Department of Justice

STATEMENT OF

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COMMITTEE ON THE JUDICIARY
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HEARING ENTITLED

"CRIMINAL PROSECUTION AS A DETERRENT TO HEALTH CARE FRAUD"

PRESENTED

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Introduction

Mr. Chairman, Ranking Member Graham and distinguished Members of the Subcommittee, I appreciate the opportunity to appear before you to discuss the Department of Justice's efforts to combat health care fraud and abuse. We are grateful for the leadership of your Subcommittee on this important topic and to you, Mr. Chairman, for inviting me to discuss the Department of Justice's enforcement efforts.

Crimes involving fraud – whether they involve mortgage, securities or commodities fraud, bribery of government officials in violation of the Foreign Corrupt Practices Act or health care fraud – can jeopardize our economy, threaten the integrity of our financial system and cost taxpayers billions of dollars. The Department has been, and will continue to be, committed to the vigorous investigation and prosecution of these crimes. Health care fraud, in particular, is one of the Department's top enforcement priorities given the vital role Medicaid and Medicare play in supporting our most vulnerable citizens, the rising cost of funding these programs, and the huge amounts of waste, fraud, and abuse.

HEALTH CARE FRAUD ENFORCEMENT

The Medicare and Medicaid programs serve essential roles in our nation's health care system. They serve vulnerable populations of seniors, people with disabilities, and various low-income Americans. Last week, the trustees who monitor the Medicare Trust Fund issued a report that said that hospital expenses will pay out more in benefits than Medicare will collect this year, and that the Hospital Insurance Trust Fund will be depleted by 2017. It is therefore vitally important that the Departments of Justice and Health and Human Services do everything possible to prevent, detect,

and prosecute health care fraud and abuse in order to return stolen Medicare dollars to the Trust Fund.

The Department, along with our partners from the Department of Health and Human Services and state law enforcement agencies is committed to this effort. Last year, the Department of Justice filed 502 criminal health care fraud cases involving charges against 797 defendants and obtained 588 convictions for health care fraud offenses – record high numbers of criminal health care fraud prosecutions since Congress established the Health Care Fraud and Abuse Control (HCFAC) program in 1996. Moreover, the Department, working with our colleagues in the Department of Health and Human Services, has obtained more than $14 billion in total recoveries, including criminal fines and civil settlements, since 1997.

The Department's prosecutions have a clear deterrent effect. Our inter-agency Departments of Justice and Health and Human Services enforcement efforts in South Florida, spearheaded by the Department's Criminal Division and U.S. Attorney's Office for the Southern District of Florida through the Medicare Fraud Strike Force, contributed to estimated reductions of $1.75 billion in durable medical equipment (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. The average prison sentence in Miami Strike Force cases was 48.8 months, which exceeded by nearly one year the overall national average health care fraud prison sentence of 37.4 months.

Our criminal and civil enforcement efforts have taught us some important lessons. In the criminal arena, we have learned to identify criminal claim trends and track systemic weaknesses so we can stop false claims before they occur. We have also learned that quick apprehension and punishment of these criminals is critical to deterring others. But we have also learned that we

cannot prosecute our way out of this problem. Instead, we must prevent criminals from accessing Medicare, Medicaid and other health care programs in the first place.

Medicare and Medicaid are extremely large programs -- federal and state spending on both programs collectively exceeds $800 billion per year. In FY 2008, the federal government devoted $1.13 billion for program integrity activities and health care fraud enforcement. The Administration is requesting in the FY 2010 Budget that Congress provide an additional $311 million in two-year funding to enhance federal program integrity and antifraud enforcement work of which $29.8 million is designated for the Department of Justice. We ask for your support for this and future antifraud funding enhancements.

HEALTH CARE FRAUD ENFORCEMENT IS A TOP DEPARTMENT PRIORITY

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. The GAO has estimated that up to 10% of health care spending may be wasted on fraudulent claims. 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. In short, health care fraud is an enormous problem that we cannot allow to continue.

The Department is committed to prosecuting all who commit health care fraud – providers and practitioners, equipments suppliers and corporate wrongdoers. In criminal enforcement actions during 2008, Department prosecutors:

- Opened 957 new criminal health care fraud investigations involving 1,641 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 involving 1,335 defendants were pending at the end of FY 2008.

Despite the staggering volume of cases, the Department has succeeded because of strategic thinking about how best to address this problem. The Medicare Fraud Strike Force in Miami is one example. 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. The Miami 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. That Strike Force includes four teams of prosecutors and federal and state agents to combat DME fraud in the Los Angeles metropolitan area. In Phase Two of the Strike Force, Fraud Section attorneys, working with federal prosecutors from the U.S. Attorney's Office, and FBI and HHS-OIG agents, charged 37 defendants in 21 indictments involving more than $55 million in fraudulent Medicare claims.

The Strike Force model for criminal health care fraud prosecutions has now become a permanent component of the United States Attorneys' Office in both the Southern District of Florida and the Central District of California.

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 in the Houston area. The Department's Criminal Division is currently planning to launch a fourth Strike Force phase, using its allocation of the supplemental funding Congress provided to the Department in the Omnibus Appropriations Act of 2009.

The Strike Force model or approach is similar in some ways to "problem-oriented policing" because it is based on obtaining an understanding of local or regional fraud schemes and focusing on the geographic areas which have the greatest rates of crime in a concentrated effort to deter fraudulent claims.

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 129 guilty pleas;
- handled 14 jury trials resulting in convictions of 18 defendants; 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:

- After a two-week criminal trial, a Miami jury convicted a physician and the court sentenced her to serve 30 years in prison for her role in an $11 million HIV infusion fraud scheme. The physician, with the assistance of a nurse who also was convicted and sentenced to seven years in prison, ordered and then provided hundreds of unnecessary HIV infusion treatments to patients who were paid cash kickbacks of $150 per visit to accept the services so the co-conspirators could steal from Medicare.

- 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 the Department of Health and Human Services' Office of the Inspector General, 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, 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. Indeed, the Criminal Division and the U.S. Attorney's Offices bring many other significant health care fraud cases.

For example, 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 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.

CIVIL ENFORCEMENT

The Department's Civil Division, using the False Claims Act, 31 U.S.C. §§ 3729-3733, plays an enormous role in the Department's efforts to protect public funds from fraudsters. 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.

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, through its Office of Consumer Litigation, also pursues many of these cases as criminal violations of the Federal Food, Drug, and Cosmetic Act (FDCA). 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 up to $800 million in civil recoveries under the federal and state False Claims Acts.

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."

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. 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.

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 requirement in the Americans with Disabilities Act 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. 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.

As part of the Department's Institutional Health Care Abuse and Neglect Initiative, the Civil Rights Division conducts reviews of conditions in health care facilities. It has 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 violated the residents' federal constitutional and statutory rights. 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.

INTER-AGENCY COOPERATION

The Department is not alone in the fight to combat fraud and preserve the integrity of the country's health care system. Because HHS directly administers the Medicare Program, maintains all the payment records and data submitted by providers, and oversees the Medicaid program in partnership with the states, the close cooperation between the Departments is critical to our success. Within the framework of HCFAC, 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). As a result of this cooperation:

- Our Strike Force model focuses interagency resources on those regions with the highest levels of Medicare program fraud.
- 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.

We also work closely with the Food and Drug Administration, including its Office of Criminal Investigations (FDAOCI), 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. These partnerships are a key to our success in stemming health care fraud and protecting the federal fisc.

MORE THAN $14 BILLION IN TOTAL RECOVERIES SINCE 1997

Working with our colleagues, during Fiscal Year 2008 alone, the Department's health care fraud litigation resulted in deposits of $1.48 billion to the 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 the Treasury as a result of these efforts.

Since the inception of the HCFAC program in 1997, the Department has obtained, according to our preliminary estimates, more than $14.4 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. The HCFAC program is the principal source of annual funding for Department of Justice efforts to combat Medicare and Medicaid fraud.

FUNDING

Earlier this year, the Omnibus Appropriations Act of 2009 provided $198 million for joint HHS and Department health care antifraud programs through an allocation adjustment for new program integrity work, predominantly for the Medicare Advantage, Medicare Part D, Medicaid and Children's Health Insurance (CHIP) 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 of which $29.8 million is designated for the Department of Justice.

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. This additional time to use these enhanced resources would permit the Department to 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.

CONCLUSION

Health care fraud enforcement has restored funds to the trust funds and protected our citizens from health care fraud schemes. 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. We are committed to prosecuting fraud and abuse in the Medicare and Medicaid programs and restoring the recovered proceeds to these programs. We look forward to working with Congress and this Committee in particular, through these efforts, to make health care available to those who have no such safety net.

Thank you for the opportunity to testify. I would be please to take any of your questions.