



Department of Justice

STATEMENT OF

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UNITED STATES DEPARTMENT OF JUSTICE**

BEFORE THE

**UNITED STATES SENATE
SPECIAL COMMITTEE ON AGING**

HEARING ENTITLED

“FRAUD IN THE MEDICARE AND MEDICAID PROGRAMS”

PRESENTED

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Mr. Chairman and distinguished Members of the Committee. I appreciate the opportunity to appear before you to discuss fraud in the Medicare and Medicaid programs. We are grateful for the leadership of your Committee on this important topic and to you, Mr. Chairman, for inviting us to discuss the Department of Justice's enforcement efforts. As United States Attorney for the Southern District of Florida, I have been committed for some time to the vigorous investigation and prosecution of health care fraud cases in South Florida.

I have been asked to provide testimony concerning the efforts of the Department of Justice (the Department) to combat fraud and abuse in the Medicare and Medicaid programs. This is a critical issue; Medicare and Medicaid are critical programs that provide an essential role in our health system. They serve vulnerable populations of seniors, people with disabilities, and various low-income Americans. Last year, my District in South Florida, prosecuted 245 individuals responsible for \$793 million of fraudulent Medicare billings. Those cases represent money that could be used to help individuals actually in need of medical care, but is instead being stolen by criminals seeking personal profit.

The Department's prosecutions have a broader impact as well: the deterrent effect of well-coordinated inter-agency investigative, administrative, civil and prosecutorial resources, laser-beam focused on widespread, but regionally targeted, health care fraud schemes. Our inter-agency Departments of Justice and Health and Human Services prosecutions, spearheaded by the Department's Criminal Division and U.S. Attorneys Offices and the Strike Force in Miami, Los Angeles, and Houston, and other HHS administrative enforcement actions targeting durable medical equipment (DME) fraud, have led, for example, to estimated reductions of \$1.75 billion in DME claim submissions and \$334 million in DME claims paid by Medicare over the 12 months following the Strike Force's inception, compared to the preceding 12-month period.

Our criminal and civil enforcement have taught us some important lessons about Medicare fraud. First, in the criminal arena, we have learned that the most aggressive criminals targeting our system are not inventing new schemes, but are copying the most successful and profitable schemes in their communities. Because these frauds are learned, we know that the schemes are both regional and viral in nature. The very claims data has proven to be some of the most compelling evidence we use in our criminal prosecutions. It allows the Department to focus its efforts. Finally, we have learned to identify criminal claim trends and track systemic weaknesses so that we can make every effort to attempt to stop false claims before they occur. We cannot prosecute our way out of this problem, we must work to eliminate fraud before money is wrongfully paid and to better prevent bad actors from gaining access to participation in the Medicare program.

Medicare and Medicaid are extremely large programs, Federal and state spending on both programs collectively exceeds \$800 billion per year. Therefore, while we must do all that we can to fight fraud and eliminate waste, it is not reasonable to have zero fraud, unless we were to restrict the programs to such an extent that access to vital services for beneficiaries would be threatened.

In my written testimony, I will describe the role the Department plays in Medicare and Medicaid program integrity, including the role of the Department's Criminal, Civil and Civil Rights Divisions, the Federal Bureau of Investigation (FBI), and the 94 U.S. Attorneys' Offices across the country. I will also address our sources of funding, our cooperative relationship with the Department of Health and Human Services, and our substantial accomplishments. I will conclude by emphasizing that a renewed and fortified program, which

continues and expands our capacity to combat health care fraud, is a critical element of this administration's health care reform agenda.

MORE THAN \$12 BILLION IN RECOVERIES RETURNED TO THE MEDICARE AND MEDICAID PROGRAMS SINCE 1997

As you know, national health care spending in the United States exceeded \$2.2 trillion and represented 16 percent of the Nation's Gross Domestic Product (GDP) in 2007. The Federal Government financed more than one-third of the Nation's health care that year; federal and state governments collectively financed 46 percent of U.S. health care costs. The National Health Care Anti-Fraud Association estimates that 3 percent of the nation's health care spending—or more than \$60 billion each year—is lost to fraud. Over the next ten years, U.S. health care spending is projected to double to \$4.4 trillion and to comprise more than 20 percent of national GDP. We must prepare for this growth today, not attempt to play catch-up in the future.

The Department is committed to rooting out and punishing individuals and corporations who commit health care fraud, including providers and practitioners, equipment suppliers, corporate wrongdoers, and other common criminals. The Department is not alone in the fight to combat fraud and preserve the integrity of the country's health care system. Within the framework of the Health Care Fraud and Abuse Control Program (HCFAC) established in 1997, we work closely with the Inspector General of the Department of Health and Human Services, as well as our colleagues at the Centers for Medicare and Medicaid Services (CMS). We also work closely with the Food and Drug Administration, including its Office of Criminal Investigations (FDAOI), the Federal Employees Health Benefits Program (FEHBP) at the Office of Personnel Management and its Office of Inspector General, and our State law enforcement partners in their Offices of Attorneys General and Medicaid Fraud Control Units.

Because health care fraud schemes frequently impact private health insurance plans, we also work with private sector health care insurance providers.

Working with our colleagues, since the inception of the HCFAC program in 1997, the Department has obtained, according to our preliminary estimates, more than \$14.3 billion in total recoveries, which include criminal fines and Federal and State civil settlements in health care fraud matters, predominantly involving losses to the Medicare program. Of this total, \$12.5 billion has been transferred or deposited back into the Medicare Trust Fund and \$1.2 billion, representing the federal share of Medicaid fraud recoveries, has been transferred to the Treasury. The monetary recoveries we achieve go right back into the Medicare and Medicaid programs to help fund the health care costs of the Americans who are enrolled in these programs.

These recoveries were made possible by the dedicated funding stream provided by the HCFAC Program, which was established by the Health Insurance Portability and Accountability Act of 1996, and the supplemental appropriations enacted by Congress, most recently earlier this year. The HCFAC program is the principal source of annual funding for Department of Justice efforts to combat Medicare and Medicaid fraud.

DEPARTMENT STRIKE FORCES SUCCESS AGAINST MEDICARE FRAUD

I would like to start by detailing a recently developed successful strategy in combating Medicare and Medicaid fraud involving durable medical equipment (DME) and Human-Immunodeficiency Virus (HIV) infusion therapy services. In 2006, I implemented a health care fraud prosecution initiative in the Southern District of Florida. Through this initiative, our prosecutors worked in partnership with the FBI and the Department of Health and Human Services (HHS), to implement a targeted criminal, civil and administrative effort against

individuals and companies that fraudulently bill the Medicare program in Miami, Florida. This effort was substantially energized in March 2007, when the Department's Criminal Division brought its expertise and resources, resulting in what is now the South Florida Medicare Fraud Strike Force. This Medicare Fraud Strike Force was structured in five teams with criminal prosecutors, a licensed nurse, federal HHS and FBI agents, and state and local police investigators. In March 2008, the Department's Criminal Division expanded the Strike Force to a second site, partnering with the United States Attorney's Office for the Central District of California, and involving four teams of prosecutors and federal and state agents to combat DME fraud in the Los Angeles metropolitan area. The Strike Force model for criminal health care fraud prosecutions has since become a permanent component of both United States Attorneys' Offices.

As I will outline for you, the Strike Force model is based on focusing the training of agents and prosecutors on how to identify and fight those highly repetitive fraud schemes, those I have described as viral, and then focusing enforcement resources and efforts in those regions that have the greatest rates of crime in a concentrated effort to deter fraudulent claims.

In March 2009, the Department's Criminal Division initiated a third Strike Force phase, in partnership with the United States Attorney's Office for the Southern District of Texas, forming three teams of prosecutors and federal and state agents targeting fraudulent DME and billing agencies in the Houston area. The Department's Criminal Division is currently planning to launch a fourth Strike Force phase in the near future using its allocation of the supplemental funding Congress provided in the Omnibus Appropriations Act of 2009.

Since its inception two years ago, the Strike Force, with a limited number of investigators and prosecutors, has:

- filed 108 cases charging 196 defendants who collectively billed the Medicare program more than half a billion dollars;
- taken 127 guilty pleas;
- handled 14 jury trials resulting in convictions of 18 others on all counts charged; and
- obtained 109 sentences of imprisonment, ranging from 30 years to 4 months of home confinement, with an average term of imprisonment of 48 months.

Here are several examples of the Strike Force successes:

- Two owners of a billing company and an employee were sentenced for conspiracy to commit health care fraud. The two owners were each sentenced to 14 years' incarceration and the employee was sentenced to 11 years. The three conspired to bill Medicare nearly \$420 million for DME purported to have been provided to Medicare beneficiaries by 85 DME companies. These claims were for equipment that not been ordered by physicians or delivered to the beneficiaries as claimed.
- A physician's assistant pleaded guilty and was sentenced to 14 years' imprisonment for his part in a \$119 million HIV infusion fraud conspiracy; three other co-defendants remain fugitives. The physician's assistant admitted to training physicians at eleven fraudulent HIV infusion clinics to prepare and submit medically unnecessary HIV infusion services that were allegedly administered to Medicare patients. He also admitted to overseeing the documentation of fraudulent services to make it appear that the clinics provided legitimate services, and to knowing that the infusion treatments billed at the clinics were medically unnecessary and/or were never provided.
- DME company owners were sentenced for conspiring to defraud the Medicare program by submitting false claims for medically unnecessary DME items and supplies, including

aerosol medications and oxygen concentrators. The companies paid kickbacks to a physician previously investigated by OIG, and to several Medicare beneficiaries in order to use their Medicare numbers to submit the fraudulent claims. The 13 convicted DME company owners involved in the scheme were ordered to pay a total of more than \$6.4 million in restitution. The 13 subjects were also sentenced to various terms of imprisonment, probation, and/or home detention, the longest prison sentence for the case being 6 years and 6 months.

- After a five-week trial, a Federal jury in Miami convicted three owners of two DME companies, a home health agency and an assisted living facility which conspired to defraud Medicare of more than \$14 million for unnecessary medicine, DME, and home health care services. Two defendants were sentenced to 51-month terms of imprisonment, and the third was sentenced to a 31-month prison term. Patients testified at trial that they took kickbacks, were falsely diagnosed with chronic obstructive pulmonary disease and prescribed unnecessary aerosol medications, including commercially unavailable compounds. A fourth co-defendant who was a dermatologist, was also convicted in a separate jury trial and was sentenced to prison for 41 months.

As proud as we are of our Strike Force initiative, it is but one element of our comprehensive health care fraud efforts.

STATUTORY BACKGROUND AND FUNDING

Social Security Act Section 1128C(a), as established by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA or the Act), created the HCFAC Program, a comprehensive program to combat fraud and abuse in health care, including both

public and private health plans. Under the joint direction of the Attorney General and the HHS Secretary, the HCFAC Program's goals are to:

- (1) coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse with respect to health plans;
- (2) conduct investigations, audits, inspections, and evaluations relating to the delivery of and payment for health care in the United States;
- (3) facilitate enforcement of all applicable remedies for such fraud;
- (4) provide guidance to the health care industry regarding fraudulent practices; and
- (5) establish a national data bank to receive and report final adverse actions against health care providers, and suppliers.

The Act requires the Attorney General and the HHS Secretary to submit a joint annual report to the Congress which identifies both:

- (1) the amounts appropriated to the Trust Fund for the previous fiscal year under various categories and the source of such amounts; and
- (2) the amounts appropriated from the Trust Fund for such year for use by the Attorney General and the HHS Secretary and the justification for the expenditure of such amounts.

The Act requires that an amount equaling recoveries from health care investigations – including criminal fines, forfeitures, civil settlements and judgments, and administrative penalties, but excluding restitution, compensation to the victim agency, and relators' shares – be deposited in the Medicare Trust Fund, also known as the Hospital Insurance (HI) Trust Fund.

All funds deposited in the Medicare Trust Fund as a result of the Act are available for the operations of the Medicare programs funded by the Medicare Trust Fund. The Act appropriates monies from the Medicare Trust Fund to an expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and the Attorney General jointly certify annually as necessary to finance anti-fraud activities. The maximum amounts available for certification are specified in the Act. Congress established the dedicated HCFAC resources to supplement the direct appropriations that HHS and the Department otherwise devoted to health care fraud investigation and prosecution. The Act specifies the total annual maximum amount collectively available to HHS (including the HHS Office of Inspector General (OIG)) and the Department for their health care fraud enforcement work, assigns specific authorities to the HHS OIG, and, beginning with fiscal year 2007, specifies the minimum amount of funding OIG must receive each year.

In Fiscal Year (FY) 1997, HIPAA authorized HHS and the Department to appropriate from the Account up to \$104 million collectively, and allowed the Departments to increase that appropriated amount by up to 15 percent annually until FY 2003. HIPAA also provided \$47 million in dedicated funding for the FBI's health care fraud investigations beginning in 1997 and increasing annually until 2003.

In FY 2003, the maximum available for HHS and the Department collectively was "capped" by statute at \$240.558 million annually. Of this total, the Office of the Inspector General (OIG) received the statutory maximum amount of \$160 million annually. The Department's litigating components and other (non-OIG) HHS components split the remaining balance amounting to \$80.558 million, which we refer to as the "wedge." The Department's litigating components received \$49.415 million annually from the wedge in FY 2003 through FY

2006. HIPAA separately appropriated \$114 million annually in dedicated funding to the FBI over this same time period to support the FBI's health care fraud investigative activities.

Section 303 of Division B of the "Tax Relief and Health Care Act of 2006" modified the FY 2003 funding cap beginning in FY 2007 to provide for annual inflation adjustments to the maximum amounts available from the HCFAC Account and to the FBI allocation, through FY 2010. In FY 2010, a fixed funding level or "cap" will be reinstated, set at the 2010 level for subsequent fiscal years, unless Congress acts to extend annual inflationary adjustments for the program.

Earlier this year, the Omnibus Appropriations Act of 2009 provided a one-time additional \$198 million for joint HHS and Department health care antifraud programs through an allocation adjustment for new program integrity work, predominantly for the Part D, Medicaid and Children's Health Insurance (CHIP), and Medicare Advantage programs. Nearly \$19 million of this new amount is designated for the Department. The Administration's FY 2010 budget seeks an additional \$311 million in two-year funding to continue and enhance this new program integrity and antifraud enforcement work.

In addition to our partners in the HHS Office of Inspector General, and Centers for Medicare and Medicaid Services, the Department combats the Nation's health care fraud with a total of fewer than 400 full-time equivalent (FTE) positions, and roughly 750 FBI agents and support staff. With \$12.5 billion returned to the Medicare Trust Fund since the inception of the HCFAC program, the average "return on investment" for funding provided by HIPAA to all "law enforcement agencies," the figures are as follows: total transfers to Medicare Trust Fund (\$3.82 to \$1) and all victims (\$4.41 to \$1). Further, we believe that the deterrent effects from our

efforts may produce far greater “returns on investment” through dramatic reductions in fraudulent billings to and payments from Medicare.

As successful as our Strike Force and other anti-fraud efforts have been, our prosecutors believe that we may be only scratching the surface. The Administration has requested additional resources for FY 2010 to support the Department’s efforts to bolster its health care fraud enforcement activities and protection of the Medicare Trust Fund. In this way, the Department can ensure that we can recruit, hire, and fully train the best and brightest attorneys and investigators to conduct and enhance this very important work, especially as the Administration and Congress seek to make health care coverage available to the millions of citizens who currently lack health insurance.

HCFAC PROGRAM ACCOMPLISHMENTS IN FISCAL YEAR 2008

During Fiscal Year 2008, the Department’s health care fraud litigation resulted in deposits of \$1.48 billion with U.S. Treasury, which was reimbursed to the Centers for Medicare and Medicaid Services, other Federal agencies administering health care programs, or paid to private “whistleblowers” who filed health care fraud litigation completed by the Department. The Medicare Trust Fund received transfers of nearly \$1.28 billion during this period as a result of these efforts, as well as those of preceding years, in addition to \$344 million representing the federal share of Medicaid money similarly transferred to CMS as a result of these efforts.

In criminal enforcement actions during 2008, prosecutors for the Department and U.S. Attorneys’ Offices:

- Opened 957 new criminal health care fraud investigations involving 1,641 potential defendants, and had 1,600 criminal health care fraud investigations involving 2,580 potential defendants pending at the end of the fiscal year; and
- Filed criminal charges in 502 health care fraud cases involving charges against 797 defendants and obtained 588 convictions for the year. Each of these figures represents an “all time high” count of federal criminal cases, defendants, and convictions.

Another 773 criminal health care fraud cases were pending trial or resolution involving 1,335 defendants charged with health care fraud violations at the end of FY 2008. The Department’s volume of pending criminal health care fraud cases has increased more than 40 percent since HCFAC program funding was fixed by statute in FY 2003.

In civil enforcement actions during 2008, attorneys for the Department and U.S. Attorneys’ Offices opened 843 new civil health care fraud investigations, and filed complaints or intervened in 226 civil health care cases.

INTER-AGENCY DOJ-HHS COOPERATION

Because HHS directly administers the Medicare Program and maintains all the payment records and data submitted by providers, and oversees the Medicaid program in partnership with the states, successful prosecution of criminal cases and litigation of civil cases requires close cooperation between the Departments. Examples of this close cooperation include the following:

- Our Strike Force model is an example of the successful focus of interagency resources on those regions with the highest levels of Medicare program fraud.
- Under the auspices of the HCFAC Program, the Department and HHS hold senior staff-level meetings on a quarterly basis that include representatives from the Office of the

Deputy Attorney General, Office of the Associate Attorney General, the Executive Office for the U.S. Attorneys, HHS Counsel to the Inspector General and Office of General Counsel, and CMS Program Integrity Director.

- Our agencies also hold quarterly CMS-law enforcement agency coordinating meetings among mid- and lower-level staff who work on specific collaborative initiatives, cases, and investigations.
- We hold monthly CMS-Department conference calls involving CMS Program Integrity and other staff with our U.S. Attorneys' Offices and FBI personnel nationwide.
- Interagency health care fraud task forces and working groups exist in a majority of federal judicial districts that consist of Assistant U.S. Attorneys, HHS and FBI investigative agents, CMS program agency personnel and Medicare Program Safeguard Contractors, Medicaid Fraud Control Units, state Attorney General staff, and some private insurer investigators.
- The OIG shares summarized information about all Medicare contractor referrals for investigation with the Department and the Department's FBI, and the FBI exchanges copies of its health care fraud case opening memoranda with OIG.
- The Criminal and Civil Divisions routinely coordinate with the OIG in the review process for issuing industry advisory opinions concerning the application of the anti-kickback statute to specific fact situations.

DEPARTMENT OF JUSTICE COMPONENTS INVOLVED IN MEDICARE AND MEDICAID ANTI-FRAUD ENFORCEMENT

Health care fraud enforcement involves the work of several different components of the Department, each of which receives funding from the HCFAC Program. I will briefly

summarize the roles that different parts of the Department play in pursuing health care fraud matters.

Civil Division

The Department's Civil Division attorneys pursue civil remedies in health care fraud matters, using the False Claims Act, 31 U.S.C. §§ 3729-3733, as the primary statutory tool. The False Claims Act (FCA) prohibits knowingly submitting false or fraudulent claims for payment from the government, and knowingly making false records or statements to conceal or decrease an obligation to pay money to the government. The penalties under the FCA can be quite large because the law provides for treble damages plus additional penalties for each false claim filed.

In addition, lawsuits are often brought by private plaintiffs, known as "relators" or "whistleblowers," under the *qui tam* provisions of the FCA, and the government will intervene in appropriate cases to pursue the litigation and recovery against the provider or company. Under the False Claims Act, a relator must file his or her complaint under seal in a United States District Court, and serve a copy of the complaint upon the USAO for that judicial district, as well as the Attorney General. The Government must then decide whether the case warrants an intervention by the government to litigate the complaint.

Since the False Claims Act was substantially amended in 1986, the Civil Division, working with United States Attorney's Offices, has recovered \$21.6 billion on behalf of the various victim federal agencies. Of that amount, \$14.3 billion was the result of fraud against federal health care programs - primarily the Medicare program. Cases involving fraud committed by pharmaceutical and device manufacturers have resulted in total criminal and civil recoveries of more than \$9.2 billion since 1999.

The Civil Division also pursues many of these cases as criminal violations of the Federal Food, Drug, and Cosmetic Act (FDCA). The Civil Division's Office of Consumer Litigation (OCL) is responsible for criminal and civil litigation and related matters arising under the FDCA and, together with the Food and Drug Administration's Office of Criminal Investigations and other agencies, is actively involved in investigating and prosecuting drug and device manufacturers and responsible individuals believed to be illegally promoting and distributing misbranded and adulterated drugs or devices. OCL works with many of the United States Attorney's Offices on these prosecutions.

For example, in January of this year, OCL and the U.S. Attorney's Office in the Eastern District of Pennsylvania prosecuted Eli Lilly and Co., which pled guilty to violating the FDCA for its illegal marketing of the anti-psychotic drug Zyprexa. Zyprexa was approved by the FDA for use in treating schizophrenia and certain aspects of bipolar disorder. Eli Lilly promoted Zyprexa for unapproved uses, including the treatment of, among other conditions, dementia, Alzheimer's dementia, agitation, and aggression, and specifically directed this effort through its long-term care sales force. That sales force targeted nursing homes and assisted living facilities, even though schizophrenia rarely occurs in the elderly. Eli Lilly sought to convince doctors to use Zyprexa to treat older patients for disorders which are prevalent in this population, despite the fact that the FDA had not approved Zyprexa for those conditions. Because the unapproved uses promoted by Eli Lilly were not medically accepted indications and, therefore, were not covered by State Medicaid programs, the company's conduct caused false claims to be submitted to Medicaid. The global settlement with Eli Lilly totaled \$1.415 billion, which included a \$515 million criminal fine, \$100 million in forfeiture, and \$800 million in civil recoveries under the False Claims Act.

In addition to these accomplishments, the Department's Elder Justice and Nursing Home Initiative, coordinated by the Civil Division, supports enhanced prosecution and coordination at federal, state, and local levels to fight abuse, neglect, and financial exploitation of the Nation's senior and infirm population. Through this Initiative, the Department also makes grants to promote prevention, detection, intervention, investigation, and prosecution of elder abuse and neglect, and to improve the scarce forensic knowledge in the field. The Department additionally pursues cases under the False Claims Act against skilled nursing homes and other long term care providers that provide services so substandard as to constitute worthless services and constitute a complete "failures of care."

The Civil Division also remains active in providing training and guidance in connection with pharmaceutical and device fraud matters. Given the nationwide scope of the defendants' conduct, as well as the complex legal and factual issues raised in these cases, the Civil Division plays a critical role in coordinating both investigative efforts and the legal positions taken by the Department and has coordinated extensive training for representatives of various federal and state enforcement and regulatory agencies..

United States Attorney's Offices

The 94 United States Attorney's Offices (USAOs) are the Nation's principal prosecutors of federal crimes, including health care fraud. The efforts of the USAOs are essential to preserving the financial integrity of our Nation's healthcare system and deterring fraud schemes that put our citizens in jeopardy. The USAOs pursue both civil and criminal cases and dedicate substantial resources to combating health care fraud. Each of the districts has a designated Criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator. Many

USAOs supplement the HCFAC program funding they receive by providing additional attorneys, paralegals, auditors, and investigators, as well as funds for litigation expenses for these resource-intensive cases.

In FY 2008, USAOs with the Department litigating components received 957 new criminal matters involving 1,641 defendants, and had 1,600 health care fraud criminal matters pending, involving 2,580 defendants. USAOs filed criminal charges in 502 cases involving 797 defendants, and obtained 588 federal health care related convictions. The USAOs also opened 849 new civil health care fraud matters and had 729 civil health care fraud matters and cases pending.¹ Let me highlight for you just two tremendous successes our USAOs had in FY 2008 in combating health care fraud. In the Eastern District of Pennsylvania, a settlement agreement was reached with the pharmaceutical manufacturer, Merck & Co., Inc. Under the agreement, Merck agreed to pay \$399 million, and interest, to resolve civil liabilities for the Medicaid rebates that the company allegedly underpaid to the federal government, 49 states, and the District of Columbia for Zocor and Vioxx. The settlement resolved allegations that Merck paid certain inducements to doctors and other healthcare professionals through 2001 in connection with its various sales programs. In the Western District of Wisconsin, Thomas Arthur Lutz (Lutz), the former President and CEO of Health Visions Corporation (Health Visions) pleaded guilty to conspiracy to defraud TRICARE, the Department of Defense's worldwide health care program for active duty and retired uniformed services members and their families, and was sentenced to 5 years in prison. On behalf of Health Visions, Lutz entered into a kickback agreement with a medical provider in the Philippines, in which the provider paid 50 percent of

¹ These statistical data include cases that are shared with or handled by attorneys in other litigating components of the Department.

the amount of the bills for medical services rendered to TRICARE patients referred by Health Visions, back to Health Visions. The court ordered Lutz and the corporation to pay \$99,915,131 in restitution. The court further ordered the corporation to liquidate its assets, pay a \$500,000 fine and forfeit \$910,910.60. USAOs receive referrals of health care fraud cases from a wide variety of sources, including the FBI, the HHS/OIG, state Medicaid Fraud Control Units, other federal, state, and local law enforcement agencies, and private insurers of medical services. The health care fraud coordinators often work with these partners in fighting health care fraud in local and regional task forces and working groups, and these also can be the basis of case referrals. Cases are also obtained by USAOs by means of *qui tam* complaints.

The Executive Office for United States Attorneys (EOUSA), through the Office of Legal Education (OLE), provides training for AUSAs and other Department attorneys, as well as paralegals, investigators, and auditors in the investigation and prosecution of health care fraud. OLE also sponsored the Health Care Fraud Coordinator's Conference for Civil and Criminal AUSAs, and Health Care Fraud for new AUSAs and Affirmative Civil Enforcement for Auditors, Investigators and Paralegals at the National Advocacy Center. Most recently, it sponsored a Health Care Fraud Trial Practice Seminar for more than 120 Department lawyers.

Criminal Division

The Criminal Division's Fraud Section develops and implements white collar crime policy, and supports the federal white collar crime enforcement community through litigation, coordination, policy, and legislative work. The Fraud Section is responsible for handling and coordinating complex health care fraud litigation nationwide. The Fraud Section also supports the USAOs with legal and investigative guidance and training, and, in certain instances, provides

trial attorneys to prosecute criminal health care fraud cases.

During FY 2008, the Fraud Section opened or filed 30 new health care fraud cases involving charges against 67 defendants; obtained 69 guilty pleas; and litigated seven jury trials, winning guilty verdicts against eight defendants on all counts charged. Prison sentences imposed in the Section's health care fraud cases during the year averaged more than 40 months, including two sentences that met or exceeded 120 months' imprisonment; and court-ordered restitution, forfeiture and fines that exceeded \$240 million. Fraud Section attorneys staffed and coordinated most of the Division's health care fraud litigation through the Medicare Fraud Strike Force prosecution teams in the Southern District of Florida (Phase One) and in Central District of California (Phase Two).

In Phase Two of the Strike Force, Fraud Section attorneys, working with federal prosecutors from the U.S. Attorney's Office for the Central District of California, and FBI and HHS-OIG agents, executed six search warrants and charged eleven defendants in nine indictments involving more than \$13 million in fraudulent claims to Medicare that were unsealed in May 2008, and arrested another 18 defendants who were charged with submitting more than \$33 million in fraudulent claims to Medicare in eight indictments during a second coordinated arrest round up during September 2008.

Fraud Section attorneys also obtained a guilty plea in the Northern District of Ohio from a physician who defrauded Medicare, Medicaid, and other health care benefit programs by causing medically unnecessary cardiology tests to be administered to patients over an eight-year period, 1998-2006. According to the plea agreement, the physician forfeited approximately \$1.9 million, surrendered his medical license, and was permanently excluded from participation in all federal health care programs. In another case, in the Southern District of California, an operator

of an unlawful Internet pharmacy pleaded guilty to conspiracy to distribute Schedule II controlled substances, including Oxycontin, Percocet, Endocet, and other prescription drugs, to customers without a prescription or a legitimate medical use. The defendant was not registered with the Drug Enforcement Administration to handle, import, distribute, or dispense controlled substances, and shipped the drugs from Southern California to customers throughout the United States. The defendant is awaiting sentencing.

In addition to health care fraud litigation, the Fraud Section also provided legal guidance to FBI and HHS agents, health program agency staff, AUSAs, and other Criminal Division attorneys on criminal, civil, and administrative tools to combat health care fraud; provided advice and written materials on patient medical record confidentiality and disclosure issues, and coordinated referrals of possible criminal HIPAA privacy violations from the HHS Office for Civil Rights; monitored and coordinated the Department responses to legislative proposals, major regulatory initiatives, and enforcement policy matters; reviewed and commented on health care provider requests to the HHS/OIG for advisory opinions, and consulted with the HHS/OIG on draft advisory opinions; worked with CMS to improve Medicare contractors' fraud detection, referrals to law enforcement for investigation, and case development work; and prepared and distributed to all USAOs and FBI field offices, state law enforcement, and private health plan fraud units, periodic summaries of recent and significant health care fraud cases

The Criminal Division's Organized Crime and Racketeering Section (OCRS) supports investigations and prosecutions of fraud and abuse targeting the 2.5 million private sector health plans sponsored by employers and/or unions, including schemes by corrupt unauthorized insurers that fraudulently entice sponsoring employers and/or unions to purchase what appears to be valid group health coverage only to discover much later that the payment of health claims will not be

made as promised. Such private sector group health plans are the leading source of health care coverage for individuals not covered by Medicare or Medicaid. OCRS also provides strategic coordination in the identification and prosecution of domestic and international organized crime groups engaged in sophisticated frauds posing a threat to the health care industry.

OCRS provides litigation support and guidance to AUSAs and criminal investigative agencies to combat corruption and abuse of employment based group health plans covered by the Employee Retirement Income Security Act [ERISA]. OCRS attorneys also provide health care fraud and abuse training and legal guidance to AUSAs and to criminal investigators and agents of the Department of Labor's Employee Benefits Security Administration and Office of Inspector General. The Section drafts and coordinates criminal legislative initiatives affecting employee health benefit plans and reviews and comments on legislative proposals affecting employee benefit plans.

One OCRS attorney is investigating and prosecuting health care frauds perpetrated by organized criminal groups and is working with the Los Angeles Medicare Fraud Strike Force. In addition, OCRS supports health care fraud prosecutions by Organized Crime Strike Force Units located within various United States Attorney's Offices. Under the International Organized Crime Initiative commenced in 2008, OCRS monitors trends in the targeting of health care by international organized criminal groups.

Civil Rights Division

The Civil Rights Division plays a critical role in the HCFAC Program. The Special Litigation Section of the Civil Rights Division is the sole Department component responsible for the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA). CRIPA authorizes

the investigation of conditions of confinement at state and local residential institutions (including facilities for persons with developmental disabilities or mental illness, and nursing homes) and initiation of civil action for injunctive relief to remedy a pattern or practice of violations of the Constitution or federal statutory rights. The review of conditions in facilities for persons who have mental illness, facilities for persons with developmental disabilities, and nursing homes comprises a significant portion of the program. The Special Litigation Section works collaboratively with the USAOs and HHS.

The Americans with Disabilities Act (ADA) provides that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132. In *Olmstead v. L.C.*, 527 U.S. 581 (1999), the Supreme Court construed Title II of the ADA to require States to place individuals with disabilities in community settings, rather than institutions, wherever appropriate. Further, Executive Order 13217, “Community-Based Alternatives for Individuals with Disabilities,” issued June 18, 2001, calls upon the federal government to assist states and localities to swiftly implement the decision of the United States Supreme Court in *Olmstead*. This Order emphasized that:

- unjustified isolation or segregation of institutionalized persons with disabilities is a form of prohibited discrimination,
- the United States is committed to community-based alternatives for individuals with disabilities, and

- the United States seeks to ensure that America's community-based programs for Americans with disabilities effectively foster independence and participation in the community.

In the context of persons residing in health care institutions operated by or on behalf of a government, the Division evaluates residential placements in each of its investigations under CRIPA, in light of the ADA's requirement that services be provided to residents in the most integrated setting appropriate to their needs. Through its CRIPA work, the Division seeks to eliminate the unjustified institutional isolation of persons with disabilities. The Division recognizes that unnecessary institutionalization is discrimination that diminishes individuals' ability to lead full and independent lives. By targeting Olmstead violations in its CRIPA program, the Civil Rights Division's CRIPA enforcement activities have enabled thousands of unnecessarily institutionalized individuals to live safely in the community with adequate supports and services.

For FY 08, the most recent full fiscal year, the Civil Rights Division commenced 19 investigations addressing compliance with the ADA, found that conditions and practices in 12 state facilities violated the ADA, entered into settlement agreements to correct identified ADA violations in two state facilities, continued investigations addressing compliance with the ADA in 12 state or city facilities, monitored compliance with agreements correcting identified ADA violations in 25 state or city facilities, and monitored the implementation of agreements regarding community placement in three jurisdictions following the closure of facilities.

As part of Department's Institutional Health Care Abuse and Neglect Initiative, and as an enhancement to ongoing CRIPA enforcement efforts, the Special Litigation Section staff conducted preliminary reviews of conditions and services at 48 health care facilities in 25 states,

the District of Columbia, and the Commonwealth of Puerto Rico during Fiscal Year 2008. The task in preliminary inquiries is to determine whether there is sufficient information supporting allegations of unlawful conditions to warrant formal investigation under CRIPA. The section reviews information pertaining to areas such as abuse and neglect, medical and mental health care, use of restraints, fire and environmental safety, and placement in the most integrated setting appropriate to individual needs. Separately, in Fiscal Year 2008, the Section opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 67 health care facilities in 23 states, the District of Columbia, the Territory of Guam, and the Commonwealth of Puerto Rico.

In Fiscal Year 2008, the Section commenced investigations of three state-operated facilities for persons with mental illness, 14 state facilities for persons with intellectual and developmental disabilities, and two state veterans nursing homes. The facilities are: Delaware State Psychiatric Hospital, in Newcastle, Delaware; Kings County Hospital Center, in Brooklyn, New York; Ancora Psychiatric Hospital, in Winslow, New Jersey; Denton State School, in Denton, Texas; Abilene State School, in Abilene, Texas; Austin State School in Austin, Texas; Brenham State School, in Brenham, Texas; Corpus Christi State School, in Corpus Christi, Texas; El Paso State Center, in El Paso, Texas; Lufkin State School, in Lufkin, Texas; Mexia State School, in Mexia, Texas; Richmond State School, in Richmond, Texas; Rio Grande State Center, in Harlingen, Texas; San Angelo State School, in Carlsbad, Texas; San Antonio State School, in San Antonio, Texas; Rosewood Center, in Owings Mills, Maryland; Central Virginia Training Center, in Lynchburg, Virginia; William F. Green State Veterans Home, in Bay Minette, Alabama; and Minnesota Veterans Home, in Minneapolis, Minnesota.

The Section found that conditions and practices at eight state facilities for persons with mental illness, two state facilities for persons with intellectual and developmental disabilities, and three nursing homes violate the residents' federal constitutional and statutory rights. Those facilities are: Georgia Regional Hospital, in Atlanta, Georgia; Georgia Regional Hospital, in Savannah, Georgia; Northwest Georgia Regional Hospital, in Rome, Georgia; Central State Hospital, in Milledgeville, Georgia; Southwest State Hospital, in Thomasville, Georgia; West Central Georgia Regional Hospital, in Columbus, Georgia; East Central Georgia Regional Hospital, in Augusta, Georgia; Oregon State Hospital, in Salem, Oregon; Beatrice State Developmental Center, in Beatrice, Nebraska; Northwest Habilitation Center, in St. Louis, Missouri; Tennessee State Veterans Homes, in Murfreesboro and Humboldt, Tennessee; and C.M. Tucker Nursing Care Facility, in Columbia, South Carolina.

The Section entered settlement agreements to resolve its investigations of one state-operated facility for persons with intellectual and developmental disabilities, and one state-operated nursing home. Those facilities are: Beatrice State Developmental Center, in Beatrice, Nebraska, and Laguna Honda Hospital and Rehabilitation Center, in San Francisco, California.

The Section continued its investigations of residential facilities for persons with developmental disabilities: Agnews Developmental Center, in San Jose, California; Sonoma Developmental Center, in Eldridge, California; Lanterman Developmental Center, in Pomona, California; Rainier Residential Rehabilitation Center, in Buckley, Washington; Frances Haddon Morgan Center, in Bremerton, Washington; Conway Human Development Center, in Conway, Arkansas; Lubbock State School, in Lubbock, Texas; Bellefontaine Developmental Center, in St. Louis, Missouri; Clyde L. Choate Developmental Center, in Anna, Illinois; and Howe Developmental Center, in Tinley Park, Illinois. The Division also continued its investigation of

Oregon State Hospital, in Salem, Oregon, a facility for persons with mental illness. In addition, the Section continued its investigations of three publicly-operated nursing homes: Charlotte Hall State Veterans Home, in Charlotte Hall, Maryland; the Laguna Honda Hospital and Rehabilitation Center, in San Francisco, California; and C.M. Tucker Nursing Care Center, in Columbia, South Carolina. In some of these matters, the Section is reviewing voluntary compliance to improve conditions.

The Section monitored the implementation of remedial agreements for 11 facilities for persons with developmental disabilities: Fort Wayne State Developmental Center, in Fort Wayne, Indiana; Clover Bottom Developmental Center, in Nashville, Tennessee; Greene Valley Developmental Center, in Greeneville, Tennessee; Harold Jordan Center, in Nashville, Tennessee; Arlington Developmental Center, in Arlington, Tennessee; New Lisbon Developmental Center, in New Lisbon, New Jersey; Southbury Training School, in Southbury, Connecticut; Woodward Resource Center, in Woodward, Iowa; Glenwood Resource Center, in Glenwood, Iowa; Woodbridge Developmental Center in Woodbridge, New Jersey; and Oakwood Community Center in Somerset, Kentucky. It also monitored the implementation of remedial agreements regarding community placements from facilities for persons with developmental disabilities in Indiana, Puerto Rico, and Washington, D.C.

The Section monitored the implementation of remedial agreements for four nursing homes: Reginald P. White Nursing Facility, in Meridian, Mississippi; Mercer County Geriatric Center, in Trenton, New Jersey; A. Holly Patterson Extended Care Facility in Uniondale, New York; and Ft. Bayard Medical Center and Nursing Home, in Ft. Bayard, New Mexico. The Section also monitored the implementation of remedial agreements regarding 11 state-operated residential facilities for persons with mental illness: Guam Mental Health Unit in the Territory

of Guam; Vermont State Hospital, in Waterbury, Vermont; Dorothea Dix Hospital, in Raleigh, North Carolina; Broughton Hospital, in Morganton, North Carolina; Cherry Hospital, in Goldsboro, North Carolina; John Umstead Hospital, in Butler, North Carolina; Metropolitan State Hospital, in Norwalk, California; Napa State Hospital in Napa, California; Atascadero State Hospital, in Atascadero, California; Patton State Hospital, in Patton, California; and St. Elizabeths Hospital, Washington, D.C.

Finally, the Section monitored the implementation of a remedial agreement regarding one residential facility for children with visual disabilities: New Mexico School for the Visually Handicapped, in Alamogordo, New Mexico.

CONCLUSION

I hope my testimony has given you a comprehensive view of the Department's essential role in prosecuting and deterring fraud on the Medicare and Medicaid programs, restoring funds illegally stolen from the trust funds, and protecting our citizens from those health care fraud schemes which have caused physical harm and loss of life. The Department is committed to the ongoing success of the HCFAC program and will continue to marshal its resources, including those provided by the HCFAC program and its own discretionary funds, to ensure that federal health care dollars are properly expended. To that end, we will prosecute fraud and abuse in the Medicare and Medicaid programs and restore the recovered proceeds to these programs. The HCFAC program pays for itself many times over and helps ensure the safety and availability of medical services to all beneficiaries. With additional resources we could do even more.