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HEALTH CARE FRAUD WORKING GROUP CONVENES

PHILADELPHIA - United States Attorney Zane David Memeger delivered opening remarks today to federal and state investigators, prosecutors, agents and auditors, along with fraud investigators and other representatives from private industry, including health insurance companies, hospital systems and other health care providers, attending the first regional Health Care Fraud Working Group meeting. The U.S. Attorney's Office will host these meetings every four months to encourage communication and coordination among agencies, promote strategic thinking with regard to areas of potential fraud, identify matters for investigation and prosecution, develop strategies to streamline investigations, and share information. The U.S. Department of Justice has directed U.S. Attorney Offices throughout the country to make efforts to address the potential for fraud involving federal funds. Today's session included personnel from agencies throughout Pennsylvania and the Delaware Valley.

"Health care fraud costs the taxpayers billions of dollars every year," said Memeger. "By bringing together those people who are on the front lines of investigating and prosecuting this type of fraud, and by sharing information and strategies, we will all become more effective at detecting fraudulent schemes and protecting the public from suffering more losses."

Health care fraud is a national problem and a top priority of the U.S. Department of Justice. To underscore the growing importance of health care fraud investigations, on March 15, 2011, the Attorney General, in public remarks, stated the following:

> "In just the last fiscal year, we obtained settlements and judgments amounting to more than $2.5 billion in False Claims Act matters alleging health care fraud B the largest annual figure in history and an increase of more than 50% from fiscal year 2009. We also opened more than 2,000 new criminal and civil health care fraud investigations, reached an all time high in the number of health care fraud defendants charged, stopped numerous large scale fraud schemes in their tracks, and returned more than $2.5 billion to the Medicare Trust Fund and more than $800 million to cash strapped state Medicaid programs."

The return-on-investment for the Health Care Fraud and Abuse Control Program, since 1997, is approximately $4.9 returned to every $1.0 expended.

"The Department of Health and Human Services' Office of Inspector General looks forward to working closely with the U.S. Attorney for the Eastern District of Pennsylvania battling health care fraud," said Special Agent-in-Charge of OIG's Philadelphia Region Nicholas

DiGiulio. “While the District already has a proud record in this fight, the initiative announced today will further step up the prosecution of those who would attack health benefit programs through schemes serving to enrich criminals at the expense of taxpayers, patients and health care providers. My agency is committed to working with our law enforcement partners to protecting beneficiaries, enforcing program rules, and holding those accountable for the fraud, waste, and abuse of scarce government health funds.”

Objectives of the Health Care Fraud Working Group meetings include fostering working relationships among agencies concerned with health care fraud, sharing information on current trends and issues in health care fraud matters, and learning more about participants’ health care fraud concerns.

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