



Testimony before the United States House of Representatives

Committee on Oversight and Government Reform

Subcommittee on Health Care, DC, Census and the National Archives

Hearing on:
“Waste, Abuse and Mismanagement in Government Health Care”

Testimony of:

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April 5, 2011
1:30PM
2154 Rayburn House Office Building



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A PERSPECTIVE ON FRAUD, WASTE, AND ABUSE
WITHIN THE MEDICARE AND MEDICAID PROGRAMS

Good afternoon Chairman Gowdy, Ranking Member Davis, and distinguished Members of the Subcommittee. I am Gerald Roy, Deputy Inspector General for Investigations at the U.S. Department of Health & Human Services' (HHS) Office of Inspector General (OIG). I thank you for the opportunity to discuss fraud, waste, and abuse within the Medicare and Medicaid programs. Today, I will discuss this issue from the perspective of a law enforcement officer with over 20 years of law enforcement experience, including 16 years of working health care fraud violations.

OIG's Role and Partners in Protecting the Integrity of Medicare and Medicaid

OIG's mission is to protect the integrity of the more than 300 programs administered by HHS. Approximately 80 percent of OIG's resources are dedicated to promoting the efficiency and effectiveness of federally funded health care programs and protecting these programs and our beneficiaries from fraud, waste, and abuse.

OIG employs more than 1,700 dedicated professionals, including a cadre of over 450 highly skilled criminal investigators trained to conduct criminal, civil, and administrative investigations of fraud and abuse related to HHS programs and operations. Our special agents have full law enforcement authority to effectuate the broad range of available law enforcement actions, including the execution of search and arrest warrants. We use state-of-the-art technologies and a wide range of law enforcement tools in carrying out these important responsibilities. We are the Nation's premiere health care fraud law enforcement agency.

Our constituents are the American tax payers, and we work hard to ensure that their money is not stolen or misspent. Thanks to the work of our dedicated professionals, over the past fiscal year, OIG opened over 1,700 health care investigations and obtained over 900 criminal convictions and civil actions. OIG investigations also have resulted in over \$3.7 billion in expected criminal and civil recoveries during that time period.

Background

On May 3, 1995, President Clinton announced Operation Restore Trust, a 2-year partnership of Federal and State agencies tasked with protecting the Medicare and Medicaid programs through shared intelligence, coordinated law enforcement, and enhanced quality of care for our program beneficiaries. Under this program, I joined OIG in October of 1995 in the San Diego Field Office after serving for nearly 5 years as a Special Agent with the U.S. Treasury Department. As an OIG Special Agent, I successfully investigated a wide variety of health care fraud matters, including cases

involving durable medical equipment (DME) schemes, ambulance transportation fraud, and corporate fraud.

Once promoted to the position of Assistant Special Agent in Charge (ASAC) in the Los Angeles Region, I began to see organized criminal enterprises entering into the lucrative field of Medicare fraud. The sophisticated nature of organized criminal enterprises in the Los Angeles area facilitated unprecedented levels of fraud, and in a span of 3 to 4 years, their concentrated efforts would have a nationwide adverse impact on Medicare.

I was promoted to Special Agent in Charge in the Los Angeles Region in October 2006. I cultivated a law enforcement environment and worked to increase public awareness of OIG agents as law enforcement officers. During this time, for example, I recognized that OIG was ill equipped to unilaterally deal with the burgeoning organized crime issue. We lacked the historical knowledge of these criminal elements and experience in fighting the street-level tactics they incorporated into health care fraud. For the first time in OIG history, I assigned agents to organized crime task forces, and we combined our expertise to tackle the problem head on. In addition to taking such innovative approaches to investigations, I laid the foundation to establish the Medicare Fraud Strike Force teams in Los Angeles before my departure to OIG Headquarters.

Since December of 2007, I have held executive-level positions in the Office of Investigations (OI), OIG Headquarters in Washington, DC. I have spearheaded OIG's collaboration and coalition building with HHS, Congress, the Department of Justice (DOJ), and Medicaid Fraud Control Units, among other stakeholders, and solidified OIG agents' role as the Federal health care fraud law enforcement experts.

Today, I hold the position of Deputy Inspector General of Investigations. I am the senior official responsible for supervising the functions of OI. I manage, direct, and coordinate the operations and resources of OI, which includes a workforce of over 630 employees composed of criminal investigators, analysts and administrative staff. I have investigative oversight of nearly 900 billion dollars in departmental expenditures.

Over the past 16 years, I have served in every capacity available to a criminal investigator in OIG, and it is from this perspective that I will share with you my observations and experiences related to the prevalence of fraud, waste, and abuse within the Medicare and Medicaid programs.

Has Fraud Changed Within the Programs?

Some of the health care fraud schemes of 16 years ago are still used by today's criminals. These schemes 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 illegal kickbacks, and/or stealing providers' or beneficiaries' identities. While many of today's health care fraud schemes continue to exploit vulnerabilities in the health care system, we are uncovering more and more fraud.

In early 1996, HHS Secretary Donna Shalala observed that many sectors of the Federal Government were experiencing a “frustrating time...amid the constraints imposed by the budget impasse and two consequent furloughs...” (Shalala, *Semi-Annual Report to Congress*, 1996). It was during this time that I opened an investigation into a San Diego-based company that was engaged in durable medical equipment (DME) fraud. The case took me from Southern California to Miami, Florida, as I gathered evidence on a father-daughter team that was perpetrating fraud on both coasts. The father-daughter team worked for several years to steal almost \$1 million before the case was ultimately referred to OIG. Combined, the investigative and prosecution processes took in excess of 3 years. The father, a former drug dealer, told us he found stealing from Medicare far safer and more lucrative than his former occupation. Their scheme was simple: they used beneficiary lists that were photocopied or faxed amongst nursing homes and other fraud perpetrators to submit paper claims for DME they never provided. Both pled guilty to health care fraud and conspiracy charges. The father was sentenced to 5 months in prison and 2 years of probation. His daughter was sentenced to 3 years of probation.

Today, we see the same general scheme on a grander, more sophisticated scale. For example, when I moved to the Los Angeles Regional Office in 2003, the shared beneficiary list used in DME fraud circulating around Los Angeles was composed of approximately 2,500 Medicare beneficiary numbers. The numbers were often handwritten and traded on the streets of Los Angeles. When I departed Los Angeles in 2007 for Washington, DC, that list contained the names and numbers of well over 100,000 beneficiaries, and it was shared electronically among countless fraud perpetrators. With that list, Medicare fraud perpetrators can steal well over a million dollars in 90 days without ever filing a single sheet of paper. Today, we estimate that 270,000 Medicare beneficiary numbers have been compromised and may be employed by criminals as part of national fraud schemes.

Although there is no precise measure of health care fraud, we know that it is a serious problem that demands an aggressive and sustained response. Although 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. 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 illegal kickbacks to physicians in return for Medicare referrals.

Organized Crime

Perhaps the most challenging and disturbing trend I have witnessed in my tenure at OIG is the rise of criminal enterprises in health care fraud. Medicare has been increasingly infiltrated by sophisticated, organized criminal networks and violent criminals.

For example, in Southern California, OIG special agents investigated an individual who set out to defraud the Medicare program by establishing multiple fraudulent DME companies. The owner used members of a street gang as nominee owners of his DME

companies, consistent with the organized crime model in which the crime boss uses foot soldiers as a front for his operations. He paid the gang members approximately \$5,000 each to establish bank accounts and fill out Medicare enrollment paperwork. The nominee owners submitted claims for reimbursement to Medicare for power wheelchairs and orthotic devices that were not medically necessary or legitimately prescribed by a physician. The criminal records for the gang members involved in this fraud ranged from assault on a peace officer to drug trafficking. Nine of the gang members and associates were indicted for charges including health care fraud and providing false statements to government agents. Of the nine defendants, eight have pled guilty and are currently serving or have completed serving jail time for their crimes. Not only is this investigation an example of one of the more prevalent fraud schemes that we are seeing, but also it highlights multitiered schemes and sophisticated criminals entering the health care fraud arena.

Health care fraud criminals are acutely aware of the time it has historically taken Medicare program integrity contractors to discover something is amiss and inform OIG of their findings. They know they have 90 days to establish a provider number, open a bank account, and bill as much money as they can using the shared beneficiary lists. When 90 days are up, after billing Medicare for millions of dollars, they drop the provider number and empty the bank account to the best of their ability. Simultaneously, they work on establishing the next provider number and bank account. To assist in their efforts, many gang members have had insiders working at the banks to ensure that identification of account holders was difficult if not impossible. One of my agents and the Department of Justice also successfully investigated and prosecuted several individuals who worked at the Medicare provider enrollment unit in Los Angeles, who were paid to facilitate provider numbers for organized criminals. So well executed were their schemes that it was difficult identifying who these criminals actually were.

The emergence of organized crime has brought new investigative challenges and raised the level of violence. In Los Angeles, we found that Eurasian organized crime family members have little to no fear of law enforcement or our judiciary system. To them, a prison sentence is a badge of honor that is expected from each gang member at some point during a life of criminal activity. We have learned that once inside prison, Eurasian gang members can pay for personal safety using their ill-gotten gains from Medicare and recruit prisoners to act as nominee clinic and DME store owners upon their release.

The new criminal is also violent. As an ASAC in Southern California, I was once asked to assist an agent in a meeting with a criminal informant to whom we had given \$10,000 to lure an elusive subject out in the open. We met at midnight at a predetermined location and waited for hours as the informant never showed. Three days later, I traveled with my agent to a community hospital 90 miles outside Los Angeles, where we had located our informant. He had been severely beaten and was so scared that he refused to cooperate further, citing not only his own safety, but that of his family. He chose to return to jail over cooperating with law enforcement.

If and when a fraud perpetrator goes outside the realm of the shared beneficiary list, we have increasingly witnessed the targeting of vulnerable beneficiaries within ethnic communities to facilitate the fraudulent actions. Our investigations have shown that fraud perpetrators are paying individuals within specific ethnic communities nominal amounts of money to secure the use of their Medicare or Medicaid identification numbers. Even worse, beneficiaries are being loaded into vans, taken to facilities and put through invasive procedures that are medically unnecessary; all for the purpose of fraudulently billing Federal health care programs. Often, language and cultural barriers impede fraud-fighting efforts in these communities.

Corporate Fraud

OIG established itself as the lead in corporate health care fraud investigations with the successful conclusion of the National Health Laboratory (NHL) investigation in 1992. The corporate entity settled civil false claims allegations for a then record-breaking \$110 million. The company's chief executive also pled guilty to health care fraud. NHL billed Medicare for additional blood tests that were marketed to customers as part of a basic blood series. The deterrent effect associated with this case resonated throughout the corporate world. The message was sent and received: engage in corporate fraud activity and OIG will hold you accountable, both financially and criminally. Unfortunately, this message did not resonate for long, even in the wake of "Operation LabScam," the Government's concentrated effort to address clinical laboratory fraud nationwide. More than \$800 million in recoveries later, corporate fraud continued.

How these cases are investigated has remained consistent over the years. Investigations of large corporations are often initiated after a "whistleblower" files a lawsuit on behalf of the Government, known as a "*qui tam*," alleging wrongdoing by the company. The allegations include information that the companies engaged in illegal activities that violated the False Claims Act. In doing so, the companies cause false claims to be submitted to Federal health care programs for payment. The investigations involve coordination among many Federal Government departments and agencies whose programs are alleged to have been harmed.

OIG often negotiates compliance obligations, known as corporate integrity agreements or CIAs, with health care providers and other corporate entities as part of the settlement of Federal health care program investigations arising under a variety of civil and administrative false claims statutes. Like the evolution of health care fraud, CIAs have also evolved to address specific aspects of corporate conduct. Current CIAs are much more tailored to address the deficiencies of the particular organization. For instance, there are CIA increased requirements that pertain to transparency; internal audits; and in the case of quality of care violations, very specific compliance measures that the entity must undertake.

The typical term of a comprehensive CIA is 5 years. These compliance measures seek to ensure the integrity of corporate activities and the Federal health care program claims

submitted by providers. Although many CIAs have common elements, each agreement addresses, in part, the specific facts of the conduct at issue.

To address large-scale corporate fraud, OIG has the authority to use one of the most powerful tools in our arsenal: exclusion from participating in Federal health care programs. Once we determine that an individual or entity is engaged in fraud or the provision of substandard care, program exclusion can be implemented. This tool bolsters our fraud-fighting efforts by removing from the Federal health care programs those who pose the greatest risk to programs and beneficiaries. I will discuss the impact of the exclusion process later in my testimony.

Today, what is most troubling to OIG is the possibility that some unethical health care corporations build in the cost of paying civil fines and penalties and implementing CIAs into their cost of doing business. Some hospital systems, pharmaceutical manufacturers, and other providers play such a critical role in the care delivery system that they may believe that they are “too big to fire” and thus OIG would never exclude them and thereby risk compromising the welfare of our beneficiaries. As long as the profit from fraud outweighs those costs, abusive corporate behavior is likely to continue.

Why Significant Health Care Fraud, Waste, and Abuse Continue

While our efforts have made a major impact on health care fraud, there is indeed a significant amount of fraud in our Federal health care programs. There are many reasons for this trend, including the pitfalls associated with a trust-based Federal health care system, low barriers to entry, lucrative targets, and the perception of low risk of detection and penalty.

Low Barriers to Entry Facilitate Fraud

Throughout my tenure at OIG, those who wish to steal from our program have enjoyed unfettered access to Federal health care programs. Since its inception, Medicare has been a program that allows “any willing provider” to provide services for beneficiaries. In other words, we have treated participation in our programs as a right, instead of a privilege. The Department has faced challenges in ensuring the integrity of the program’s provider and supplier enrollment processes. While the majority of providers are innocent and provide invaluable services to beneficiaries, a small percentage of providers and suppliers intent on defrauding these programs have continuously exploited weaknesses in the enrollment process. Many of the criminals prosecuted in our Strike Force investigations have been able to defraud the program of millions of dollars because of these low barriers of entry. Without enhanced enrollment standards, such as proper background checks, these fraudulent providers and suppliers drain resources that should be spent on providing care to beneficiaries.

We have long advocated strengthening enrollment standards and making participation in Federal health care programs as a provider or supplier a privilege. Recently, the

Department has made strides in strengthening enrollment standards; and we will continue to work with the Department as it makes improvements in this area. It is more efficient and effective to protect the programs and beneficiaries from unqualified, fraudulent, or abusive providers and suppliers upfront than to try to recover payments or redress fraud or abuse after it occurs. Ensuring adequate and appropriate provider and supplier enrollment standards and screening is an essential first step to strengthening the integrity of the Medicare and Medicaid programs.

Low Risk of Detection and Lesser Penalties

Amongst the criminals who steal from Medicare, there is the perception of a low risk of detection. While organized crime figures use their 90-day window of opportunity to avoid being identified, other more brazen criminals discuss Medicare fraud openly on the streets as a safe and easy way to get rich quick.

We must make defrauding Federal health care programs less attractive by increasing the risk of swift detection and the certainty of punishment. As part of this strategy, law enforcement must accelerate the Government's response to fraud schemes. The Strike Force model has proved highly successful in this regard. The Medicare Fraud Strike Force is a critical component of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiative. Strike Forces are collaborative efforts, combining OIG's law enforcement skills and resources with those of our partners in the Federal Bureau of Investigation, Medicaid Fraud Control Units, and other State and local law enforcement agencies. Strike Force cases focus on the development and implementation of a technologically sophisticated and collaborative approach to combat fraud. Using this streamlined investigative approach, not only have Strike Force investigations enabled us to identify perpetrators of health care fraud earlier in their fraud schemes, but also we have significantly cut down the amount of time to fully adjudicate a case.

Additionally, there is the perception amongst criminals that if the fraud scheme is uncovered, the penalties are far less severe than imposed for other crimes. And while this may have been true in the recent past, this perception, however, is no longer reality.

During my tenure at OIG, I have seen significant changes to the sentencing guidelines, and prison sentences for health care fraud have increased significantly. And for these changes, I would like to thank the Committee and the Congress for being our strong ally in fighting health care fraud. In just the last 15 years, the Congress has enacted a number of Federal offenses that specifically target health care, including fraud^{7[1]} false statements,^[2] theft or embezzlement,^[3] money laundering,^[4] and obstruction.^[5] These

^[1] 18 U.S.C. § 1347

^[2] 18 U.S.C. § 1035

^[3] 18 U.S.C. § 669

^[4] 18 U.S.C. § 1956

^[5] 18 U.S.C. § 1518

offenses are all important tools for law enforcement in prosecuting a Federal health care case. Thanks to you and your colleagues, wrongdoers also can now be required to forfeit property derived from the commission of health care fraud.^[6] And just last year, the Affordable Care Act directed the U.S. Sentencing Commission to dramatically increase the Federal sentencing guidelines for health care fraud offenses, especially those that involve large losses.^[7] The Commission issued draft amendments for comment early this year. In addition to enacting these strong criminal enhancements, the Congress strengthened the Government's civil remedies by amending the Federal False Claims Act in 2009 and 2010. All of these changes improved the Government's ability to pursue fraud, waste, and abuse in the Federal health care programs. These laws make clear that the Congress and the Federal executive branch are joined in an effort to identify and stop fraudulent practices, punish the wrongdoers, and recapture the funds lost to fraud.

Through the Strike Force, we are seeing the positive effects of these more stringent guidelines with more and longer sentences mandating time in prison. According to DOJ, in fiscal year 2010, more than 94 percent of Strike Force defendants were convicted; of which 86 percent received prison terms. The average prison term for Strike Force defendants was over 40 months. This is more than double the 1995 average prison term for health care fraud violations investigated by OIG.

Sustained Law Enforcement Efforts Are Critical to Success

Operation Restore Trust, the Government's first national antifraud effort, is one of many examples of OIG's efforts to hold perpetrators of health care fraud accountable. Operation Restore Trust was responsible for \$187 million in recoveries, 74 criminal convictions, 58 civil settlements, and 218 exclusions from Federal health care programs. The lessons learned during Operation Restore Trust, including the importance of collaboration, have been critical to our ongoing antifraud initiatives. Its stated goals are similar to those of today's HEAT initiative. The HEAT initiative, established by Secretary Kathleen Sebelius and Attorney General Eric Holder in May 2009, is an unprecedented partnership that brings together senior officials from both Departments with the stated goals of sharing information, spotting fraud trends, coordinating prevention and enforcement strategies, and developing new fraud prevention tools.

Operation Restore Trust produced many important results. In addition to resulting in enforcement actions and recoveries, the Operation built and strengthened relationships among law enforcement agencies and within HHS. It also provided a foundation for the creation of the Health Care Fraud and Abuse Control (HCFAC) Program, which continues to be the main source of funding for OIG's fraud-fighting efforts.

However, after Operation Restore Trust concluded, external attention to health care fraud waned and some of the same fraud problems reemerged. This "pilot program" was never

^[6] 18 U.S.C. § 982

^[7] ACA, § 10606

expanded beyond the original five States of California, Texas, Florida, Illinois, and New York. Data from the Centers for Medicare & Medicaid Services reveal that Operation Restore Trust reduced expenditures in fraud hotspots on which it focused -- home health and DME. However, as interest waned from those outside OIG, expenditures in those two arenas began a steady climb. In the years that followed, the fraud problem was burgeoning, with modifications to old schemes going “viral” and organized criminals discovering new ways to exploit the programs.

Making an Impact on Fraud

While I consider the state of health care fraud to be at a critical level, reinvigorated partnerships and an emphasis on this issue by various stakeholders reinforces my belief that a concerted, sustained effort will make significant strides towards eradicating health care fraud, waste, and abuse. Together, with our law enforcement partners, we are using new techniques to combat fraud. For example, the Medicare Fraud Strike Forces under HEAT are concentrating antifraud efforts in geographic areas at high risk for Medicare fraud and implemented new processes regarding the identification of health care fraud cases and the manner in which they are investigated and prosecuted. Coincidentally, we find ourselves running Strike Forces in the same five Operation Restore Trust States: California, Texas, Florida, Illinois, and New York. We have also added Michigan and Louisiana to the list. Strike Force cases focus on the development and implementation of a technologically sophisticated and collaborative approach. By using Medicare data early in the investigative process, we can spot fraud as it is occurring and catch those criminals who, for years, operated in anonymity. If my DME fraud case from 1996 were to be investigated using the Strike Force model, the combined investigative and prosecution processes associated with the father-daughter team would be less than a year. Most likely, their prison sentences would have been significantly increased.

From a law enforcement perspective, we are making a substantial impact on fraud. In February, HEAT Strike Forces engaged in the largest Federal health care fraud takedown in history. Teams across the country arrested over 100 defendants in 9 cities, including doctors, nurses, health care company owners and executives, and others, for their alleged participation in Medicare fraud schemes involving more than \$225 million in false billing. More than 300 special agents from OIG participated in partnership with other Federal and State agencies. The defendants charged as a part of the operation are accused of various health-care-related crimes ranging from violating the anti-kickback statute to money laundering, to aggravated identity theft.

As of March 31, 2011, our Strike Force efforts nationwide have charged over 840 defendants; obtained over 420 convictions; and secured over \$380 million in court-ordered restitutions, fines, and penalties.

We are focusing on corporate fraud as well. One way to address the “too big to fire” issue discussed above is to alter the cost-benefit calculus of the corporate executives who run these companies. By excluding the individuals who are responsible for the fraud, either directly or because of their positions of responsibility in the company that engaged

in fraud, we can influence corporate behavior without putting patient access to care at risk. For example, in 2008, we excluded three former executive officers of the pharmaceutical company Purdue Frederick based on their convictions for misbranding of the painkiller OxyContin. Each of the executives was convicted based on his status as a responsible corporate officer.

As I mentioned earlier, OIG also has the discretionary authority to exclude certain owners, officers, and managing employees of a sanctioned entity (i.e., an entity that has been convicted of certain offenses or excluded from participation in the Federal health care programs) even if the executive has not been convicted of a crime. This authority, section 1128(b)(15) of the Social Security Act, allows OIG to hold responsible individuals accountable for corporate misconduct. OIG has used this exclusion authority in over 30 cases since it was added to the statute in 1996. But until recently, we had typically applied this exclusion authority to individuals who controlled smaller companies, such as pharmacies, billing services, and DME companies and not to executives of large complex organizations like a drug or device manufacturer.

We intend to use this essential fraud-fighting tool in a broader range of circumstances. For example, in addition to excluding the Purdue Frederick executives, we recently excluded an owner (and former executive) of Ethex Corporation under our section (b)(15) exclusion authority. Ethex operated manufacturing facilities in St. Louis. In March of last year, Ethex pled guilty to felony criminal charges after it failed to inform the Food and Drug Administration about manufacturing problems that led to the production of oversized tablets of two prescription drugs. The owner was excluded for 20 years.

We are mindful of our obligation to exercise this authority judiciously, and we do not propose to exclude all officers and managing employees of a company that is convicted of a health-care-related offense. However, when there is evidence that an executive knew or should have known of the underlying criminal misconduct of the organization, OIG will operate with a presumption in favor of exclusion of that executive. We have published guidance on our Web site that sets out factors we will consider when determining whether a section (b)(15) exclusion should be imposed in a particular case.^[8] This guidance alerts health care providers and executives to the standards of ethical conduct and responsibility to which they will be held accountable by OIG. Even if we decide exclusion of a major health care entity is not in the best interests of Federal health care programs and their beneficiaries, we may decide that executives in positions of responsibility at the time of the fraud should no longer hold such positions with entities that do business with the programs.

Conclusion

From a law enforcement perspective, Medicare and Medicaid are under siege by fraud perpetrators from all walks of life. And as some 70 million “baby boomers” near

^[8] Available online at http://oig.hhs.gov/fraud/exclusions/files/permissive_excl_under_1128b15_10192010.pdf.

retirement, the Medicare rolls will grow and the workforce that supports the program with taxes will shrink. In years to come, controlling fraud, waste, and abuse will play a considerable role in ensuring the solvency of our Federal health care programs that were put in place to ensure that our children, senior citizens, the disabled, and low income citizens have adequate health care.

In my tenure at OIG, I have never seen a more focused spotlight on this important issue. The partnerships between OIG, DOJ, and the Centers for Medicare & Medicaid Services are strong. The potential to make a lasting impact on fraud, waste, and abuse has never been better.

Our motto in the Office of Investigations is simple and powerful: Mission Focus. We understand that we protect the Nation's most vulnerable citizens and the Federal health care programs on which they depend. OIG Special Agents diligently and effectively investigated health care fraud long before the issue hit the national spotlight. We will be here for the American taxpayers if the spotlight is no longer focused on this important issue. But I submit that it is not in this Nation's best interest to let our attention wane.

From my perspective, we cannot afford to let up on our efforts. Sustained funding sources and continued interest from Congress and American taxpayers are paramount to our future success.

Biography:
Gerald T. Roy

As the Deputy Inspector General of Investigations (DIGI), Mr. Roy is the senior official responsible for supervising the functions of the Office of Investigations (OI) within the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG). He manages, directs, and coordinates the operations and resources of OI, which includes a workforce of over 500 employees comprised of criminal investigators, analysts and administrative staff.

Mr. Roy has served in OI since 1995, initially as a Special Agent in the San Diego field office where he successfully investigated a breadth of healthcare fraud matters including cases involving durable medical equipment and clinical laboratories. He led cases through trial and was responsible for numerous criminal convictions and multi-million dollar civil settlements. Mr. Roy was frequently detailed to domestic and international secretarial protective operations. He was the regional firearms training coordinator and a certified emergency medical technician.

In August 2003, Mr. Roy was promoted to Assistant Special Agent in Charge (ASAC) in the Los Angeles Region where he focused investigations into organized crime's impact on Medicare. As an ASAC, he led the successful effort to foster working relationships and collaborate with law enforcement partners, financial institutions and U.S. Attorneys' Offices.

Mr. Roy was promoted to Special Agent in Charge in the Los Angeles Region in October 2006. He cultivated a law enforcement environment and worked to increase public awareness of OI agents as law enforcement officers. Mr. Roy promoted innovative approaches to investigations and prosecutions and laid the foundation to establish the Medicare Fraud Strike Force teams in L.A. Mr. Roy expanded implementation of the awards system, increased training opportunities, and encouraged participation in team events such as the law enforcement Baker to Vegas relay race.

In December 2007, Mr. Roy was promoted to the Assistant Inspector General for Investigations (AIGI) in OI Headquarters in Washington, D.C. where he was responsible for effectively managing five OI regional offices, two Headquarters branches and approximately 200 staff. Under his leadership as AIGI, Mr. Roy helped OI become the Federal Government's premier health care law enforcement agency through his major contributions to the success of the HEAT initiative. Mr. Roy's strong collaboration and coalition building throughout his work with the Department, Congress, the Department of Justice and Medicaid Fraud Control Units, among other stakeholders, led to recognition of OI agents as the Federal health care fraud law enforcement specialists. He was also instrumental in increasing OI's civil and criminal conviction record and the twenty-five percent increase in OI's monetary recoveries from \$3 billion in 2008 to over \$4 billion in 2009.

Mr. Roy has devoted his career to Federal law enforcement. Prior to joining HHS OIG, he investigated high-profile public corruption cases, priority-sensitive internal affairs matters and bank fraud as an agent for the U.S. Department of the Treasury. He began his federal law enforcement career as an Inspector for the Immigration and Naturalization Service.

Mr. Roy is a graduate of the University of California at San Diego and holds a Master's Degree in Criminology, Law and Society from the University of California at Irvine.