



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

**Testimony Before the United States House of Representatives
Committee on Ways and Means:
Subcommittee on Oversight**

“Fraud in Medicare”

Testimony of:

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Testimony of:
Gary Cantrell

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Good morning Chairman Roskam, Ranking Member Lewis, and other distinguished members of the Oversight Subcommittee. I am Gary Cantrell, Deputy Inspector General for Investigations for the Office of Inspector General (OIG), U.S. Department of Health and Human Services (HHS). I appreciate the opportunity to testify about OIG's efforts to combat Medicare fraud, a top priority. OIG is a leader in the fight against Medicare fraud. We use data analytics to detect and investigate Medicare fraud and to target our resources for maximum results. Those results have included, for example, almost \$15 billion in investigative receivables and more than 2,700 criminal actions in the past 3 years. Data-driven efforts are key to staying ahead of the evolving Medicare fraud schemes we uncover, which can involve complex criminal networks and too often cause patient harm in addition to financial loss. Our partnerships with other Government entities and the private sector are also invaluable to our enforcement successes. But we are not focused solely on enforcement. The best way to combat fraud is by preventing it in the first place, and OIG's oversight efforts support all aspects of program integrity. We also strive to cultivate a culture of compliance in the industry through various efforts, including guidance.

OIG IS A LEADER IN THE FIGHT AGAINST MEDICARE FRAUD

OIG's mission is to protect the integrity of the HHS programs and operations and the health and welfare of the people they serve. Fighting fraud in Medicare is a critical component of that mission. Medicare spending in 2013 totaled almost \$583 billion, and the program served more than 52 million aged and disabled individuals.¹ Protecting those beneficiaries and the integrity of that Federal spending is paramount.

OIG advances our mission through a robust program of audits, evaluations, investigations, enforcement actions, and compliance efforts. In today's testimony, I focus on our investigation and enforcement activities, led by OIG's Office of Investigations, in collaboration with our attorneys, evaluators, auditors, and data analytics experts. The Office of Investigations is the law enforcement component of OIG and investigates fraud

¹ Data from *Medicare Trustees Report 2014*, available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2014.pdf>.

and abuse against HHS programs and holds wrongdoers accountable for their actions. Our special agents have full law enforcement authority and affect a broad range of actions, including the execution of search warrants and arrests.² We use state-of-the art investigative techniques and innovative data analytics to fulfill our mission.

OIG investigations have produced record-setting results. During the last 3 fiscal years (FY2012-FY2014), OIG investigations have resulted in \$14.8 billion in investigative receivables (dollars ordered or agreed to be paid to government programs as a result of criminal, civil, or administrative judgments or settlements); 2,709 criminal actions; 1,172 civil actions; and 10,363 program exclusions.

The return on investment for our work is significant. OIG and our HHS and Department of Justice (DOJ) partners have returned \$7.70 for every \$1 invested in the Health Care Fraud and Abuse Control Program (HCFAC).³ HCFAC is OIG's largest funding source. Since HCFAC's inception in 1997, the HCFAC program activities have returned more than \$27.8 billion to the Medicare Trust Fund. HCFAC's continued success confirms the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud, and to protect program beneficiaries.

OIG USES DATA ANALYTICS TO DETECT AND INVESTIGATE MEDICARE FRAUD AND TO TARGET OUR RESOURCES FOR MAXIMUM RESULTS

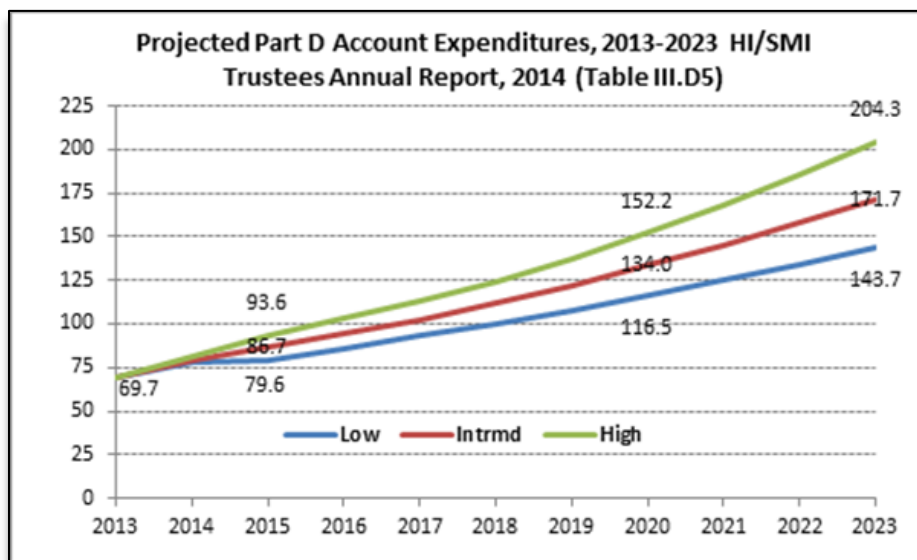
OIG is a front-runner in the use of data analytics to detect and investigate health care fraud. We use innovative analytic methods to analyze billions of records and data points to identify trends that may indicate fraud, geographical hot spots, emerging schemes, and individual providers of concern. At the macro-level, we analyze data patterns to assess fraud risks across Medicare services and provider types and geographically to prioritize and deploy our resources. At the micro-level, we use data analytics, including near-real-time data, to identify fraud suspects and conduct our investigations as efficiently and effectively as possible.

Our approach to fighting prescription drug fraud provides an example. Prescription drug abuse is a serious national problem. OIG has been monitoring the growth in Medicare Part D spending for drugs, which totaled \$69.7 billion in 2013 and is projected to total \$171.7

² Inspector General Act of 1978.

³ Data from the *FY 2014 Health Care Fraud and Abuse Control Program Report*, available at <http://oig.hhs.gov/publications/docs/hcfac/FY2014-hcfac.pdf>.

billion by 2023.⁴ These estimates alone underscore the need for strong program integrity and enforcement efforts. However, that trend is just one consideration. We combine our field intelligence with data analytics to assess vulnerabilities across the program and to deploy our special agents to investigate the most egregious cases of suspected fraud. For example, we worked with OIG’s evaluators to develop indicators of questionable billing for Part D drugs that may be associated with fraud and abuse based on our experience with prescription drug investigations. OIG evaluators designed studies using sophisticated data analytics to identify questionable billing by retail pharmacies, prescribers with aberrant patterns, individuals writing prescriptions without authority to prescribe, and Schedule II drugs billed as refills. These studies generated numerous law enforcement leads, resulting in multiple ongoing investigations. They also identified systemic vulnerabilities in the Part D program and made recommendations to CMS to better prevent fraud.



Data Analytics Have Been a Key Factor in the Success of Our Medicare Fraud Strike Force

The remarkable success of the Medicare Fraud Strike Force (Strike Force) showcases the effectiveness of our use of data analytics to detect and investigate health care fraud. Strike forces began in March of 2007. In 2009, HHS and DOJ announced the creation of the Health Care Fraud Prevention and Enforcement Action Team, a joint agency initiative known as HEAT. A key component of HEAT is Strike Force, which harnesses the efforts of OIG and

⁴ The Board of Trustees Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2014 Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 2014.

DOJ, including headquarters, Offices of U.S. Attorneys, and the Federal Bureau of Investigation, along with State and local law enforcement, to fight Medicare fraud in geographic hotspots. The Strike Force teams use near-real-time data to pinpoint fraud hotspots and aberrant billing as it occurs. This coordinated and data-driven approach to identifying, investigating, and prosecuting fraud has produced record breaking results. Since their inception in March 2007, Strike Force teams have charged more than 2,097 defendants who have collectively billed the Medicare program for more than \$6.5 billion.⁵

HEAT actions have led to a 75 percent increase in individuals charged with criminal health care fraud during the initial stages, and the program has maintained significant enforcement success throughout its history.⁶ Through HEAT, we have expanded Strike Force teams to operate in nine locations: Miami, Florida; Detroit, Michigan; southern Texas; Los Angeles, California; Tampa, Florida; Brooklyn, New York; southern Louisiana; Chicago, Illinois; and Dallas, Texas.

In a recent example, a national Strike Force operation in May 2014 resulted in charges against 90 individuals, including 27 doctors, nurses, and other medical professionals, for their alleged participation in multiple Medicare fraud schemes spanning many health care services. Collectively, the doctors, nurses, licensed medical professionals, health care company owners and others were charged with conspiring to submit approximately \$260 million in fraudulent billings.⁷ The cases are currently being prosecuted and investigated by Strike Force teams.

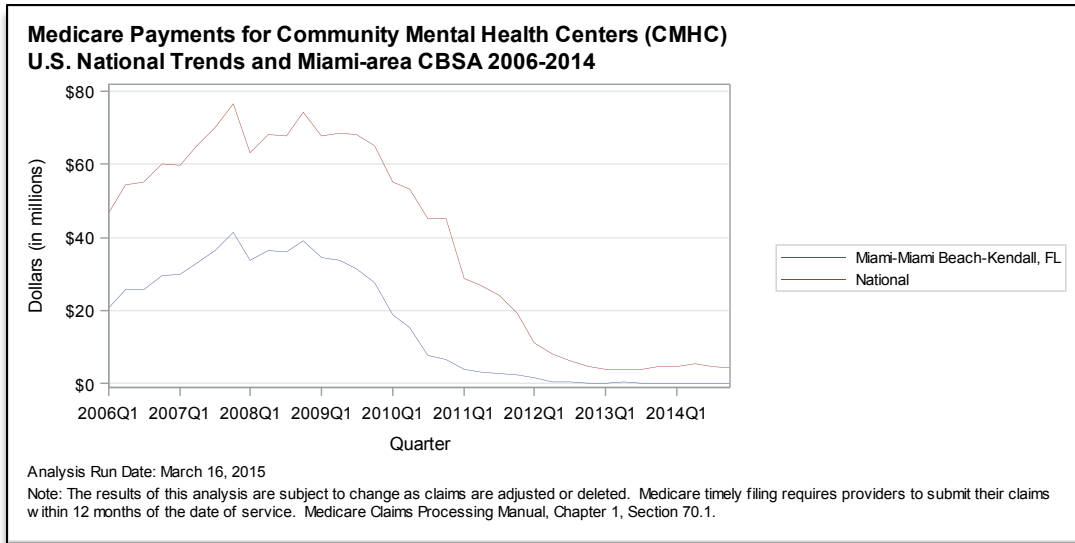
Our Data-Driven Approach Produces Measurable Results

As a result of our data-driven enforcement efforts, we have seen strong and sustained declines in Medicare payments, both nationally and in specific geographical areas of increased enforcement. Our criminal prosecutions and monetary recoveries have increased, while we have seen a measurable decrease in payments for certain fraud-prone health care services. In one example, following targeted enforcement and other oversight activities, payments for Community Mental Health Centers (CMHCs) nationally decreased from \$70 million to under \$5 million per quarter following Federal enforcement and oversight action.

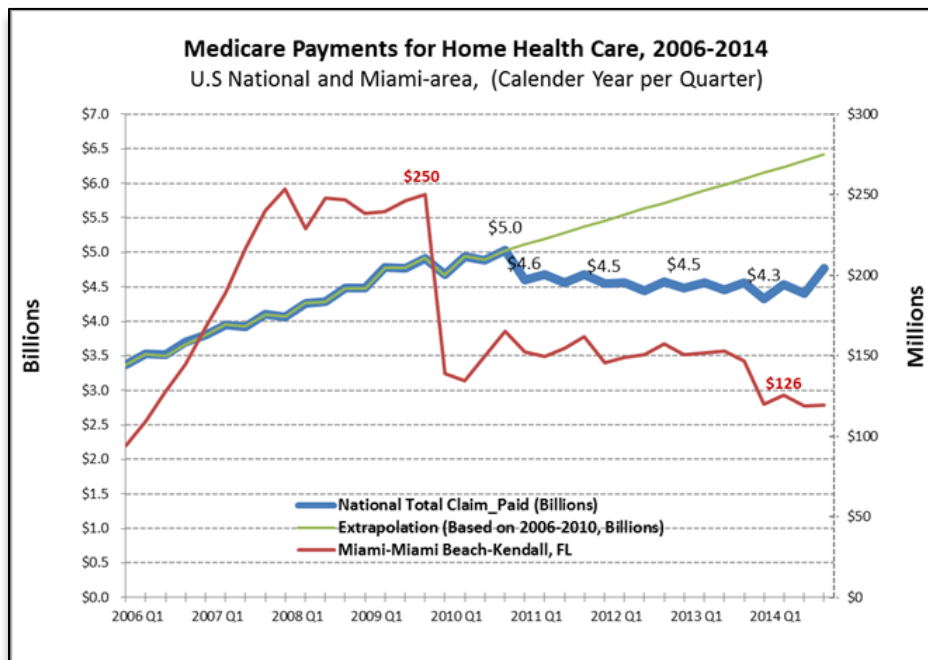
⁵ Data from the FY 2014 *Health Care Fraud and Abuse Control Program Report*, available at <http://oig.hhs.gov/publications/docs/hcfac/FY2014-hcfac.pdf>.

⁶ See *HEAT Task Force*, available at <http://oig.hhs.gov/fraud/strike-force>.

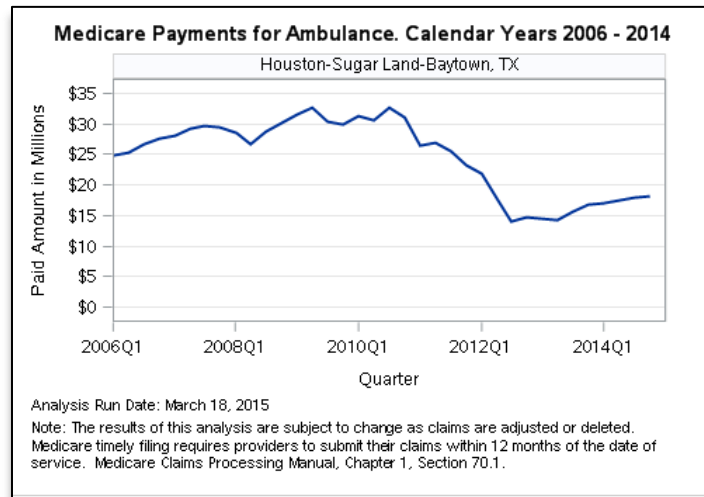
⁷ See *Medicare Fraud Strike Force charges 90 individuals for approximately \$260 million in false billing*, available at <http://www.hhs.gov/news/press/2014pres/05/20140513b.html>.



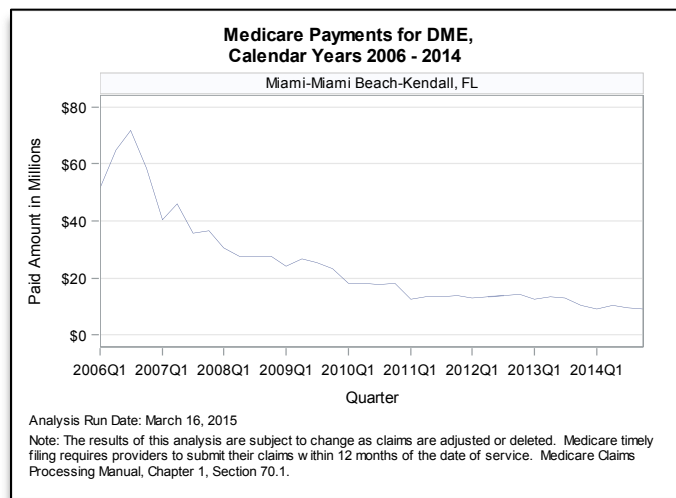
Coordination between the Strike Force teams and the Centers for Medicare & Medicaid Services (CMS) has also contributed to a dramatic decline in payment for home health care in Miami and throughout Florida. After OIG uncovered billing schemes relating to home health outlier payments, CMS put into effect a limit on the percentage of outlier payments that each home health agency (HHA) can claim. Since 2010, Medicare payments for home health care nationally decreased by more than \$250 million per quarter, more than \$1 billion annually.



We have also seen sustained declines in Medicare payments for durable medical equipment (DME) and ambulance services in targeted areas following Federal enforcement and oversight action. Total Medicare payments for ambulance services in Houston, one of the targeted geographic areas, are down more than 40 percent from \$32 million to \$18 million per quarter since 2010.



In 2007, numerous federal oversight and administrative initiatives were launched by CMS, OIG, and others, including the Medicare Fraud Strike Force. Miami-area DME payments decreased from over \$40 million per quarter in 2007, before the Strike Force's first takedown, to \$15 million per quarter in 2011 - with approximately \$100 million in annual savings thereafter. These unprecedented results highlight our continued need for strong data analytic efforts to detect and investigate health care fraud.



MEDICARE FRAUD SCHEMES DRAIN BILLIONS OF DOLLARS AND OFTEN HARM BENEFICIARIES

Fraud Evolves and Migrates

As our health care system evolves, so do the associated fraud schemes. OIG monitors Medicare payments to detect fraud schemes through data analytics and real-time field intelligence from our agents and program integrity partners. Fraud schemes can recur over long periods of time, or emerge as new schemes develop. For example, billing for home health services that are not received is a recurring fraud scheme. By its very nature, this fraud is difficult to detect if both the patient and physician conspire with a fraudulent home health agency to bill for services that were not rendered. An emerging variation of this theme is a beneficiary who receives adult daycare services billed as home health services. Not only is the billing of these services misrepresented, but the services are neither allowed nor medically necessary.

Fraud schemes also migrate. Fraud migration can be associated with enforcement efforts, such as targeted Strike Force action; administrative efforts, such as billing edits and changes in payment policy; or simply because fraud is known to be transient. For example, increased enforcement effort in a specific geographical area may result in migration of criminals to a different geographical area to continue their criminal activity. Fraud also expands and replicates in certain geographical areas as criminals collaborate with one another. If a fraud scheme is successful and continues uninterrupted, criminals will duplicate the scheme, even if the original criminal mastermind has moved to another area. OIG and other program integrity partners diligently track fraud migration of both types and respond as needed to the constantly evolving landscape of health care fraud.

Medicare Fraud is Often Perpetrated by Complex Criminal Networks

Description of Fraud Schemes

OIG continues to investigate complex health care fraud schemes perpetrated by criminal networks. These groups take a systematic, organized approach to committing fraud and can establish hierarchies within their networks. Criminal networks have become a pervasive problem in fraud schemes involving home health, DME, prescription drugs, transportation, and medical clinic settings. Criminal networks may either solicit persons to use as business owners for a sham corporation, or may steal physician or other identities to use for billing false claims to Medicare. They often hire recruiters to buy lists of Medicare patient names and identification numbers or identify parties willing to participate in the

fraud schemes. These groups pose a huge threat to the integrity of the Medicare trust funds because their primary objective is to organize with the intent of stealing as much money from Medicare as quickly as possible.

Enforcement Action

We have worked diligently to stop criminal enterprises by strategically partnering with other law enforcement entities and DOJ. In a recent Strike Force case, an organized criminal network perpetrated a \$6.2 million Medicare fraud scheme involving Miami HHAs. The owners of the HHAs solicited payments from and offered bribes to other businesses to participate in the fraudulent billings. The HHAs used patient recruiters to find complicit Medicare patients and then paid kickbacks for the use of their identities in billing Medicare for home health and therapy services that were never provided. Co-conspirators included clinic owners, therapists, and complicit Medicare beneficiaries. Two of the subjects in the case were each sentenced to serve over 5 years imprisonment, and both were ordered to pay over \$6.2 million in restitution. Others are awaiting sentencing in this matter.

Our investigation of a Michigan pharmacist unraveled a sophisticated criminal enterprise. Twenty-six defendants were convicted for defrauding Medicare of nearly \$58 million. A pharmacist concealed his ownership of 26 pharmacies through the use of straw-owners consisting of physicians, fellow pharmacists, and associates. The pharmacy owners offered and paid kickbacks, bribes, and other inducements to prescribers in exchange for their writing fraudulent prescriptions for Medicare patients. The leader behind the criminal enterprise was sentenced to 17 years in prison and ordered to pay \$18.9 million in restitution, and 5 of his co-conspirators have been sentenced to a combined 19 years in prison and ordered to pay more than \$8.4 million in restitution.

Along with our law enforcement partners and DOJ, we investigated the largest Medicare fraud scheme ever perpetrated by a single criminal enterprise successfully charged by DOJ. Armenian nationals established phantom medical clinics using stolen physician identities to submit entirely fictitious bills to Medicare. Patients did not receive treatments and doctors did not perform services in these “phantom clinics.” The criminals successfully operated over 118 phantom clinics responsible for submitting \$163 million in false claims to Medicare. One of the leaders of this fraud scheme was sentenced to 125 months in prison, and over 28 defendants were charged in total.

Medical Identity Theft Harms Medicare and Its Beneficiaries

Description of Fraud Schemes

Medical identity theft in relation to Medicare occurs when a beneficiary's personally identifiable information (PII) is stolen and then used to fraudulently bill Medicare for medical services, equipment, or prescription drugs. Medical identity theft is on the increase;⁸ it is rampant and is a key element in many of the health care fraud schemes investigated by OIG.

Medical identity theft is often accomplished with the use of recruiters or marketers. Recruiters entice beneficiaries to give their identifying information (including their Medicare numbers or Health Insurance Claim Numbers) by promising the beneficiaries some kind of kickback. This can be in the form of money, services, equipment, prescriptions, or narcotics. Other avenues of illegally acquiring beneficiary PII include the use of insiders who may work in the health care profession and have access to large amounts of beneficiary PII. These insiders steal large volumes of beneficiary PII and then sell it to co-conspirators who have the ability to bill Medicare using this information.

Enforcement Action

Although it may be difficult to predict when and where a fraudulent entity will commit Medical identity theft in the furtherance of health care fraud, OIG has had successes in ensuring that such entities are investigated and prosecuted for these actions.

OIG investigated an HHA owner who paid illegal kickbacks to patient recruiters to obtain the information of Medicare beneficiaries; this information was then used to submit over \$12 million in false claims to Medicare for home health services that were not medically necessary or were not provided. The HHA owner also created fake patient files in an attempt to fool a Medicare auditor and make it appear as though home health services were provided and were medically necessary. This subject has pleaded guilty to Medicare fraud and tax fraud.

OIG investigated a hospice health care fraud case in which the owner paid another individual large sums of money to illegally obtain names and PII for multiple Medicare beneficiaries. The hospice owner then used that illegally obtained beneficiary information

⁸ Ponemon Institute, *Fifth Annual Study on Medical Identity Theft*, February 2015, p. 2, available at http://medidfraud.org/wp-content/uploads/2015/02/2014_Medical_ID_Theft_Study1.pdf.

to fraudulently bill Medicare for millions of dollars of hospice services that were never provided or were for beneficiaries who were not eligible for the hospice services. The hospice owner was sentenced to 70 months imprisonment and 3 years of supervised release. The individual who sold the beneficiary PII for illegal use was sentenced to 14 months imprisonment and 3 years of supervised release for her part in the conspiracy.

OIG investigated a pharmacy chain owner who engaged in a health care fraud scheme by submitting false claims for prescription refills. The pharmacy owner billed Medicare and Medicaid for prescription refills when the beneficiaries had not requested refills and indeed did not receive the refills. The medications targeted for these refills were often expensive HIV and cancer medications intended for very ill customers. The pharmacy owner, along with co-conspirators, falsely used the names and PII of hundreds of beneficiaries to conduct this fraud. This subject was convicted by jury of health care fraud and aggravated identity theft.

OIG Prioritizes Fraud Cases That Jeopardize Patients' Health or Safety

Description of Fraud Schemes

As previously noted, expenditures in Medicare Part D are increasing significantly. The sales of most medications occur legally and go to patients with a documented need. However, OIG is seeing an increasing amount of fraud in Part D and has a wide portfolio of work involving pharmaceutical matters, including prescription drug diversion.⁹ The prescription fraud schemes are complex crimes involving many co-conspirators, including health care professionals, patient recruiters, pharmacies, and complicit beneficiaries. Often it involves other crimes, such as criminal enterprises and medical identity theft. OIG has made Part D fraud one of its top priorities. Our concern is prompted not only by program financial losses, but also by the predictable patient harm that occurs when prescription drugs are not used in their intended manner.

Enforcement Action

In an egregious example of patient harm, a 34 year-old traveling health care technician accessed Fentanyl while on duty. Fentanyl is a powerful pain medication and anesthetic and is a controlled substance. The technician was aware he was infected with the hepatitis C virus. While on duty, he would take the syringes of Fentanyl, inject himself with the drug, refill the syringes with saline, and replace them for use on unsuspecting patients. During this process, he contaminated the syringes with his infected blood. The syringes, now

⁹ See *Spotlight on Drug Diversion*, available at <http://oig.hhs.gov/newsroom/spotlight/2013/diversion.asp>.

tainted with hepatitis C, were injected directly into patients, thereby infecting them with the virus. At least 45 of the patients contracted hepatitis from these injections. After an investigation by OIG and law enforcement partners, he received a 39-year sentence.

Another example of controlled drug fraud involved a physician who wrote illegal prescriptions for complicit beneficiaries, who were transported by the vanload to his practice. There they received medically unnecessary prescriptions for oxycodone-based products. The pseudo-patients used Medicare, Medicaid, and private insurance cards to pay for the prescriptions, then passed more than 700,000 pills to 6 different drug trafficking organizations. The physician along with 61 of his associates received a combined 253 years in prison. The physician himself received 20 years and was ordered to forfeit \$10 million.

Prescription drug fraud and diversion are not limited to controlled substances, but also involve expensive, non-controlled substances, which are often not dispensed by the pharmacy. Both medication groups lead to patient harm when the drugs are not used in medically necessary or approved manner.

An example of non-controlled drug fraud involved a Detroit area hematologist-oncologist. The physician prescribed and administered aggressive chemotherapy and other infusion therapies to patients who did not need them or did not have cancer. He exploited vulnerable patients with a fearful diagnosis, solely to increase billings to Medicare and private insurers. Approximately \$225 million in claims were submitted to Medicare over 6 years. The physician has pleaded guilty, and is awaiting sentencing.

OIG COLLABORATES WITH GOVERNMENT AND PRIVATE SECTOR PARTNERS DOMESTICALLY AND GLOBALLY TO COMBAT HEALTH CARE FRAUD

OIG continuously looks for ways to enhance the relevance and impact of our work by engaging and working with domestic and international partners. For example, because of the need for international assistance to locate and apprehend fugitives from our health care investigations that have left the United States, OIG partners with INTERPOL, the Bureau of Diplomatic Security, and other law enforcement agencies. We currently have over 170 fugitives from our health care fraud investigations. In 2011, OIG established a Most Wanted Fugitive Web site to assist in locating fugitives who are running from health care fraud charges. Since OIG's Most Wanted Fugitives Web site was launched, more than 50 fugitives have been captured. OIG is also actively engaged in the Global Health Care Anti-Fraud Network (GHCAN), which was founded in 2011 to promote partnership and

communication between international organizations in order to reduce and eliminate health care fraud around the world.¹⁰

Domestically, OIG collaborates with internal and external stakeholders to combat health care fraud, as demonstrated by our leadership in both the Healthcare Fraud Prevention Partnership (HFPP)¹¹ and The National Health Care Anti-Fraud Association (NHCAA). HFPP is a groundbreaking partnership between the Federal and private sectors to share data and information for purposes of detecting and combating fraud, waste, and abuse in health care. The HFPP was created as a voluntary public-private partnership, between the Federal Government, State officials, private health insurance organizations, and health care anti-fraud associations. NHCAA is the leading national nonprofit organization focused exclusively on combating health care fraud and abuse.¹² The NHCAA mission is to protect and serve the public interest by increasing awareness and improving the detection, investigation, civil and criminal prosecution, and prevention of health care fraud and abuse.

OIG RECOMMENDS PROGRAM INTEGRITY IMPROVEMENTS TO HELP PREVENT MEDICARE FRAUD

Bringing fraud perpetrators to justice is fundamental to OIG's mission; however, enforcement alone will not solve the problem. The most effective way to fight fraud is to prevent it from occurring. One of the ways OIG seeks to achieve that goal is by making recommendations to address fraud vulnerabilities and better safeguard the Medicare program and its beneficiaries. Below are highlights of key OIG recommendations to help prevent some of the fraud schemes outlined in my testimony. For further details and additional OIG recommendations, see OIG's *Compendium of Unimplemented Recommendations* issued earlier this month.¹³

- **Prescription Drug Abuse: CMS should restrict certain Part D beneficiaries to a limited number of pharmacies or prescribers.** This practice, known as "lock-in," is currently used by some State Medicaid programs and could help reduce inappropriate drug utilization by Part D beneficiaries.¹⁴

¹⁰ For more information on GHCAN, visit: <http://www.ghcan.org/>.

¹¹ For more information on HFPP, visit: <http://hfpp.cms.gov/>.

¹² For more information on NHCAA, visit: <http://www.nhcaa.org/>.

¹³ The *Compendium* is available online at <http://oig.hhs.gov/reports-and-publications/compendium/files/compendium2015.pdf>.

¹⁴ *Part D Beneficiaries With Questionable Utilization Patterns for HIV Drugs*, OEI-02-11-00170, August 2014.

- **Medicare Part C and D Fraud Reporting: CMS should require Medicare Part C (Medicare Advantage) and Part D plan sponsors to report fraud and abuse incidents.** Oversight of Medicare Part C (Medicare Advantage or MA) and Medicare Part D is hampered by a lack of accurate, timely, and complete data on fraud and abuse incidents that would facilitate oversight efforts.¹⁵
- **Inappropriate Home Health Care: CMS should enhance its oversight mechanisms to improve compliance with the home health “face-to-face” requirement.** HHAs are required to obtain documentation that the provider who certifies that a Medicare beneficiary needs home health care had a face-to-face encounter with that beneficiary. This safeguard is intended to reduce inappropriate payments for home health care, but OIG found high rates of noncompliance.¹⁶
- **Social Security Numbers on Medicare Cards: Removing Social Security numbers from Medicare cards is one step that would help protect the PII of Medicare beneficiaries.**¹⁷ Experts in health care program integrity advise that Medical Identity Theft is a prevalent and increasing crime that is closely linked to Medicare fraud, and additional safeguards are needed to protect the identities of beneficiaries.

CONCLUSION

The need to protect the Medicare program and the beneficiaries it serves from fraud and harm has never been more important. OIG, working with our internal and external partners, will continue using data analytics to target our resources for maximum results. We would like to express our appreciation to Congress for their sustained commitment towards our mission and appreciate the Committee’s interest in the vital issue of protecting our Medicare program from fraud. This concludes my testimony. I would be happy to answer your questions. Thank you.

¹⁵ *MEDIC Benefit Integrity Activities in Medicare Parts C and D*, OEI-03-11-00310, January 2013.

¹⁶ *Limited Compliance With Medicare’s Home Health Face-to-Face Documentation Requirements*, OEI-01-12-00390, April 2014.

¹⁷ *CMS Response to Breaches and Medical Identity Theft*, OEI-02-10-00040, October 2012.