

HEALTH CARE FRAUD INVESTIGATIONS

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
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HEALTH CARE FRAUD INVESTIGATIONS

WEDNESDAY, SEPTEMBER 28, 2016

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:00 a.m., in Room 1100, Longworth House Office Building, the Honorable Peter Roskam [Chairman of the Subcommittee] presiding.
[The advisory announcing the hearing follows:]



WAYS AND MEANS

CHAIRMAN KEVIN BRADY

Chairman Roskam Announces Hearing on Health Care Fraud Investigations

House Committee on Ways and Means Subcommittee on Oversight Chairman Peter J. Roskam (R-IL) today announced that the Subcommittee will hold a hearing on health care fraud investigations. **The hearing will take place on Wednesday, September 28, 2016 at 10:00 AM in Room 1100 of the Longworth House Office Building.**

Oral testimony at the hearing will be from the invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

Details for Submission of Written Comments:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, October 12, 2016**. For questions, or if you encounter technical problems, please call (202) 225-3625 or (202) 225-2610.

Formatting Requirements:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and

submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>.

Chairman ROSKAM. The subcommittee will come to order.

Good morning and welcome to the Ways and Means Subcommittee on Oversight's hearing on health investigations and Medicare fraud. Fraud is a serious problem throughout health care with some experts estimating that up to 10 percent of healthcare spending is fraudulent. That would mean that Medicare alone, that this committee has jurisdiction over, the government is spending nearly \$60 billion a year in fraudulent payments. That is an incredible cost. Think about it in the context of this time of year where people are trying to negotiate different end-of-year spending plans and how much more flexibility you would have with \$60 billion that weren't being literally thrown away. This hearing is a continuation of the subcommittee's work over the past 2 years in trying to understand the causes and solutions to this incredible problem.

One aspect to the problem is that not only taxpayers impacted, but may fraud schemes actively harm patients. In the past, a lot of our discussions have been focused in on the financial aspects alone. And while finances do matter, we need to recognize that this hurts people. And one of the most egregious examples is the case of Dr. Fata, a well-known cancer physician in Michigan. He purposely misdiagnosed people, so think about that. He misdiagnosed people, went to them falsely, told them that they had cancer, which they didn't have. And think about the heart sink of that news, manipulating them in order to provide them with treatments which he would bill Medicare and private health insurance companies for in the millions of dollars. Several patients who were perfectly healthy ended up dying because of his actions.

In other instances, fraudsters may bill Medicare for opioids and other prescription drugs and then sell them on the black market. Here not only is the taxpayer footing the bill for unnecessary narcotics, but also this contributes to the country's growing opioid and painkiller epidemic. I know nearly every Member of Congress has

seen this uptick—not just an uptick, an incredible high rate of activity—in this area in all of our congressional districts across the country. So, even when a fraudster doesn’t physically harm someone, the fraud creates significant and long-term damage down the line.

Many fraudsters steal beneficiaries’ identities and use them to bill Medicare, another issue that Congress is dealing with and this committee is dealing with. Once a person’s identity is stolen and used to improperly collect Medicare benefits, that person can be prohibited from accessing necessary care down the line, because they are already in Medicare system and receiving service.

So think about it: A fraudster gets your benefit. Then you legitimately need something. You go to Medicare, and Medicare says, “Sorry, your benefit has already been used up.” “Well, what do you mean my benefit has been used up? It has not been used up. I haven’t used it.” And a fraudster has done it. So, if it can be done, fraudsters are finding a way to do it.

At the beginning of this Congress, this subcommittee held a hearing on Medicare fraud and improper payments from the 10,000-foot level. We heard from the Centers for Medicare & Medicaid Services, or CMS, about their methods to detect and prevent improper payments, and the results were not particularly reassuring.

Despite the fact that Congress has given the agency expanded authority to stop payments before they are made, it continues to rely disproportionately on pay-and-chase, or making the payment and only checking after the fact to see if it was proper. One of the difficulties that we in Congress have when trying to legislate to reduce improper payments and also fraud is how the budget process works. According to the Congressional Budget Office, or CBO, preventing the government from spending money improperly is not savings because the money should have never been paid in the first place. I mean, this logic just completely suspends all bits of rationality that should foster it. It makes no sense in the real world, and that is not how American families handle their own household finances.

And this committee finds it just outrageous to be told in pursuing some of these things, well, that doesn’t, quote, “score well.” The fact is money is going out the door, and there are steps Congress can take to stop these crimes and save taxpayers from having to pay billions of dollars in improper payments in fraud.

Additionally, CBO does not take into account that cost that fraud incurs in addition to the stolen money. These costs include the amount of time and resources that law enforcement needs to investigate and prosecute cases, attempting to retrieve the money already out the door in fraudulent payments, or in repairing patient harm.

And no one can deny that the drug crisis continues to grow. We have spent billions of dollars fighting the drug epidemic. Just a few months ago, Congress passed CARA, the Comprehensive Addiction and Recovery Act, that authorizes \$620 million over 10 years to help fight the opioid epidemic. It is an important step, but we also need to focus on healthcare fraud contributes to that problem.

Last year, we got a closer look at some of the tools CMS uses to detect fraud. Members of the subcommittee took a field trip, and we went up to CMS' Center for Program Integrity in Baltimore. We got to see the fraud prevention system, CMS' predictive analytics program, firsthand, and we were encouraged by what we saw. But we remain concerned that CMS relies too heavily on pay-and-chase, rather than preventing potentially fraudulent payments from getting out the door. And we hope to see greater improvements going forward.

At our hearing last year, I drew a comparison between how the private sector and the government investigate fraud. In the private sector, a credit card company can detect unusual behavior—and guess what, my credit card has been—whether my credit card has been stolen instantaneously, and this actually happened to me. A witness from Visa testified that their improper payment rate is less than 1 percent. Compare that to the numbers that I have been talking about a minute ago, that are well over 10 percent. But when I asked CMS why it can't do the same thing, the witness from CMS said, "Well, Medicare claims are more complicated." And it is one of those answers, at first blush, you say, "Oh, yeah, that's right; Medicare claims are more complicated," but in fact, if Medicare claims are more complicated, it is more complicated for fraudsters to make them look legitimate. So then isn't it true and doesn't it follow that predictive analytics and other data analysis would make it easier for that to be disclosed? It is important not only to save taxpayers but also to save patients who are being harmed by these criminals.

But no matter how good data analytics get, there will still be the need for investigations and law enforcement, and that is the final piece of puzzle, and that is what we are focusing on today. We have got an excellent panel of witnesses, who I will introduce in a few minutes. They have been active in detecting, investigating, and prosecuting fraud cases. Two of our witnesses worked on the Dr. Fata investigation that I referenced earlier. And thanks in part to their tenacious work, he has been sentenced to 45 years in prison. The work these witnesses do is incredibly important, and I know I speak for the whole subcommittee. I look forward to their insights.

Now, I would like to yield to my friend and colleague, the Ranking Member, Mr. Lewis.

Mr. LEWIS. Good morning.

Mr. Chairman, before we begin, I would like to announce that today is the last hearing for Drew Crouch, the Democratic Oversight Subcommittee staff director. This is actually the second time that Drew worked for the committee. He first joined the Ways and Means Committee tax staff in 2009 and served with us for over 4 years. Drew returned last year to be the Oversight Subcommittee staff director. Working with Drew has been wonderful. He is pleasant, passionate, and committed. His work is so good that others keep stealing him, but I hope that he will not forget us and will keep doing the good work, the people's work, in his next great position. Drew is a good and kind spirit, and he will be deeply missed. I want to thank him for his years of service and wish him good luck in his next position.

Mr. Chairman, I want to thank you for holding this hearing today, but I would also like to thank all of the witnesses for being with us today. Each and every person here knows that Medicare is an important program for seniors and the disabled. Fifty-six million people rely on Medicare to receive health care.

Today, several witnesses will speak about a terrible criminal case where a doctor treated healthy patients with chemotherapy. Medicare is a key part of the very fabric of our country, signed into law by President Lyndon Johnson in 1965. What is happening is unbelievable. It is unreal. That is what makes these stories so alarming.

I applaud the Obama Administration on their effort to take a hard line on waste, fraud, and abuse. They launched the HEAT Task Force, which coordinates resources and information across the government agencies. The administration also developed a Medicare fraud prevention system which uses advanced technology to track possible fraud.

It is also worth noting that the Affordable Care Act has stronger tools to fight fraud. These include new penalties, better funding for the healthcare fraud and abuse control account, new screening and enrollment tools for Medicare and Medicaid.

Let me be clear: People who are committing fraud in Medicare are criminals; no doubt about it. They prey on the disadvantaged, the sick, the weak, the elderly among us. Each and every one of us must do our best to fight and end Medicare fraud. Congress has a duty, a mission, a mandate and a moral obligation to provide the necessary resources for law enforcement to investigate and prosecute these criminals.

There is no doubt that the stories we will hear about are horrible. But in our fight against fraud, we must be mindful. We must be careful, and we must put Medicare patients first. Patients must continue to have access to necessary medical treatment. We must do all we can to preserve their choice of doctors and hospital. My friend, this is not a Democratic issue or a Republican issue. This is a question of standing up for all Americans, especially for seniors and for the disabled. It is what is right. It is what is just. It is what is fair.

And, again, Mr. Chairman, I want to thank you for holding today's hearing. And I look forward to the testimony of our witnesses.

Chairman ROSKAM. Thank you, Mr. Lewis. And I think you said it well; this is a question of standing up. And three people who have stood up are witnesses today.

The first is Barbara McQuade, United States attorney of the Eastern District of Michigan. You will find two sympathetic ears in former U.S. attorneys here, Mr. Meehan and Mr. Holding.

Abhijit Dixit, special agent, Office of Investigations, Office of Inspector General, Department of HHS. Welcome.

And Scott Ward, senior vice president, Health Integrity, LLC.

You each have 5 minutes for your testimony, and we welcome you.

Ms. McQuade, you are recognized.

**STATEMENT OF BARBARA MCQUADE, UNITED STATES
ATTORNEY, EASTERN DISTRICT OF MICHIGAN**

Ms. MCQUADE. Chairman Roskam, Ranking Member Lewis, distinguished Members of the Committee, thank you so much for inviting me to speak to you today about the Department of Justice's efforts to combat healthcare fraud. I am deeply honored to be with you here today.

Every year, the Federal Government spends hundreds of billions of dollars to provide health care to the most vulnerable members of our society. And while most medical providers are doing the right thing, some exploit Medicare and other healthcare programs for their own financial benefit. This fraud deprives patients of resources needed to pay for medical services and places patients at risk of harm from unnecessary treatments. Medicare fraud also motivates some doctors to overprescribe opioids to patients who don't need them for legitimate medical purposes, and that is contributing to our Nation's opioid epidemic. For these reasons, fighting healthcare fraud is the top priority of Department of Justice.

The Department brings the vast majority of its civil cases under the False Claims Act. Since 2000, our attorneys, working with other Federal, State, and local law enforcement agencies, have recovered over \$1 billion every year in FCA settlements and judgments.

In fiscal year 2015, the Department recovered over \$2 billion in civil healthcare settlements and judgments, and anticipates matching, if not exceeding, that amount this fiscal year. Since 2009, the Department has recovered over \$18.5 billion in civil healthcare fraud cases.

The Department's criminal healthcare fraud efforts have also been a success. Beginning in March of 2007, the Criminal Division's Fraud Section, working with the U.S. Attorney's Office, the FBI, HHS OIG, and State, and local law enforcement agencies launched the Medicare Fraud Strike Force in Miami. Based on the success of these efforts and increased appropriated funding for healthcare fraud from Congress and the administration, strike force operations are now in nine areas of the United States, including Detroit. The strike force focuses on the worst offenders in regions with the highest known concentrations of fraud.

Today, our criminal enforcement efforts are at an all-time high. In 2016, the Department of Justice organized the largest national healthcare fraud takedown in history, both in terms of individuals charged and the loss amount. On June 22, Attorney General Lynch and Secretary Burwell announced that the nationwide takedown, led by the Medicare Fraud Strike Force and 36 U.S. attorneys' offices, including mine, resulted in charges against 301 individuals, including 61 doctors, nurses, and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving \$900 million in false billings.

In addition, CMS suspended payments to a number of providers using authority provided by the Affordable Care Act. Cases included schemes to submit claims to Medicare for treatments that were medically unnecessary or never provided or allegations that patient recruiters were paid cash kickbacks in return for supplying

beneficiary information to providers so that those providers could submit false Medicare claims.

The AUSAs in my own district, working with the strike force, have handled a wide variety of healthcare matters. And I would like to talk particularly about the case of Dr. Farid Fata, which Chairman Roskam mentioned. Dr. Fata was a licensed medical doctor who owned and operated Michigan Hematology Oncology, the largest cancer treatment center in Michigan. A former office manager at Fata's clinic reported to the Department that Fata was administering chemotherapy to patients who did not need it. The investigation showed that, from 2007 to 2013, Fata prescribed and administered unnecessary aggressive chemotherapy cancer treatments and intravenous iron and other infusion therapies to patients. Some of his patients did not have cancer at all. Fata then submitted fraudulent claims to Medicare and other insurers for these unnecessary treatments. On August 6, 2013, Fata was charged an indictment. He pleaded guilty of 13 counts of healthcare fraud and related charges. And in July 2015, he was sentenced to 45 years in prison for his role in his healthcare fraud scheme that included administering unnecessary infusions and injections to 553 individual patients and submitting bills to Medicare and other insurance companies totaling \$34 million in fraudulent claims.

Thank you for this opportunity to provide an overview of the Department's healthcare efforts and successes. I would be happy to respond to any questions that you might have at the appropriate time.

Chairman ROSKAM. Thank you, Ms. McQuade.

[The prepared statement of Ms. McQuade follows:]



Department of Justice

STATEMENT OF

**BARBARA L. MCQUADE
UNITED STATES ATTORNEY
EASTERN DISTRICT OF MICHIGAN**

BEFORE THE

**SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES**

FOR A HEARING ON

HEALTH CARE FRAUD INVESTIGATIONS

**PRESENTED
SEPTEMBER 28, 2016**

**Statement of
Barbara L. McQuade
United States Attorney, Eastern District of Michigan
Before the Subcommittee on Oversight
Committee on Ways and Means
U.S. House of Representatives
September 28, 2016**

Chairman Roskam, Ranking Member Lewis, and distinguished Members of the Committee, thank you for inviting me to speak with you today about the Department of Justice's efforts to combat health care fraud. I am honored to appear before you on behalf of the Department of Justice (the Department), along with the Office of Inspector General, Department of Health and Human Services (HHS-OIG). The Department is grateful to the Committee for its leadership in this area, and we appreciate the opportunity to appear before you here today.

Health care fraud is a serious and costly problem in our country. It threatens the integrity of Medicare, as well as all federal, state, and private health care programs. Every year the Federal Government spends hundreds of billions of dollars to provide health care to the most vulnerable of our society – our seniors, children, disabled, and needy. We have a duty to ensure that these funds are spent on providing proper medical treatment to our citizens. While most medical providers and health care companies are doing the right thing, there are some that target Medicare and other government and private health care programs for their own financial benefit. Every dollar stolen from our health care programs is one dollar too many. Medicare and Medicaid fraud deprives patients of resources needed to pay for medically necessary services. It also places patients at risk of harm from unnecessary or unapproved treatments. For these reasons, fighting health care fraud is a priority of the Department.

The 93 United States Attorneys and their assistants (AUSAs), and the Criminal Division, Fraud Section's Medicare Fraud Strike Force trial attorneys are the principal prosecutors of federal criminal health care fraud violations, representing the Department and the interests of the American taxpayer. Together with attorneys from the Civil and Civil Rights Divisions (the Civil Rights Division enforces the Civil Rights of Institutionalized Persons Act), we appear in both criminal and civil cases in the federal courts in the 94 judicial districts across the country, and with agents from the Federal Bureau of Investigation (FBI), our colleagues at HHS-OIG and the Centers for Medicare and Medicaid Services (CMS), and other affected federal and state agencies, we are fighting back against health care fraud. We investigate, prosecute, and secure prison sentences for hundreds of defendants every year, recovering billions of dollars in stolen funds, and making significant strides in prosecuting unscrupulous individuals and corporations.

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC or the Program) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS), acting through the Inspector General, designed to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse. Because coordination across Departments is an integral part of preventing and prosecuting health care fraud, in 2009 the Health Care Fraud Prevention and Enforcement Action Team (HEAT), was created. HEAT is a senior level joint task force created and designed to marshal the combined resources of the Department and HHS to combat all facets of the health care fraud problem. Under the current leadership of Attorney General Loretta E. Lynch and HHS Secretary Sylvia Mathews Burwell, we continue to be committed to making fighting health care fraud a Cabinet-level priority for both the Department and HHS. In Fiscal Year 2015, the government's health care fraud and prevention efforts recovered approximately \$2.4 billion related to health care fraud and false claims and returned these funds to CMS, the U.S. Treasury, other federal agencies, and individuals. By joining forces to coordinate federal, state, and local law enforcement activities to fight health care fraud, the Department's efforts have been successful.

THE DEPARTMENT'S CIVIL HEALTH CARE FRAUD WORK

The Department's civil attorneys – both in the United States Attorneys' Offices and the Department's Civil Division – aggressively pursue civil enforcement actions to root out fraud and to recover funds on behalf of federal health care programs, like Medicare and Medicaid. The Department brings the vast majority of its civil cases under the False Claims Act (FCA), 31 U.S.C. §§ 3729- 3733, one of the Department's most powerful civil enforcement tools. This success under the FCA is reflected in the results: Since 2000, our attorneys, working with the HHS-OIG, the FBI, TRICARE (the government-funded health care program for certain military personnel and their dependents), the U.S. Department of Veterans Affairs, FEHBP (the health care program for federal employees, funded in part by the government), and other federal, state, and local law enforcement agencies, have recovered over \$1 billion every year in FCA settlements and judgments. In Fiscal Year 2015, the Department recovered over \$2 billion in civil health care fraud settlements and judgments and anticipates matching, if not exceeding, that amount this fiscal year. Since 2009, the year the HEAT Initiative was launched, the Department has recovered over \$18.5 billion in cases involving fraud against federal health care programs.

The Civil Division has successfully pursued hundreds of FCA cases against various health care providers. Matters involving pharmaceutical and device manufacturers continue to constitute some of the most significant matters pursued by the Civil Division this past year. The

Civil Division also pursued several significant matters involving alleged violations of the Anti-Kickback Statute (AKS), which prohibits the willful solicitation or payment of remuneration to induce the referral or purchase of a good or service covered by federal health care programs, as well matters involving alleged claims for services that were not medically necessary or eligible for reimbursement.

As an example of these significant matters, in the area of device companies, in this fiscal year, Olympus Corporation of the Americas – the largest distributor of endoscopy and related equipment – and its subsidiary, Olympus Latin America Inc., agreed to pay \$646 million to resolve criminal and civil claims relating to a kickback scheme involving the marketing and selling of its endoscopy equipment. The combined federal and state civil settlement of \$310.8 million included a \$267 million recovery for the United States – the largest amount paid to the Federal Government for violations involving the AKS by a medical device company. The government alleged that Olympus paid remuneration to physicians and hospitals, including consulting payments, foreign travel, lavish meals, and millions of dollars in grants and free endoscopes to induce hundreds of millions of dollars in the sales of endoscopes and related equipment. The government further alleged that Olympus lacked an effective compliance program to monitor or stop this fraudulent conduct.

In the area of pharmaceutical companies, in this fiscal year, Wyeth and Pfizer, Inc. agreed to pay \$784.6 million to resolve FCA claims that Wyeth underpaid rebates owed under the Medicaid Drug Rebate Program (MDRP) and caused the submission of false claims to federal health care programs. The Federal Government's portion was approximately \$413 million. Pursuant to the MDRP, drug manufacturers must pay quarterly rebates to state Medicaid programs in exchange for Medicaid's coverage of the manufacturers' drugs. The government alleged that Wyeth underpaid drug rebates for its proton pump inhibitor drugs, Protonix Oral and Protonix IV, by failing to disclose to the Medicaid program the "best prices" Wyeth had offered to thousands of hospitals under a contract that bundled the two drugs together. Wyeth allegedly offered hospitals steep discounts on these two drugs with the expectation that patients would continue using Protonix Oral after they were discharged from the hospitals. The United States alleged that by failing to account for these steep hospital discounts, Wyeth underestimated and underpaid the quarterly rebates it owed on those drugs to the state Medicaid programs.

These significant cases represent the continued success of the collaborative efforts of the Department's civil attorneys – both in the United States Attorneys' Offices and the Department's Civil Division, and our federal, state, and local partners.

THE DEPARTMENT'S CRIMINAL HEALTH CARE FRAUD WORK

The Department's criminal health care fraud efforts have also been a tremendous success. Beginning in March 2007, the Criminal Division's Fraud Section, working with the United States Attorney's Offices, the FBI and law enforcement partners in HHS-OIG, and state and local law enforcement agencies, launched the Medicare Fraud Strike Force in Miami-Dade County, Florida, to prosecute individuals and entities that claim to provide legitimate health care services, but instead exist solely for the purpose of defrauding Medicare and other government health care programs. Based on the success of these efforts and increased appropriated funding for the HCFAC program from Congress and the Administration, federal law enforcement has expanded Strike Force operations to a total of nine areas in the United States – Miami and Tampa, Florida; Detroit, Michigan; Los Angeles, California; Dallas and Southern Texas; Brooklyn, New York; Southern Louisiana; and Chicago, Illinois. In sum, the Strike Force focuses on the worst offenders in regions with the highest known concentration of fraudulent activities.

Today, our criminal enforcement efforts are at an all-time high. In Fiscal Year 2016, the Department organized the largest national health care fraud takedown in history, both in terms of individuals charged and the loss amount. On June 22, 2016, Attorney General Lynch and Secretary Burwell announced that the nationwide takedown led by the Medicare Fraud Strike Force and 36 U.S. Attorneys' Offices resulted in charges against 301 individuals, including 61 doctors, nurses, and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$900 million in false billings. In addition, CMS suspended payment to a number of providers using its payment suspension authority as provided in the Affordable Care Act. Typical health care fraud cases involved in the takedown include schemes to submit claims to Medicare for treatments that were medically unnecessary or never provided; or allegations that patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers so that those providers could submit false Medicare claims.

On the investigative side, in recent years the Federal Government has prioritized health care fraud prevention, which has allowed the Department, United States Attorney's Offices, the FBI, and HHS to expand and develop new tools that facilitate the detection and investigation of fraudulent providers. For example, CMS incorporates data from Medicare and Medicaid into a system called the Integrated Data Repository. This system can be accessed and utilized to support criminal investigations by federal prosecutors and agents, as well as state agencies. Increased use of this system has led to smarter investigations and prosecutions, as targets' fraudulent claims leave a trail in the data that can be used to identify or confirm suspected fraudulent practices, corroborate witness testimony, and develop new leads.

This “smart” investigation and prosecution model has increased law enforcement’s ability to detect high-risk providers and suppliers in geographic and health service areas across the country. Data analysis techniques also enable law enforcement to allocate resources to address emerging schemes and schemes that migrate from one community to another. These new data analytics not only powerfully assist in fighting fraud, but also assist in further safeguarding the public fisc. Using data to identify and quantify aberrant billing trends and financial damage to government health care programs, we are better able to focus and shift resources to build cases against high-impact targets in high-risk fraud regions. Indeed, investigators, AUSAs, and Strike Force prosecutors alike regularly analyze claims data from their districts in order to determine which actors (both locally and nationwide) pose the greatest risk to the Medicare system.

RECENT MEDICARE FRAUD STRIKE FORCE OPERATIONS

The success of the Department’s Medicare Fraud Strike Force program was recently recognized in a New York Times editorial, which noted that the Department’s progress in combating health care fraud goes beyond saving money, but also leads to better patient care and is crucial to maintaining the public’s confidence in the health care system.¹ An example of how the Strike Force works to save money and provide better health care is the eleven-count indictment issued against five individuals who managed and controlled a network of Brooklyn, New York area clinics that purported to provide physical and occupational therapy to Medicare and Medicaid beneficiaries. The defendants and their co-conspirators paid bribes and kickbacks to beneficiaries and Brooklyn-area ambulance drivers in order to induce the beneficiaries to be subjected to medically unnecessary physical therapy treatment at the clinics. The defendants billed Medicare and Medicaid for over \$86 million for this purported treatment and were paid over \$38 million. The defendants then used over 15 different shell companies to launder their shares of the proceeds from the fraud and hide the proceeds from the IRS in order to avoid paying taxes on any of the stolen Medicare and Medicaid Funds.

Another example of working to recover money and provide better care occurred in June 2016 when the Strike Force charged an owner and operator of a medical clinic, Amex Medical; the manager of Amex; and a physician in Houston, Texas, with conspiracy to commit health care fraud. The charges stemmed from the defendants’ role in an \$18 million Medicare fraud scheme whereby the defendants would sell fraudulent home health certifications signed by co-conspirator physician to various home health agencies in Houston. In June 2016, a grand jury returned a second indictment against the same physician in Houston, Texas, charging him and the owner of Milten Clinic with one count of conspiracy to commit health care fraud stemming from their roles in a \$19.2 million Medicare fraud scheme. In this scheme, the owner of the

¹ Fraud and Other Threats to Medicare, *New York Times* (July 28, 2016), available at http://www.nytimes.com/2016/07/28/opinion/fraud-and-other-threats-to-medicare.html?_r=0.

clinic sold false home health certifications signed by the same physician to numerous home health agencies in Houston, Texas. Both of these cases are filed and ongoing cases.

U.S. ATTORNEY'S OFFICE FOR THE EASTERN DISTRICT OF MICHIGAN

The AUSAs in my own district, working with the Strike Force, have handled a wide variety of health care matters, including false billings by doctors and other providers of medical services, overcharges by hospitals, Medicaid fraud, kickbacks to induce referrals of Medicare and Medicaid patients, fraud by pharmaceutical and medical device companies, and failure of care allegations against nursing home owners. The following is a recent example of a case brought by the Eastern District of Michigan Strike Force, which demonstrates the health care fraud efforts in my district:

DOCTOR FARID FATA

Farid Fata, M.D

Doctor Fata was a licensed medical doctor who owned and operated Michigan Hematology Oncology P.C. (MHO) cancer treatment clinic. MHO had seven locations in Eastern Michigan. A former office manager at Fata's clinic noticed that many staff were quitting Fata's practice. One doctor who quit reported to the office manager that Fata was administering chemotherapy to patients who did not need it. This doctor also reported that Fata's patients who were in hospice care were taken out of hospice care and put on chemotherapy treatments.

In 2013, the office manager reported these allegations to the Department. The FBI, HHS-OIG, and the Internal Revenue Service Criminal Investigation Division (IRS-CI) and were brought in as part of the Medicare Fraud Strike Force, under the supervision of the Criminal Division's Fraud Section and the U.S. Attorney's Office of the Eastern District of Michigan, to investigate Dr. Fata. Their investigation, which included examining a large amount of records, showed that from August 2007 to approximately August 2013, Fata prescribed and administered unnecessary aggressive chemotherapy, cancer treatments, and intravenous iron and other infusion therapies to patients. Fata then submitted fraudulent claims to Medicare and other insurers for these unnecessary treatments. To further his scheme, Fata solicited kickbacks from Guardian Angel Hospice and Guardian Angel Home Health Care in exchange for his referral of patients to those facilities. Fata also used the proceeds of the health care fraud at his medical practice, MHO, to promote the carrying on of additional health care fraud at United Diagnostics, where he administered unnecessary and expensive positron emission tomography (PET) scans for which he billed a private insurer.

After conducting their investigation, on August 6, 2013, Fata was charged and arrested with, among other things, health care fraud, conspiracy, and money laundering. At the time of his arrest Fata had the largest private cancer clinic in the state of Michigan. Fata pleaded guilty in September 2014, to 13 counts of health care fraud, one count of conspiracy to pay or receive kickbacks and two counts of money laundering. On July 10, 2015, Fata was sentenced to serve 45 years in prison for his role in his health care fraud scheme that included administering medically unnecessary infusions or injections to 553 individual patients and submitting to Medicare and private insurance companies approximately \$34 million in fraudulent claims.

The Results of Collaborative Efforts

The above example demonstrates that health care fraud, even especially complex health care fraud, can be targeted quickly and successfully. The Strike Force and United States Attorney's Office teams successfully facilitated the coordination of the necessary agents and personnel needed to immediately investigate and stop Fata's dangerous actions.

In addition to the success of the Strike Force Model, AUSAs in my district have also had success in combatting health care fraud. Along the lines of patient harm, the opioid epidemic in our country negatively and tragically impacts so many people's lives. The problem is compounded when trusted medical providers abuse the health care system for their own private gain, such as Dr. Oscar Linares, who my office prosecuted.

Between April 1, 2008 and March of 2011, Linares operated the Monroe Pain Center located in Eastern, Michigan. Investigation by the Drug Enforcement Administration, the FBI, HHS, the Internal Revenue Service, and local law enforcement agencies showed that Linares prescribed millions of dosage units of Schedule II, III and IV narcotics, including opiates such as Oxycontin, oxycodone, and opana to patients. Their investigation showed that Linares prescribed controlled substances for as many as 250 patients per day, and paid bonuses to his employees when the number of patients who were prescribed controlled substances in a single day exceeded 200. Based on undercover patient visits, employee interviews and former patient interviews, it was established that Linares actually saw very few of the patients. Even when he briefly saw a patient, there was no legitimate examination or doctor-patient relationship.

In 2011, Linares was charged with unlawfully distributing prescription drug controlled substances, including the Schedule II prescription drug OxyContin (oxycodone), and health care fraud. Linares pled guilty to these charges on December 29, 2015. Linares admitted to illegally prescribing over 1.2 million dosage units of controlled substances, a conservative estimate. Linares also fraudulently billed Medicare by submitting patients to medical tests without regard to their symptoms or medical conditions. He was sentenced on July 12, 2016 to 57 months in prison followed by three years of supervised release. He was also ordered to forfeit to the United

States approximately \$236,000 seized from bank accounts; jewelry, such as Tiffany, Mont Blanc, Rolex, and Invicta watches; luxury vehicles, including a 2005 Bentley Continental, two Hummers, a 2005 Porsche 911, a 1987 Ferrari Testarossa, a 2007 Lincoln Town Car, and a 2006 Lexus RX400; two boats; Mont Blanc luxury items; and Louis Vuitton luggage and accessories. All of the above items were proceeds from his illegal billing of the Medicare program.

In pronouncing the sentence, United States District Court Judge Victoria Roberts described the case as “a serious breach of the public trust,” and “deliberate drug dealing by a doctor.” She termed Linares’ crimes as a “callous disregard” of his “obligation to do no harm.” Referencing the significant number of medical professionals convicted in similar cases, she stated, “This court cannot tolerate the level of abuse that has been going on by medical professionals.” The same will not be tolerated by the Department.

CONCLUSION

In 1996, HIPAA established a national HCFAC under the joint direction of the Attorney General and the Secretary of HHS. The program was designed to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse. In its twentieth year of operation, strengthened by the new tools and resources provided by the Affordable Care Act, and reaffirmed by the commitment of the HEAT initiative to improve law enforcement coordination, the program’s continued success again confirms the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud or abuse, and to protect program beneficiaries.

AUSAs in the U.S. Attorneys’ Offices, trial attorneys in the Civil, Civil Rights, and Criminal Divisions, the FBI and HHS agents, as well as other federal, state, and local law enforcement partners are working together across the country with unprecedented success. We are poised to continue these successes in the years ahead, and look forward to continuing this important work with our federal, state, and local partners to that end. Thank you for the opportunity to provide this overview of the Department’s health care fraud efforts and successes. I would be happy to respond to any questions you might have.



Chairman ROSKAM. Mr. Dixit.

STATEMENT OF ABHIJIT DIXIT, SPECIAL AGENT, OFFICE OF INVESTIGATIONS, OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. DIXIT. Good morning, Chairman Roskam, Ranking Member Lewis, and distinguished Members of the Subcommittee. I am Abhijit Dixit, a special agent with the United States Department of Health and Human Services, Office of the Inspector General. Thank you for the opportunity to testify and describe the work that I and my fellow agents perform to protect Medicare and Medicaid beneficiaries and to fight against healthcare fraud.

I am here this morning to give you a field agent's perspective in the investigation of providers that defraud healthcare programs. The work of our special agents has a valuable and positive impact across the Nation. During the last 3 fiscal years, OIG investigations have resulted in over \$10.9 billion, 2,856 criminal actions, 1,447 civil actions, and 11,343 program exclusions.

It is important to point out OIG investigations are typically conducted in partnership with investigators of other Federal and State agencies, as well as private sector. OIG participates in Medicare Fraud Strike Force teams that combine the resources of Federal, State, and local law enforcement to prevent and combat healthcare fraud across the country.

A clear example of success came in June 2016 when I and approximately 350 fellow OIG agents partnered with over 1,000 law enforcement personnel to execute the largest healthcare fraud take-down in history involving approximately \$900 million in false billings. Despite our success, more work remains to be done across the Nation. To accomplish our mission, we employ sophisticated data analytics, which is a valuable tool in detecting fraud. However, it is necessary to combine the insights gained with field intelligence. Traditional field intelligence is obtained through witness and subject interviews, execution of search of warrants and surveillance, which is critical to reveal the scope and nature of the fraud scheme and whether patients are being harmed.

I would like to emphasize that Medicare fraud is not a victimless crime. It is not just about the loss of taxpayer dollars when fraud is committed. Medicare beneficiaries can suffer physical harm. One case of which I was personally involved is of a Detroit area hematologist-oncologist, Dr. Fata, who was sentenced last year to serve 45 years in prison. Dr. Fata used false cancer diagnosis and unwarranted dangerous treatments as tools to steal millions of dollars from Medicare.

Let me describe my work as a field agent for this case. The initial phase of the investigation, determining whether the allegations were credible, lasted just 5 days. Near real-time data was retrieved and analyzed to identify witnesses who could give us more information. As evidence was uncovered, it became clear that patient-related decisions were made to maximize reimbursement rather than to advance the best interest of the patient. At this point, traditional law enforcement techniques were deployed and a command post was set up to relay information directly and immediately to a pros-

ecution team. On the fifth day, Dr. Fata was arrested, and six search warrants were executed.

OIG special agents are specifically trained to identify and address potential patient harm and work with law enforcement team prior to the execution of the operation to protect patients. In conjunction with DOJ and the FBI, a victim assistance hotline was set up to provide around-the-clock information to affected patients. We also deployed additional staff to each operational site that morning.

While such stark cases of direct physical harm in the pursuit of profit like this one are not the most common, it is far from the only example.

Another priority for the OIG is the enforcement and prevention of prescription drug fraud. In one example of prescription drug diversion, a Michigan pharmacist, Mr. Patel, and a network of pharmacies were among 37 defendants convicted for their roles in a widespread scheme to defraud Medicare and Medicaid of nearly \$58 million.

In conclusion, I would like to underscore the commitment of the OIG in protecting program beneficiaries in fighting healthcare fraud. The highly specialized investigative work of our special agents combined with cutting-edge data analytics continue to prove effective in making a valuable and positive impact.

Thank for the opportunity to speak to you today. I would be happy to answer any questions.

Chairman ROSKAM. Thank you, Mr. Dixit.

[The prepared statement of Mr. Dixit follows:]



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***

Health Care Fraud Investigations

Testimony of:

Abhijit Dixit
Special Agent
Office of Investigations
Office of Inspector General
Department of Health and Human Services

September 28, 2016

10:00 a.m.

Location: 1100 Longworth House Office Building

Testimony of:

Abhijit Dixit

Special Agent, Office of Investigations

Office of Inspector General, U.S. Department of Health and Human Services

Good morning, Chairman Roskam, Ranking Member Lewis, and distinguished Members of the Subcommittee. I am Abhijit Dixit, a Special Agent with the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG). I appreciate this opportunity to describe the work that my fellow OIG agents and I in Detroit do to protect Medicare and Medicaid beneficiaries and to fight health care fraud.

I am here this morning to give you a field agent's perspective. I investigate medical providers that defraud Federal health care programs through the submission of false claims or other prohibited acts and, in doing so, place the safety and well-being of program beneficiaries at risk. Today, my testimony will describe both the manner in which OIG investigates allegations of health care fraud and the schemes that present continued threats to the integrity of the Medicare and Medicaid programs.

The work of OIG's special agents has a valuable and positive impact across the country. During fiscal years 2013 through 2015, OIG investigations nationally resulted in more than \$10.9 billion in investigative receivables, or dollars ordered or agreed to be paid to Government programs as a result of criminal, civil, or administrative judgments or settlements. In addition, our investigations led to 2,856 criminal actions, 1,447 civil actions, and 11,343 program exclusions.¹ Beyond these statistical accomplishments, OIG special agents are on the front lines, interacting daily with Medicare and Medicaid beneficiaries and providers. Though difficult to quantify, a valuable part of our work is protecting beneficiaries from harm.

It is important to point out that our special agents' work is typically conducted in partnership with other Federal and State agencies as well as the private sector. We partner with other investigators, auditors, evaluators, and attorneys in OIG and in other agencies to most effectively investigate and prosecute fraud. These partnerships are invaluable in our enforcement successes. For example, OIG has strong relationships with Medicaid Fraud Control Units (MFCUs), which are State-level investigative units with which we work on the majority of our Medicaid investigations. As a former MFCU investigator, I know firsthand the benefits of leveraging the specialized knowledge of agents in each State's Medicaid program. Through several task forces and other partnerships we often work hand in hand with multiple Federal agencies.

OIG also participates in Medicare Fraud Strike Force teams that combine the resources of Federal, State and local law enforcement entities to prevent and combat health care fraud across the country. The Medicare Strike Force effort began in March 2007 and expanded to seven cities, including Detroit, in 2009. The Strike Force, which now operates in nine locations, has charged more than 2,900 defendants who collectively have falsely billed the Medicare program over \$8.9 billion. A clear example of success came in June 2016, when I was among

¹ OIG has the authority to exclude individuals and entities from federally funded health care programs. The effect of an exclusion is that no payment will be made by any Federal health care program for any items or services furnished, ordered or prescribed by an excluded individual or entity.

approximately 350 OIG agents who partnered with more than 1,000 other law enforcement personnel to execute the largest health care fraud takedown in history. The takedown, led by the Medicare Fraud Strike Force, resulted in criminal and civil charges against 301 individuals, including 61 doctors, nurses, and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately \$900 million in false billings.

Through coordinated enforcement efforts across the country, including those of the Strike Force teams, criminal prosecutions and monetary recoveries have increased while we have seen a measurable decrease in payments for certain medical services targeted by fraud schemes. We believe that one measure of success is that annual Medicare payments for home health services nationally decreased by more than \$1 billion since calendar year 2010. In Detroit, payments to home health care agencies have decreased by \$100 million annually. These declines followed targeted enforcement activities as well as policy changes, such as the implementation of temporary moratoriums on new home health agency enrollments, increased payment suspensions, and payment reforms. OIG identifies systemic vulnerabilities and makes recommendations to the Centers for Medicare & Medicaid Services (CMS) to better prevent fraud. In the case of moratoriums, OIG provides information and CMS evaluates the existing provider and supplier base, including factors such as how a temporary moratorium will affect access to care. Despite this measurable success, more work remains in Detroit and across the nation.

OIG USES SOPHISTICATED DATA ANALYTICS AND REAL-TIME FIELD INTELLIGENCE TO ENHANCE ENFORCEMENT EFFORTS

The schemes used to steal money from Medicare and Medicaid are multifaceted. Schemes can be as simple as billing for a service not actually performed, or as complex as an organized criminal enterprise. The perpetrators of these frauds can range from highly respected physicians to individuals with no prior experience in the health care industry. Regardless, they all have one thing in common – greed. Unscrupulous providers motivated by greed often put profit before patients' health and safety, creating potentially dangerous patient care environments.

Health care fraud cases share similarities. However, no two cases are exactly the same, and each investigation presents unique challenges. OIG receives complaints or investigative leads from a variety of sources, including the OIG hotline, law enforcement partners, beneficiaries, providers, and informants. Traditional means of identifying fraud include conducting interviews of cooperating witnesses and surveillance.

To accomplish our mission, OIG employs data analytics and real-time field intelligence to detect and investigate program fraud and to target our resources for maximum impact. OIG is a leader in the use of data analytics, employing a dedicated data analytics unit. Gathering claims data and other electronic information from multiple sources and efficiently and effectively merging that information into a manageable and usable format is a highly specialized skill. Our special agents have direct access to Medicare claims data and use innovative methods to analyze billions of data points to identify trends that may indicate fraud, geographical hot spots, emerging schemes, and individual providers of concern. We also use data throughout an investigation to identify

potential witnesses or co-conspirators and conduct interviews as efficiently and effectively as possible.

It should be noted that although data analytics is important and helpful, it is necessary to combine the insights gained from it with valuable field intelligence. For example, the data alone may not reveal the complex structure of a criminal enterprise. Data analytics may not determine whether kickbacks are being paid, services are being rendered, or patients are being harmed. Traditional field intelligence obtained by investigators through witness and subject interviews, execution of search warrants, surveillance, and evidence review is still critical in revealing the scope and nature of a fraud scheme.

OIG PRIORITIZES FRAUD CASES THAT JEOPARDIZE PATIENTS' HEALTH OR SAFETY

I would like to emphasize that Medicare and Medicaid fraud affects more than the public coffers. When fraud is committed, beneficiaries can suffer harm and neglect.

OIG addresses all allegations of fraud as swiftly as possible by allocating scarce investigator time on the basis of available information. However, certain allegations of patient harm further heighten the sense of urgency, and we mobilize our teams and work around the clock to protect patients. An example of this, in which I was personally involved, is the case of a Detroit-area hematologist-oncologist, Dr. Farid Fata, sentenced last year to serve 45 years in prison. Dr. Fata used false cancer diagnoses and unwarranted, dangerous treatments as tools to steal millions of dollars from Medicare and private insurance companies.

When the Department of Justice (DOJ) received a complaint from Dr. Fata's office manager, OIG and our law enforcement partners acted immediately. We simultaneously began the initial phase of the investigation—determining whether the allegations were credible—and took steps to protect the potentially affected patients.

From the investigative perspective, we retrieved and analyzed near real-time claims data to identify witnesses who could give us more information. We also began deploying traditional law enforcement techniques, which included conducting surveillance, interviewing key witnesses, serving subpoenas, and reviewing documents. We established a command post as a single point for investigators to relay information immediately to a prosecution team. All available special agents were given assignments and worked through the weekend to identify the credibility of the allegation. Once we were able to develop enough evidence to corroborate the initial allegation, we obtained several warrants. Before executing any warrant, we develop an operational plan. In this case, the plan included information about the subject to be arrested, his criminal history and background; team assignments; emergency information, including the address of the nearest hospital; and detailed information about the location where the search and arrest warrants would be executed. A judge signed the warrants at approximately 4 a.m. On the same day, just after 6 a.m., the doctor was arrested and six search warrants were executed.

OIG special agents are trained to identify and address potential patient harm. Using this training, I worked with the law enforcement team before the operation was executed to protect patients in many ways beyond the criminal investigation and prosecution. We deployed additional staff to each operational site where warrants were executed to provide information directly to patients and the public. OIG agents and other law enforcement personnel referred affected patients to a specially created victim-assistance hotline, staffed by DOJ, which provided around-the-clock information.

We accomplished all of this—the initial phase of the investigation, the arrest, and the patient protection efforts—in just 5 days.

Additionally, CMS suspended payments to Dr. Fata. As evidence was uncovered, it became clear that patient-related decisions were made to maximize reimbursement rather than to advance the best interests of the patient. Dr. Fata pleaded guilty to health care fraud and other charges for his role in this scheme that included administering medically unnecessary infusions or injections to 553 individual patients and submitting to Medicare and private insurance companies approximately \$34 million in fraudulent claims.

While such stark examples of direct physical harm to patients are rare, the case of Dr. Fata is far from the only example of a provider subjecting patients to significant harm in the pursuit of profit.

Dr. Aria Sabit, another Detroit-area physician, performed unnecessary, invasive spinal surgeries and implanted costly and unnecessary medical devices, all at the expense of his patients' health and welfare. Dr. Sabit, a neurosurgeon, lied to patients about the procedures' medical necessity and what he actually did. He persuaded patients to undergo spinal fusion surgery that included specific medical devices designed to stabilize and strengthen the spine. But he did not perform that surgery. Instead, Dr. Sabit performed a different operation not related to lumbar and thoracic fusion. He also sometimes billed for implants not provided and falsified operative reports that he knew would later be used to support his fraudulent insurance claims. Dr. Sabit subsequently billed Medicare, Medicaid and private insurance companies \$11 million for those fraudulent services. In some cases, patients experienced serious bodily injury and ended up in worse condition than before the surgery. Dr. Sabit has pleaded guilty in two separate criminal cases and awaits sentencing.

Other examples, which are found in numerous OIG investigations, include physicians writing medically unnecessary controlled substance prescriptions for pseudo-patients in exchange for cash or submission by a patient to medically unnecessary services – for which the provider would bill. Such medically unnecessary services include diagnostic testing, uncomfortable nerve conduction studies, or monthly office visits.

CERTAIN HEALTH CARE PROGRAMS ARE CONSISTENTLY TARGETS FOR FRAUD

The fraud schemes we see in Detroit mirror those across the country, but with distinct variations. Often, fraud schemes evolve and migrate from one region of the country to another. To avoid

detection as enforcement increases, either through law enforcement action or policy and payment changes, criminal networks may conduct geographical research to “test” combinations of billing codes identifying payment edits before the “breakout” billing and subsequent submission of a high number of false claims. The “breakout” billing is often visible through targeted data analytics, and OIG special agents work with our multidiscipline experts to identify these spikes early to prevent further fraud. Several organized criminal enterprises migrated from Miami, which is often considered “ground zero” for health care fraud, to Detroit. We have closely coordinated with our Miami office to target these schemes. Program areas susceptible to widespread fraud include, among others, home- and community—based services, and prescription drugs. OIG focuses on these areas and they represent a significant portion of our enforcement efforts, both in Detroit and nationally.

OIG PRIORITY: ENFORCEMENT AND PREVENTION OF HOME- AND COMMUNITY-BASED SERVICES FRAUD

Home- and community-based services, including Medicare home health and Medicaid personal care services (PCS), help beneficiaries continue to live in their homes and avoid costly and disruptive facility-based care. Although OIG has had significant successes in combatting fraud in these programs, we continue to identify and investigate fraudulent providers in Medicare Strike Force areas, including Detroit. OIG home health investigations (which is where I have had the most experience) have resulted in more than 350 criminal and civil actions and \$975 million in investigative receivables for fiscal years 2011 - 2015.

Home health fraud schemes generally involve billing for services that are not medically necessary and/or not provided. For example, in April 2016 Dr. Jacques Roy and three home health agency (HHA) owners were convicted for their roles in a \$375 million fraud scheme. At the time, this was the nation’s largest home health care fraud carried out by a single doctor. As part of the scheme, the perpetrators recruited patients at homeless shelters, in grocery stores, and by door-to-door solicitation to sign up for Medicare home health services. Dr. Roy falsely certified, and later recertified, beneficiaries as being eligible to receive home health care. His office staff falsified medical documentation to support the eligibility certifications and support billing for services that were never provided. Dr. Roy also visited some of the recruited patients’ homes and then billed Medicare for unnecessary home visits. Two additional HHA owners and an office manager pleaded guilty for their roles in this scheme. Dr. Roy awaits sentencing.

OIG identified Dr. Roy following proactive data analytics targeting suspicious billing. The physician’s office processed and approved certifications for 11,000 unique Medicare beneficiaries from more than 500 different home health agencies. Typical physicians refer fewer than 100 patients for home health services. Our data analysis identified this physician as an extreme outlier, but that was only the beginning of this investigation. The massive scope, multiple co-conspirators, and falsified records meant the dedication of significant OIG investigative resources to protect patients and taxpayer dollars. During execution of the search warrant in this case, the amount of physical and digital evidence collected was unprecedented, and presented challenges to the investigative team. Arrangements were made to store the over

900 boxes seized, and nearly all of OIG’s digital investigations staff were required to handle the 40 terabytes of data seized.

The investigation of six metro Detroit-area HHAs is another example in Michigan involving kickbacks and the billing of Medicare for nonrendered or medically unnecessary home health services. Our investigations resulted in the convictions of 14 physicians, HHA owners, and patient recruiters. The investigation revealed that beneficiaries’ personal information was acquired by patient recruiters. In exchange for their personal information, the recruiters gave the beneficiaries cash and illicit prescription drugs. One of the HHA owners, Naseem Minhas, charged with \$4 million in fraudulent billing, admitted that in addition to paying kickbacks, he assisted in creating false patient files to make it appear as though the patients needed and received the services. To date, these convictions have resulted in just over 36 years in prison sentences.

OIG is committed to protecting the financial integrity of home- and community-based services and the health and welfare of the people served. We previously published a personal care services [Portfolio](#)² and recently published a home health [online Portfolio](#),³ which pulls together information about our body of home health work, including enforcement actions, reports, and recommendations.

OIG PRIORITY: ENFORCEMENT AND PREVENTION OF PRESCRIPTION DRUG FRAUD

Another priority for OIG is enforcement action against and prevention of prescription drug fraud. Prescription drug abuse is a rapidly growing national health care problem, and our nation is in the midst of an unprecedented opioid epidemic.⁴ As of early September 2016, OIG had 678 pending complaints and cases involving Medicare Part D, which represents a 152-percent increase in the last 5 years.

Medicare and Medicaid prescription drug diversion—the redirection of prescription drugs for an illegal purpose—is a serious component of this epidemic. Although the diversion of controlled substances, such as opioids, is of paramount concern, the diversion of noncontrolled substances is becoming more common. In these cases, noncontrolled substances are combined with opioids and other controlled substances to exaggerate the user’s “high” – making noncontrolled drugs susceptible to abuse. Fraud related to both controlled and noncontrolled drugs results in significant financial losses to Medicare and Medicaid and, more importantly, may also result in patient harm and even death.

In one example of prescription drug diversion, a Michigan pharmacist and a network of pharmacies were among 37 defendants convicted for their roles in a widespread scheme to defraud Medicare and Medicaid of nearly \$58 million. According to the indictment, the

² *Personal Care Services: Trends, Vulnerabilities, and Recommendations for Improvement* (OIG-12-12-01)

³ [HHS OIG Online Portfolio: Home Health](#)

⁴ Centers for Disease Control and Prevention, *Prescription Painkiller Overdoses at Epidemic Levels* [press release], Nov. 1, 2011.

pharmacist either owned or controlled 26 pharmacies, although he concealed his ownership and control over many years through the use of “straw” owners. The pharmacist offered and paid kickbacks, bribes, and other inducements to prescribers who wrote fraudulent prescriptions for patients under Medicare, Medicaid, and private insurance, and directed the patients to fill the prescriptions at one of his pharmacies.

The scheme was detected when OIG special agents reviewed prescription drug claims data for a physician under investigation in another matter. The network of pharmacies began to emerge as an outlier. OIG joined forces with other law enforcement agents who had also identified the pharmacy network as suspicious. The investigation involved examining records for evidence of kickback payments, interviewing witnesses and other cooperators, surveillance, and the execution of multiple arrest and search warrants.

Evidence revealed that the pharmacist and those working for him billed Medicare and other insurers for dispensing the medications, despite the fact that the medications were medically unnecessary and/or were never provided. From January 2009 to August 2011, his pharmacies dispensed approximately 250,000 doses of OxyContin, 4.6 million doses of Vicodin, 1.5 million doses of Xanax, and 6,100 pint bottles of codeine cough syrup.

The pharmacist was sentenced to 17 years in prison and ordered to pay \$18.9 million in restitution. In addition, 14 other pharmacists, 9 doctors, 6 business associates, 4 patient recruiters/drug dealers and 3 pharmacy technicians were sentenced to a combined 92½ years in prison, and ordered to pay collectively more than \$84 million in restitution.

Combatting prescription drug fraud continues to be an enforcement priority, and OIG will remain vigilant in investigating emerging trends.

CONCLUSION

In conclusion, I would like to underscore OIG’s commitment to protecting program beneficiaries and fighting health care fraud. The highly specialized investigative work of our special agents, combined with cutting edge data analytics, continue to prove effective in making a valuable and positive impact. By leveraging partnerships and building on the success of the Medicare Strike Force, OIG’s investigators will continue to prevent, detect, and fight fraud.

It has been a pleasure to discuss our work and to describe some of our recent successes in protecting Medicare and Medicaid beneficiaries from harm and taxpayer dollars from theft. Thank you again, for inviting OIG to speak with the Subcommittee today. I hope that our work and this testimony will assist you in your oversight efforts. I would be happy to answer any of your questions.

Chairman ROSKAM. Mr. Ward.

**STATEMENT OF SCOTT WARD, SENIOR VICE PRESIDENT,
HEALTH INTEGRITY LLC**

Mr. WARD. Good morning, Chairman Roskam, Ranking Member Lewis, and distinguished Members of the Subcommittee. I am Scott Ward, senior vice president of Health Integrity and program director of ZPIC Zone 4. I am here today, and I appreciate the opportunity, to tell the committee about the important work that we do at the Centers for Medicare & Medicaid Services in protecting the integrity of the Medicaid and Medicare program.

Health Integrity is a nonprofit corporation incorporated in 2006 and is a wholly owned subsidiary of the Quality Health Strategies. Our corporate headquarters are in Easton, Maryland, and we have offices located throughout the United States. We have 285 nationwide employees. And we also have a large resource pool of statisticians, data analysts, predictive modeling specialists, medical directors, nurses, certified coders, subject-matter experts on policy, communication specialists, auditors, and investigators. Our staff understands the healthcare delivery system and the differences in provider fraud, waste, and abuse actions across all provider types in all settings and in the fee-for-service and managed-care payment environments.

We also understand how fraud is committed and how abusive practices lead to poor and inadequate patient care and program vulnerabilities. We also know how beneficiary and provider improper actions cause wasteful expenditures of program funds and ultimately improper payments. Our contracts with CMS include all aspects of the Medicare program integrity operation. We are the Zone Program Integrity Contractor for Zone 4, which investigates fee-for-service claims for Medicare and Medicaid in Texas, Oklahoma, New Mexico, and Colorado. We are also the National Benefit Integrity Medicare Prescription Drug Contractor with a responsibility to identify and investigate incidents of fraud, waste, and abuse in the Medicare Advantage and the Medicare prescription drug programs.

We also have the Audit Medicaid Integrity Contractor that identifies Medicaid overpayments in 34 States and the District of Columbia. Additionally, we hold a UPIC IDIQ as well.

Health Integrity was awarded the ZPIC Zone 4 contract on September 30, 2008, and was the first ZPIC awarded by CMS. The primary focus of the ZPIC is to protect the Medicare trust fund by preventing, detecting, and deterring fraud, waste, and abuse in the Medicare and Medicaid programs.

The ZPIC authority includes investigating and analyzing Medicare Parts A, B, durable medical equipment, home health, hospice, and the Medicare and Medicaid data match programs operating in conjunction with State Medicaid agencies.

These investigative activities are conducted through proactive and reactive methods and actions that may be taken to correct these problems to help ensure that future fraudulent billing practices or improper payments are not made. Investigative leads are both reactive and proactive. Reactive leads are identified from outside source complaints, such as referrals from Medicare Adminis-

trative Contractor, beneficiary complaints, ex-employees, Office of Inspector General hotline complaints, and the CMS fraud prevention system. Proactive leads are identified through data analysis, local knowledge, subject-matter expertise, and policy review.

During Health Integrity's investigative process, Health Integrity is constantly looking to implement any available administrative action that can be taken to effectuate a correction or elimination of the identified fraudulent or abusive claim submission or medical service scheme. ZPIC uses multiple tools to combat fraud, waste, and abuse. These efforts are effective through or collaborative partnerships with CMS, law enforcement and other stakeholders. The work that ZPIC does is an important function in the overall CMS effort to combat fraud, waste, and abuse in the Medicare and Medicaid programs. We are proud of our contributions we have made in this process.

This concludes my statement, and I would be welcome to take any questions you may have.

Chairman ROSKAM. Thank you, Mr. Ward. I thank all of you.
[The prepared statement of Mr. Ward follows:]

Health Care Fraud Investigations
Testimony before the
Committee on Ways and Means Subcommittee on Oversight

By

S. Scott Ward, CFE, AHFI
Senior Vice President
Health Integrity, LLC

September 28, 2016

Good morning, Chairman Roskam, Ranking Member Lewis, and members of the subcommittee. I am Scott Ward, Senior Vice President of Health Integrity, LLC and Program Director for ZPIC Zone 4. I appreciate the opportunity to tell the committee about the important work we do to support the Centers for Medicare & Medicaid Services (CMS) in protecting the integrity of the Medicare and Medicaid programs.

Health Integrity, LLC—a non-profit corporation incorporated in 2006—is a wholly-owned subsidiary of Quality Health Strategies, Inc. (QHS). Health Integrity’s corporate headquarters are located in Easton, MD; we have nine branch offices in Maryland, Texas, Pennsylvania, Florida, and Georgia. With 285 nationwide employees, Health Integrity’s large resource pool includes statisticians, data analysts, predictive modeling specialists, medical directors, registered nurses, certified coders, subject matter experts, communication specialists, auditors, investigators, and business analysts. Our staff understands the healthcare delivery system and the differences in provider fraud, waste and abuse actions across all provider types, all settings of care, and in the fee-for-service and managed care payment environments.

HI is a trusted, experienced and highly competent Medicare and Medicaid contractor for CMS and selected states. We understand how fraud is committed, how abusive practices lead to poor and inadequate patient care and program abuse/vulnerabilities. We also know how beneficiary and provider improper actions cause wasteful expenditures of program funds and ultimately improper payments.

Our contracts with CMS include all aspects of the Medicare program integrity operations. We are the Zone Program Integrity Contractor (ZPIC) for Zone 4 that reviews Medicare fee-for-service claims for the states of Texas, Colorado, Oklahoma, and New Mexico. In addition, we are the National Benefit Integrity Medicare Prescription Drug Contractor (NBI MEDIC) with responsibility to identify and investigate incidents of fraud, waste, and abuse in the Medicare Advantage (Part C) and Medicare Prescription Drug (Part D) programs. We are also the Audit Medicaid Integrity Contractor (Audit MIC) that identifies Medicaid overpayments in as many as 34 states and the District of Columbia.

ZPIC Contractual Operations

Health Integrity (HI) was awarded the ZPIC Zone 4 contract on September 30, 2008 as the first ZPIC awarded by CMS. The primary focus of the ZPIC is to protect the Medicare Trust Fund by preventing, detecting, and deterring fraud waste and abuse in the Medicare and Medicaid programs. The ZPIC's authority includes investigating and analyzing Medicare Parts A&B, DME, home health, hospice and the Medicare-Medicaid data match programs operated in conjunction with state Medicaid agencies. These investigative activities are conducted through proactive and reactive activities to identify program violations so that immediate actions may be taken to correct these problems and help ensure that future fraudulent billing practices or improper payments are not made.

The process in which the ZPIC obtains a lead for investigation is through multiple channels, all of which, go through the hands of multiple Health Integrity departments each with their unique functions and expertise. There are both reactive and proactive leads. Reactive leads are identified from outside source complaints (e.g. referrals from the Medicare Administrative Contractor (MAC), beneficiary complaint, ex-employees, Office of Inspector General (OIG) hotline complaints and the CMS Fraud Prevention System). The Fraud Prevention System (FPS) uses predictive models to identify suspicious providers. HI receives Alert Summary Reports (ASR) from FPS on a daily basis that identifies providers in Zone 4 for possible fraud, waste, and abuse. HI utilizes information in the ASR and conducts additional data analysis and research to determine if the ASR warrants investigation. Proactive leads are identified through data analysis, local knowledge, subject matter expertise, and policy review.

Health Integrity utilizes Intake Investigators to review the incoming proactive and reactive leads to conduct a preliminary analysis of multiple factors including: the amount of money involved in the allegations, the seriousness of allegation (i.e. is quality of care a factor), Medicaid exposure, type of allegation (e.g. medical necessity vs non-rendered services), the area in which the allegation is located, and the source itself. The results are applied to a prioritization matrix to determine the priority level of the investigation. When the lead meets criteria for investigation it is passed onto the investigative team headed by Lead Investigators who maintain quality control of work product and workload equality.

A typical preliminary investigation includes interviewing beneficiaries, site verifications of provider offices (to determine they are an active provider and ruling out False Front providers), and further background review (e.g. further data analysis which would include peer review,

procedure and utilization review, referring provider review, and cross-claim analysis between Medicare and Medicaid). In this process, the Investigator determines the need for Prepay and Postpay review. HI deploys a multidisciplinary team which includes investigators, nurses and data analysts to review requests for prepay and postpay analysis. This helps to define resources needed for the investigation, the parameters of the review, and necessity of conducting review.

During this preliminary process, other administrative actions are considered for action such as revocation of the provider and payment suspension of future claims submitted by the provider. This helps define for the Investigator milestones to watch for during the process and is further defined through investigative file review with their Lead Investigator. If an investigation determines a postpay review is warranted, the Data team is engaged to define the Medicare claims universe/population and a Statistically Valid Random Sample is drawn. Provider records, principally the patients' medical records are requested at this point. The Medical Review Team then reviews the obtained provider records and analyzes the details of the medical services documented against Medicare National and Local Coverage Determinations, Federal Register requirements for meeting the Medicare standards for claiming medical services, Medicare Program Eligibility Documents, and specific state Medicaid Policies in the event that the patients/beneficiaries are dually eligible for Medicare and Medicaid services. In the case of dual eligible involved claims, state Medicaid records are obtained and considered in the investigation.

During the entire investigation, Health Integrity is looking to implement any available administrative action that can be taken to effectuate a correction or elimination of the identified fraudulent or abusive claims submission or medical service scheme. For instance, if the provider is not located at the physical office location where they say they practice medicine or deliver the medical service and no change of location is noted at the MAC, Health Integrity will implement

an administrative revocation action to remove the provider from the Medicare program and suspended payment for any pending claims. A revocation implements a maximum 3-year “time out” from billing Medicare whereas the suspension holds all payments until a medical review can be performed to determine if an overpayment condition exists if the claims were paid.

If during an investigation, it was determined there is a credible allegation of fraud, Health Integrity will request a suspension of payment (through CMS) to determine the actual overpayment. This process includes a medical review of any claims that are suspended in payment. The ending result is an actual amount of “proper” payments left in escrow that can be applied to any inappropriate payments identified in the postpay review of records. During a typical investigation, where postpay determines or interviews determine credible allegations of fraud, Health Integrity will draft a referral to the OIG for further law enforcement processing. In the instance where OIG is unable to accept the referral, a copy is sent to the FBI and if the Medicaid program is involved (full dual eligible beneficiaries) the State Medicaid agency and Medicaid Fraud Control (MFCU) are sent a copy, as well. If the referral is accepted by OIG, Health Integrity assists Law Enforcement with their investigation through the established Request For Information (RFI) process where the OIG outlines the assistance they need. In the event the referral is not accepted by any agency, HI will request from the provider any overpayments noted and education materials will be given the provider, if no further administrative action could occur.

Examples of this process is our work on the Riverside General Hospital Investigation. A complaint on this provider was received by our Contract Task Order 2 Medi-Medi Department with an allegation that services were not rendered as claimed. Through proactive analysis, it was determined that the facility was supplying an abnormally high number of partial hospitalization

services and acting as a community mental health center. Our investigators interviewed beneficiaries and determined that patients were not receiving services as claimed by Riverside. The facility was placed on suspension and 100% prepay review which in turn resulted in a significant overpayment and savings for the Medicare Trust Fund. The provider was referred to law enforcement which resulted in 5 people indicted and convicted (combined 85 years in prison and over \$77 million in restitution). Health Integrity provided expert and fact testimony during the trial. In addition, the provider was revoked from participation in the Medicare program.

Another example is the Doctor Jacques Roy case, originally identified through proactive data analysis. This case involved over 77 home health agencies in which Roy allegedly referred patients for unnecessary home health services. The case escalated to an identified \$375 million in Medicare payment fraud. Health Integrity assisted law enforcement by placing 77 home health agencies on payment suspension, conducted in excess of seven hundred beneficiary interviews that resulted in the identification of additional overpayments and revocations. This case resulted in a conviction of Roy (and three other defendants) in April 2016 in which, Roy was convicted of conspiracy of health care fraud. Health Integrity provided expert and fact testimony during the trial.

Another example includes collaboration with CMS and the Texas State Medicaid Health and Human Services-OIG to conduct onsite investigations. In the past year, Health Integrity and CMS has conducted three separate projects involving home health agencies and referring providers with no prior relationships (beneficiaries referred by provider but no prior relationship with said referred provider). To date, these efforts have resulted in multiple payment suspensions, revocations, and referrals to law enforcement. Most recently, one of the referring physicians was indicted and arrested in McAllen, Texas.

Health Integrity's work as a ZPIC also includes identifying and reporting program vulnerabilities to CMS for their consideration in making program policy or procedure changes. For instance:

Health Integrity identified a gap in Medicare policy in how many different providers could provide diabetic test strips to one patient. In Oklahoma, we found up to 15 DME providers were providing diabetic tests strips to one patient. Through beneficiary interviews, it was determined that the patient in fact had several different types of diabetic monitors that they were using that were provided "free" by these agencies. The current policy does not support the number of monitors a patient can have; therefore, leaving a vulnerability for providers to take advantage of the system.

The work of the ZPIC's is an important function in the overall CMS effort to combat fraud, waste and abuse in the Medicare program. We are proud of the contributions we have made in this process. This concludes my prepared statement and I welcome your questions.

Chairman ROSKAM. I think it is so interesting. We have a lot of questions for you. And the first person that you will hear from is Mr. Holding.

Mr. HOLDING. Thank you, Mr. Chairman.

Ms. McQuade, Mr. Dixit, it is truly a notable case, the Fata case.

Ms. McQuade, how did you originally find out about the case? What was the trigger that got you looking at Dr. Fata?

Ms. MCQUADE. The Dr. Fata case to us from a whistleblower. The office manager in his office was someone who heard from some of the doctors, noticed that some of them were resigning, and found out that Dr. Fata was prescribing unnecessary medical treatment. So he came into the office, and as Agent Dixit said, we took it very seriously. We, frankly, thought it sounded too outrageous to be true, but we knew that, if it was true, we needed to act quickly. And so I am very proud of how hard the agents and prosecutors worked around the clock to be able to take him down within 5 days, to make sure that, as Ranking Member Lewis has said, patient care needs to be of paramount concern. And it was in that case, and that is why I am so proud of the work of those prosecutors and agents.

Mr. HOLDING. Did you have a grand jury open looking at fraud and just plugged that in there? Did you bring it to a grand jury, or did you just have enough evidence to go and get an arrest warrant?

Ms. MCQUADE. We charged him in a complaint initially and then continued to investigate additional incidents, continued to talk to additional witnesses, and ultimately presented it to a grand jury. But we were able to act quickly by charging him in a complaint and executing the six search warrants on a Tuesday morning.

One thing that was very important to us was making sure that patient care continued and so, again, due to the good thinking of the agents and the prosecutors, came up with a protocol so that patients could obtain their patient records and patient files even after they had been seized by agents so that they could take them to another cancer provider and to ensure continued patient care.

Mr. HOLDING. And how long—it was a period of 6 years that he had been doing this, \$34 million, multiple patient deaths.

Mr. Dixit, you referenced sophisticated data analysis that you all used, I assume, to proactively to look for fraud. So how was he able to elude data—your sophisticated data analysis for so long to such a great extent?

Mr. DIXIT. Thank you for that question, Congressman. Data analytics is a very valuable tool, as I stated in my statement. But it has to be combined with field intelligence. We do, along with the ZPIC and CMS folks, we actually do a lot of proactive work. However, unless you actually go to the field and find out who the actual provider is and how many providers are in that particular practice, all we know is that he will be an outlier. That is indicative of fraud, but it is not necessarily fraud. It does not rise to an—

Mr. HOLDING. So, in the scope of your work, when you see an outlier like that, what do you do?

Mr. DIXIT. We further the investigation. We combine it with surveillance. We find out—we get a better picture. We have ZPIC and folks, analysts, who are experts in data analysis. We find out, is

it one provider billing say \$30 million, or is it 10 providers billing \$30 million? It makes a big difference.

Once he is an outlier, we start doing our investigative techniques, like surveillance, talking to witnesses, beneficiaries, and we get a better picture of whether or not we should proceed on the criminal side.

Mr. HOLDING. Can you give me some idea of the scope of outliers out there that you would be looking at on any given quarter, month?

Mr. DIXIT. I can't exactly quantify it with a number. But I can give you an example of one of the cases I worked, which came straight from a proactive data analysis system. We had a physician in Michigan who, through proactive data analysis—the ZPIC actually forwarded it to us—stated that if this provider would have provided these services, that particular doctor would have had to travel 450 miles in that one day and perform 36 hours of services, which is practically impossible. Yes, we opened the case for further investigation, and that individual was indicted and convicted.

Mr. HOLDING. Ms. McQuade, did this go to trial?

Ms. MCQUADE. No, the case did not go to trial. Ultimately, Dr. Fata entered a guilty plea and was sentenced to 45 years in prison.

Mr. HOLDING. During the process of negotiating that, did he raise any defense at all?

Ms. MCQUADE. He really did not. Ultimately, at his sentencing hearing, he admitted to the judge that he had been motivated both by greed and by power, so it was an interesting statement on his part. But he never really mounted much of a defense. I think his goal was mitigating his sentence at the end of the day. But we were pleased that the judge imposed a sentence—although we sought a higher sentence—a sentence of 45 years, which, for a 50-year-old man, is a substantial sentence.

Mr. HOLDING. Right.

Mr. Chairman, I yield back.

Chairman ROSKAM. Mr. Lewis.

Mr. LEWIS. Thank you very much, Mr. Chairman.

Let me thank each of the witnesses for being here.

Can you tell me maybe just speculate, what motivates doctors or other medical professionals to engage in fraud, Medicare fraud? Is it simple greed? People have to conspire and have to engage in a conspiracy to get doctors and other health providers, pharmacists and others.

Mr. DIXIT. Thank you for that question, Congressman. What we see in Detroit, what I have seen personally in Detroit, I will give you an example, which will make a better point of this case. We worked a home health agency case where the defendant won, out of 20 defendants that were indicted in that \$13 million case. The defendant was arrested. The day of his arrest, he was interviewed. He cooperated with law enforcement. And he told us that he was not a medical professional. He worked at a Church's Chicken. For him, it was easier to get into the field, sign up with Medicare, and start billing for services that were never rendered. However, he did learn a scheme from a different health agency owner and wanted to start his own because he did not want to make just dimes and

dollars. He wanted to make millions of dollars. So that is one part of it.

We also see another part of it where individuals that try to do the right thing at the beginning get sidelined because there is a lot of fraud. Fraud is a problem. Obviously, we all know that fraud is a problem. But we do have doctors who have come in and proffered with U.S. attorneys and agents who tell us it was impossible for them to actually perform the services without getting involved. Did they stop? No. So were they convicted? Eventually, yes. Greed got the better of all of them at one point, but the motivation we see in Detroit is all about money.

Mr. LEWIS. Is organized crime involved?

Mr. DIXIT. We see a variety of cases, we see simple folks who have no medical background all the way up to sophisticated doctors like Dr. Farid Fata. In this particular case that I was talking about, the home health agency case, we had four home health agency owners, three doctors, physical therapists. They all operated exactly like a criminal enterprise. One would not do without the other. One had to do—for example, the physical therapists had to make up these sheets if Medicare came looking whether or not the service was provided. It was all done at the back end. They would bill Medicare upfront, but all the fraudulent paperwork, everything else was done on the back end. Everyone served a purpose. It was a criminal enterprise, yes.

Mr. LEWIS. Would others like to comment?

Ms. MCQUADE. Congressman Lewis, I don't know that we see traditional organized crime groups being involved in Medicare fraud, but as Agent Dixit said, there are sometimes very complex and sophisticated conspiracies designed to defraud Medicare and other insurance programs. I do believe that the motivation is greed, that there is substantial money to be made, and that is what motivates this work.

Another case that we had that does result in patient harm and harm to the community involved a doctor in Monroe, Michigan, named Oscar Linares, who set up what can be described as a pill mill. And I am certain that he did it for greed because he used his funds to buy things like Rolex watches and luxury vehicles, like a Bentley and a Ferrari. And so I believe that his motivation was greed, but he was prescribing oxycodone, pain pills, to people who did not need it for medical necessity. He saw more than 250 patients a day and was putting these pills out into the community. And in exchange, he would have the patient submit to unnecessary medical treatments or unprovided medical treatments for which he would bill Medicare. So he made a lot of money. And in the process, many, many people were provided with prescription opioids that I believe contributes to our Nation's opioid epidemic. And as you know, it is a gateway to heroin use and overdose deaths. So it is a serious problem that does, as you said, impacts patient harm.

Mr. LEWIS. Thank you.

I yield back, Mr. Chairman.

Chairman ROSKAM. Mr. Rice of South Carolina.

Mr. RICE. Thank you, Mr. Chairman.

Medicare is certainly a noble and essential program provided by the Federal Government. It is a promise made to our seniors, and

we have to make that promise solid and keep it—and make sure it is kept. It is also one of the largest, most expensive programs run by the Federal Government. We paid more for Medicare services in 2015, about 20 percent more than we paid for our national defense. With \$20 trillion in debt, we have to make sure that those dollars are spent wisely. Obviously, we have to eliminate every drop of fraud that we possibly can. I know that 99 percent of the people using Medicare are certainly honest and deserving people, but there are always crooks out there. And I appreciate very much what you do to detect those and to bring them to justice.

The Fata case is an example that is shocking to everybody that he could bill I think it was \$60 million—is that right?—over 6 years and not be detected until a whistleblower came along.

Mr. DIXIT, why is it that a whistleblower had to come along? How long would it have been had that whistleblower not come along? Had somebody not within his practice not come and turned him in, how long would it have taken us to detect this astounding level of fraud?

Mr. DIXIT. Thank you for that question, Congressman. Unfortunately, I do not have an answer for that. Unless the office manager or citizens that are concerned or beneficiaries that see fraud happening, unless they come forth, which is one of our main sources of referrals, along with the OIG hotline, referrals from ZPIC, proactive data analysis, I wouldn't be able to tell you with any assurance that anybody would have come forward or we would have found that particular issue.

Mr. RICE. Okay. Well, can you tell me—we have these tools for predictive analysis—can you tell me what percentage of these fraud cases are brought as a result of predictive analysis versus whistleblowers, people coming forward and fessing up.

Mr. DIXIT. I can't quantify a percentage, but I would be happy to get back to the subject-matter experts who actually work in this area and get back to you at a later date with a percentage.

Mr. RICE. I would love to see that. I would love to know. That would give me some indication of the effectiveness of the predictive analysis.

Mr. Ward, I think your job is detecting this fraud, right?

Mr. WARD. Yes, sir.

Mr. RICE. You talked about outliers. You look at statistical analysis of Medicare providers I suppose and you look at things that just don't make sense, right? You look at outliers?

Mr. WARD. That is correct.

Mr. RICE. Is there a procedure for auditing those outliers? Do we have an ongoing, like the IRS, annual audit procedure where we select providers for review?

Mr. WARD. Yes. That actually occurs at the Medicare Administrative Contractor level. The contractor that actually pays the claims, they do, on an annual basis, they develop a probe plan of audits that they are going to conduct on specific services that are billed when they see—when they do data analysis, and then they coordinate with the ZPICs to determine areas that they think could potentially be fraudulent as well as they review the OIG's annual plan for areas that they are going to focus on.

Mr. RICE. All right. So, coming back to you, Mr. Dixit, can you tell me, as a result of these audits, what percentage of the criminal prosecutions that you do are as a result of these audits versus whistleblowers versus predictive analysis?

Mr. WARD. Well——

Mr. RICE. Mr. Dixit.

Mr. DIXIT. Thank you, again, but once again, I can't quantify the number in terms of percentage, but we would be more than happy to get back to you. We have data analysts who actually work in this field, and we will get you a percentage for sure.

Mr. RICE. Thank you.

Mr. Ward, in the process of these contractors that you say are doing the audits, so the government is hiring independent contractors to do—the government is not doing it itself, right? Is that what you said?

Mr. WARD. Correct.

Mr. RICE. So do you know the mechanics of choosing who they are going to audit? Do they focus on outliers? Do they do random audits like the IRS? Do you have any idea of the procedure?

Mr. WARD. My knowledge of how the Medicaid—Medicare Administrative Contractor develops that is limited. They do statistically valid sampling. They look at areas where maybe there is over utilization of certain claims, you know, code types, different—or just billing spikes, things of that nature, and then they determine from that who they might probe.

Mr. RICE. My time is up, but I have one more question for you, and that is, based on your—I have read this memo, and it says that we don't have a good number on what the actual fraud is, but that is your job. So I would just like your opinion. What percentage of the actual fraud and abuse are we catching?

Mr. WARD. Are you taking about nationwide or just area?

Mr. RICE. Yeah, nationwide.

Mr. WARD. That would be hard for me to——

Mr. RICE. Is it more or less than 50 percent?

Mr. WARD. Probably less than 50 percent.

Mr. RICE. Thank you, sir.

Chairman ROSKAM. Mr. Crowley of New York.

Mr. CROWLEY. Thank you all. I will be very brief. I thank you all for your testimony this morning before the committee. And I want to thank the chairman and the Ranking Member, all the members, for continuing to delve into what has been a historical problem facing our Nation, and that is Medicare fraud.

Mr. Dixit, I applaud your work in protecting beneficiaries from Medicare fraud every day. Thank you to all of you for what you do every day. This is important work that you are engaged in and you outline very clearly how fraud harms beneficiaries as well as the taxpayers, and some of these cases horrendously in terms of poisoning, literally poisoning people, not only with opiates but with other drugs intended to fight cancer, but in their own nature are in essence poison themselves to kill those bad cells.

The Affordable Care Act added several important tools to fight against fraud. Always knowing that those who are intent on committing fraud will find ways around the law. We did give additional tools. It gave increased funding to combat fraud and provided new

tools to screen providers so that we can prevent criminals from getting into the system on the front end, improved data analytics, and instituted more payment review to check for problems before money goes out the door.

Mr. DIXIT, can you talk about how increased funding, improved data analytics, and more forward fighting tools has helped you do your job?

Mr. DIXIT. Thank you, Congressman. Data analytics, as I stated earlier, has been an extremely powerful tool for agents to analyze and protect fraud. At least they are indicative of fraud. Combined with agents and resources on the ground, we work with State and local law enforcement. Data has always pointed us in the right direction, taken—combined with agents going into the field and following up on surveillance techniques. And to get a better picture of what we are actually seeing has helped us immensely. So data analytics, the more analysis we do on data, we figure out where the problems are. We can identify geographic hot spots. We can identify, for example, if there is a physician billing for services and it is in cahoots with a home health agency owner, we can actually do data analysis to see who the highest paid home health agency is through data analytics. Of course, we will have to combine that to see—because data analytics is not going to tell us whether the home health agency owner is paying any kickbacks to that doctor. So, combined, it is a very valuable tool.

Mr. CROWLEY. It is one of a number of tools that were added through the Affordable Care Act, is that correct, including additional funding and other tools to fight fraud?

Mr. DIXIT. I cannot speak to the funding portion of it. I am a field agent, so my expertise is limited in the funding portion as to what we are getting regarding where the funding stream is coming from. I can have the folks at our office headquarters get back to you on that particular issue.

Mr. CROWLEY. I would suggest additional funding has been made through the Affordable Care Act that is there to help you fight the fraud that you are involved in every day. So, on behalf of the American people, I want to thank you for your efforts, all of your efforts. I yield back the balance of my time.

Chairman ROSKAM. Thank you.

Mr. Reed of New York.

Mr. REED. Thank you, Mr. Chairman.

And before I get started, I just want to kind of put in perspective what we are talking about here. We are spending about \$600 billion, to my understanding, looking at the material before me on Medicare. The improper payments, including fraud payments, totals about \$60 billion I think is what the reports show us. Out of that of \$60 billion, there is a debate whether it is 18 to 50 percent of it is actual fraud as opposed to just improper billing situations, which is also an issue, which is outside the scope of this hearing today.

But just to put that \$60 billion figure in perspective, we are talking about an amount of money that is twice the level at \$60 billion that the entire U.S. Government spends on the National Institutes of Health. National Institutes of Health is a leading public agent trying to fight cures for some of the most devastating diseases

amongst us as American citizens. It is three times as much as the Nassau—NASA budget. Not Nassau, that is in New York. My colleague from New York had me thinking of that. NASA budget. It is about the size of my home State of New York State, Department of Parks and Recreation budget. All the money we spend in New York State for our parks and recreation services for the entire State of New York is equivalent to what we are talking about here today. And so what I am very interested in looking at—and Mr. Ward, I am very interested in your testimony that you have submitted here, because I am too also a firm believer in data analytics, predictive analytics, the algorithms that go into the software that create that analytic possibility. So I just want to ask some—because you are the contractor, you are the contractor that is utilizing a lot of these analytics on a day-to-day basis is my understanding from your testimony. Is that correct?

Mr. WARD. Yes.

Mr. REED. Okay. So I just want to make sure, are there any issues with the data itself that you are getting from CMS, from Medicare, that is a problem in order for you to run it through that computer software analytic program the algorithms that are there. Are there any data exchange? Are you getting the data you need in order to input that into the system?

Mr. WARD. Yes, we are actually getting the data.

Mr. REED. And the data comes in a way that you can read it and run it through the programs.

Mr. WARD. Yes.

Mr. REED. Okay. That is very good to hear, because we haven't heard that in other agencies and departments.

So let's talk a little bit about what other data could you be interested in looking at that would improve the analytic capacity that you have as a contractor looking at this issue?

Mr. WARD. Well, in addition to the Medicare claims data, if we had—we do have some abilities, and we have been looking at areas of using like doing Web analysis to look at social media and things of that to compare. There have been some piloting efforts that we have used to identify, to kind of put some—

Mr. REED. How about other agencies of the U.S. Government?

Mr. WARD. If we had access to, like, maybe Internal Revenue Service records, maybe State Department records, Immigration records as well, that might be helpful too.

Mr. REED. And why would that be helpful?

Mr. WARD. Well, using the State Department records or maybe Immigration, we would be able to tell if someone maybe has a physician—for example, we had a physician that we are currently working an investigation in the Houston area where he was billing for Medicare, and then we ended up contacting him, and we found out that he has been in Dubai for several months, because we were going to interview him. So we looked at his claims history, and we coordinated with the Office of Inspector General, who—they coordinated with Immigration and found out that, yes, they could give us specific dates of when his passport, when he left, and never returned to the country. We would be able to identify immediately the provider needs to be put on a payment hold and ultimately could be revoked for billing for services not rendered.

Mr. REED. I appreciate that. Mr. Dixit, as a field agent, what other data would you be looking for outside the Medicare sphere that might be helpful to you?

Mr. DIXIT. I would double down on what Mr. Ward said. We as law enforcement agents do have access to multiple systems where we can work in conjunction with other Federal agencies. For example, we work a lot with marshals on our fugitive program. We work a lot with—

Mr. REED. Do you interact on a data analytic basis? If had you that data stream coming in—you are talking about physically you have to go march to the Marshals Office and say: Who are you working on? This is Mr. John Doe that triggered—one of our analytics produced him as a target, and now I have to call you and do that.

That is very—that is time-consuming. Is there anything you could do on a more proactive predictive analytic basis that would help you?

Mr. DIXIT. Not that I can think of off the top of my head. But we do data analysis in terms of like—for example, we see dead beneficiaries that are being billed over and over and over again in our data analytic program. When we analyze the data, we find out that Medicare beneficiaries have been billed thousands of dollars and have died 2 years ago; they are deceased.

Mr. REED. And you don't have access to that info?

Mr. DIXIT. No, we do have access to that. I am just saying that is one of those.

Mr. REED. An example.

Mr. DIXIT. Just an example. If we could—I can't—off the top of my head, I can't think of anything else that might help us, but those are the things that we ask the ZPIC to provide. We get a data download, and we will ask ZPIC to give us, "Can you also include the date of death, if possible?" So they add that, and it is helpful.

Mr. REED. Thank you very much.

I yield back.

Chairman ROSKAM. Mr. Davis of Illinois.

Mr. DAVIS. Thank you very much, Mr. Chairman.

I also want to thank all of our witnesses for being here today. You know, nothing is more important, I don't believe, that the government does to intervene on behalf of individual citizens than the Medicare program, especially as we see the continuing aging of individuals who reach that point and who, without these services, in many instances, would have no resources at all to get the medical care that they need.

I less remember the days when we used to have the great big discussions about Medicare mills and Medicaid mills and the high level of fraud that existed, so much to the extent that there would be people lined up in some of these places to go in and see physicians.

Unfortunately, there have always been a number of people in our country who operate on the principle that if you find a sucker, bump his head. And, unfortunately, many of those have been involved in the practice of medicine. They have been involved in the administration and management of activities. And so I applaud the

Federal Government, especially in what we have done in the last few years through the Affordable Care Act to try and put an end to as much of this fraud as we can possibly do. And I note that, in the last 3 years, we recovered a record-breaking \$10.7 billion, which certainly is not chump change, and it is certainly an indication that there is some effort underway.

Let me ask each one of you, I have always been told that an ounce of prevention is worth much more than a pound of cure. What can we do more proactively to try and prevent fraud and abuse?

And we will just perhaps start with you, Ms. McQuade.

Ms. MCQUADE. Yes, thank you Congressman. I think that is an outstanding strategy to prevent any kind of crime from happening in the first place. Some of the things that we are doing is gathering stakeholders together for regular meetings to talk about fraud trends so that we can share information with each other and identify the trends, because they evolve. Criminals are very entrepreneurial, and when one scheme gets detected, they move on to another. So that is one thing we are doing and certainly probably could be done more of in other parts of country.

We also do outreach work to citizens to talk to them and ask them to help us by reading their explanations of benefits and ensure that Medicare is not being billed for services that were not rendered. And there is a website there, StopFraud.gov and a phone number that they can call if they see that.

One of the other things that is being done is HHS is sending letters to the top billers that can be identified as the outliers in the home healthcare arena and explaining to them what the rules are in hopes of deterrence in fraud. If they might be those outliers because they are engaged in fraud, maybe a letter saying, "We are watching you and just wanted to make sure you understood the rules," maybe will prevent some fraud from occurring.

And then, finally, under the Affordable Care Act, there is a new provision that helps stop the flow of fraudulent funds in that CMS may now suspend Medicare payments upon credible allegations of fraud so an indictment can at least stop the flow of funds at that point. So those are some of the things that we are doing. But I agree with you that prevention is certainly a worthwhile endeavor.

Mr. DAVIS. Mr. Dixit.

Mr. DIXIT. Thank you for that question, Congressman. Let me give you a field agent's perspective on what we do as agents in the field to try to prevent further fraud. We reach out to Medicare beneficiaries on a daily basis. We do a lot of witness interviews. So we educate Medicare beneficiaries to look at their explanation of benefits: "If you see something that you never received, please call us." We will hand out our cards. That is one we try to prevent.

Another very important point I want to make is indicted folks who come in and cooperate with the government, they give a lot of information about fraud that is just beginning. That is another very valuable tool that we have, but we have cooperators, informants. Agents do a lot of outreach while they are working cases, while asking us to give us information, leads, anything new, and also to just watch their benefits and let us know if there is anything—

Mr. DAVIS. Thank you very much.

Mr. WARD. Thank you for that question, Congressman. Just to bolster what my colleagues have said, we think that communication, more communication, is probably one of the things you can do to help stop more of the fraud, waste, and abuse, but from a ZPIC perspective, one of the things that we have done over the last couple of years is we have utilized more of the administrative actions and tools that we have had put forth to us. We have utilized payment suspension and prepayment review of providers much more to get a better picture of what they are doing and stopping the money immediately from going out the door. And then we have had more of use of revocation of the healthcare provider as well. We try really hard to make sure that we look at the providers that are in question to see if they do meet the criteria to be revoked and not be allowed to participate in the program.

Mr. DAVIS. Thank you very much, Mr. Chairman.

Chairman ROSKAM. Mr. Marchant of Texas.

Mr. MARCHANT. Thank you, Mr. Chairman.

I would like to talk about a case that broke in 2012 in Dallas. In Dallas, it was known as the Dr. Roy case, and it involved a doctor who used home health agencies kind of as a recruiting group, fed the clients, patients to him. And, frankly, it was something that was on the front page of every newspaper, all the TV stations, radio stations. It created quite a level of awareness in the Dallas-Fort Worth area about this that we still today in my office get emails and calls from time to time because people are a little frightened that this fraud undermines a program that they depend very heavily on. And because there is so much fraud, they are not getting the reimbursement or the care they deserve because there are so many dollars going away from the program that could be plowed back into the program.

So the public is very interested. I don't think they are particularly accusatory toward the government in that they think we are part of it, but they are very concerned that it takes so long from the beginning of the crime to when the people are convicted. And they don't understand that long time lapse. And I think you can understand that.

We have a unique system. You get a bill; we pay it. You come back later and investigate whether it is a good bill. Almost—even if I get an electric bill, I look at my electric bill, and I kind of say, "Does this sound right?" You know, I make kind of a quick analysis on all my bills. And I think everybody here in the room probably does the same thing. And then I pay it. But our system is very unique, and because of that, I understand that there are long delays.

Can each of you just talk about how you discovered, those of you that were involved in that case, how you discovered this fraud, and what tools did you use that were at your disposal at that time to solve this case, and what additional tools you might have needed to solve this case faster? Let's start with—I think, Mr. Dixit, you were involved with this.

Mr. DIXIT. Thank you for that question, Congressman. I personally did not work on the Dr. Roy case. Let me take that back, actually. I did do an interview for the Dr. Roy case in Detroit. Dr. Roy's

scheme was so widespread that his employees at some point started leaving with fear of prosecution.

One of the individuals, I got a lead from the Dallas office. One of the Dallas agents contacted me to interview this particular individual, and that is how I got involved in this case. But let me just go back and tell you that the scheme for the Dr. Roy case is something that we have seen nationwide. What we refer to as recruiters or marketers or they call themselves community liaisons, they go door-to-door, grocery stores, homeless shelters, solicit beneficiaries for their numbers.

They might pay them cash and oral prescriptions—narcotic prescriptions—in exchange for their Medicare number, which is then billed by the home health agency owners for no services ever provided. And Dr. Roy was one of those individuals who would sign off on those prescriptions and also those home health referrals.

This actually, just so you know, is, and I am sure you are aware of it, is the largest healthcare fraud, home health agency fraud takedown, perpetrated by one single doctor. We see a lot of multiple doctor cases that come to that amount, but this is one single doctor.

Mr. MARCHANT. And in 2012, did we have the same level of data analytics then in place that we do now, Mr. Ward?

Mr. WARD. We, actually, in 2012, we had better data analytics than when Dr. Roy was first discovered. He was first identified back in 2010, and a referral was made on that, but it was such a complex case that it required a lot of field investigative work, in addition to the original data analytics that were done. From a ZPIC standpoint, we did over 700 beneficiary interviews related to Dr. Roy. That is individual patient interviews to identify where patients weren't homebound and things of that nature.

So our data analytics are much more improved from 2009 today, and in 2012, they were much better as well. They improve, you know, on an almost weekly basis.

Mr. MARCHANT. Thank you.

Thank you, Mr. Chairman.

Chairman ROSKAM. Mr. Smith of Missouri.

Mr. SMITH. Thank you, Chairman Roskam.

Thank you to the witnesses for being here. We are here to discuss a topic that is very important to me and the folks that I represent in southeast and south central Missouri. We hear a lot about fraud, and we hear estimates of more than 50 billion in fraud each year paid by Medicare. We talk a lot about loss to taxpayers, but I want to talk about damage to patients.

In many cases, patients are harmed. One important aspect of investigating healthcare fraud is whether there is patient harm. In July, I learned that the University of Missouri, where I graduated from, agreed to pay the Federal Government \$2.2 million to settle a claim that their healthcare program physicians committed fraud.

According to a U.S. attorney prosecuting the case, a Federal investigation found that physicians had not reviewed radiology images. I am curious how these types of settlements are reached, and that is why I ask you, Ms. McQuade, can you discuss the considerations you use to determine an appropriate sentence or settlement for Medicare fraud?

Ms. MCQUADE. Thank you, Congressman.

So I am not familiar with the Missouri case in particular, but in other kinds of cases, in a criminal case, we are governed by sentencing guidelines, and so those will offer an advisory range for what a sentence ought to be in terms of a prison sentence and will also offer an advisory range for a fine. So that is the starting point for any negotiations in a criminal case.

In a civil case, there are a number of different ways one might quantify an appropriate settlement. You could look to fraudulent dollars actually expended. Some of the False Claims Act permits triple damages, so you could start at that as a triple point and, for the certainty and swiftness of a settlement, come down from that number. Oftentimes, ability to pay of an organization is also a factor that is considered.

So all of those things are considered. But I can assure you that at the U.S. Attorney's Office, perhaps unlike private law firms, we constantly strive for what is in the best interest of justice and what is in the best interest of the victims and prepare to go to trial in cases where we cannot reach an appropriate settlement that we believe meets those aspirational goals.

Mr. SMITH. Is patient harm a consideration in your settlement negotiations?

Ms. MCQUADE. It is. It is certainly considered an aggravating factor. Under those sentencing guidelines, patient harm is an aggravating factor, and it is something that we would consider in terms of the egregiousness of the conduct.

Mr. SMITH. Do you have a list of crimes that are considered egregious to determine an appropriate sentence?

Ms. MCQUADE. It is difficult to talk about all of them, but we have a few examples. There is the Dr. Fata case, which in my view is the most egregious, providing chemotherapy to patients who did not need it, some of whom did not have cancer. We had another case involving a Dr. Sabit who installed medical devices—claimed to install a medical device into people's backs, performing back surgeries, instead replaced it with a cheaper material for his own cost savings, resulting in real patient harm and the need for additional surgeries by some of those patients.

So the patient harm can really range from a whole number of things—exposure to unnecessary nuclear stress tests and radiation—so it is a wide spectrum of things. But patient harm is certainly something that is considered in imposing any kind of sentence or fine.

Mr. SMITH. Thank you, Ms. McQuade.

I yield back, Mr. Chairman.

Chairman ROSKAM. Mr. Renacci of Ohio.

Mr. RENACCI. Thank you, Mr. Chairman. I want to thank the witnesses for being here. You know, it is frustrating. I was in the healthcare profession for almost three decades before I came here, and I know back home people are very frustrated because they know there is fraud and abuse. And as a healthcare provider, I saw it around me. At least I thought I saw it around me, but you can never prove it. So I realize you guys are in a very tough situation, and I appreciate the work you are doing.

But the American people are sitting here listening, and look, there are three types of people out there: There are those that commit fraud and are caught, and we have talked about some of those. There are those that commit fraud and are not caught. And there are those that don't commit fraud that are accused, which is even worse.

So I hear a lot from those that are accused and then are not convicted or committed, and they have to go through a process. In fact, I heard from one agency that spent more in defending themselves in legal fees than the total revenues of the whole company for that year, so those are the issues that concern me as well too.

But that still doesn't mean we shouldn't be going after those that have committed fraud and haven't been caught. And I am trying to figure out, in that universe, those that are caught—we already know those, those are the ones you are talking about—those that have been potentially said you have committed fraud and then aren't, and then those that we haven't caught. Is there any—and maybe, Mr. Ward, can you tell me, out of those that are potential fraud abusers, do we have a statistic that says, “We have gone after, you know, 100 and convicted 10, 5, 20, 30, 70,” is there a number on that, at least?

Mr. WARD. I don't know that I would be qualified to answer that question.

Mr. RENACCI. I mean, because these are the statistics and these are the things I know would help everybody up here on the dais and would also help the American people understand we are going after fraud.

I mean, if you say that, “Look, we went after 100 people and we caught 99,” that is a pretty good statistic. If you say, “We went after 100 and caught 5,” people are going to say, what are we doing wrong?

But the problem that I am hearing today, which is very frustrating for me and very frustrating for anybody watching this, is that we are not quantifying this in numbers. We are not saying, “Look, there are”—one member up here asked how many people—what is the estimate of fraud, and we are not getting any numbers, so it is very frustrating.

You can come here and tell us about the ones you caught, but what frustrates the American people are the ones you haven't caught, and I would love to hear what we are doing.

The other thing that is so important—I also heard this from one of the members—you can catch somebody after they have committed 50, 100, 300 million dollars' worth of fraud. You are never going to get that money back. They are going to prison, but we have lost a lot of money. So how do we somehow put this—wrap this package up and be able to say to the American people, “We know there is fraud; here is our percentages”? I mean, I would have loved for somebody to come today and say: Look, we have this analytic procedure. We know that there is, you know, 20 percent fraud. We are—we do an analysis that means we look at 1,000 people. Out of those 1,000 people, we catch 200.

These are the kind of numbers that I make us feel comfortable. Are there any answers you can give me to make me feel com-

fortable—who is frustrated and the American people that are frustrated?

Mr. DIXIT. Well, I can say that we have folks back at headquarters who do keep a tab of the complaints that come in, how many cases are investigated, how many are criminal actions, how many are civil actions. I guess, in my oral statement, I had a quick short paragraph regarding the numbers, but we can get back to you in detail regarding numbers, if you want, though. We do have folks that will get back to you at a later date on that particular question.

Mr. RENACCI. I would appreciate that.

Mr. DIXIT. I also want to answer the question regarding the money. I do want to make one—I do want to emphasize that one of the missions of OIG agents is to make that trust fund whole. We do want to bring money back to Medicare and all the government programs that lost it. So we work with the Department of Justice and FBI and try, during our investigative process, forfeiture warrants is one of the things that we always do and try and seize and take back whatever we can.

Mr. RENACCI. And I am not taking away anything the three of you are doing. I am very happy to hear what you are doing. I am trying to figure out the big picture of how we can do it better, and this—but I also want to make sure that any constituent that has been accused of fraud, it would be great to hear how many have been accused, and I hope at some point I can get that information: if they have been accused and then how many have been convicted. That is an important number, because if we are going after—we can say we are going after 1,000 people, but if we are only convicting 1 out of 1,000, that is not a good number.

Ms. MCQUADE. Congressman, I believe the conviction rate is around 95 percent in healthcare fraud cases.

Mr. RENACCI. Now, I am talking about the ones that we go after on a statistical basis because I did hear that we don't have that number, I thought.

Mr. WARD. Well, we can get you those numbers. I didn't come prepared for that. I mean, one of the things that we do is we—there are several different levels of how the investigative work and some do not meet—are not egregious enough. We prioritize them in a manner to where some of them can be handled administratively.

So I am not sure if this is the answer to your question, but some of the things, when we identify through data analytics, outliers or things that do not meet medical policy or outside of what the local or national coverage determination, we do things like we put auto deny edits into the Medicare claim system, meaning that, when those claims hit the system, they are just automatically denied out. They are not—there is no cost to process.

I mean, they are submitting claims that will be automatically captured and denied and never paid or processed, so that is something we can give you some numbers on cost savings. But then you have other levels where they may require more investigative methods and will require referrals to the Office of Inspector General to look at it for criminal or civil investigation and then essentially go to the Department of Justice for prosecution.

Mr. RENACCI. All right. Thank you.

I yield back.

Chairman ROSKAM. Thank you. I just have a couple of questions to follow up and then maybe some wrap-up comments.

Mr. Dixit, Mr. Reed was asking you about the billing with dead beneficiaries. Can you just walk us through that? It is kind of one of those things, we hear that and say, how can this possibly happen? So what is it that we—and that seems just a fundamental thing.

So what is it that, number one, how does it happen? Number two, how can we be intentional about stopping that one? That seems like it is low-hanging fruit.

Mr. DIXIT. Thank you, Chairman.

Doctors who actually bill for services not rendered never see the beneficiaries. They never realize that the beneficiary has passed away 4 months ago. They keep billing for the beneficiary on what is allowable under the Medicare guidelines.

When ZPIC, sometimes through proactive analysis, data analysis, ZPIC will send us this particular complaint and say something to the effect of, "There is a doctor who is billing for dead beneficiaries." That is when we start opening the investigation. Of course, we go to the beneficiary's home, make sure that we go to vital statistics, other Federal, State, and local partners that we work with and get the necessary documentation to make sure that the beneficiary is deceased. The reason it happens is because the doctor never sees anyone to begin with.

Chairman ROSKAM. How is it—I understand. I understand your point. How is it possible, in your view—or Mr. Ward, weigh in here as well—how is it possible that there is not—I mean, at some point the Social Security office makes a declaration that this person has passed away, and there is a recognition that that person has passed away. How is it—how is this continuing to be possible? Can you just walk through the mechanics of it, when everybody else knows that the individual has passed away, that the payment system doesn't know that the individual has passed away?

Mr. WARD. Well, one of the things that we have noticed from the ZPIC standpoint is that we see there is a delay in the Social Security databases known as the common working file, which links back to CMS' files and updating, so sometimes you can have a delay in a report of the death of a beneficiary, sometimes 60, sometimes 90 days, and in that period of time, you can get those billings, and the system won't recognize it.

Chairman ROSKAM. Okay. So then can we at least get some comfort in the knowledge that after that 60- or 90-day period, those kinds of claims are not—false claims are not happening anymore?

Mr. WARD. Yes. They will—once that is hitting the system where the beneficiary is deceased, those claims should be kicked out through edits that will show that the beneficiary has deceased and that it is not a valid claim. But, on occasion, sometimes, if that information is missed or if certain modifiers are put into place, claims can go through the system. There are some occasions where, when there is hospice related or sometimes durable medical equipment, where services may have been rendered and then the bene-

ficiary ends up being deceased, where the claim will continue to pay.

Chairman ROSKAM. For how long, would you estimate?

Mr. WARD. Maybe 30 days, maybe 45 days.

Chairman ROSKAM. Okay. So, Mr. Dixit, did I over interpret your response to Mr. Reed? I thought you said that this could happen for years, and what Mr. Ward is saying is that it is a shorter duration than that. So what is your view?

Mr. DIXIT. I guess what I was trying to say is that there are multiple beneficiaries. I might have misspoken. Multiple beneficiaries that are billed every 2 to 3 weeks. We don't see a dead beneficiary being billed for 5 or 6 years. I don't have the exact number off the top of my head how long they actually bill a dead beneficiary for, but what we do see is like, for example, a doctor that I worked had 1,700 beneficiaries. You saw 1,700 active beneficiaries, but he was not seeing all these beneficiaries.

So, when a person passed away—there are multiple beneficiaries that are passing away—he would keep billing them. So we have close to about \$200,000 in billings within a span of 60 days for multiple beneficiaries that have passed away.

Chairman ROSKAM. Uh-huh. I want to piggyback a little bit on Mr. Renacci's point a couple of minutes ago. And I think that there is the—I think what is actually emerging is a consensus on this issue and that there are a lot of people now—and it is a consensus that is based on necessity.

You know, in the old days, there was a lot of money around Washington, D.C. You know what I mean. These budgets were flush and so forth. And now, with this increasing downward pressure from a financial point of view, I think folks are looking over the landscape and saying: We have got to do things better, smarter, faster, and cheaper, and more efficiently. And the first place to start is the notion of not paying people who are ripping off a system.

You know what I mean? That is just so intuitive, and that is why you hear this unanimous cheering for you but also asking a very simple question: What can we do? What can we do more to help you?

So what recommendation would you have, each of you? Ms. McQuade, let's start with you. You kind of got into it a little bit with Mr. Davis from Illinois in that he was asking you a question, and your response was what you are doing, which is, hey, listen, we are all in the business of selling, so good for you. But can you give us a sense of what would actually—what do you want us to know? What is helpful for us to know moving forward?

Ms. MCQUADE. Well, we appreciate the investment that Congress makes into our work. And as you know, the return on investment is \$6 for every \$1 that is spent in terms of recovery. I would like to think that the work we do and when we publicize our work with convicting doctors and other healthcare fraud criminals, that that has a deterrent effect on others when they see that there are criminal consequences to that action, so I think continuing to fund our work is one thing that can be done.

But of course, that is more of a pay-and-chase model that occurs after the fact. One tool that would be helpful to us is to continue

to enhance the data that we have available to us. An emerging area is pharmaceutical fraud, prescription drugs. I know, in Michigan, our electronic database that doctors can enter data into for prescriptions is incomplete and imperfect, and an improved database would help us to see which doctors are prescribing medication, so that would be one tool that would be helpful to us to improve our work.

Chairman ROSKAM. Okay. Improved pharmaceutical database. Okay.

Mr. DIXIT, what do you think? What do you want us to know?

Mr. DIXIT. Thank you for that question, Congressman, and thank you for your continued support for the OIG and its mission.

As a field agent, in my perspective, more agents, more resources, more boots on the ground as a force multiplier for agents who are doing this work. That would help every agent in every jurisdiction to investigate more, spread the wealth, so to speak, will be more efficient and effective.

Chairman ROSKAM. Okay. Mr. Ward, how about from your point of view?

Mr. WARD. You know, I can say over the span of my career, I have seen very many iterations of how this program has progressed and how I have seen fraud progress as well with it, and I can't—I can say right now, with our work that we do with the CMS and with our law enforcement partners, that it is probably the most aggressive that it has ever been in my career as far as how successful we are being, so I appreciate your continued support.

I think probably the most important thing to continue this fight is that we do get your support and collaboration with CMS and with the OIG and the Department of Justice as well.

Chairman ROSKAM. Yeah, I think—you know, one of the areas, kind of in closing, one of the areas that Mr. Blumenauer and I are working on, a member of the Ways and Means Committee, from Oregon, and that is a secure ID bill, in other words, having a—using the same technology that the Department of Defense uses to limit access to sensitive places. It is well deployed in the Federal Government, and we have got a pilot program that says let's use this in Medicare and let's make sure that there is data that matches between a beneficiary and a provider so that, you know, the sale of a Medicare number underneath, you know, a bridge somewhere to manipulate and rip the system off, that can't happen, so that that is part of the legislative remedy.

I think this idea of more boots on the ground, I understand. We wrestle with that same question on intelligence issues, national intelligence issues, the tension between, you know, the data side and having people in country and so forth. You are describing essentially the same thing.

There is an element of prevention that really, I think, we can be very satisfied with, and these numbers are so big, they just take your breath away. So while they are impressive, the work that you are doing, we would be so much better off if we basically put you out of business. If it were up at the front end, and these claims data were so tight and so well screened and so intuitive, that you—the types of fraudulent claims that you had to chase down were, you know, were just di minimis, that would be so satisfying, I

think, all the way around. And then we could have great debates in this Congress about how to spend an additional \$60 billion that we could save, and we can figure out ways to do it more much efficiently.

But on behalf of the entire subcommittee, thank you very much for what you are doing, number one, the work that you are doing and your willingness to spend time with us today. I appreciate it.

The committee is adjourned.

[Whereupon, at 11:20 a.m., the subcommittee was adjourned.]

