Department of Justice

STATEMENT

OF

GREG ANDRES
ACTING DEPUTY ASSISTANT ATTORNEY GENERAL
CRIMINAL DIVISION
DEPARTMENT OF JUSTICE

BEFORE THE

SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ENTITLED

"NEW TOOLS FOR CURBING WASTE AND FRAUD IN MEDICARE AND MEDICAID"

PRESENTED ON

MARCH 9, 2011

Statement of
Greg Andres
Acting Deputy Assistant Attorney General
Criminal Division
Department of Justice

Before the
Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security
Committee on Homeland Security and Governmental Affairs
United States Senate

Entitled
"New Tools for Curbing Waste and Fraud in Medicare and Medicaid"

Presented on
March 9, 2011

I. INTRODUCTION

Chairman Carper, Ranking Member Brown, and distinguished Members of the Subcommittee: Thank you for inviting me to speak with you today about the Department of Justice's efforts to combat health care fraud through criminal prosecution. I am privileged to appear before you on behalf of the Department of Justice, along with my colleagues Deputy Administrator and Director Budetti, Director King, Inspector General Levinson, and Volunteer Coordinator Carson. The Department is grateful to the Subcommittee for its leadership in this area, and we appreciate the chance to testify here today.

Health care fraud is a significant law enforcement problem. The federal government spends hundreds of billions of dollars every year to fund Medicare and other government health care programs, and taxpayers rightly expect these funds to be used to provide health care to seniors, children, the poor, and the disabled. Most medical professionals work hard to comply with the rules. But too many doctors, nurses, and others in the health care industry devote their

energies elsewhere – to schemes that cheat taxpayers and patients alike, and defraud Medicare and other government programs.

At the Justice Department, together with our colleagues at the Department of Health and Human Services ("HHS"), we are fighting back. We investigate, prosecute, and secure prison sentences for hundreds of defendants every year, and we are recovering billions of dollars in stolen funds. With the additional resources provided to us by Congress over the past two years, we are making significant strides in this battle. In FY 2010, we collectively recovered a record $4.02 billion on behalf of taxpayers, $2.86 billion of which was deposited back into the Medicare Trust Fund. This represents a $1.47 billion (or 57 percent) increase over the amount recovered in FY 2009, which was itself a record amount at the time. Indeed, over the past three years, we have collectively recovered an average of nearly $7 for every dollar of funding that Congress has appropriated for health care fraud enforcement. Furthermore, in FY 2010 the Justice Department brought criminal health care fraud charges against 931 defendants – the most ever in a single fiscal year – and we secured 726 convictions, also a record.

II. BACKGROUND

Before focusing more closely on our criminal law enforcement efforts, I would like to provide you with a brief overview of the Justice Department's successful return on investment in fighting health care fraud, and of the different Department components involved in that effort. In the Health Insurance Portability and Accountability Act of 1996, Congress created the Health Care Fraud and Abuse Control Program ("HCFAC Program" or "Program"). The Program was established under the joint direction of the Justice Department and HHS to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse. Our enforcement efforts have never been stronger than they are today. Since the HCFAC Program

was established, the two Departments have returned more than $21.3 billion to the federal government, of which over $18 billion has been returned to the Medicare Trust Fund. Over the life of the HCFAC Program, this amounts to an average return on investment ("ROI") of $4.90 for every $1.00 expended. The average ROI over the past three years has been even higher. As reported in the HCFAC Program's annual report for FY 2010, the average ROI for the period 2008-2010 was $6.80 for every $1.00 expended, nearly $2.00 higher than the historical average.

This increased ROI is the result of a significant expansion of enforcement efforts at both the Justice Department and HHS. On May 20, 2009, Attorney General Holder and HHS Secretary Sebelius announced the creation of the Health Care Fraud Prevention and Enforcement Action Team ("HEAT"), an interagency effort created to tackle all aspects of the health care fraud problem. With the creation of HEAT, the Justice Department and HHS committed to making the battle against health care fraud a Cabinet-level priority, and the results have been extremely strong. HHS' Office of the Inspector General ("HHS-OIG") and the Centers for Medicare & Medicaid Services ("CMS") have closely partnered and provided significant investigative and administrative support to the HEAT effort.

The Justice Department has a multi-faceted litigation approach to fighting health care fraud, with the Criminal Division, the Civil Division, the Civil Rights Division, the U.S. Attorneys' Offices, and the Federal Bureau of Investigation (FBI) all contributing substantial resources to the effort. The Civil Division aggressively pursues civil enforcement actions aimed at rooting out waste, fraud, and abuse in the health care industry, often through use of the False Claims Act, 31 U.S.C. §§ 3729-3733. Through its Office of Consumer Protection Litigation ("OCPL"), the Civil Division also invokes the Food, Drug and Cosmetic Act ("FDCA"), which authorizes both civil and criminal actions. Since 2000, the Civil Division, working closely with

the FBI, HHS-OIG, U.S. Attorneys' Offices around the country, and other law enforcement agencies, has recovered over $1 billion every year on behalf of defrauded federal health care programs; in FY 2010 the Department secured approximately $2.5 billion in civil health care fraud recoveries, more than in any other previous year.

The Civil Rights Division also plays an important role in the Department's efforts to protect the nation's health care system. The Special Litigation Section of the Civil Rights Division is responsible for enforcing the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, *et seq*. CRIPA authorizes the investigation of conditions of confinement at state and local residential institutions and the initiation of civil actions for injunctive relief to remedy a pattern or practice of Constitutional or federal statutory violations at such institutions.

The Justice Department's primary investigative and enforcement arm is the FBI. Working closely with U.S. Attorneys' Offices across the country and DOJ litigating components, the FBI serves to identify, investigate, and aid in the prosecution of health care fraud. With over 750 FBI personnel dedicated solely to health care fraud investigations, the Justice Department is able to aggressively address fraud not only in Strike Force locations, but also in any of the over 450 locations where the FBI has investigative personnel stationed. The FBI leverages these resources and works collaboratively with HHS-OIG investigative personnel and other agencies to address significant health care fraud through coordinated investigations targeting the most egregious offenders and fraudsters.

Finally, the Criminal Division, together with the U.S. Attorneys' Offices, the FBI, and OCPL, is responsible for the Department's criminal health care fraud enforcement efforts. These efforts, which I will focus on in more detail below, have been a tremendous success. Since the

inception of the HEAT initiative, we have aggressively prosecuted health care fraudsters, leading, in FY 2010, to the largest number of criminal health care fraud convictions since the HCFAC Program was created.

III. CRIMINAL HEATLH CARE FRAUD ENFORCMEMENT

Criminal health care fraud enforcement is aimed at holding accountable doctors, nurses, health care providers, and others who conspire to cheat government health care programs, including Medicare and Medicaid. Today our criminal enforcement efforts are at an all-time high. In FY 2010, we brought criminal charges against 931 defendants, the most in any single fiscal year since the HCFAC Program began, and approximately 16 percent more than in FY 2009. Moreover, we secured 726 criminal health care fraud convictions, also the most in any year of the HCFAC Program, and approximately 24 percent more than in FY 2009. In total, last fiscal year the Justice Department opened 1,116 new criminal health care fraud investigations involving 2,095 potential defendants.

The strong performance of our criminal enforcement efforts is due in large part to the strategic thinking behind our response. In 2007, the Criminal Division launched the Medicare Strike Force in collaboration with the U.S. Attorney's Office for the Southern District of Florida and the Miami Divisions of the FBI and HHS-OIG, to root out fraud and abuse among durable medical equipment ("DME") suppliers and Human Immunodeficiency Virus ("HIV") infusion therapy providers in South Florida. The Strike Force uses data analysis techniques to identify aberrational billing patterns in Strike Force cities, permitting law enforcement teams to target emerging or migrating schemes along with chronic fraud by criminals operating as health care providers or suppliers. Federal agents and analysts review Medicare data and other intelligence to identify potential targets who may be billing for fictitious or medically unnecessary services.

In March 2008, the Criminal Division expanded the Strike Force to Los Angeles, another health care fraud hot spot; in May 2009, as the HEAT initiative was announced, we expanded the Strike Force to Houston and Detroit; in December 2009, we added Brooklyn, Tampa, and Baton Rouge; and just last month, we expanded the Strike Force to include Chicago and Dallas, bringing the total number of Strike Force cities to nine.[1]

The Strike Force has been an unqualified success. In FY 2010, the Strike Force secured 240 convictions (217 guilty pleas and 23 trial convictions), more than in any other year of Strike Force operations. One goal of the Strike Force is to identify targets using the "data-driven" approach described above, and then bring those cases as expeditiously as possible. This model is working. Cases are initiated and brought to conclusion quickly, and defendants are going to prison for substantial periods. In FY 2010, the average amount of time from indictment to sentencing in Strike Force cases was approximately 9 months; more than 94 percent of Strike Force defendants were convicted; and over 86 percent were sentenced to prison terms. Since HEAT's inception, the average prison term for Strike Force defendants is over 40 months.

During FY 2010, we also carried out what was then the largest federal health care fraud takedown in history. In July 2010, Attorney General Holder, Secretary Sebelius, and FBI Director Mueller announced charges against 94 defendants – including doctors, medical assistants, health care executives, and others – in Strike Force cities Miami, Baton Rouge, Brooklyn, Detroit, and Houston. These defendants were charged with collectively submitting more than $251 million in false claims to the Medicare program.

This was followed, just last month, by what now stands as the largest federal health care fraud takedown ever. On February 17, 2011, Attorney General Holder and Secretary Sebelius

[1] With funds requested in the President's FY 2012 Budget, the Department has plans to expand the Strike Force to additional cities.

announced charges against more than 110 defendants in all nine Strike Force cities. Doctors, nurses, health care company owners and executives, and others were charged with defrauding the Medicare program of over $240 million. Typical of Strike Force cases, many of the defendants charged in the February takedown participated in alleged schemes to submit claims to Medicare for treatments that were medically unnecessary or never provided. In addition, the indictments and complaints allege that patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers so that those providers could submit false Medicare claims.

In addition to prosecuting defendants for health care fraud, we are also seeking and receiving substantial prison sentences for those convicted. For example:

- On December 14, 2010, defendant Bernice Brown, the president of a Detroit-area clinic, and defendant Daniel Smorynski, the clinic's vice president, were sentenced in the Eastern District of Michigan to 151 months and 109 months in prison, respectively. They had previously been convicted at trial of charges relating to a $23 million fraudulent physical and occupational therapy scheme.
- And on November 23, 2010, defendant Flor Crisologo, the owner and operator of a Miami clinic, was sentenced in the Southern District of Florida to 120 months in prison for her role in a $22 million HIV infusion fraud scheme. Crisologo's clinic billed Medicare for providing hundreds of medically unnecessary infusion treatments to HIV-positive Medicare beneficiaries who were recruited to visit the clinic in exchange for cash kickbacks.

Indeed, in just the first five weeks of 2011, more than 20 defendants were sentenced on their health care fraud convictions**:**

- On February 10, defendant Guy Ross, a medical assistant, was sentenced in the Eastern District of Michigan to 36 months in prison for participating in a Medicare fraud scheme operated out of two Detroit-area companies that purported to provide in-home health services.
- The day before, on February 9, two other defendants – Grant Johnson and Elizabeth Egan – were sentenced in the same district on their guilty pleas to Medicare fraud.
- On February 4, eight Miami-area nurses were sentenced in the Southern District of Florida to prison for their roles in an $18.7 million home health care Medicare fraud scheme, and a ninth was sentenced to two years' probation.
- On January 28, defendant Lissbet Diaz, a nurse, was sentenced in the Southern District of Florida to 18 months in prison for participating in a fraudulent Medicare home health care fraud scheme.
- Two days before that, on January 26, defendant Melvin Young, a patient recruiter for Ritecare LLC, was sentenced in the Eastern District of Michigan to 40 months in prison for participating in a Medicare fraud scheme.
- On January 18, defendant Darrell Nichols, a patient recruiter, was sentenced in the Eastern District of Michigan to 15 months in prison for participating in a Detroit-area Medicare fraud scheme involving fraudulent claims for diagnostic testing.
- One week earlier, on January 11-12, defendant Basil Obasi Kalu, an employee of Onward Medical Supply, a Houston-area DME company, was sentenced to 70 months in prison for his role in a Medicare fraud scheme. Kalu was sentenced

along with three patient recruiters, one of whom received a 46-month sentence, and one delivery driver.

- And on January 4, defendant Howard Grant, a doctor, was sentenced to 41 months in prison on his guilty plea to participating in the Onward Medical Supply DME Medicare fraud scheme. Grant was sentenced along with defendant Obisike Nwankwo, a delivery driver, and defendant John Lachman, Onward Medical Supply's manager.

In addition to ensuring that health care fraudsters go to prison, the Strike Force seeks to identify and stop ongoing frauds and to recover public funds lost to health care fraud schemes. In October 2010, for example, the Criminal Division, the U.S. Attorney's Office for the Southern District of Florida, the FBI, and HHS announced the unsealing of a 13-count indictment against two Miami health care companies, American Therapeutic Corporation ("ATC") and Medlink Professional Management Group, Inc., as well as four owners and senior managers of the companies, for engaging in a $200 million fraud scheme involving billing for purported mental health services. At the same time, the Civil Division announced that it had filed a civil action for injunctive relief against these same defendants and two other companies and obtained a temporary restraining order to freeze the assets of the indicted companies and individuals. Last month, the Criminal Division, the U.S. Attorney's Office for the Southern District of Florida, the FBI, and HHS announced the unsealing of a 38-count superseding indictment in this case that charges an additional 20 individuals, including three doctors, with various criminal health care fraud offenses. The ATC case is perhaps the largest Medicare Strike Force case ever brought, and represents the first time that the Strike Force has indicted a corporation.

Further, I want to mention the important work of the Civil Division's OCPL, which, together with U.S. Attorneys' Offices around the country, is authorized to bring civil and criminal actions for violations of the FDCA. OCPL pursues the unlawful marketing of drugs and medical devices, fraud on the Food & Drug Administration, and the distribution of adulterated products, among other violations. In FY 2010, OCPL's efforts yielded more than $1.8 billion in criminal fines, forfeitures, restitution, and disgorgement, the largest health care-related one-year recovery under the FDCA in Department history.

In short, prosecutors in the Criminal Division's Fraud Section, the Civil Division's OCPL, the nation's U.S. Attorneys' Offices, and the FBI are working hard – and with great success – with federal, state, and local law enforcement agents to investigate and prosecute health care fraud wherever we find it.

IV. AFFORDABLE CARE ACT PROVISIONS

Finally, I would like to address certain key provisions in the Patient Protection and Affordable Care Act of 2010 ("ACA" or "Act"), Pub. L. 111-148. The Act made several important revisions and additions to federal criminal and civil statutes that the Justice Department uses in health care fraud cases. These changes are likely to have – and are already having – a significant impact on our health care fraud enforcement efforts.

For example, the ACA clarifies that neither the health care fraud statute, 18 U.S.C. § 1347, nor the anti-kickback statute, 42 U.S.C. § 1320a-7b, requires the government to prove that the defendant had actual knowledge of the specific statute or the specific intent to violate that statute. This is an important clarification that effectively abrogates judicial constructions of the phrase "knowingly and willfully" in both statutes that had made it harder for the government to prove health care fraud violations.

The ACA also expands the definition of "federal health care fraud offense" in 18 U.S.C. § 24 to include violations of the anti-kickback statute and other offenses. As a result of this change, the proceeds of these crimes are now subject to criminal forfeiture under 18 U.S.C. § 982(a)(6) and the offenses now qualify as "specified unlawful activity" under the money laundering statutes.

In addition, the Act directs the U.S. Sentencing Commission to amend the U.S. Sentencing Guidelines to clarify that, when calculating the loss attributable to a health care fraud offense, the total amount that the defendant billed to a federal health care program comprises prima facie evidence of the defendant's intended loss; and to increase the guideline ranges for health care fraud schemes involving a loss of $1 million or more. In January, the Sentencing Commission published proposed amendments to the sentencing guidelines to implement these directives, and last month it held a public hearing on the amendments. These proposed amendments, if they become law, will subject health care fraud defendants to the possibility of even greater prison time than they already face, a prospect that we believe will be a more effective deterrent.

The ACA also makes several significant changes to the law governing employee group health benefit plans subject to title I of the Employee Retirement Income Security Act of 1974 and multiple employer welfare arrangements ("MEWAs") regulated by ERISA. First, the ACA prohibits false statements in the sale or marketing of employee health benefits by MEWAs. Second, the ACA adds that new offense and other ERISA offenses governing employee health care benefits generally to the definition of "federal health care offense."

In addition, the Act confers new subpoena power on the Attorney General for the investigation of claims under CRIPA. Finally, the Act provides significant additional funding for our collective health care fraud enforcement efforts.

The ACA's statutory revisions and the additional funding provided by the Act will strengthen the Justice Department's criminal and civil enforcement efforts, and we look forward to taking advantage of these and other new tools as we continue the fight against health care fraud.

V. CONCLUSION

Prosecuting health care fraud is a high priority for the Department of Justice. Every day, in Strike Force cities and elsewhere around the country – from New York to Los Angeles, and cities in between – federal prosecutors, and law enforcement agents at the federal, state, and local levels are working hard to investigate and prosecute those intent on defrauding Medicare and other government health care programs. Our efforts over the last two years, since the inception of the HEAT initiative, have been remarkably successful. The number of people charged with health care fraud and the number of criminal convictions are both higher than they have ever been. We are poised to continue these efforts in the months and years ahead, and look forward to continuing to work closely with the FBI, HHS-OIG, CMS, and others toward that end.

Thank you for the opportunity to provide the Subcommittee with this overview of our health care fraud enforcement efforts. I look forward to answering any questions you may have.