

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

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

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

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

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

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

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

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

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

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

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

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

OIG's work has also demonstrated that Medicare and Medicaid pay too much for certain services and products and that aligning payments with market costs could produce substantial savings. For example, in 2007, OIG reported that Medicare reimbursed suppliers for pumps used to treat pressure ulcers and wounds based on a purchase price of more than \$17,000, but that suppliers paid, on average, approximately \$3,600 for new models of these pumps. Likewise, in 2006, Medicare allowed approximately \$7,200 in rental payments over 36 months for an oxygen concentrator that cost approximately \$600 to purchase. Beneficiary coinsurance alone for renting an oxygen concentrator for 36 months exceeded \$1,400 (more than double the purchase price).

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

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

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

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

The Affordable Care Act Enhances Health Care Oversight and Enforcement Activities

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

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

Provisions in section 6402 of the Affordable Care Act will enhance OIG's effectiveness in detecting fraud, waste, and abuse by expanding OIG's access to and uses of data for conducting oversight and law enforcement activities. For example, section 6402 exempts OIG from the

prohibitions against matching data across programs in the Computer Matching and Privacy Protection Act and authorizes OIG to enter into data sharing agreements with the Social Security Administration (SSA).

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

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

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

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

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

In addition to promoting data access and integrity, health care reform includes numerous program integrity provisions that support an effective health care integrity strategy. Consistent with the OIG's five-principle strategy, these include authorities and requirements to strengthen provider enrollment standards; promote compliance with program requirements; enhance program oversight, including requiring greater reporting and transparency; and strengthen the Government's response to health care fraud and abuse.

Section 6401 of ACA requires the Secretary to establish procedures for screening providers and suppliers participating in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The Secretary is to determine the level of screening according to the risk of fraud, waste,

and abuse with respect to each category of provider or supplier. At a minimum, providers and suppliers will be subject to licensure checks. The ACA also authorizes the Secretary to impose additional screening measures based on risk, including fingerprinting, criminal background checks, multi-State database inquiries, and random or unannounced site visits. These provisions address significant vulnerabilities that OIG has identified in Medicare's enrollment standards and screening of providers and are consistent with recommendations that we have made to prevent unscrupulous providers and suppliers from participating in Medicare.

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

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

Consistent with OIG recommendations, the ACA also facilitates and strengthens program oversight by increasing transparency and reporting requirements. The new transparency requirements will shine light on financial relationships and potential conflicts of interest between health care companies and the physicians who prescribe their products and services. Specifically, section 6002 requires all U.S. manufacturers of drug, device, biologics, and medical supplies covered under Medicare, Medicaid, or CHIP to report information related to payments and other transfers of value to physicians and teaching hospitals. This information will be made available on a public Web site. The types of payments subject to disclosure have been the source of conflicts of interest and, in some cases, part of illegal kickback schemes in many of OIG's enforcement cases. OIG already includes similar disclosure requirements in our corporate integrity agreements with pharmaceutical manufacturers as part of the settlement of these cases. The requirement of public disclosure of these payments will help the Government, as well as the health care industry and the public, to monitor relationships and should have a sentinel effect to deter kickbacks and other inappropriate payment relationships.

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

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

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

Each of these integrity provisions advances the fight against fraud, waste, and abuse. Further, we expect that the combined impacts of these new program integrity measures will be greater than the sum of the parts. Preventing unscrupulous providers and suppliers from gaining access to the health care programs and beneficiaries is the first step in an integrated integrity strategy. Requiring compliance programs and providing guidance helps to ensure that those permitted to participate in the programs do not run afoul of the law or program requirements. Expanded oversight and reporting requirements will help the Government, industry, and the public monitor the programs and identify potential fraud, waste, and abuse more quickly and effectively. In combination, the ACA's new enforcement authorities and tools will help change the calculus undertaken by criminals when deciding whether to target Medicare and Medicaid by increasing the risk of prompt detection and the certainty of punishment.

Funding of the Health Care Fraud and Abuse Control Program is vital to the fight against fraud, waste, and abuse.

In addition to providing new authorities and enforcement tools, the Affordable Care Act provides critical new funding that will enable OIG to expand and strengthen current enforcement and oversight efforts to combat fraud, waste, and abuse.

The HCFAC program is a comprehensive effort, under the joint direction of the Attorney General and the Secretary of HHS, acting through OIG, designed to coordinate Federal, state and local law enforcement activities with respect to health care fraud and abuse. The HCFAC program provides OIG's primary funding stream to finance anti-fraud activities such as:

- support of Criminal and Civil False Claims Act investigations and enforcement;
- support of administrative enforcement activities;
- evaluations of Medicare contractor operations;
- Medicare and Medicaid reimbursement for prescription drugs and other issues;
- audits of payments to hospitals, home health agencies, Medicare Advantage plans, and Medicare Part D plans;
- expansion of our use of technology and innovative data analysis to enhance our oversight and enforcement activities;
- monitoring of providers under corporate integrity agreements;
- issuance of advisory opinions and other guidance to the health care industry; and
- establishment of Medicare Fraud Strike Force teams;¹

From its inception in 1997 through 2009, HCFAC Program activities have returned more than \$15.6 billion to the Federal Government through audit and investigative recoveries, with a return on investment of more than \$4 for every \$1 invested in OIG, DOJ, and FBI investigations, enforcement, and audits.² HCFAC-funded activities have a further sentinel effect, which is not captured in this return-on-investment calculation. HCFAC-funded activities are a sound investment, and HHS and DOJ are receiving vital new HCFAC funding – \$10 million per year for 10 years in FYs 2011–2020 in ACA, and an additional \$250 million spread across FY 2011–2016 in the Health Care and Education Reconciliation Act of 2010. With our share of this critical new funding, OIG will expand our Medicare and Medicaid investigations, audits, evaluations, enforcement, and compliance activities to support our health care program integrity efforts.

New Health Care Delivery Models Will Require New Approaches to Fighting Fraud

Experience has taught us that how health care programs pay for services dictates how the programs are defrauded. For example, when Medicare pays on a fee-for-service basis, the incentive is to bill for excessive, unnecessary services. When the program pays on a capitated basis, the incentives are reversed; unethical providers stint on needed care. Health care reform

¹ Medicare Fraud Strike Forces are a joint OIG-DOJ initiative used to fight concentrations of Medicare fraud in specific geographic “hot spots.” Strike Force teams include special agents from OIG and FBI, DOJ prosecutors, and oftentimes State and local law enforcement officials.

² The \$4 to \$1 return on investment is a 3-year rolling average from 2006-2008, which is used to help account for the natural fluctuation in returns from investigative, enforcement, and audit activities.

legislation contains numerous provisions that encourage the evolution of delivery and payment models to improve quality and enhance efficiencies through greater integration, collaboration, and coordination among providers. These models include, for example, accountable care organizations, medical homes, gainsharing, and bundled payment systems. These new payment and delivery models will require a fresh examination of fraud and abuse risks.

As these new models develop in the health care market, the existing fraud and abuse laws will remain important fraud-fighting tools. However, some new arrangements may require new approaches to combating fraud, waste, and abuse. Moreover, depending on their design and operation, some new arrangements may pose different risks that will need to be addressed. These risks could include, for example, stinting on care, discrimination against sicker patients, misreporting quality and performance data, and gaming of payment windows to “double bill” for otherwise bundled services. Further, industry stakeholders have raised concerns that existing fraud and abuse laws designed to restrain the influence of money on medical decisionmaking may complicate or impede certain reforms because the fraud and abuse laws generally restrict economic ties between parties in a position to generate Federal health care program business for each other.

Innovative Use of Data Will Continue To Be Central to OIG’s Program Integrity Efforts

Health care fraud schemes have become more sophisticated and better able to morph quickly in response to anti-fraud initiatives. Innovative uses of information technology have dramatically enhanced OIG’s ability to respond to this challenge. For example, OIG is capitalizing on technology to process and review voluminous electronic evidence obtained during our health care fraud investigations. Using Web-based investigative software, OIG analyzes large quantities of email or other electronic documents more efficiently and identifies associations among emails contained in multiple accounts based on content and metadata. This technology is enabling investigators to complete in a matter of days analysis that used to take months with traditional investigative tools. Recently, OIG expanded the impact of this cutting-edge technology by making it available to our law enforcement partners for use in joint investigations.

Efficient and effective analysis of claims data to detect fraud indicators also is shaping how we deploy our law enforcement resources. OIG is using data to take a more proactive approach to identifying suspected fraud. In 2009, OIG organized the multidisciplinary, multiagency Advanced Data Intelligence and Analytics Team (Data Team) to support the work of the Health Care Fraud Enforcement and Prevention Action Team (HEAT). The Data Team, composed of experienced OIG special agents, statisticians, programmers, and auditors and DOJ analysts, combines sophisticated data analysis with criminal intelligence gathered from special agents in the field to more quickly identify health care fraud schemes, trends, and geographic “hot spots.” For example, the Data Team has identified locations where billing for certain services is more than 10 times the national average. The Data Team’s analyses inform the deployment of Strike Force resources and selection of new locations to focus and leverage Government resources in the areas with concentrations of health care fraud. Medicare Fraud Strike Forces have been established in seven fraud hot spots – Miami, Los Angeles, Detroit, Houston, Brooklyn, Tampa, and Baton Rouge.

As of May 31, 2010, our Strike Force efforts nationwide have charged over 550 defendants; obtained over 300 convictions; resulted in the sentencing of over 250 defendants; and secured over \$260 million in court-ordered restitutions, fines, and penalties. We believe that our Strike Forces also have had a marked sentinel effect. Though deterrence is difficult to quantify, we have empirical evidence that our data-driven Strike Force model for investigating and prosecuting health care fraud has resulted in reductions in improper claims to Medicare. Claims data showed that during the first 12 months of the Strike Force (March 1, 2007, to February 29, 2008), claim amounts submitted for DME in South Florida, a particularly hot spot for DME fraud, decreased by 63 percent to just over \$1 billion from nearly \$2.76 billion during the preceding 12 months.

OIG uses advanced data analytics and information technology in our evaluation and audit work as well as in our investigations. OIG program evaluators use empirical analyses to identify patterns of potential fraud and abuse and alert CMS to these findings so that it can take appropriate fraud prevention and oversight measures. For example, we recently analyzed all Medicare home health claims that were submitted and fully paid in 2008 to identify geographic areas that exhibited aberrant Medicare home health outlier payment patterns. Our analysis found that Miami-Dade County accounted for more home health outlier payments in 2008 than the rest of the Nation combined. We also found that 23 counties nationwide exhibited aberrant home health outlier payment patterns similar to that of Miami-Dade County but to a lesser extent. These findings demonstrate that home health services in Miami-Dade County, as well as other counties, warrant additional review as part of ongoing antifraud activities, such as HEAT.³

OIG is currently conducting an analysis of national billing patterns of pharmacies, prescribers, and beneficiaries for Part D drugs in 2009. Using claims data, we will identify questionable patterns that may suggest drug diversion, billing for drugs not provided, and other types of fraud. We are conducting similar analyses for other services as well: ongoing work on outpatient therapy services and independent diagnostic testing facilities will identify high-utilization counties and providers and identify claims with unusual characteristics suggestive of fraud.

OIG is also using advanced data analysis techniques to monitor whether and how criminals are adapting their fraud schemes in response to the Government's program integrity efforts. For example, in the coming months, we will issue a report analyzing how utilization of two specific inhalation drugs may have changed in the wake of Medicare program integrity efforts targeting one, but not the other, of the two drugs. We are also using a combination of claims and sales data to determine whether the amount of the drug in question billed by South Florida suppliers and paid for by Medicare exceeded the total amount of the drug distributed for sale in the area. By using innovative data analysis to detect unusual patterns, OIG is able to target high-risk services and geographic regions and make recommendations to address systemic vulnerabilities.

To perform timely and independent audits and evaluations of the Medicare and Medicaid programs, OIG has established a data warehouse. By bringing data from CMS into OIG's servers, the data warehouse improves expediency by providing OIG staff with direct access to

³ *Aberrant Medicare Home Health Outlier Payment Patterns in Miami-Dade County and Other Geographic Areas in 2008*. Issued December 2009. Available online at: <http://oig.hhs.gov/oei/reports/oei-04-08-00570.pdf>.

program data (rather than having to request data from CMS on a case-by-case basis); integrates claims data by type of service (e.g. inpatient, physician/supplier, prescription drugs) for cross-service data analysis; and facilitates OIG's use of sophisticated data analysis tools. In addition to claims data, we also obtain reference data (e.g., provider demographics, cost reports, beneficiary/recipient eligibility data, Drug Enforcement Administration active and retired registrants, the SSA Master Death file, and other health care-related resources). Having more robust data and information enhances our ability to detect fraud and abuse.

Despite having these essential tools in OIG's antifraud arsenal, we are acutely aware of the increasing sophistication of the criminals who are intent on exploiting the health care system. We are committed to enhancing existing data analysis and mining capabilities and employing advanced techniques, such as predictive analytics and social network analysis, to counter new and existing fraud schemes. As part of that commitment, we are developing a consolidated data access center, which will integrate business intelligence tools and data analytics into our fraud detection efforts. It will also provide the opportunity to access, analyze, and share data – consistent with applicable privacy, security, and disclosure requirements – with our law enforcement partners. Such a centralized data access center will enhance the efficiency and coordination of our collective efforts by giving law enforcement agents an opportunity to put the pieces together and see the totality of the fraud scheme.

Through this data-enhanced collaboration, law enforcement will be able to increase the numbers of credible investigative leads, recoveries, and avoidances of improper Medicare and Medicaid payments and detect emerging fraud and abuse schemes and trends. In addition, these tools will support our effective targeting of audits and evaluations to identify program vulnerabilities and recommend systemic solutions.

Conclusion

Health care fraud, waste, and abuse cost taxpayers billions of dollars every year and require focused attention and commitment to solutions. The Affordable Care Act provides additional authorities and resources that will significantly enhance our effectiveness in fighting health care waste, fraud and abuse. Through the dedicated efforts of OIG professionals and our collaboration with HHS and DOJ partners, we have achieved substantial results in the form of recoveries of stolen and misspent funds, enforcement actions taken against fraud perpetrators, improved methods of detecting fraud and abuse, and recommendations to remedy program vulnerabilities. Thank you for your support of this mission. I would be happy to answer any questions that the Committee may have.