Prevention and Enforcement Action Team (HEAT) has been integral to these successes. The HEAT initiative marshals significant resources across the Government to prevent health care fraud, waste, and abuse; crack down on those who commit fraud; and enhance existing partnerships between HHS and DOJ.

## *Medicare Fraud Strike Forces Are a Proven Success In Fighting Fraud*

Medicare Fraud Strike Force Teams are an essential component of HEAT.<sup>1</sup> Strike Force teams are designed to identify and investigate fraud, and prosecute perpetrators quickly. Strike Force teams are composed of dedicated prosecutors from DOJ and U.S. Attorneys Offices and Special Agents from OIG; the Federal Bureau of Investigation (FBI); and, in some cases, State and local law enforcement agencies. These “on the ground” enforcement teams are supported by data analysts and CMS program experts. This coordination and collaboration has accelerated the Government’s response to criminal health care fraud, substantially decreasing the average time from the start of an investigation to its prosecution.

Strike Force Teams use sophisticated data analysis and a collaborative approach to focus enforcement resources in geographic areas at high risk for fraud. Strike Force cases are data driven to pinpoint fraud hot spots through the identification of suspicious billing patterns as they occur in real time. The Strike Force model has proven highly successful. Since their inception in 2007, Strike Force operations in nine cities have led to more than 1,200 individuals being charged for fraud schemes involving approximately \$3.7 billion in claims.

### **Case Study: ABC Home Health and Florida Home Health**

The fraud scheme involving ABC Home Health and Florida Home Health (ABC/Florida) provides a case study into the investigative underpinnings of Strike Force activities.<sup>2</sup> In ABC/Florida, more than 50 individuals were convicted in connection with a \$25 million fraud scheme relating to home health and physical therapy services. ABC/Florida billed the Medicare program for expensive physical therapy and home health services that either were not medically necessary, never provided, or both.

The scheme involved kickbacks and bribes paid to patients, patient recruiters, and doctors. Doctors were paid up to \$300 per prescription, plans of care (POCs), and medical certifications for medically unnecessary therapy and services. These providers falsified patient files with descriptions of non-existent medical conditions, such as hand tremors, unsteady gait and poor vision, to make it appear that beneficiaries qualified for home health and therapy services. Patients were paid up to \$1,500 per month to attest to services that were not medically necessary or never rendered. Patient recruiters were paid up to \$500 per patient to keep patients enrolled with the home health agency.

### *Initial Phase of the Investigation*

In late 2008, the Miami Strike Force team began investigating ABC, based on a lead from a law enforcement source. ABC, as with most of our Strike Force cases, followed an investigative

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<sup>1</sup> OIG and DOJ launched their Strike Force efforts in 2007 in south Florida to identify, investigate, and prosecute DME suppliers and infusion clinics suspected of Medicare fraud. Building on the success in Miami, Strike Force teams have been established in eight more locations—Los Angeles; Detroit; Houston; Brooklyn; Baton Rouge; Tampa; and, most recently, Dallas and Chicago.

<sup>2</sup> Press releases available at <http://www.justice.gov/usao/fls/PressReleases/111206-02.html> and <http://www.justice.gov/usao/fls/PressReleases/110204-03.html>.

model that has proven highly successful in these cases: 1) analyze and evaluate Medicare claims data, 2) obtain the Medicare enrollment application, 3) identify the medical biller, 4) obtain and analyze relevant banking information, and 5) identify the “true” owner of the Medicare provider that is under investigation as well as suspected co-conspirators. As part of this process, we analyzed Medicare billing data to look for billing anomalies, examined bank records for evidence of kickback payments, and interviewed witnesses and cooperators with inside information. Through this process, we developed an “investigative snapshot” of the suspected fraudulent activity.

As part of the investigation, we conducted time analysis reports – for example, a report flagged as an indicator of potential fraud might show a home health aide billed for visits to 15 people 3 times per day. Analyzing such data could reveal that it is physically impossible to actually conduct that many visits due to traffic considerations, complexity of services, and hours in the day. We also learned that different home health agencies were billing for the same beneficiaries – patient recruiters sometimes shop beneficiaries to different home health providers in an attempt to get more money.

We also worked with cooperating medical providers who reviewed the data with the investigating agents and helped determine whether billings matched what was actually on patient charts. The investigation revealed falsified patient files and aberrant billing patterns attributable to ABC/Florida. Bank records showed large sums of money transferred to sham companies and subsequently turned into cash.

Within about 6 months, we had built a strong enough case to obtain indictments for eight subjects, including two owners of ABC/Florida. These indictments included charges of health care fraud, conspiracy to commit health care fraud, kickbacks, and conspiracy to commit money laundering.

These indictments are not the end of the story, but rather led to a series of follow up investigations and indictments based on evidence obtained from search warrants executed at ABC/Florida and owner Gladys Zambrana’s home. Agents discovered incriminating evidence at both locations including payment kickback ledgers and cash payments designated for health care personnel and patient recruiters. After procuring this evidence, we continued to analyze billing data, medical records, financial records, and interviews with cooperators to ferret out co-conspirators in the fraud.

Simultaneously, we worked with CMS to guard against similar fraud schemes. ABC/Florida’s scheme exploited Medicare’s “outlier” payments – additional payments to home health for beneficiaries who incur unusually large costs. ABC/Florida and its conspirators were claiming that beneficiaries were sicker than they really were to cash in on undue outlier payments. OIG took a broader look and found that ABC/Florida was not an isolated case. In fact, in 2008, Miami-Dade County accounted for 52 percent of the \$1 billion Medicare paid nationally in home health outlier payments, while only 2 percent of all Medicare beneficiaries receiving home health

services resided there.<sup>3</sup> To address these abuses, CMS set a limit on the percentage of outlier payments that each home health agency can claim.

Claims data indicate that these program integrity efforts have had a significant impact. In Miami, Medicare's total home health payments dropped by more than a third and its home health outlier payments dropped by more than 90 percent from 2009 to 2011.

As the investigation continued from June 2009 through December 2011, agents secured cooperation from ABC/Florida personnel who had been indicted. Actionable intelligence developed from these cooperators revealed that many other home health agencies were engaged in frauds similar to ABC/Florida.

This intelligence, coupled with medical record reviews and analysis of financial and billing data, helped agents identify additional co-conspirators, which in turn led to supplementary indictments in the February 2011 national Strike Force round-up.

As a result of additional intelligence from cooperating witnesses, search warrants were executed at Courtesy Medical Center (Courtesy Medical), which was instrumental in perpetuating the ongoing fraud – the tending physician (Dr. Dweck) at Courtesy Medical was responsible for prescribing home health services for beneficiaries billed by ABC. Agents obtained a ledger from Courtesy Medical which detailed all the home health agencies that were paying kickbacks to Courtesy Medical and Dr. Dweck for home health prescriptions. The foregoing led to additional indictments that were part of the September 2011 national Strike Force takedown.<sup>4</sup>

### **September 2011 Takedown**

On September 7, 2011, HHS and DOJ announced a nationwide Strike Force takedown in eight cities resulting in charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$295 million in false billing. At that point, this coordinated takedown involved the highest amount of false Medicare billings in a single takedown in Strike Force history.

The schemes included submitting claims to Medicare for treatments that were medically unnecessary and oftentimes never provided. In many cases, patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers, so that the providers could submit fraudulent billing to Medicare for services that were medically unnecessary or never provided.

In Miami, over 40 defendants, including one doctor and one nurse, were charged for their participation in various fraud schemes involving a total of \$159 million in false billings for home health care, mental health services, occupational and physical therapy, durable medical equipment (DME) and HIV infusion. In some instances, beneficiaries who were residents of halfway houses were allegedly threatened with eviction if they did not agree to attend the mental health center.

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<sup>3</sup> <http://oig.hhs.gov/oei/reports/oei-04-08-00570.pdf>

<sup>4</sup> <http://www.justice.gov/opa/pr/2011/September/11-ag-1148.html>.

Additional defendants were charged in Houston, Baton Rouge, Los Angeles, Brooklyn, Detroit, and Chicago for schemes involving home health and DME. One defendant allegedly sold beneficiary information to 100 different Houston-area home health care agencies in exchange for illegal payments.

### *Orchestrating a Strike Force Round Up*

The September 2011 takedown exemplifies the numerous benefits of conducting large scale operations. Due to the viral nature of health care fraud, it is more effective to make multiple arrests on the same day in particular geographic areas with high volumes of fraud. Once it becomes public that a subject has been arrested, others that may be involved in the criminal activity may try to flee to avoid arrest or send their illegal proceeds off-shore. Executing searches and arrests of numerous suspects simultaneously helps law enforcement maintain the element of surprise. In addition, we can save money and increase efficiency when we leverage resources from local law enforcement partners in these fraud-intense areas, instead of transporting agents from across the country. Finally, the national recognition given to large scale, nationwide operations serves as a deterrent effect.

Once DOJ determines that numerous cases are nearing indictment, senior officials with OIG and DOJ coordinate with the Strike Force teams to plan the execution of search and arrest warrants. Coordination meetings may begin on weekly basis and ramp up to daily briefings nearing the date of a takedown.

Close coordination among the takedown cities is critical. For example, prior to the September 2011 operation, subjects of cases worked by the Detroit Strike Force were determined to be living in Miami, necessitating coordination between the two Strike Forces.

Senior officials ensure that the Strike Force teams have the necessary tools and appropriate number of agents to safely and efficiently carry out the operation. We may also request personnel assistance from other Inspector General (IG) offices, through the Mutual Assistance Program, to help execute search and arrest warrants. During the September 2011 operation, we were assisted by 14 agents from 5 different IGs, including United States Postal Service, Department of Homeland Security, Social Security Administration, Department of Transportation, and Railroad Retirement Board.

The scale of a round up, i.e., the number of people who will be arrested and the number of search warrants executed, evolves throughout the planning process based on investigative case developments.

### *Agents On the Ground*

Agents planning large-scale strike force operations are responsible for locating subjects to be arrested and verifying where those individuals reside. This includes researching subjects' background for criminal history, weapons possession, and other information such as family members that may be encountered during the arrest. Agents may also conduct surveillance of the arrest location.

Each lead case agent develops an operational plan, which includes subject information, including criminal history and background; team assignments; emergency information, including the address to the nearest hospital; and detailed information about the location where the search and/or arrest warrant will be executed.

Prior to the execution of the operation, the case agent is responsible for securing arrest and/or search warrants. The agent must also coordinate with the U.S. Marshals Service and Pre-Trial Services for support with prisoner processing.

The lead case agent also conducts an operational briefing for arrest teams, often the evening prior to an operation. Agent assignments are given during this time based on particular agent's skill sets and operational needs. For example, assessments are made regarding the need for weapons and tactical support, linguistic skills for witness interviews, and computer forensics. This intricate, detailed planning is done to not only ensure a successful operation, but to guarantee the safety of all participants.

On the day of an operation, we typically hold a pre-dawn meeting proximate to the place where the warrant will be executed. During these meetings, agents review information with a focus on safety, such as whether arrest subjects have a violent criminal history and whether there are firearms known to be at the location.

Arrest warrants are often served in conjunction with search warrants. Evidence seized during an operation might include billing ledgers, phone records, receipts, computers, thumb drives, and other electronic and non-electronic evidence. Criminals are increasingly using technology to defraud Medicare. We have a team of expert computer forensic examiners to seize and analyze electronic evidence.

After an arrest, the suspect is processed, which includes taking photos, fingerprints, and obtaining basic biographical information. We may also conduct post-arrest interviews to obtain additional information related to the alleged scheme. Once the prisoner is processed, s/he appears before a Magistrate for an initial appearance, typically on the same day as the arrest.

Post-arrest, OIG agents are still on the job providing pre-trial support, such as preparing witnesses for trial, ensuring witnesses are available for interviews, reviewing evidence, gathering additional evidence, preparing evidence for trial, and ultimately testifying at trial.

### *Dedicated, Resourceful, and Well-Trained Agents Are the Cornerstone of Every Investigation*

Highly specialized and advanced training underpins our successful investigations and operations. OIG special agents participate in a rigorous 12-week basic training program at the Federal Law Enforcement Training Center (FLETC). That regimen, known as the Criminal Investigator Training Program, trains agents on skills including interviewing, surveillance, undercover operations, criminal case management, legal training, writing and execution of search and arrest warrants, courtroom testimony, physical techniques and conditioning, tactical training, firearms,

vehicle handling skills, physical evidence, and other courses that provide the essential knowledge, skills, and abilities needed by new special agents.

Upon completion of FLETC basic training, OIG agents complete 6 weeks of specialized training geared toward OIG's health care mission. OIG is the only agency focusing full time on combating fraud, waste, and abuse in Medicare and Medicaid, and OIG special agents develop extensive subject matter expertise in health care fraud investigations. This specialized training covers, among other things, an in-depth education on Medicare and Medicaid, a wide range of health care fraud schemes and current trends, medical identity theft, organized criminal activity in health care fraud, undercover operations related to health care fraud, and advanced law enforcement training in areas such as firearms and defensive tactics.

As OIG continues to encounter more sophisticated and dangerous criminal enterprises in health care fraud, OIG special agents hone their defensive skills through quarterly firearms and defensive tactics training. Many OIG agents undergo advanced technical training on investigative technology, data analysis, advanced tactics, and use of the law enforcement rifle system during enforcement operations.

### **The Future of Fraud Fighting**

We are at a turning point in our fight against fraud. For typical Strike Force cases, we have significantly decreased the average time from the start of an investigation to its prosecution. Our specialized training and advanced data analytics have changed the way we investigate cases. Historically, we had built cases from the bottom up, investigating individual criminals and working our way to the top of the pyramid. Data analytics now enable us to more quickly identify the head of a criminal enterprise from which we can also more swiftly identify the co-conspirators and related schemes.

With new enforcement tools in the Affordable Care Act, payment suspensions will help ensure that the Government can effectively stop perpetrators from absconding with ill-gotten program funds. Important changes to the False Claims Act, the Federal anti-kickback statute, OIG's administrative authorities, and the Federal Sentencing Guidelines, among others, will help the Government more effectively prosecute those who defraud or abuse Federal health care programs.

As we continue to fight fraud in the face of technologically sophisticated criminals, we must continually build on our capabilities to maintain our success. We will utilize our resources to develop knowledgeable professionals able to collect and analyze the growing volume of computer and other electronic evidence seized during search warrants. As we confront increasing violence and weapons in the field, we will continue to provide our agents the training and equipment necessary to ensure their safety. Finally, we will continue to utilize data analytics to identify the locations and program areas most vulnerable to fraud and allocate our resources accordingly. This strategy has resulted in significant accomplishments, including achieving a return on investment of more than \$7 to \$1 over the past three years.

## Conclusion

Our fraud investigations are one essential tool among many that OIG brings to bear to protect HHS programs, beneficiaries, and taxpayers. OIG employs a comprehensive and holistic approach to:

- prevent and detect health care fraud, waste, and abuse;
- ensure that programs are run efficiently and effectively;
- promote compliance by health care providers and suppliers;<sup>5</sup> and
- hold accountable those who defraud Medicare or Medicaid.

Through the dedicated efforts of OIG professionals and our collaboration with HHS and DOJ partners, we have achieved substantial results in the form of recoveries of stolen and misspent funds, enforcement actions taken against fraud perpetrators, improved methods of detecting fraud and abuse, and recommendations to remedy program vulnerabilities.<sup>6</sup> Finally, we have enhanced tools and authorities and have engaged in new initiatives aimed at achieving our mission. Thank you for your support of this mission.

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<sup>5</sup> More information on OIG's compliance initiatives is available at <http://oig.hhs.gov/compliance/>.

<sup>6</sup> More information on OIG's program integrity activities can be found in OIG's Semiannual Report to Congress, available at <http://oig.hhs.gov/reports-and-publications/semiannual/index.asp>, Compendium of Unimplemented Recommendations, <http://oig.hhs.gov/reports-and-publications/compendium/2011.asp>, Top Management & Performance Challenges, <http://oig.hhs.gov/reports-and-publications/top-challenges/2011/>, and the annual Health Care Fraud and Abuse Control Program (HCFAC) Report, <http://oig.hhs.gov/reports-and-publications/hcfac/index.asp>.