



Department of Justice

STATEMENT OF

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BEFORE THE

**SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES**

FOR A HEARING ON

HEALTH CARE FRAUD INVESTIGATIONS

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**Statement of
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Before the Subcommittee on Oversight
Committee on Ways and Means
U.S. House of Representatives
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Chairman Roskam, Ranking Member Lewis, and distinguished Members of the Committee, thank you for inviting me to speak with you today about the Department of Justice's efforts to combat health care fraud. I am honored to appear before you on behalf of the Department of Justice (the Department), along with the Office of Inspector General, Department of Health and Human Services (HHS-OIG). The Department is grateful to the Committee for its leadership in this area, and we appreciate the opportunity to appear before you here today.

Health care fraud is a serious and costly problem in our country. It threatens the integrity of Medicare, as well as all federal, state, and private health care programs. Every year the Federal Government spends hundreds of billions of dollars to provide health care to the most vulnerable of our society – our seniors, children, disabled, and needy. We have a duty to ensure that these funds are spent on providing proper medical treatment to our citizens. While most medical providers and health care companies are doing the right thing, there are some that target Medicare and other government and private health care programs for their own financial benefit. Every dollar stolen from our health care programs is one dollar too many. Medicare and Medicaid fraud deprives patients of resources needed to pay for medically necessary services. It also places patients at risk of harm from unnecessary or unapproved treatments. For these reasons, fighting health care fraud is a priority of the Department.

The 93 United States Attorneys and their assistants (AUSAs), and the Criminal Division, Fraud Section's Medicare Fraud Strike Force trial attorneys are the principal prosecutors of federal criminal health care fraud violations, representing the Department and the interests of the American taxpayer. Together with attorneys from the Civil and Civil Rights Divisions (the Civil Rights Division enforces the Civil Rights of Institutionalized Persons Act), we appear in both criminal and civil cases in the federal courts in the 94 judicial districts across the country, and with agents from the Federal Bureau of Investigation (FBI), our colleagues at HHS-OIG and the Centers for Medicare and Medicaid Services (CMS), and other affected federal and state agencies, we are fighting back against health care fraud. We investigate, prosecute, and secure prison sentences for hundreds of defendants every year, recovering billions of dollars in stolen funds, and making significant strides in prosecuting unscrupulous individuals and corporations.

FIGHTING MEDICARE AND MEDICAID FRAUD IS A PRIORITY OF THE DEPARTMENT OF JUSTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a national Health Care Fraud and Abuse Control Program (HCFAC or the Program) under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS), acting through the Inspector General, designed to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse. Because coordination across Departments is an integral part of preventing and prosecuting health care fraud, in 2009 the Health Care Fraud Prevention and Enforcement Action Team (HEAT), was created. HEAT is a senior level joint task force created and designed to marshal the combined resources of the Department and HHS to combat all facets of the health care fraud problem. Under the current leadership of Attorney General Loretta E. Lynch and HHS Secretary Sylvia Mathews Burwell, we continue to be committed to making fighting health care fraud a Cabinet-level priority for both the Department and HHS. In Fiscal Year 2015, the government's health care fraud and prevention efforts recovered approximately \$2.4 billion related to health care fraud and false claims and returned these funds to CMS, the U.S. Treasury, other federal agencies, and individuals. By joining forces to coordinate federal, state, and local law enforcement activities to fight health care fraud, the Department's efforts have been successful.

THE DEPARTMENT'S CIVIL HEALTH CARE FRAUD WORK

The Department's civil attorneys – both in the United States Attorneys' Offices and the Department's Civil Division – aggressively pursue civil enforcement actions to root out fraud and to recover funds on behalf of federal health care programs, like Medicare and Medicaid. The Department brings the vast majority of its civil cases under the False Claims Act (FCA), 31 U.S.C. §§ 3729- 3733, one of the Department's most powerful civil enforcement tools. This success under the FCA is reflected in the results: Since 2000, our attorneys, working with the HHS-OIG, the FBI, TRICARE (the government-funded health care program for certain military personnel and their dependents), the U.S. Department of Veterans Affairs, FEHBP (the health care program for federal employees, funded in part by the government), and other federal, state, and local law enforcement agencies, have recovered over \$1 billion every year in FCA settlements and judgments. In Fiscal Year 2015, the Department recovered over \$2 billion in civil health care fraud settlements and judgments and anticipates matching, if not exceeding, that amount this fiscal year. Since 2009, the year the HEAT Initiative was launched, the Department has recovered over \$18.5 billion in cases involving fraud against federal health care programs.

The Civil Division has successfully pursued hundreds of FCA cases against various health care providers. Matters involving pharmaceutical and device manufacturers continue to constitute some of the most significant matters pursued by the Civil Division this past year. The

Civil Division also pursued several significant matters involving alleged violations of the Anti-Kickback Statute (AKS), which prohibits the willful solicitation or payment of remuneration to induce the referral or purchase of a good or service covered by federal health care programs, as well matters involving alleged claims for services that were not medically necessary or eligible for reimbursement.

As an example of these significant matters, in the area of device companies, in this fiscal year, Olympus Corporation of the Americas – the largest distributor of endoscopy and related equipment – and its subsidiary, Olympus Latin America Inc., agreed to pay \$646 million to resolve criminal and civil claims relating to a kickback scheme involving the marketing and selling of its endoscopy equipment. The combined federal and state civil settlement of \$310.8 million included a \$267 million recovery for the United States – the largest amount paid to the Federal Government for violations involving the AKS by a medical device company. The government alleged that Olympus paid remuneration to physicians and hospitals, including consulting payments, foreign travel, lavish meals, and millions of dollars in grants and free endoscopes to induce hundreds of millions of dollars in the sales of endoscopes and related equipment. The government further alleged that Olympus lacked an effective compliance program to monitor or stop this fraudulent conduct.

In the area of pharmaceutical companies, in this fiscal year, Wyeth and Pfizer, Inc. agreed to pay \$784.6 million to resolve FCA claims that Wyeth underpaid rebates owed under the Medicaid Drug Rebate Program (MDRP) and caused the submission of false claims to federal health care programs. The Federal Government's portion was approximately \$413 million. Pursuant to the MDRP, drug manufacturers must pay quarterly rebates to state Medicaid programs in exchange for Medicaid's coverage of the manufacturers' drugs. The government alleged that Wyeth underpaid drug rebates for its proton pump inhibitor drugs, Protonix Oral and Protonix IV, by failing to disclose to the Medicaid program the "best prices" Wyeth had offered to thousands of hospitals under a contract that bundled the two drugs together. Wyeth allegedly offered hospitals steep discounts on these two drugs with the expectation that patients would continue using Protonix Oral after they were discharged from the hospitals. The United States alleged that by failing to account for these steep hospital discounts, Wyeth underestimated and underpaid the quarterly rebates it owed on those drugs to the state Medicaid programs.

These significant cases represent the continued success of the collaborative efforts of the Department's civil attorneys – both in the United States Attorneys' Offices and the Department's Civil Division, and our federal, state, and local partners.

THE DEPARTMENT'S CRIMINAL HEALTH CARE FRAUD WORK

The Department's criminal health care fraud efforts have also been a tremendous success. Beginning in March 2007, the Criminal Division's Fraud Section, working with the United States Attorney's Offices, the FBI and law enforcement partners in HHS-OIG, and state and local law enforcement agencies, launched the Medicare Fraud Strike Force in Miami-Dade County, Florida, to prosecute individuals and entities that claim to provide legitimate health care services, but instead exist solely for the purpose of defrauding Medicare and other government health care programs. Based on the success of these efforts and increased appropriated funding for the HCFAC program from Congress and the Administration, federal law enforcement has expanded Strike Force operations to a total of nine areas in the United States – Miami and Tampa, Florida; Detroit, Michigan; Los Angeles, California; Dallas and Southern Texas; Brooklyn, New York; Southern Louisiana; and Chicago, Illinois. In sum, the Strike Force focuses on the worst offenders in regions with the highest known concentration of fraudulent activities.

Today, our criminal enforcement efforts are at an all-time high. In Fiscal Year 2016, the Department organized the largest national health care fraud takedown in history, both in terms of individuals charged and the loss amount. On June 22, 2016, Attorney General Lynch and Secretary Burwell announced that the nationwide takedown led by the Medicare Fraud Strike Force and 36 U.S. Attorneys' Offices resulted in charges against 301 individuals, including 61 doctors, nurses, and other licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$900 million in false billings. In addition, CMS suspended payment to a number of providers using its payment suspension authority as provided in the Affordable Care Act. Typical health care fraud cases involved in the takedown include schemes to submit claims to Medicare for treatments that were medically unnecessary or never provided; or allegations that patient recruiters, Medicare beneficiaries, and other co-conspirators were paid cash kickbacks in return for supplying beneficiary information to providers so that those providers could submit false Medicare claims.

On the investigative side, in recent years the Federal Government has prioritized health care fraud prevention, which has allowed the Department, United States Attorney's Offices, the FBI, and HHS to expand and develop new tools that facilitate the detection and investigation of fraudulent providers. For example, CMS incorporates data from Medicare and Medicaid into a system called the Integrated Data Repository. This system can be accessed and utilized to support criminal investigations by federal prosecutors and agents, as well as state agencies. Increased use of this system has led to smarter investigations and prosecutions, as targets' fraudulent claims leave a trail in the data that can be used to identify or confirm suspected fraudulent practices, corroborate witness testimony, and develop new leads.

This “smart” investigation and prosecution model has increased law enforcement’s ability to detect high-risk providers and suppliers in geographic and health service areas across the country. Data analysis techniques also enable law enforcement to allocate resources to address emerging schemes and schemes that migrate from one community to another. These new data analytics not only powerfully assist in fighting fraud, but also assist in further safeguarding the public fisc. Using data to identify and quantify aberrant billing trends and financial damage to government health care programs, we are better able to focus and shift resources to build cases against high-impact targets in high-risk fraud regions. Indeed, investigators, AUSAs, and Strike Force prosecutors alike regularly analyze claims data from their districts in order to determine which actors (both locally and nationwide) pose the greatest risk to the Medicare system.

RECENT MEDICARE FRAUD STRIKE FORCE OPERATIONS

The success of the Department’s Medicare Fraud Strike Force program was recently recognized in a New York Times editorial, which noted that the Department’s progress in combating health care fraud goes beyond saving money, but also leads to better patient care and is crucial to maintaining the public’s confidence in the health care system.¹ An example of how the Strike Force works to save money and provide better health care is the eleven-count indictment issued against five individuals who managed and controlled a network of Brooklyn, New York area clinics that purported to provide physical and occupational therapy to Medicare and Medicaid beneficiaries. The defendants and their co-conspirators paid bribes and kickbacks to beneficiaries and Brooklyn-area ambulance drivers in order to induce the beneficiaries to be subjected to medically unnecessary physical therapy treatment at the clinics. The defendants billed Medicare and Medicaid for over \$86 million for this purported treatment and were paid over \$38 million. The defendants then used over 15 different shell companies to launder their shares of the proceeds from the fraud and hide the proceeds from the IRS in order to avoid paying taxes on any of the stolen Medicare and Medicaid Funds.

Another example of working to recover money and provide better care occurred in June 2016 when the Strike Force charged an owner and operator of a medical clinic, Amex Medical; the manager of Amex; and a physician in Houston, Texas, with conspiracy to commit health care fraud. The charges stemmed from the defendants’ role in an \$18 million Medicare fraud scheme whereby the defendants would sell fraudulent home health certifications signed by co-conspirator physician to various home health agencies in Houston. In June 2016, a grand jury returned a second indictment against the same physician in Houston, Texas, charging him and the owner of Milten Clinic with one count of conspiracy to commit health care fraud stemming from their roles in a \$19.2 million Medicare fraud scheme. In this scheme, the owner of the

¹ Fraud and Other Threats to Medicare, *New York Times* (July 28, 2016), available at http://www.nytimes.com/2016/07/28/opinion/fraud-and-other-threats-to-medicare.html?_r=0.

clinic sold false home health certifications signed by the same physician to numerous home health agencies in Houston, Texas. Both of these cases are filed and ongoing cases.

U.S. ATTORNEY'S OFFICE FOR THE EASTERN DISTRICT OF MICHIGAN

The AUSAs in my own district, working with the Strike Force, have handled a wide variety of health care matters, including false billings by doctors and other providers of medical services, overcharges by hospitals, Medicaid fraud, kickbacks to induce referrals of Medicare and Medicaid patients, fraud by pharmaceutical and medical device companies, and failure of care allegations against nursing home owners. The following is a recent example of a case brought by the Eastern District of Michigan Strike Force, which demonstrates the health care fraud efforts in my district:

DOCTOR FARID FATA

Farid Fata, M.D

Doctor Fata was a licensed medical doctor who owned and operated Michigan Hematology Oncology P.C. (MHO) cancer treatment clinic. MHO had seven locations in Eastern Michigan. A former office manager at Fata's clinic noticed that many staff were quitting Fata's practice. One doctor who quit reported to the office manager that Fata was administering chemotherapy to patients who did not need it. This doctor also reported that Fata's patients who were in hospice care were taken out of hospice care and put on chemotherapy treatments.

In 2013, the office manager reported these allegations to the Department. The FBI, HHS-OIG, and the Internal Revenue Service Criminal Investigation Division (IRS-CI) and were brought in as part of the Medicare Fraud Strike Force, under the supervision of the Criminal Division's Fraud Section and the U.S. Attorney's Office of the Eastern District of Michigan, to investigate Dr. Fata. Their investigation, which included examining a large amount of records, showed that from August 2007 to approximately August 2013, Fata prescribed and administered unnecessary aggressive chemotherapy, cancer treatments, and intravenous iron and other infusion therapies to patients. Fata then submitted fraudulent claims to Medicare and other insurers for these unnecessary treatments. To further his scheme, Fata solicited kickbacks from Guardian Angel Hospice and Guardian Angel Home Health Care in exchange for his referral of patients to those facilities. Fata also used the proceeds of the health care fraud at his medical practice, MHO, to promote the carrying on of additional health care fraud at United Diagnostics, where he administered unnecessary and expensive positron emission tomography (PET) scans for which he billed a private insurer.

After conducting their investigation, on August 6, 2013, Fata was charged and arrested with, among other things, health care fraud, conspiracy, and money laundering. At the time of his arrest Fata had the largest private cancer clinic in the state of Michigan. Fata pleaded guilty in September 2014, to 13 counts of health care fraud, one count of conspiracy to pay or receive kickbacks and two counts of money laundering. On July 10, 2015, Fata was sentenced to serve 45 years in prison for his role in his health care fraud scheme that included administering medically unnecessary infusions or injections to 553 individual patients and submitting to Medicare and private insurance companies approximately \$34 million in fraudulent claims.

The Results of Collaborative Efforts

The above example demonstrates that health care fraud, even especially complex health care fraud, can be targeted quickly and successfully. The Strike Force and United States Attorney's Office teams successfully facilitated the coordination of the necessary agents and personnel needed to immediately investigate and stop Fata's dangerous actions.

In addition to the success of the Strike Force Model, AUSAs in my district have also had success in combatting health care fraud. Along the lines of patient harm, the opioid epidemic in our country negatively and tragically impacts so many people's lives. The problem is compounded when trusted medical providers abuse the health care system for their own private gain, such as Dr. Oscar Linares, who my office prosecuted.

Between April 1, 2008 and March of 2011, Linares operated the Monroe Pain Center located in Eastern, Michigan. Investigation by the Drug Enforcement Administration, the FBI, HHS, the Internal Revenue Service, and local law enforcement agencies showed that Linares prescribed millions of dosage units of Schedule II, III and IV narcotics, including opiates such as Oxycontin, oxycodone, and opana to patients. Their investigation showed that Linares prescribed controlled substances for as many as 250 patients per day, and paid bonuses to his employees when the number of patients who were prescribed controlled substances in a single day exceeded 200. Based on undercover patient visits, employee interviews and former patient interviews, it was established that Linares actually saw very few of the patients. Even when he briefly saw a patient, there was no legitimate examination or doctor-patient relationship.

In 2011, Linares was charged with unlawfully distributing prescription drug controlled substances, including the Schedule II prescription drug OxyContin (oxycodone), and health care fraud. Linares pled guilty to these charges on December 29, 2015. Linares admitted to illegally prescribing over 1.2 million dosage units of controlled substances, a conservative estimate. Linares also fraudulently billed Medicare by submitting patients to medical tests without regard to their symptoms or medical conditions. He was sentenced on July 12, 2016 to 57 months in prison followed by three years of supervised release. He was also ordered to forfeit to the United

States approximately \$236,000 seized from bank accounts; jewelry, such as Tiffany, Mont Blanc, Rolex, and Invicta watches; luxury vehicles, including a 2005 Bentley Continental, two Hummers, a 2005 Porsche 911, a 1987 Ferrari Testarossa, a 2007 Lincoln Town Car, and a 2006 Lexus RX400; two boats; Mont Blanc luxury items; and Louis Vuitton luggage and accessories. All of the above items were proceeds from his illegal billing of the Medicare program.

In pronouncing the sentence, United States District Court Judge Victoria Roberts described the case as “a serious breach of the public trust,” and “deliberate drug dealing by a doctor.” She termed Linares’ crimes as a “callous disregard” of his “obligation to do no harm.” Referencing the significant number of medical professionals convicted in similar cases, she stated, “This court cannot tolerate the level of abuse that has been going on by medical professionals.” The same will not be tolerated by the Department.

CONCLUSION

In 1996, HIPAA established a national HCFAC under the joint direction of the Attorney General and the Secretary of HHS. The program was designed to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse. In its twentieth year of operation, strengthened by the new tools and resources provided by the Affordable Care Act, and reaffirmed by the commitment of the HEAT initiative to improve law enforcement coordination, the program’s continued success again confirms the soundness of a collaborative approach to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud or abuse, and to protect program beneficiaries.

AUSAs in the U.S. Attorneys’ Offices, trial attorneys in the Civil, Civil Rights, and Criminal Divisions, the FBI and HHS agents, as well as other federal, state, and local law enforcement partners are working together across the country with unprecedented success. We are poised to continue these successes in the years ahead, and look forward to continuing this important work with our federal, state, and local partners to that end. Thank you for the opportunity to provide this overview of the Department’s health care fraud efforts and successes. I would be happy to respond to any questions you might have.