Department of Justice

STATEMENT OF

EDWARD N. SISKEL
ASSOCIATE DEPUTY ATTORNEY GENERAL

BEFORE THE

SUBCOMMITTEE ON HEALTH
SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

ENTITLED

"REDUCING FRAUD, WASTE AND ABUSE IN MEDICARE"

PRESENTED

JUNE 15, 2010

INTRODUCTION

Chairmen Stark and Lewis , Ranking Members Herger and Boustany, and distinguished Members of the Subcommittee, I appreciate the opportunity to appear before you to discuss the efforts of the Department of Justice to enforce laws against health care fraud, along with our partners in the Department of Health and Human Services and other federal and state law enforcement agencies. We are grateful for the Subcommittee's leadership on this important topic, and to the Chairman for inviting me to discuss the Department of Justice's enforcement efforts to combat fraud in the health care system.

Every year, hundreds of billions of dollars are spent to provide health security for American seniors, children, and to the poor and disabled. We have a duty to ensure that taxpayer funds are well spent and that our citizens who receive treatment paid for by Medicare and other government programs are receiving proper medical care. While most medical providers and health care companies are doing the right thing, unfortunately billions of dollars that could be spent on patient care are lost each year to fraud schemes. This is unacceptable. Medicare fraud also can corrupt the medical decisions health care providers make with respect to their patients and thereby put patients at risk of harm. For these reasons, the Department of Justice, through its Criminal, Civil, and Civil Rights divisions, along with the United States Attorneys' Offices and the FBI, has redoubled its efforts to protect the public from health care fraud and to help ensure the integrity of patient care.

FIGHTING MEDICARE FRAUD IS A PRIORITY OF THE DEPARTMENT OF JUSTICE

Health care fraud represents billions of dollars in losses each year to taxpayers and private industry, drives up the cost of health care, and requires an urgent response from every level of government and the private sector. The Department of Justice, in coordination with the Department of Health and Human Services, and other federal and state law enforcement agencies, recognizes the need to recover those funds and to ensure that such fraud does not reoccur.

In 1997, Congress established the Health Care Fraud and Abuse Control (HCFAC) Program under the joint direction of the Attorney General and the Department of Health and Human Services, acting through HHS's Inspector General, to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. Since the inception of the program through fiscal year 2009, our Departments have returned more than $16.3 billion to the federal government, of which $15.6 billion went back to the Medicare Trust Fund. With $15.6 billion returned to the Medicare Trust Fund, the average return on investment to the Trust Fund for funding provided to law enforcement agencies by the 1996 law that created the program, HIPAA, is approximately $4 per dollar spent. These efforts have resulted in more than 5,600 criminal convictions for health care fraud offenses.

Because coordination across agencies is an integral part of preventing and prosecuting health care fraud, Attorney General Holder and Secretary Sebelius together pledged to strengthen our fight against waste, fraud and abuse in Medicare. To improve that coordination, in May

2009, they announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) – a senior-level, joint task force, which the Deputy Attorney General oversees along with his counterpart, the Deputy Secretary of HHS, that is designed to marshal the combined resources of both agencies in new ways to combat all facets of the health care fraud problem. With the creation of the HEAT team, we re-committed to making fighting health care fraud a Cabinet-level priority for both DOJ and HHS.

In the just one year since we announced the HEAT Initiative, we have had some remarkable successes. In terms of enforcement, we expanded the Medicare Fraud Strike Force (Strike Force) last summer from two to four cities, and in December expanded to three more cities. The Strike Force is an example of the Department's recent strategic thinking about how to bolster our efforts to combat health care fraud. The Strike Force prosecution model involves analyzing Medicare data to identify hot spots of unexplained high-billing levels in concentrated areas that, combined with field intelligence from our law enforcement agents and investigators, help expedite health care fraud investigations and prosecutions. Strike Force teams are now operating in South Florida, Los Angeles, Detroit, Houston, Brooklyn, Baton Rouge and Tampa.

These expanded efforts have already produced substantial results, including several takedowns of numerous health care fraud perpetrators which I will discuss in more detail later in my testimony. In total, since the announcement of the HEAT Initiative last May, Strike Force prosecutors have filed over 120 cases charging more than 290 defendants, negotiated about 130 guilty pleas, and litigated twelve jury trials obtaining convictions of sixteen defendants. Just as important, we have seen that these enforcement actions have a significant deterrent effect. In the first 12 months following the announcement of Strike Force operations in the Miami area, there was an estimated reduction of $1.75 billion in durable medical equipment (DME) claim submissions and $334 million in DME claims paid by Medicare, compared to the preceding 12-month period.

In fiscal year 2009, federal prosecutors nationwide filed criminal charges in 481 health care fraud cases involving charges against 803 defendants and obtained 583 convictions for health care fraud offenses. In addition, they opened 1,014 new criminal health care fraud investigations involving 1,786 individuals or entities. During that same time period, the Department of Justice opened 886 new civil health care fraud matters and filed complaints in 283 civil health care fraud cases.

The HEAT initiative also has focused on civil fraud enforcement under the False Claims Act, the Anti-Kickback Act, and Food, Drug, and Cosmetic Act. During fiscal year 2009, the Department of Justice's vigorous efforts to combat health care fraud accounted for $1.6 billion in civil settlements and judgments. Last fall, Pfizer Inc. and its subsidiary Pharmacia & Upjohn Company Inc. agreed to pay $2.3 billion to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products. This is the largest health care fraud settlement in the history of the Department of Justice, the largest criminal fine of any kind imposed in the U.S., and the largest ever civil fraud settlement against a pharmaceutical company.

Another goal of the HEAT initiative is to provide more effective legal authorities by identifying and eliminating statutory and regulatory impediments to our health care fraud prevention and enforcement efforts. The new health care reform legislation, the Affordable Care Act of 2010, moves us a long way toward attaining this goal. I'll just briefly mention a few key provisions of the Act:

• One provision directs the Sentencing Commission to increase the federal sentencing guidelines for health care fraud offenses, by 20-50% for crimes that involve $1 million or more in losses.

• Another provision clarifies that a violation of the anti-kickback statute constitutes a violation of the False Claims Act. This will ensure that all claims resulting from illegal kickbacks can be considered false, even if the claims are submitted by an innocent third-party and not directly by the wrongdoers themselves.

The Act also provides several new administrative authorities for stepped-up oversight of providers and suppliers participating in Medicare, including mandatory licensure checks, that will help keep those who seek to steal from these programs from receiving provider numbers and billing Medicare. Other newly enacted administrative authorities include:

• For the first time, the HHS Secretary may impose a moratorium on the enrollment of providers and suppliers.

• The Act authorizes the Secretary to withhold payment under Medicare to providers of services or suppliers for claims pending an investigation of fraud.

• The legislation requires providers and suppliers to establish compliance plans as a condition of enrollment in Medicare and to submit claims to Medicare within 12 months of the date of service. And,

• Providers, suppliers, and Medicare health and prescription drug plans must self-report and return Medicare overpayments within 60 days of identification.

All of these new statutory provisions provide excellent means through which the Department and HHS can, and will, increase prosecutions, seek increased penalties for criminals, prevent those who seek to commit fraud from billing the system in the first place, and recover more American taxpayers' dollars that in previous years would have been lost to fraud and abuse.

In fiscal year 2010, the federal government is devoting $1.48 billion for program integrity activities through the health care fraud and abuse control account, of which the Department of Justice litigating components will receive $85 million.[1] The President's 2011 Budget includes an additional $250 million in two-year discretionary funding to enhance program integrity and antifraud enforcement work of which $60 million is designated for the Department of Justice,

[1] The allocation to the Department of Justice litigating components includes mandatory HCFAC funding of $55.3 million and discretionary funding of $29.8 million for fiscal year 2010.

including the Federal Bureau of Investigation, to continue to expand our criminal and civil health care fraud enforcement efforts, while working closely with the Department of Health and Human Services and other federal and state agencies.

Equally important to our efforts in combating health care fraud is our partnership with State and local law enforcement. Recognizing the importance of this cooperation and coordination, Attorney General Holder and Secretary Sebelius recently reached out to all State Attorneys General regarding the most recent HEAT initiatives and to identify some areas for increased partnership.

The President has asked the Department of Justice and HHS to convene a series of regional fraud prevention summits around the country over the next few months. The first summit will take place in Miami on July 16. Other summits will follow in, for example, Los Angeles, Las Vegas, Detroit, Boston, New York, and Philadelphia.

These summits will bring together representatives from federal, state, and local law enforcement agencies, including State Attorneys General, representatives from the private sector including healthcare providers, hospitals, and doctors to share information about trends in health care fraud and to ensure effective referral mechanisms and procedures for joint investigations.

Second, the Acting Deputy Attorney General recently sent a memo to every United States Attorney in the country asking them to convene regular health care fraud task force meetings to facilitate the exchange of information with partners in the public and private sector, and to help coordinate ant-fraud efforts. All of the U.S. Attorneys have been asked to schedule the first meeting by August 16, 2010.

One purpose of these regional summits and regular task force meetings will be to share information about emerging fraud schemes so that we can stop them before they happen and educate the public to be our first line of defense. For example, we have heard increasing reports about seniors being asked to provide their Social Security numbers in order to receive a "donut hole" check under the Affordable Health Care Act, raising concerns about potential identity theft scams. We need to make sure that seniors understand there is no need to share any personal identifying information with anyone to receive these payments and that they should be wary of anyone seeking such information.

The remainder of my testimony will describe the key activities of each Department component and highlight their recent accomplishments.

CRIMINAL DIVISION'S EFFORTS TO FIGHT HEALTH CARE FRAUD AND ABUSE

The Department of Justice's efforts to fight health care fraud have succeeded in part because of strategic thinking about how to respond to this growing problem. The Strike Force was launched by the Criminal Division in collaboration with the United States Attorney's Office in the Southern District of Florida in 2007 to target durable medical equipment (DME) and HIV infusion fraud in Miami. In March 2008, the Criminal Division expanded the Strike Force to a second phase, partnering with the United States Attorney's Office for the Central District of California and HHS to combat DME fraud in the Los Angeles metropolitan area. The Strike Force model for criminal health care fraud prosecutions has now become a permanent component of the United States Attorneys' Offices in both the Southern District of Florida and

the Central District of California. In May 2009, as part of the HEAT initiative, the Department expanded the Strike Force to Houston and Detroit, and in December of last year we added three more cities – Brooklyn, Tampa, and Baton Rouge – bringing the total number of Strike Force locations to seven.

The Strike Force's mission is to supplement the criminal health care fraud enforcement activities of the United States Attorneys' Offices by targeting 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 then gather and develop additional investigative intelligence to identify potential targets who are operating as health care providers or suppliers and may be billing for fictitious or medically unnecessary services. A key focus of the HEAT initiative is to make sure that investigators and prosecutors are getting real-time access to claims data in a useable format so that we can develop these cases quickly and effectively.

Typically in each Strike Force city, three to five teams of federal, state, and local investigators, work under the guidance of Criminal Division prosecutors and Assistant United States Attorneys, to investigate fraudulent activity and, where appropriate, bring criminal and civil cases against the most serious perpetrators. Our goal is to bring these cases as quickly and responsibly as possible once the fraud is identified to assure that viral fraud schemes do not spread between regions within our country. Strike Force prosecutors usually charge defendants for the total amount of fraudulent claims billed to the Medicare program, and where the facts merit, seek enhanced sentences for "relevant conduct" under the guidelines. After developing evidence to support arrests of individual targets and suspects, court processing of Strike Force cases from indictment to disposition and sentencing can occur within a matter of months. While variations in case processing time occur from district to district, the median time from indictment to sentencing for more than 200 defendants sentenced in Miami Strike Force cases to date has been about six months. Strike Force defendants are also more likely to receive prison sentences and longer terms of imprisonment than more traditional criminal health care fraud defendants. During the three fiscal years since the Strike Force's inception, over 94 percent of all Strike Force defendants were convicted and sentenced to terms of imprisonment compared to 64 percent of all criminal health care fraud defendants. The average prison term for Strike Force defendants was 44 months, which was about 10 percent longer than the overall national average for federal health care fraud defendants over this same period.

The HEAT Initiative has produced significant enforcement results since last May following our expansion of Strike Force locations and the scope of targeted schemes to include fraudulent physical and occupational therapy clinics, home health agencies, and enteral nutrition and feeding supplies, in addition to DME and HIV infusion:

- On June 24, 2009, the Criminal Division and United States Attorney's Office for the Eastern District of Michigan announced seven indictments charging 53 people in schemes involving physical, occupational, and infusion therapy to defraud Medicare of more than $50 million in the Detroit metropolitan area.
- On June 26, 2009, the Criminal Division and United States Attorney's Office for the Southern District of Florida indicted eight Miami-area residents in connection with a $22

million scheme to submit false claims to Medicare from two fraudulent providers for purported home health services.

- On July 29, 2009, the Criminal Division and United States Attorney's Office for the Southern District of Texas announced the unsealing of seven indictments charging 32 people in schemes involving false billing for "arthritis kits," which consist of sets of orthotic braces that are purportedly used for the treatment of arthritis-related conditions, power wheelchairs and enteral feeding supplies to defraud Medicare of more than $16 million in the Houston metropolitan areas.
- On October 21, 2009, Strike Force prosecutors in the Central District of California announced arrests of 20 defendants, most of them residing in the Los Angeles area, for participating in Medicare fraud schemes that resulted in more than $26 million in fraudulent billings to the Medicare program. The same day, Houston Strike Force prosecutors announced charges against six additional defendants in a new case and a superseding indictment involving fraudulent billings for "arthritis kits."
- On December 15, 2009, the Departments of Justice and HHS announced indictments of another 30 individuals charged by Strike Force prosecutors in Miami, Detroit, and Brooklyn with submitting more than $61 million in fraudulent billings to Medicare for various schemes involving unnecessary medical tests, durable medical equipment, home health services, and injection and infusion treatments. DOJ and HHS also announced plans to expand Strike Force operations to the Eastern District of New York, Middle District of Louisiana, and Middle District of Florida.
- On January 14, 2010, 13 defendants were indicted in Detroit for a home health care scheme to defraud the Medicare program of more than $14.5 million.
- On March 30, 2010, DOJ prosecutors indicted six Miami-area residents for their alleged role in a $13.6 million health care fraud scheme involving a Miami-area HIV infusion clinic that billed the Medicare program for HIV infusion therapy services that were medically unnecessary and were never provided.
- On May 5, 2010, DOJ and HHS announced the indictments of four Brooklyn, N.Y.-area residents who were charged in connection with a $2.8 million health care fraud scheme allegedly operated from a Brooklyn-area clinic that purported to specialize in providing physical therapy and various diagnostic tests that were not actually rendered and were not medically necessary.
- On May 14, 2010 the Department arrested a Miami-area resident who owned and operated an HIV infusion clinic and charged her for allegedly participating in a $23 million HIV infusion Medicare fraud scheme.

Typically, defendants in Strike Force indictments include physicians, nurses and other medical professionals, along with DME company or medical clinic owners, executives and/or employees, who are charged with participating in schemes to submit claims for services or products that were medically unnecessary and oftentimes, never provided. In many if not most cases, defendants paid kickbacks to medical professionals and beneficiaries for use of their Medicare information to support fictitious claims for items or services that were never provided. In other cases, defendants have been charged with aggravated identity theft for stealing physician or beneficiary information to support fraudulent claims. In some cases, indictments allege that

beneficiaries were deceased at the time they allegedly received the items or services. Finally, a few cases have involved actions which put patients at risk of harm or injury by subjecting them to infusion or injection treatments that they did not need.

Since its inception nearly three years ago, Strike Force prosecutors from the Criminal Division and United States Attorneys' Offices together have:

- filed 310 cases charging over 585 defendants who collectively billed the Medicare program more than $1.3 billion dollars;
- taken more than 330 guilty pleas;
- litigated 26 jury trials resulting in convictions of 35 defendants and only five acquittals;
- obtained sentences to imprisonment for 94% of defendants convicted, and
- imprisoned defendants received an average sentence of 44 months.

The Strike Force is just one tool designed to fight the most aggressive criminal schemes. The Division's Organized Crime and Racketeering Section also supports investigations and prosecutions of fraud and abuse targeting 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. The Department's 93 United States Attorney's Offices throughout the nation bring many other significant Medicare fraud cases with criminal and civil prosecutors who work on health care fraud cases along with attorneys in the Department's Civil and Civil Rights Divisions, and are aided significantly by FBI field offices around the country.

THE DEPARTMENT'S CIVIL LITIGATING COMPONENTS' HEALTH CARE FRAUD EFFORTS

The primary enforcement tool possessed by the Department of Justice to pursue civil remedies in health care fraud matters is the False Claims Act (FCA), 31 U.S.C. §§ 3729-3733. In addition to the Department of Justice being able to go after false claims directly, lawsuits are often brought by private plaintiffs, known as "relators," under the *qui tam* provisions of the FCA. The *qui tam* provisions allow private citizens to sue, on the government's behalf, companies and others that defraud the government. The government then can intervene in appropriate cases to pursue the litigation and recovery against the defendant. Since the False Claims Act was substantially amended in 1986 and through FY 2009, the Civil Division, working with United States Attorneys, has recovered $24 billion on behalf of the various victim federal agencies. Of that amount, $15.9 billion was the result of fraud against federal health care programs – primarily the Medicare program. Indeed, just since January of 2009, the Department has recovered more than $3 billion in health care matters brought under the False Claims Act.

A significant component of the Department's civil health care fraud caseload consists of cases alleging misconduct by manufacturers of pharmaceutical and device products. For example, in April of this year, we obtained a $520 million settlement agreement with

AstraZeneca LP and AstraZeneca Pharmaceuticals LP to resolve allegations that AstraZeneca illegally marketed the anti-psychotic drug Seroquel for uses not approved as safe and effective by the FDA. The federal recovery in AstraZeneca was approximately $302 million.

Last fall, the Department announced the largest health care fraud settlement in its history in a case involving Pfizer, which paid $2.3 billion in combined criminal fines and civil recoveries (of which $1 billion was a civil fraud recovery). The Civil Division's Office of Consumer Litigation and the United States Attorney's Office for the District of Massachusetts secured a criminal conviction against Pfizer subsidiary Pharmacia and Upjohn Co., for its illegal marketing of the painkiller, Bextra.

Health care fraud that affects the health, safety, and well-being of Medicare and Medicaid beneficiaries is of paramount concern to the Department. The Department recently negotiated a $24 million settlement to resolve allegations that a national chain of Small Smiles dental clinics was providing unnecessary dental services to children on Medicaid in order to maximize the company's Medicaid reimbursements.

The Civil Division also leads an Elder Justice and Nursing Home Working Group, which focuses on health care fraud involving elderly patients, such as the provision of substandard care and the failure of care the residents are entitled to receive. Such conduct not only wastes taxpayer dollars, but also threatens the health and safety of some of our most vulnerable citizens.

In addition to these matters, the Civil Division and United States Attorneys offices, as a part of our health care fraud enforcement efforts, investigates and pursues False Claims Act matters that are predicated on claims that doctors and others were paid kickbacks or other illegal remuneration to induce referrals of Medicare or Medicaid patients in violation of the Physician Self-Referral laws, commonly referred to as the "Stark" laws, the Anti-kickback Statute, and the civil monetary penalties statute. These statutes have been extremely important in protecting the integrity of our health care system and have proven useful in going after fraudsters.

Another way the Civil Division fights health care fraud is through the criminal prosecutions by the Office of Consumer Litigation (OCL). OCL investigates and prosecutes drug and device manufacturers and responsible individuals believed to be illegally promoting and distributing misbranded and adulterated drugs and devices in violation of the Federal Food, Drug, and Cosmetic Act ("FDCA"). OCL pursues various violations of the FDCA, including those involving products that are not manufactured in conformance with current good manufacturing practices.

Earlier this year, for example, working together with its partner in the U.S. Attorney's Office in the Eastern District of Missouri, OCL prosecuted a subsidiary of KV Pharmaceuticals, Ethex Corporation, for failing to promptly inform FDA of drug manufacturing problems involving oversized tablets of two prescription drugs. Ethex pled guilty to two felony violations of the FDCA and was fined more than $23 million. Ethex was also ordered to pay more than $4 million in administrative forfeiture and restitution to the Medicaid and Medicare programs. Ethex also ageed to injunctive relief in a companion civil case designed to ensure compliance with current good manufacturing practices.

The Civil Rights Division also plays a critical role in the Department's protection of the nation's health care system. The Special Litigation Section of the Civil Rights Division is the Department component responsible for the Civil Rights of Institutionalized Persons Act (CRIPA) and its role is to ensure that the civil rights of residents in public, state or locally-run, institutions (including facilities for persons with developmental disabilities or mental illness, and nursing homes) are fully protected. The Department's CRIPA work goes hand-in-hand with the Civil Rights Division's work under Title II of the Americans with Disabilities Act to uphold individuals' federal rights to receive adequate supports and services in the most integrated setting appropriate to their needs. The Department recognizes that unnecessary institutionalization is discrimination that diminishes individuals' ability to lead full and independent lives. As a result of our CRIPA and ADA enforcement activities, thousands of unnecessarily institutionalized individuals have been able to live safely in the community with adequate supports and services.

The Department's work in this area recently has been strengthened. The Affordable Care Act ("Affordable Care Act"), which the President signed into law on March 23, 2010, expands CRIPA by providing the Department with subpoena authority in enforcing this statute. The Department will continue to seek the cooperation of institutions and their controlling governmental bodies in pursuing investigations under CRIPA. Its newly enacted CRIPA subpoena power will foster such cooperation and, when cooperation is withheld, will greatly enhance the Department's ability to safeguard the civil rights of institutionalized persons.

In this regard, as part of the Department's Institutional Health Care Abuse and Neglect Initiative, the Civil Rights Division in FY 2009 pursued 19 investigations regarding conditions in 23 public healthcare facilities. Also in FY 2009, the Division addressed conditions and practices at 13 state facilities for persons with intellectual and developmental disabilities, eight state facilities for persons with mental illness, and three state operated nursing homes. The Division entered five settlement agreements regarding these 24 facilities. The Division was unable to settle one case involving a facility for persons with developmental disabilities, and that case is currently in contested litigation.

UNITED STATES ATTORNEYS' ENFORCEMENT EFFORTS

The 93 United States Attorneys and their AUSAs are the nation's principal prosecutors of federal crimes, including health care fraud (HCF). Each district has a designated Criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator charged with overseeing the United States Attorneys' Offices' (USAOs) commitment to fighting HCF wherever it occurs. The USAOs play a major role in this Department priority by investigating and litigating affirmative civil cases and criminal cases to recover funds wrongfully taken from the Medicare Trust Fund and other taxpayer-funded health care systems as a result of fraud. Civil and criminal AUSAs investigate and litigate a wide variety of HCF matters including, false billings by doctors and other providers of medical services, overcharges by hospitals, kickbacks to induce referrals of Medicare patients, fraud by pharmaceutical and medical device companies, and failure of care allegations against nursing home and mental health facility owners. The USAOs partner with the Civil Division in investigating and resolving significant cases, including

the Astra Zeneca and Pfizer matters I mentioned earlier. In addition, the USAOs are partnering with the Criminal Division in the Medicare Fraud Strike Force Initiative.

The USAOs took a leadership role in developing a training conference for the Strike Force teams, attended by Criminal attorneys, AUSAs, and agents. The AUSAs have successfully litigated numerous Strike Force cases, as well as assisting the Criminal Division attorneys in additional Strike Force investigations and litigation. Each of the Strike Force USAOs now has direct access to Medicare data, as well as support from data analysts to assist in their investigations.

Other notable health care fraud successes of U.S. Attorneys' Offices which are illustrative of the kinds of cases the USAOs handle across the nation include:

- In the Northern District of California, in partnership with the Office of Consumer Litigation, the U.S. Attorney's Office prosecuted former CEO of InterMune Inc.. The defendant was convicted of wire fraud for the creation and dissemination of false and misleading information about the efficacy of InterMune's Actimmune (Interferon gamma-1b) as a treatment for idiopathic pulmonary fibrosis ("IPF"). The CEO has not been sentenced yet, but faces a maximum sentence of 20 years.

- In the Southern District of Texas, a hospital group based in McAllen, Texas, has agreed to pay the United States $27.5 million to settle claims that it violated the False Claims Act, the Anti-Kickback Statute and the Stark Statute between 1999 and 2006, by paying illegal compensation to doctors in order to induce them to refer patients to hospitals within the group.

- In the District of New Hampshire, four pharmaceutical companies, Mylan Pharmaceuticals, Inc., UDL Laboratories, Inc., AstraZeneca Pharmaceuticals LP, and OrthoMcNeil Pharmaceutical, Inc., entered into settlement agreements for a total of $124 million to resolve claims that they violated the False Claims Act by failing to pay appropriate rebates to state Medicaid programs for drugs paid for by those programs.

- In the Southern District of New York, the former senior manager of corporate benefits for Hitachi America Ltd. ("Hitachi America"), was sentenced to 57 months in prison for defrauding the Hitachi America Group Health and Welfare Plan (the "Plan") of more than $6 million. The defendant used the company's insurance plan funds to pay for personal and family expenses, including, at least $1 million in payments to defendant's credit cards; more than $2 million in checks made payable to the defendant; approximately $42,000 for a Lexus automobile registered to defendant; and approximately $625,000 to purchase a house in Vero Beach, Florida. In addition to the prison term, the court sentenced the defendant to three years of supervised release, and ordered restitution in the amount of $7,497,906.

- In the Central District of California, the former co-owner of City of Angels Medical Center (City of Angels) was sentenced to 37 months in federal prison for paying illegal kickbacks for referrals of "patients" who were recruited from Los Angeles' "Skid Row"

and was ordered to pay $4.1 million in restitution for his role in the scheme that defrauded Medicare and Medicaid by recruiting homeless persons from Skid Row for unnecessary medical services. The medical center entered into sham contracts intended to conceal the illegal kickbacks paid, and billed Medicare and Medicaid for in-patient services to the recruited homeless beneficiaries, including those for whom hospitalization was not medically necessary. The Department also has been successful in obtaining consent judgments in the aggregate amount of $20 million against the parent company and individual owners of City of Angels.

- In the Eastern District of Pennsylvania, Willowcrest Nursing Home and Willow Terrace long-term nursing care residence settled allegations that arose from an investigation of Willowcrest's sub-standard pressure ulcer treatment and prevention, incontinence care, pain-management, nutrition, weight monitoring, infection control, and diabetic care. This quality-of-care settlement is the first in which a health care facility is required to hire a full-time physician assistant or nurse practitioner whose sole responsibility will be to regularly and continuously treat its residents. The settlement also provides that Willowcrest and Willow Terrace will, among other things, pay $305,072 to the Medicaid program.

FBI'S HEALTH CARE FRAUD INVESTIGATIONS

Health care fraud investigations are among the highest priority investigations within the FBI's White Collar Crime Program, along with Public Corruption and Corporate Fraud. The FBI currently sponsors several national initiatives designed to combat Medicare, Medicaid, and private insurance fraud in every health care sector to include, home health, durable medical equipment, infusion therapy, and Internet pharmacy. In order to address the nationwide health care fraud threat, the FBI utilizes sophisticated investigative techniques—from undercover operations to wiretaps—not only to collect evidence for prosecution, but also to find and stop criminals before they take action.

The FBI is actively pursuing health care fraud in every region of the country. It has local task forces and working groups to address health care fraud in every one of its 56 field offices, and it is shifting resources to regions where an increase in fraud schemes is detected. FBI's field office-level task forces and working groups are comprised of HHS-OIG, U.S. Attorneys' Offices, state and local law enforcement agencies and, in many districts, private insurance company special investigative units and Medicare contractors that refer suspected fraud activity that is investigated jointly by the law enforcement agencies that are involved in the task force or working group. These task forces and working groups, which meet regularly, provide a structure to address the unique health care fraud in each region.

In the past few years, the number of pending FBI health care fraud investigations has steadily increased, and now number in excess of 2,500 cases. In the past 18 months, prosecutors have criminally charged 1,469 defendants and secured more that 1000 convictions as a result of FBI-led health care fraud investigations.

CONCLUSION: LOOKING FORWARD

As I hope is clear from this discussion, the Department of Justice, together with our partners at HHS and from state and local law enforcement, has made combating health care fraud a significant priority. The Department has devoted substantial resources and leadership from the highest levels to the HEAT initiative in order to be smarter and more effective about how we detect, deter and prosecute health care fraud. As we have seen time and time again, the only way we can be truly effective in protecting the integrity of our Federal health programs is by combining the full panoply of our federal resources, expertise, and information across agency and jurisdictional lines. The Department of Justice looks forward to working with Congress as we continue our important mission to prevent, deter, and prosecute health care fraud.