

Good morning Chairmen Stark and Lewis, Ranking Members Herger and Boustany, and other distinguished Members of the Subcommittees. I am Lewis Morris, Chief Counsel to the Inspector General for the U.S. Department of Health & Human Services (HHS). I thank you for the opportunity to appear before you today to discuss new tools in the recently enacted Patient Protection and Affordable Care Act (Affordable Care Act or ACA) that will help to combat fraud, waste, and abuse in the health care system.

Fraud, waste, and abuse cost taxpayers billions of dollars each year and put beneficiaries' health and welfare at risk. The impact of these losses and risks is exacerbated by the growing number of people served by these programs and the increased strain on Federal and State budgets. With new and expanded programs under the Affordable Care Act, it is critical that we strengthen oversight of these essential health care programs.

My testimony will describe OIG's strategy for strengthening the integrity of the health care system and how the Affordable Care Act significantly bolsters that effort. It will also describe how OIG is using data, technology, and cutting edge techniques to advance the fight against health care fraud.

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

Although there is no precise measure of health care fraud, we know that it is a serious problem that demands an aggressive response. While the majority of health care providers are honest and well-intentioned, a minority of providers who are intent on abusing the system can cost taxpayers billions of dollars.

Health care fraud schemes commonly include billing for services that were not provided or were not medically necessary, purposely billing for a higher level of service than what was provided, misreporting costs or other data to increase payments, paying kickbacks, and/or stealing providers' or beneficiaries' identities. The perpetrators of these schemes range from street criminals, who believe it is safer and more profitable to steal from Medicare than trafficking in illegal drugs, to Fortune 500 companies that pay kickbacks to physicians in return for referrals.

Many OIG investigations target fraud committed by criminals who masquerade as Medicare providers and suppliers but who do not provide legitimate services or products. The rampant fraud among durable medical equipment (DME) suppliers in South Florida is a prime example. In these cases, our investigations have found that criminals set up sham DME storefronts to appear to be legitimate providers, fraudulently bill Medicare for millions of dollars, and then close up shop and reopen in a new location under a new name and repeat the fraud. The

criminals often pay kickbacks to physicians, nurses and even patients to recruit them as participants in the fraud scheme.

The Medicare program is increasingly infiltrated by violent criminals, and our investigations are also finding an increase in sophisticated and organized criminal networks. For example, in Los Angeles in 2008, six men were charged with running an organized crime ring that stole nearly \$2 million from Federal and private insurers. These criminals stole money from Medicare and other insurers by stealing the identities of legitimate providers and then funneled these funds into other criminal enterprises, including illegal drug rings. During the arrests in these cases, investigators encountered and seized weapons and ammunition, including assault rifles, submachine guns, and handguns, as well as bullet-proof vests.

Some fraud schemes are viral, i.e., schemes are replicated rapidly within geographic and ethnic communities. Health care fraud also migrates – as law enforcement cracks down on a particular scheme, the criminals may shift the scheme (e.g., suppliers fraudulently billing for DME have shifted to fraudulent billing for home health services) or relocate to a new geographic area. To combat this fraud, the Government's response must also be swift, agile, and organized.

Health care fraud is not limited to blatant fraud by career criminals and sham providers. Major corporations such as pharmaceutical and medical device manufacturers and institutions such as hospitals and nursing facilities have also committed fraud, sometimes on a grand scale. OIG has a strong record of investigating these corporate and institutional frauds, which often involve complex billing frauds, kickbacks, accounting schemes, illegal marketing, and physician self-referral arrangements. In addition, we are seeing an increase in quality of care cases involving allegations of substandard care.

Waste of funds and abuse of the health care programs also cost taxpayers billions of dollars. In fiscal year (FY) 2009, the Centers for Medicare & Medicaid Services (CMS) estimated that overall, 7.8 percent of the Medicare fee-for-service claims it paid (\$24.1 billion) did not meet program requirements. Although these improper payments do not necessarily involve fraud, the claims should not have been paid. For our part, OIG reviews claims for specific services, based on our assessments of risk, to identify improper payments. For example, an OIG audit uncovered \$275.3 million in improper Medicaid payments (Federal share) from 2004 to 2006 for personal care services in New York City. As another example, an OIG evaluation of payments for facet joint injections (a pain management treatment) found that 63 percent of these services allowed by Medicare in 2006 did not meet program requirements, resulting in \$96 million in improper payments.

OIG's work has also demonstrated that Medicare and Medicaid pay too much for certain services and products and that aligning payments with market costs could produce substantial savings. For example, in 2007, OIG reported that Medicare reimbursed suppliers for pumps used to treat pressure ulcers and wounds based on a purchase price of more than \$17,000, but that suppliers paid, on average, approximately \$3,600 for new models of these pumps. Likewise, in 2006, Medicare allowed approximately \$7,200 in rental payments over 36 months for an oxygen concentrator that cost approximately \$600 to purchase. Beneficiary coinsurance alone for

renting an oxygen concentrator for 36 months exceeded \$1,400 (more than double the purchase price).

OIG's Five-Principle Strategy Combats Health Care Fraud, Waste, and Abuse

Combating health care fraud requires a comprehensive strategy of prevention, detection, and enforcement. OIG has been engaged in the fight against health care fraud, waste, and abuse for more than 30 years. Based on this experience and our extensive body of work, we have identified five principles of an effective health care integrity strategy.

1. Enrollment: Scrutinize individuals and entities that want to participate as providers and suppliers prior to their enrollment or reenrollment in the health care programs.
2. Payment: Establish payment methodologies that are reasonable and responsive to changes in the marketplace and medical practice.
3. Compliance: Assist health care providers and suppliers in adopting practices that promote compliance with program requirements.
4. Oversight: Vigilantly monitor the programs for evidence of fraud, waste, and abuse.
5. Response: Respond swiftly to detected fraud, impose sufficient punishment to deter others, and promptly remedy program vulnerabilities.

OIG uses these five principles in our strategic work planning to assist in focusing our audit, evaluation, investigative, enforcement, and compliance efforts most effectively. These broad principles also underlie the specific recommendations that OIG makes to HHS and Congress. The Affordable Care Act includes provisions that reflect these program integrity principles and that we believe will promote the prevention and detection of fraud, waste, and abuse in the health care system.

The Affordable Care Act Enhances Health Care Oversight and Enforcement Activities

The breadth and scope of health care reform alter the oversight landscape in many critical respects, and as a result OIG will assume a range of expanded oversight responsibilities. The ACA provides us with expanded law enforcement authorities, opportunities for greater coordination among Federal agencies, and enhanced funding for the Health Care Fraud and Abuse Control (HCFAC) program. In addition, new authorities for the Secretary and new requirements for health care providers, suppliers, and other entities will also promote the integrity of the Medicare, Medicaid, and other Federal health care programs. The following are a few examples of how the ACA will strengthen our oversight and enforcement efforts.

Effective use of data and ensuring the integrity of information are critical to the success of the Government's anti-fraud efforts.

Provisions in section 6402 of the Affordable Care Act will enhance OIG's effectiveness in detecting fraud, waste, and abuse by expanding OIG's access to and uses of data for conducting oversight and law enforcement activities. For example, section 6402 exempts OIG from the prohibitions against matching data across programs in the Computer Matching and Privacy Protection Act and authorizes OIG to enter into data sharing agreements with the Social Security Administration.

The law also requires the Department to expand CMS's integrated data repository (IDR) to include claims and payment data from Medicaid, Veterans Administration, Department of Defense, Social Security Administration (SSA) and Indian Health Service and fosters data matching agreements among Federal agencies. These agreements will make it easier for the Federal Government to help identify fraud, waste and abuse.

Further, the ACA recognizes the importance of law enforcement access to data. Access to "real-time" claims data – that is, as soon as the claim is submitted to Medicare – is especially critical to identifying fraud as it is being committed. Timely data is also essential to our ability to respond with agility as criminals shift their schemes and locations to avoid detection. We have made important strides in obtaining data more quickly and efficiently, and the Affordable Care Act will further those efforts.

In addition to claims data, access to records and other information is of critical importance to our mission. Pursuant to section 6402 of the ACA, OIG may, for purposes of protecting Medicare and Medicaid integrity, obtain information from additional entities – such as providers, contractors, subcontractors, grant recipients, and suppliers – directly or indirectly involved in the provision of medical items or services payable by any Federal program. This expanded authority will enable OIG to enhance our oversight of the Medicare and Medicaid programs. For example, OIG audits of Part D payments can now follow the documentation supporting claims all the way back to the prescribing physicians.

Ensuring the integrity of information is also crucial, and the Affordable Care Act provides new accountability measures toward this end. For example, section 6402 provides OIG with the authority to exclude from the Federal health care programs entities that provide false information on any application to enroll or participate in a Federal health care program. The ACA also provides new civil monetary penalties for making false statements on enrollment applications, knowingly failing to repay an overpayment, and failing to grant timely access to OIG for investigations, audits, or evaluations.

The Affordable Care Act provides the Secretary with new authorities and imposes new requirements that are consistent with OIG's health care integrity strategy and recommendations.

In addition to promoting data access and integrity, health care reform includes numerous program integrity provisions that support an effective health care integrity strategy. Consistent with the OIG's five-principle strategy, these include authorities and requirements to strengthen

provider enrollment standards; promote compliance with program requirements; enhance program oversight, including requiring greater reporting and transparency; and strengthen the Government's response to health care fraud and abuse.

Section 6401 of ACA requires the Secretary to establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The Secretary is to determine the level of screening according to the risk of fraud, waste, and abuse with respect to each category of provider or supplier. At a minimum, providers and suppliers will be subject to licensure checks. The ACA also authorizes the Secretary to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State database inquiries, and random or unannounced site visits. These provisions address significant vulnerabilities that OIG has identified in Medicare's enrollment standards and screening of providers and are consistent with recommendations that we have made to prevent unscrupulous providers and suppliers from participating in Medicare.

Health care providers and suppliers must be our partners in ensuring the integrity of Federal health care programs and should adopt internal controls and other measures that promote compliance and prevent, detect, and respond to health care fraud, waste, and abuse. OIG dedicates significant resources to promoting the adoption of compliance programs and encouraging health care providers to incorporate integrity safeguards into their organizations as an essential component of a comprehensive antifraud strategy. For example, starting later this year, OIG will conduct compliance training programs for providers, compliance professionals, and attorneys across the country. This compliance training will bring together representatives from Federal and State agencies to address local provider, legal, and compliance communities. The training will focus on methods to identify fraud risk areas and compliance best practices so that providers can strengthen their own compliance efforts and more effectively identify and avoid illegal schemes that may be targeting their communities.

The Affordable Care Act authorizes the Secretary to require providers and suppliers to adopt, as a condition of enrollment, compliance programs that meet a core set of requirements, to be developed in consultation with OIG. In addition, the ACA requires skilled nursing facilities and nursing facilities to implement compliance and ethics programs, also in consultation with OIG. These new requirements are consistent with OIG's longstanding view that well-designed compliance programs can be an effective tool for promoting compliance and preventing fraud and abuse. These provisions are also consistent with recent developments in States that have made compliance programs mandatory for Medicaid providers.

Consistent with OIG recommendations, the ACA also facilitates and strengthens program oversight by increasing transparency and reporting requirements. The new transparency requirements will shine light on financial relationships and potential conflicts of interest between health care companies and the physicians who prescribe their products and services. Specifically, section 6002 requires all U.S. manufacturers of drug, device, biologics, and medical supplies covered under Medicare, Medicaid, or CHIP to report information related to payments and other transfers of value to physicians and teaching hospitals. This information will be made available on a public website. The types of payments subject to disclosure have been the source of conflicts of interest and, in some cases, part of illegal kickback schemes in many of OIG's

enforcement cases. OIG already includes similar disclosure requirements in our corporate integrity agreements with pharmaceutical manufacturers as part of the settlement of these cases. The requirement of public disclosure of these payments will help the Government, as well as the health care industry and the public, to monitor relationships and should have a sentinel effect to deter kickbacks and other inappropriate payment relationships.

The quality of care in nursing homes also may improve with the increased transparency required by the Affordable Care Act. Section 6101 requires nursing facilities and skilled nursing facilities to report ownership and control relationships. Disclosure of these relationships is critical to facilitating better oversight of and responding to quality of care and other issues. Historically, law enforcement has struggled to determine responsibility within an organization's management structure. We have had to resort to resource intensive and time consuming investigative and auditing techniques to determine the roles and responsibilities of various management companies that are affiliated with a single nursing facility. Establishing accountability is challenging in part because corporations sometimes intentionally construct byzantine structures that obscure responsible parties from view. OIG has seen a variety of methods used to conceal true ownership, including establishing shell corporations, creating limited liability companies (LLCs) to manage operations of individual homes, creating LLCs for real estate holdings, and creating affiliated corporations to lease and sublease among the various inter-owned corporations. The new requirements for disclosure of ownership and control interests will help ensure that corporate owners and investment companies that own nursing homes will no longer be able to provide substandard care, deny responsibility, and leave underfunded shell companies to take the blame.

Additional transparency provisions in the ACA will shine light on the administration of the Medicare and Medicaid programs. Section 6402 will require Medicare and Medicaid program integrity contractors to provide performance statistics, including the number and amount of overpayments recovered, number of fraud referrals, and the return on investment of such activities, to the Inspector General and the Secretary. This latter requirement is consistent with OIG's call for greater accountability in the performance and oversight of CMS' program integrity contractors.

In addition to strengthening the Government's ability to detect fraud and abuse, the Affordable Care Act strengthens the Government's ability to respond rapidly to health care fraud and hold perpetrators accountable. For example, it expressly authorizes the Secretary, in consultation with OIG, to suspend payments to providers based on credible evidence of fraud. Significantly, the ACA also increases criminal penalties under the Federal Sentencing Guidelines for Federal health care offenses and expands the types of conduct constituting Federal health care fraud offenses under Title 18 of the United States Code. Put simply, criminals who commit health care fraud are going to be cut off from the Medicare Trust Funds faster, serve longer prison terms, and face larger criminal fines.

Each of these integrity provisions advances the fight against fraud, waste, and abuse. Further, we expect that the combined impacts of these new program integrity measures will be greater than the sum of the parts. Preventing unscrupulous providers and suppliers from gaining access to the health care programs and beneficiaries is the first step in an integrated integrity strategy.