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OFFICE OF INSPECTOR GENERAL

Testimony of:
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Hearing:
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and Taxpayers?"

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Good morning, Chairman Nelson, Ranking Member Collins, and distinguished Members of the Committee. I am Brian Martens, an Assistant Special Agent in Charge based in the Miami Region with the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG). I appreciate this opportunity to describe the work of our Special Agents in South Florida to fight Medicare fraud and protect seniors.

We are having a positive impact in Florida and across the country. As reflected in the most recent Health Care Fraud and Abuse Control Program (HCFAC) Report,¹ OIG efforts, together with those of our law enforcement partners, have led to a record setting return on investment of over \$8 to \$1. Through coordinated enforcement efforts across the country, including those of the Medicare Fraud 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. One such example is the drop we have seen in Community Mental Health Center (CMHC) Medicare payments. Following targeted enforcement activities, nationwide Medicare CMHC payments fell from an annual \$273 million to \$31 million over a 4-year period. Florida is an area where CMHCs were geographically concentrated. Despite our measurable successes in combatting fraud, South Florida continues to be a hot spot of health care fraud and Miami is considered “ground zero.”

In Florida, we are seeing fraud schemes quickly evolve. As enforcement efforts target certain schemes, new permutations of those schemes arise. Not only are fraud schemes mutating, they are migrating – geographically and even between parts of the Medicare program. We are seeing an evolution of beneficiaries’ roles in health care fraud – including unknowing victims and

¹ Report produced annually by the Department of Health and Human Services and the Department of Justice, available at <http://oig.hhs.gov/reports-and-publications/hcfac/index.asp>.

complicit participants. We also continue to see organized criminal networks operating in a systematic approach to steal money from Medicare. The criminals committing these crimes are often dangerous and we regularly encounter stockpiles of weapons when we execute arrests and enforcement operations. These criminals are taking advantage of those most vulnerable in our society – the elderly and the disabled.

Medicare fraud is not a typical white collar financial crime. And it is not a victimless crime – it can affect patients, their families, the health care system and all taxpayers. And it's not just about the money – when fraud is committed, Medicare beneficiaries can suffer physical harm.

Take for example the case of an HIV-positive beneficiary who lived in a socio-economically depressed area in South Florida. He lived in a boarded up mobile home and was being paid cash by a professional patient recruiter to go to a specific clinic for his HIV treatment. Only instead of getting the expensive HIV drug treatment he needed and paid for by Medicare, he willingly accepted a vitamin mixture in exchange for cash. During our investigation, a medical doctor in the community complained that the patients in that clinic were using the cash kickbacks to purchase drugs and alcohol, yet those habits only made the HIV-positive patients sicker.

Thankfully, the majority of our cases don't involve direct physical harm to patients. However, Medicare fraud can create hardships for beneficiaries in many ways:

- Medicare fraud can distort a patient's medical history when false records are created to support false claims. If a patient's identification number is stolen and used for false claims, that patient may be denied necessary equipment or care because Medicare's records indicate that patient already received those services. For instance, if a patient needs a wheelchair, but a fraudulent claim has already been submitted for one, what is the patient to do?
- If a Medicare beneficiary number is compromised, there is currently no way for the patient to get a new number, which leaves the patient vulnerable to identity theft. We had a recent case in Tampa in which stolen Medicare numbers and personally identifiable

information were used to file tax returns and the criminals received fraudulent tax refunds.

Beneficiaries are vulnerable and can be adversely affected by Medicare fraud. But it is important that I tell you today about another role that beneficiaries play in Medicare fraud, particularly in Florida.

Medicare fraud needs at least two elements to succeed: 1) health care providers who bill Medicare; and 2) patients, or “beneficiaries,” on whose behalf Medicare is billed. Beneficiary roles can be categorized into three types:

1. Unknowing victims – for example, victims of medical identity theft.
2. Unwitting beneficiaries – for example, beneficiaries who have received some type of medical service or product but were not aware that it was medically unnecessary or was billed improperly to Medicare. Some of these beneficiaries suffer physical harm from the medical service.
3. Complicit participants – for example, beneficiaries who use their Medicare numbers for personal financial gain. This can take the form of beneficiaries selling their Medicare number to be used in fraud schemes, or receiving payments to obtain unnecessary or inappropriate medical treatment solely for the purpose of defrauding Medicare. Beneficiaries can make around \$1,500 in cash per month plus other benefits for participating in such schemes. Unfortunately, we see complicit beneficiary participants involved in a lot of our Medicare fraud cases in South Florida.

Fraud schemes can be both viral and migratory. For example, we first saw the HIV fraud scheme in Miami. Through aggressive targeted prosecution and increased enforcement efforts in Miami, we saw the decrease of those services billed under Medicare Part B in Miami and saw the fraud scheme surface in Detroit, Michigan. In Detroit, the schemes were even organized by some of the relatives and co-conspirators of the Miami perpetrators.

Now, the HIV scheme is again resurfacing in Miami; however, it is now being billed under Medicare's managed care program, Part C, perhaps in part because of fraud prevention measures implemented in Medicare Part B.

Medicare Part D, specifically pharmacy fraud, is an area where we are seeing the largest increase in our South Florida case work. Prescription drug fraud is a complex crime that can involve many co-conspirators – drug distributors and traffickers, health care professionals, patient recruiters, drug-seeking patients, and pharmacies may all play a role. Criminal enterprises are also becoming an increasing presence in prescription drug fraud.

It is important to note that OIG prescription drug fraud cases are not limited to investigating schemes involving only controlled substances. Our work is increasing in matters involving high-cost, noncontrolled, name brand prescription drugs such as respiratory, anti-psychotic, and HIV/AIDS medications.

Another area in which the schemes continue to evolve is home health services. Although we have seen a decrease in home health payments, the area remains rife with fraud and is one of our top priorities. Home health schemes were initially characterized by billing Medicare for expensive long term skilled nursing visits to administer insulin injections to diabetics. However, the scheme has changed and now involves billing for physical therapy and occupational therapy.

To combat these and other schemes, we strategically leverage partnerships with other law enforcement agencies, CMS, and the private sector. For example, in Maine where we have only four agents, our partnerships are extremely important. Our agents in Maine have successfully worked Medicare cases involving prescription drugs, medical identity theft, and home health fraud as we see in Florida; however, Medicaid fraud comprises the majority of our work in Maine.

Health care providers and beneficiaries can serve as the front line of defense by refusing to participate in these schemes and reporting suspected fraud.

I began my testimony by telling you about some of the outstanding results of our Medicare fraud enforcement efforts. However, it is important to note that OIG's mission is challenged by declining resources at a time when prescription drug fraud and other schemes are on the rise. Our Part D investigative caseload has almost quadrupled over the past 5 years, while at the same time, Strike Force teams are not operating at full strength due to funding shortfalls and hiring freezes. The additional funding in OIG's 2015 budget request would, among other things, support additional boots on the ground in Florida and in other high health care fraud areas across the country. We appreciate this Committee's support.

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