STATEMENT OF

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ON

"PREVENTING MEDICARE FRAUD:
HOW CAN WE BEST PROTECT SENIORS AND TAXPAYERS?"

BEFORE THE
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"Preventing Medicare Fraud: How Can We Best Protect Seniors and Taxpayers?"
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Chairman Nelson, Ranking Member Collins, and members of the Committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We have made important strides in reducing fraud, waste, and abuse across our programs with the strong support of this Committee and the Congress.

Thanks in part to the authorities and resources provided by the Affordable Care Act and the Small Business Jobs Act of 2010, CMS has powerful tools that help improve our efforts to detect and prevent fraud, waste, and abuse in Medicare. CMS's approach has two key components: prevention and collaboration. By shifting the agency beyond a "pay and chase" approach and by collaborating in unprecedented ways with our State partners, law enforcement, and the private sector, CMS is making great strides in protecting the integrity of CMS's programs, including Medicare.

Earlier this year, the government announced that in fiscal year (FY) 2013, its fraud, waste, and abuse prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the record-breaking recovery of $4.33 billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers.[1] Over the last five years, the administration's enforcement efforts have recovered $19.2 billion, up from $9.4 billion over the prior five-year period. Over the last three years, the average return on investment of the HCFAC program is $8.10 for every dollar spent, which is an increase of $2.70 over the average ROI for the life of the HCFAC program since 1997.

Preventing Fraud in the Medicare Program

One of the most fundamental changes in the administration's approach to fraud-fighting is a focus on prevention. For far too long, CMS and our law enforcement partners were forced to

[1] http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf

"pay and chase" by paying claims and then working to identify and recoup fraudulent payments. Now, CMS has a variety of tools to keep fraudsters out of our programs, and to uncover fraudulent schemes quickly, before they drain valuable resources from our Trust Funds.

Strengthening Provider Enrollment

The Affordable Care Act required CMS to implement categorical risk-based screening of providers and suppliers who want to participate in the Medicare and Medicaid programs, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to receive greater scrutiny prior to their enrollment or revalidation in Medicare. Categories of providers and suppliers designated as limited risk undergo verification of licensure and a wide range of database checks to ensure compliance with any provider or supplier-specific requirements. Categories of providers and suppliers designated as moderate or high categorical risk are subject to all the requirements in the limited screening level, plus additional screening including unannounced site visits.

The Affordable Care Act also required CMS to screen all existing 1.5 million Medicare suppliers and providers under the new screening requirements. CMS embarked on an ambitious project to revalidate the enrollment information of all existing providers and suppliers, and these efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. Since March 25, 2011, more than 770,000 providers and suppliers have been subject to the new screening requirements and over 260,000 provider and supplier practice locations had their billing privileges deactivated for non-response as a result of these screening efforts.[2] Since implementation of the Affordable Care Act's requirements, CMS has also revoked 17,534 providers' and suppliers' ability to bill the Medicare program. These providers and suppliers were removed from the program because they had felony convictions, were not operational at the address CMS had on file, or were not in compliance with CMS rules, such as licensure requirements.

[2] Deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

CMS is also aware of concerns related to fraud, waste, and abuse in the Medicare Part D program, as well as concerns that compliance with program requirements could be improved. CMS appreciates the thoughtful work of the Congress[3] and the Department of Health & Human Services (HHS) Office of Inspector General (OIG)[4] that highlights the potential for fraud, waste, and abuse in Part D. To address these concerns, we have proposed applying similar approaches for ordering by, and enrollment of, physicians and non-physician practitioners to the Medicare Part D program that were implemented for Medicare Parts A and B. Our proposal would require that physicians and non-physician practitioners who write prescriptions for covered Part D drugs to be enrolled in Medicare for their prescriptions to be covered under Part D. This requirement would help CMS ensure that Part D drugs are prescribed only by qualified individuals. We have also issued a proposal that would allow CMS to revoke a prescriber's enrollment based on abusive prescribing practices and patterns. This proposal would provide CMS the authority to revoke a physician's or eligible professional's Medicare enrollment if CMS determines that he or she has a pattern or practice of prescribing Part D drugs that is abusive and represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements. Additionally, prescribing authority could be revoked if a prescriber's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs.

Enrollment Moratoria

The Affordable Care Act provides the Secretary the authority to impose a temporary moratorium on the enrollment of new Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers and suppliers, including categories of providers and suppliers, if the Secretary determines the moratorium is necessary to prevent or combat fraud, waste, or abuse under these programs. States affected are required to determine whether the imposition of a moratorium

[3] For example, http://www.hsgac.senate.gov/subcommittees/Federal-financial-management/hearings/costs-of-prescription-drug-abuse-in-the-medicare-part-d-program

[4] HHS OIG has a large body of work examining Part D billing including: OEI-02-09-00603, OEI-02-09-00608, OEI-02-09-00140, OEI-03-11-00310, OEI-07-09-00150, OEI-07-10-06004

would adversely affect Medicaid beneficiaries' access to medical assistance and notify the Secretary if there would be an adverse effect. When a moratorium is imposed, existing providers and suppliers may continue to deliver and bill for services, but no new applications will be approved for the designated provider or supplier-types in the designated areas, allowing CMS and its law enforcement partners to continue efforts to remove bad actors from the program while blocking provider entry or re-entry into markets that CMS has determined have a significant potential for fraud, waste or abuse. CMS is required to re-evaluate the need for such moratoria every six months.

In the last year, CMS has used this authority to fight fraud, waste, and abuse, and to safeguard taxpayer dollars while ensuring patient access to care is not interrupted. In July 2013, CMS announced temporary moratoria on the enrollment of new home health agencies (HHAs) and ambulance companies in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground-based ambulance suppliers in and around Houston.[5] In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas (Fort Lauderdale, Detroit, Dallas, and Houston), and a new temporary moratorium on the enrollment of ground ambulance suppliers in the metropolitan Philadelphia area.[6] CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area.

Before taking these actions, CMS consulted with HHS OIG, the Department of Justice (DOJ), and the relevant State Medicaid Agencies, and found that fraud trends warranted moratoria on certain types of providers in these geographic areas. CMS also reviewed key factors of potential fraud risk including a disproportionately high number of providers and suppliers relative to the number beneficiaries, and extremely high utilization. All the geographic areas included in the moratoria ranked as high-risk in these fraud risk factors.

[5] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html
[6] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html

CMS carefully examined Medicare beneficiary access to services in all of these areas, and concluded that the moratoria will not affect access to care. The Agency also worked closely with each of the affected states to evaluate patient access to care, and these states reported that Medicaid and CHIP beneficiaries will continue to have access to services. During the moratoria period, CMS and the affected states will continue to monitor access to care to ensure that Medicare, Medicaid, and CHIP beneficiaries are receiving the services they need.

Fraud Prevention System

Our prevention efforts in Medicare and Medicaid strike an important balance: protecting beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers and suppliers, while ensuring that taxpayer dollars are not lost to fraud, waste, and abuse. CMS quickly implemented the requirements of the Small Business Jobs Act of 2010, which calls for the use of predictive modeling and other analytic technologies to identify and prevent fraud, waste, and abuse, just nine months after the President signed the bill into law. Since June 30, 2011, when CMS launched the Fraud Prevention System (FPS), CMS has been applying advanced analytics to Medicare fee-for-service (FFS) claims on a streaming, national basis. When FPS predictive models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for review and investigation. The FPS helps CMS target fraudulent providers and suppliers, reduce the administrative and compliance burdens on legitimate ones, and prevent fraud so that funds are not diverted from providing beneficiaries with access to quality health care. These important tools help protect the Medicare Trust Funds by preventing funds from being spent on these questionable providers and suppliers.

The FPS is used by CMS's Zone Program Integrity Contractors (ZPICs) and the HHS OIG Office of Investigations. When suspect behavior or billing activity is identified, the ZPICs perform specific program integrity functions for the Medicare FFS program. Complementing the ZPICs' traditional activities, ZPICs are now using the FPS as a primary source of leads to prevent, identify, and investigate fraud. The FPS screens claims data before payment is made, allowing CMS to rapidly implement administrative actions, such as revocation, payment suspension, or prepayment review, as appropriate. The FPS generates a prioritized list of leads

for ZPICs to review and investigate Medicare fraud in their designated region. The FPS also gives CMS a provider-level view of ZPIC activities and administrative actions, making it a useful management tool.

Early results from the FPS show significant promise and CMS expects increased returns as the system matures over time. As reported in the FPS FY 2012 Report to Congress,[7] in its first year of implementation, the FPS stopped, prevented or identified an estimated $115.4 million in improper payments. The FPS achieved a positive return on investment, saving an estimated $3 for every dollar spent in the first year; CMS anticipates that the ability of FPS to identify bad actors and focus investigative resources on most egregious schemes will continue to expand.

National Correct Coding Initiative

CMS has developed the National Correct Coding Initiative (NCCI), which consists of edits designed to reduce improper payments in Medicare Part B and Medicaid. This program was originally implemented with procedure-to-procedure edits to ensure accurate coding and reporting of services by physicians.[8] In addition to procedure-to-procedure edits, CMS established the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Medicare Part B claims as part of the NCCI program.[9] NCCI edits are updated quarterly and, prior to implementation, edits are reviewed by national healthcare organizations and their recommendations are taken into consideration before implementation. Since October 2008, all procedure-to-procedure edits and the majority of MUEs have been made public and posted on the CMS website.[10] The use of the NCCI procedure-to-procedure edits saved the Medicare program $483 million in FY 2012, and the NCCI methodology procedure-to-procedure edits applied to practitioner and outpatient hospital services have prevented the improper payment by Medicare of over $5 billion since 1996 based on savings reports from claims-processing contractors.

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[7] http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf

[8] Procedure-to-procedure edits stop payment for claims billing for two procedures that could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal or gender considerations.

[9] MUEs stop payment for claims that are beyond the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single data of service.

[10] Certain edits are not published because of CMS concerns that they may be used or manipulated by fraudulent individuals and entities.

Coordination and Collaboration to Detect Fraud, Waste, and Abuse

CMS's approach to program integrity once involved stand-alone programs with siloed communications that did not engage other Federal partners or allow for shared best practices. Now, however, thanks to a variety of efforts, Federal, State, and local law enforcement health care fraud activities are being coordinated to a greater extent than ever before. CMS is also engaging with the private sector in new ways to better share information to combat fraud.

CMS uses a variety of different contractors to administer and oversee the Medicare FFS program. Each of these contractors has different roles and responsibilities. Some contractors specifically assist CMS in combating fraud and identifying improper payments, while others assist CMS's fraud fighting efforts as part of their broader responsibilities as FFS contractors that process claims and recover overpayments**.**

CMS is working to integrate the program integrity functions for audits and investigations across Medicare and Medicaid from work currently performed by several existing contractors, including ZPICs, Program Safeguard Contractors, and the Medicaid Integrity Contractors. CMS has begun market research into the creation of Unified Program Integrity Contractors that would improve our relationships with providers while leveraging existing resources. The goal is to foster cooperation and communication between the different regional program integrity contractors to ensure a national approach to providers or trends that cut across regions; additionally, we believe it will be beneficial to have contractors focused on both Medicare and Medicaid fraud, waste and abuse.

CMS also continues to refine our Medicare Part D program integrity efforts and enhance our oversight of the Medicare Drug Integrity Contractor (MEDIC), which is charged with identifying and investigating potential fraud, and abuse, and developing cases for referral to law enforcement agencies. The MEDIC has implemented a new proactive data analysis effort to identify potential program vulnerabilities, which it shares with a variety of fraud fighting partners, including Part D Plan Sponsors.

Healthcare Fraud Prevention Partnership (HFPP)

CMS has established an ongoing partnership with the private sector to fight fraud, waste, and abuse across the health care system. Making data collections available in this way can assist payers in evaluating trends, recognizing patterns consistent with potential fraud, waste, and abuse, and potentially uncovering schemes or bad actors they could not otherwise identify using only their own information. Such collaboration is the purpose of the Healthcare Fraud Prevention Partnership (HFPP), which currently has 35 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse.

The HFPP has successfully completed several proof-of-concept studies, and additional studies are underway. One of the proof-of-concept studies involved the sharing of payment codes which a partner determined to be commonly mis-billed or abused in some way, as well as fraud schemes their organization has encountered, including details about the scheme such as the geographic area where it manifested. Based on this study, partners have taken substantive actions including implementing payment edits regarding some of the abused codes, as well as conducting investigations into the fraud schemes shared by another partner where they had exposure as well. This resulted in putting providers on payment suspension through, in some cases, complete termination from their plan.

Command Center

Collaboration between program officials and law enforcement is a critical cornerstone in improving health care fraud, waste, and abuse detection and investigation. As a natural progression from early collaborative meetings, on July 31, 2012, CMS opened its Command Center, which provides the advanced technologies and collaborative environment for a multi-disciplinary team of experts and decision makers to more efficiently coordinate policies and case actions, reduce duplication of efforts, and streamline fraud investigations for more immediate administrative action. The Command Center has become a Center of Excellence and has quickly attracted visitors from across the Federal Government and other entities, including international groups that are interested in learning more about our efforts. Since its opening, the Command Center has supported 93 missions that included over 688 unique participants from CMS and our

partners, including HHS OIG and the Federal Bureau of Investigation. These collaborative activities will enable CMS to more quickly and efficiently take administrative actions such as revoking Medicare billing privileges and suspending payments. CMS is also working with other Federal agencies in the Command Center to pool resources to tackle cross-cutting issues surrounding fraud, waste, and abuse prevention.

Health Care Fraud Prevention & Enforcement Action Team

In addition to CMS's commitment to collaboration, the sustained success of Health Care Fraud Prevention & Enforcement Action Team (HEAT) demonstrates the effectiveness of the Cabinet-level commitment between HHS and DOJ to prevent and prosecute health care fraud. Since its creation in May 2009, HEAT has played a critical role in identifying new enforcement initiatives and expanding data sharing to a cross-government health care fraud, waste, and abuse data intelligence sharing workgroup. A key component of HEAT is the presence of Medicare Strike Force Teams, interagency teams of analysts, investigators, and prosecutors, who target emerging or migrating fraud schemes such as criminals masquerading as healthcare providers or suppliers.

In May 2013, a nationwide takedown by Medicare Fraud Strike Force operations in eight cities resulted in charges against 89 individuals, including doctors, nurses and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $223 million in false billings. The defendants charged were accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statute, and money laundering. The charges were based on a variety of alleged fraud schemes involving various medical treatments and services, primarily home health care, but also including mental health services, psychotherapy, physical and occupational therapy, durable medical equipment (DME), and ambulance services. This coordinated takedown was the sixth national Medicare fraud takedown in Strike Force history.

In the six and a half years since its inception,[11] Strike Force prosecutors have filed more than 788 cases charging more than 1,727 defendants who collectively billed the Medicare program more than $5.5 billion; 1,137 defendants pleaded guilty and 148 others were convicted in jury trials;

[11] Specifically, the period from May 7, 2007, through September 30, 2013.

1087 defendants were sentenced to imprisonment for an average term of about 47 months.

This collaborative effort is having a measurable impact on Medicare reimbursements for certain medical services that have been targeted by the Medicare Strike Force. For instance, Medicare payments for DME in Miami have been subject to both an overwhelming law enforcement response and an aggressive and multifaceted strategy by CMS to address the epidemic of fraud. Since 2006, when payments hit an all-time high, exceeding $73 million in one quarter, these payments have decreased to $15 million a quarter. Similarly, Strike Force and CMS activity targeting fraud in Community Mental Health Centers (CMHCs) began in 2008 and accelerated in 2010, ultimately leading to a payment decrease from the peak in 2008 of $70 million a quarter to a decline to $10 million per quarter.

Field Offices

CMS has designated program integrity field offices located in or near the HEAT cities of Miami, Los Angeles, and New York that provide a CMS presence in high risk fraud areas of the country. All three field offices have staff that are designated CMS Strike Force Liaisons, who coordinate with law enforcement, facilitate data analysis, and expedite suspension requests. The field offices also work with CMS central office and the ZPICs to conduct data analysis to proactively identify targets, and to coordinate efforts among various contractors and agencies to identify local issues and vulnerabilities with national or regional impact.

The field offices develop solutions to the most challenging program integrity issues in their region. In Miami, for example, the field office has boots on the ground working to root out fraud in home health by performing provider and beneficiary interviews. The Los Angeles staff is working with county Emergency Medical Service licensing authorities, CMS contractors, and local law enforcement to address emerging schemes among ambulance providers. The New York staff have collaborated with New York and New Jersey licensing boards to identify providers whose licensure actions were not being posted to public websites timely, resulting in identification of more than a dozen providers whose licenses to practice were revoked. New York field staff have also testified as Medicare expert witnesses in thirteen Medicare civil and criminal fraud trials and sentencing hearings in 6 states and Puerto Rico in the past two

years. These efforts have resulted in nearly 100 revocations of Medicare billing privileges in FY 2013.

Coordinated and Integrated Efforts to Detect, Prevent, and Deter Fraud, Waste, and Abuse

As we have implemented new efforts that make it harder for bad actors to enroll or bill in our systems, we are always evaluating how to make it easier for legitimate physicians and other providers to participate in Medicare and care for beneficiaries. Providers enrolling in Medicare for the first time now have a much easier experience enrolling than in years past. Everything can be submitted online, using the web-based "PECOS" (the Provider Enrollment, Chain and Ownership System – the official record of every provider in Medicare). CMS is also employing new technologies to communicate with physicians, including email, Facebook, and Twitter. We also recognize the risks and challenges that many physicians face in today's healthcare landscape. We are dedicated to helping physicians stay on track with important updates in our Medicare and Medicaid operations. The Center for Program Integrity is making it easier for physicians to resolve issues of identity theft.[12] We're providing information on how to protect physicians' medical identity,[13] numerous educational toolkits,[14] and Continuing Medical Education[15] on CMS program integrity activities.

Enrollment Special Study

The Enrollment Special Study is a project designed to stop fraudulent providers from obtaining new Medicare provider numbers, reduce the number of habitual "bad providers" from re-entering the Medicare system after they have been kicked out, and shift from the pay-and-chase approach that has existed in years past. In this project, site visits are conducted prior to enrollment, and providers are targeted for a closer review. The project is limited to CMHCs, Comprehensive Outpatient Rehabilitation Facilities, and Independent Diagnostic Testing Facilities in South Florida. Once the Medicare Administrative Contractor conducts a site visit, it assesses the provider's individual risk, based on historical fraud risk factors developed by CMS. If the

[12] http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/ProviderVictimPOCs.pdf
[13] http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/SafeMed-ID-Products.pdf
[14] http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Provider-Education-Toolkits/provider-ed-tools.html
[15] http://www.stopmedicarefraud.gov/forproviders/index.html

provider appears to be suspect or pose an elevated risk of fraud, the provider is referred to the ZPIC for investigation and administrative action, as appropriate. This project began as a one year project in July 2009 and has been extended due to its success.

Educating Beneficiaries: A Key Tool in Preventing Fraud

Beneficiary involvement is a key component of all of CMS's anti-fraud efforts. Alert and vigilant beneficiaries, family members, and caregivers are some of our most valuable partners in stopping fraudulent activity. Information from beneficiaries and other parties helps us to quickly identify potentially fraudulent practices, stop payment to suspect providers and suppliers for inappropriate services or items, and prevent further abuses in the program. We also want to recognize this Committee for the creation of The United States Special Committee on Aging Fraud Hotline and commend your efforts in educating seniors and others about the dangers of fraud.

CMS is making it easier for seniors to help us fight fraud, waste, and abuse. In June 2013, CMS began sending redesigned Medicare Summary Notices (MSNs),[16] the explanation of benefits for people with Medicare fee-for-service, to make it easier for beneficiaries to spot fraud or errors. The new MSNs include clearer language, descriptions and definitions, and have a dedicated section that tells beneficiaries how to spot potential fraud, waste, and abuse. Beneficiaries are encouraged to report fraud, waste, and abuse to 1-800-MEDICARE, and this is promoted in the re-designed MSN. CMS has an incentive reward program that currently offers a reward of 10 percent of the amount recovered up to $1,000 paid to Medicare beneficiaries and other individuals whose tips about suspected fraud lead to the successful recovery of funds. Last year, CMS released a proposed rule that if finalized, would increase these rewards to 15 percent of the amount recovered up to $10 million.[17]

Senior Medicare Patrols

CMS has also been partnering with the Administration for Community Living (ACL) to lend support to the Senior Medicare Patrol (SMP) program, a volunteer-based national program that

[16] http://blog.medicare.gov/2013/06/06/redesigned-with-you-in-mind-your-medicare-summary-notice/
[17] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-04-24.html

educates Medicare beneficiaries, their families, and caregivers to prevent, detect, and report Medicare fraud, waste and abuse. The SMP program empowers Medicare beneficiaries through increased awareness and understanding of health care programs and educates them on how to recognize and report fraud. During 2012, SMP program grantees' staff and more than 5000 volunteers reached nearly 1.5 million people with group education sessions and one-on-one counseling.[18] SMP projects also work to resolve beneficiary complaints of potential fraud in partnership with State and national fraud control and consumer protection entities, including Medicare contractors, State Medicaid fraud control units, State attorneys general, HHS OIG, and the Federal Trade Commission.

Moving Forward

Medicare fraud, waste, and abuse affect every American by draining critical resources from our health care system. The Administration has made stopping fraud and improper payments a top priority. We have more tools than ever before to move beyond "pay and chase" and implement strategic changes in pursuing and detecting fraud, waste, and abuse. We are focused on preventing fraud before it happens by stopping fraudsters from enrolling or maintaining enrollment in Medicare or Medicaid, using sophisticated analytics to identify improper billing before claims are paid, and by rapid pursuit and implementation of administrative actions that are appropriate to the behavior. Our comprehensive program integrity strategy implements innovative data technologies and draws on expertise from across the country. As we integrate strategies and engage our Federal, State, and private sector partners, Medicare will become a stronger, more effective program. I look forward to working with this Committee and the Congress as we continue to make improvements in protecting the integrity of our health care programs and safeguarding taxpayer resources.

[18] http://oig.hhs.gov/oei/reports/oei-02-13-00170.pdf.