



# Department of Justice

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STATEMENT

OF

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BEFORE THE

SUBCOMMITTEE ON HEALTH  
COMMITTEE ON ENERGY AND COMMERCE  
U.S. HOUSE OF REPRESENTATIVES

CONCERNING

"MEDICARE PROGRAM EFFICIENCY AND INTEGRITY"

PRESENTED ON

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**Statement of  
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Senior Counsel to the Deputy Attorney General &  
Special Counsel for Health Care Fraud**

**Before the  
Committee on Energy and Commerce  
Subcommittee on Health**

**April 18, 2007**

Mr. Chairman and distinguished members of the subcommittee, I appreciate the opportunity to appear before you to discuss Medicare program integrity. We are grateful for the leadership of your subcommittee on this important topic and to you, Mr. Chairman, for inviting us to discuss the Department of Justice's enforcement efforts.

I have been asked to provide testimony concerning the efforts of the Department of Justice to combat fraud and abuse in the Medicare program. Presently, I advise the Deputy Attorney General on health care fraud enforcement policy. In that capacity, I am responsible for coordinating the efforts of all the components within the Department of Justice that are charged with investigating and enforcing the civil and criminal laws concerning health care fraud. I am also responsible for high-level, inter-agency coordination with my colleagues at the Department of Health and Human Services Office of the Inspector General (HHS-OIG) and at the Centers for Medicare and Medicaid Services (CMS). Finally, I am an Assistant United States Attorney from the Southern District of Florida (SDFL), a district that is extremely engaged in investigating and prosecuting those who take advantage of seniors, endanger the health and lives of seniors, and defraud the Medicare program.

In my written testimony, I will describe the role the Department of Justice plays in Medicare program integrity, including the role of the Criminal and Civil Divisions of the Department of Justice, the Federal Bureau of Investigation, and the 93 U.S. Attorney's Offices across the country. I will address our sources of funding, our cooperative relationship with the Department of Health and Human Services, and our accomplishments. I will conclude by describing some of the particular initiatives we are launching in SDFL to fight fraud.

## **OVER \$11 BILLION IN RECOVERIES RETURNED TO THE MEDICARE AND MEDICAID PROGRAMS SINCE 1997**

The Department of Justice is committed to rooting out and punishing individuals and corporations who commit health care fraud, including providers and practitioners, equipment suppliers, and corporate wrongdoers. The Department of Justice is not alone in the fight to combat fraud and preserve the integrity of the country's health care system. 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 (FDA-OCI), the Federal Employees Health Benefits Program (FEHBP) at the Office of Personnel Management and its Office of Inspector General, and with our State law enforcement partners in their Offices of Attorneys General and Medicaid Fraud Control Units.

Working with our colleagues, since the inception of the Health Care Fraud and Abuse Control (HCFAC) program in 1997, the Department has obtained, according to our preliminary estimates, \$11.87 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, \$10.4 billion has been transferred or deposited back into the Medicare Trust Fund and \$604 million, representing the federal share of Medicaid fraud recoveries, has been transferred to CMS. 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.

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. This program provides the principal source of steady funding for Department of Justice efforts to combat Medicare fraud.

### **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 Health Care Fraud and Abuse Control 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:

- (1) to coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse with respect to health plans;
- (2) to conduct investigations, audits, inspections, and evaluations relating to the delivery of and payment for health care in the United States;
- (3) to facilitate enforcement of all applicable remedies for such fraud;

- (4) to provide guidance to the health care industry regarding fraudulent practices; and
- (5) to 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 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 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.<sup>1</sup> All funds deposited in the Trust Fund as a result of the Act are available for the operations of the Medicare programs funded by the 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 Attorney General jointly certify 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 DOJ 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 DOJ 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 DOJ to appropriate from the Account up to \$104 million collectively, and allowed the Departments to increase that appropriated amount by up to 15% annually until FY 2003. HIPAA also provided \$47 million in dedicated funding for the FBI's health care fraud investigations beginning in 1997 which also increased annually until 2003.

Since FY 2003, the maximum available for HHS and the Department of Justice (DOJ) collectively was fixed by statute at \$240.558 million annually. Of this total, the OIG received the statutory maximum amount of \$160 million annually. The DOJ litigating components and

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<sup>1</sup>Also known as the Hospital Insurance (HI) Trust Fund. All further references to the Medicare Trust Fund refer to the HI Trust Fund.

other (non-OIG) HHS components split the remaining \$80.558 million, which we refer to as the “wedge.” Thus, of the \$240.558 million maximum amount, the DOJ litigating components have received \$49.415 million annually from FY 2003 through FY 2006. Separately, HIPAA appropriated \$114 million annually to the Federal Bureau of Investigation (FBI) over this same time period to support the Bureau’s health care fraud investigative activities.

Section 303 of Division B of the “Tax Relief and Health Care Act of 2006,” signed by President Bush last December, provides for annual inflation adjustments to the maximum amounts available from the HCFAC Account and for the FBI starting in FY 2007 for each year through FY 2010. In FY 2010, a fixed funding level or “cap” is reinstated at the 2010 level. The annual inflationary adjustments in the Tax Relief and Health Care Act of 2006 will help sustain the Department’s current level of criminal and civil health care fraud enforcement activities during the period of 2007-2010. We anticipate, however, that current funding levels alone will be insufficient to address the accumulated numbers of pending cases resulting from the cap on funding since FY 2003, the growth in the Medicare program due largely to the prescription drug benefit program (Part D), and an anticipated increase in referrals associated with the substantial increases in anti-fraud funding to HHS agencies from the Deficit Reduction Act of 2005. The President’s FY 2008 budget includes an additional \$183 million through a discretionary cap adjustment proposal for new program integrity work, predominantly for the Part D and Medicare Advantage programs, of which \$17.5 million is designated for the Department of Justice.

#### **HCFAC PROGRAM ACCOMPLISHMENTS IN FISCAL YEAR 2006**

During Fiscal Year 2006, the Department “won or negotiated” approximately \$2.2 billion in judgments and settlements, and it attained additional administrative impositions in health care fraud cases and proceedings.<sup>2</sup> The Medicare Trust Fund received transfers of nearly \$1.55 billion during this period as a result of these efforts, as well as those of preceding years, in addition to \$117.1 million representing the federal share of Medicaid money similarly transferred to CMS as a result of these efforts.<sup>3</sup>

In criminal enforcement actions during 2006, prosecutors for the Department and U.S. Attorneys' Offices:

- Opened 836 new criminal health care fraud investigations involving 1,448 potential defendants, and had 1,677 criminal health care fraud investigations involving 2,713 potential defendants pending at the end of the fiscal year; and

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<sup>2</sup> Actual collections, transfers, and deposits that ultimately result from health care fraud judgments and settlements may not equal the total “won or negotiated” during FY 2006.

<sup>3</sup> Note that some of the judgments, settlements, and administrative actions that occurred in FY 2005 will result in transfers in future years, just as some of the transfers in FY 2005 are attributable to actions from prior years.

- Filed criminal charges in 355 health care fraud cases involving charges against 579 defendants and obtained 547 convictions for the year.

In civil enforcement actions during 2006, attorneys for the Department and U.S. Attorneys' Offices:

- Opened 698 new civil health care fraud investigations, and had 1,268 civil health care fraud investigations pending at the end of the fiscal year; and
- Filed complaints or intervened in 217 civil health care cases.

Since the inception of the HCFAC program in 1997, the Department's criminal and civil enforcement efforts funded through that program have returned nearly \$11.87 billion total to the federal government, including more than \$10.4 billion transferred to the Medicare Trust Fund and \$604 million representing the federal share of Medicaid fraud recoveries transferred to CMS. We have secured more than 4,500 criminal convictions for health care fraud related offenses, the vast majority involving Medicare fraud.

### **INTER-AGENCY DOJ-HHS COOPERATION**

Because the Department of Health and Human Services administers the Medicare Program and maintains all the payment records and data submitted by providers, successful prosecution of criminal cases and litigation of civil cases requires close cooperation between the Departments. Examples of this close cooperation include the following:

- Under auspices of HCFAC Program, DOJ 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, 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-DOJ conference calls involving CMS Program Integrity and other staff with our USAO 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 include private insurer investigators.
- The OIG shares summarized information about all Medicare contractor referrals for investigation with the FBI and DOJ, and the FBI exchanges copies of its health care fraud case opening memorandums with OIG.

- DOJ participated in the planning and presentation of a Medicaid Fraud training conference sponsored by the Inspector General of the Department of Health and Human Services, and it conducted a nationwide closed circuit training session for federal and state law enforcement officials on the HIPAA privacy rule and other privacy laws and regulations.
- Last year DOJ attorneys and support staff trained CMS regional and central office staff hired to administer the Medicare prescription drug benefit and monitor the prescription drug plans on federal health care fraud statutes and possible fraud schemes which may occur in the Medicare Prescription Drug (Part D) program. Department attorneys and staff also conducted two national training seminars for CMS Medicare Drug Integrity Contractor staff hired to conduct program integrity and anti-fraud work for the Part D program.

### **DEPARTMENT COMPONENTS INVOLVED IN MEDICARE 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 of the Department of Justice

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. The Civil Division also pursues many of these cases as criminal violations of the Food, Drug, and Cosmetic Act.

In FY 2006, the Civil Division opened or filed a total of 239 health care fraud cases or matters. In addition to any new cases that are filed, however, there remain a significant number of matters that the Division continues to move toward resolution. At the end of FY 2005, there remained 680 open cases. Many of these health care fraud cases, typically those involving corporate or institutional providers, involve millions of documents and hundreds of witnesses, require experienced litigation support personnel to amass and organize the evidence, and need knowledgeable consultants to provide their expertise about the fraudulent schemes.

Since the False Claims Act was substantially amended in 1986, the Civil Division, working with United States Attorney's Offices, has recovered \$18.2 billion on behalf of the various victim federal agencies. Of that amount, \$11.5 billion was the result of fraud against federal health care programs - primarily the Medicare program. Cases involving violations of the Food, Drug, and Cosmetic Act, or other types of fraud by pharmaceutical manufacturers in connection with federal health benefit programs, have resulted in total criminal and civil recoveries of over \$5.2 billion since 1999.<sup>4</sup> The Civil Division's Office of Consumer Litigation works with many of the United States Attorney's Office on these prosecutions.

In addition to these accomplishments, the Department's Nursing Home and Elder Justice 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 is pursuing number of cases under the FCA involving providers' egregious "failures of care."

#### United States Attorneys Offices

The 93 United States Attorneys Offices (USAOs) are the nation's principal prosecutors of federal crimes, including health care fraud. The USAOs pursue both civil and criminal cases and dedicate substantial resources to combating health care fraud. Each of the 93 districts has a designated Criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator. HCFAC funding supports about 100 attorney and 81 support positions, and many USAOs supplement the HCFAC program funding they receive by providing for additional attorneys, paralegals, auditors, and investigators, as well as funds for litigation expenses for these resource-intensive cases.

In FY 2006, USAOs received 836 new criminal matters involving 1,448 defendants, and had 1,677 health care fraud criminal matters pending,<sup>5</sup> involving 2,713 defendants. USAOs filed criminal charges in 355 cases involving 579 defendants, and obtained 547 federal health care related convictions. During the last fiscal year, USAOs also opened 698 new civil health care fraud matters and had 1,268 civil health care fraud matters and cases pending.

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

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<sup>4</sup> A portion of this \$5.3 billion is included in the reported False Claims Act recoveries for this same period.

<sup>5</sup> When a USAO accepts a criminal referral for consideration, the office opens it as a matter pending in the district. A referral remains a matter until an indictment or information is filed or it is declined for prosecution.

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. Under the False Claims Act, a *qui tam* plaintiff (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 USAO must then decide whether the case warrants an intervention by the government to litigate the complaint.

The Executive Office for the 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. For instance, in FY 2006, EOUSA and the Civil Division participated in the planning and presentation of a Medicaid Fraud training conference sponsored by the Inspector General of the Department of Health and Human Services, and it joined with both the Civil and Criminal Divisions to conduct a nationwide closed circuit training for federal and state law enforcement officials on the HIPAA privacy rule and other privacy laws and regulations. EOUSA and the Office of Legal Education 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, and, most recently, it sponsored a Health Care Fraud Trial Practice Seminar for over 120 Department lawyers.

#### Criminal Division of the Department of Justice

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, training, and, in certain instances, provides trial attorneys to prosecute criminal health care fraud cases.

In FY 2006, the Fraud Section provided guidance to FBI agents, AUSAs and Criminal Division attorneys on criminal, civil, and administrative tools to combat health care fraud, and worked at an interagency level through the following activities:

- coordinating large scale multi-district health care fraud investigations;
- providing frequent advice and written materials on confidentiality and disclosure issues arising in the course of investigations and legal proceedings regarding patient medical records, including HIPAA health information privacy requirements, compliance with the Substance Abuse Patient Medical Records Privacy Act and regulations, and coordinating referrals from the HHS Office for Civil Rights of possible criminal violations of HIPAA privacy provisions providing training and training materials for AUSAs, investigative agents, support staff, program agency officials, and state and local law enforcement on health care fraud enforcement and medical records privacy issues;

- providing training and training materials for AUSAs, investigative agents, support staff, program agency officials, and state and local law enforcement on health care fraud enforcement and medical records privacy issues;
- monitoring and coordinating Departmental responses to legislative proposals, major regulatory initiatives, and enforcement policy matters related to prevention, deterrence and punishment of health care fraud and abuse;
- reviewing and commenting on health care provider requests to the HHS/OIG for advisory opinions, and consulting with HHS/OIG on draft advisory opinions per HIPAA requirements;
- working with USAOs and CMS to improve Medicare contractors' fraud detection, referrals to law enforcement for investigation, and case development work;
- preparing and distributing to all USAOs and FBI field offices periodic summaries of recent and significant health care fraud cases; and
- organizing, overseeing and participating in interagency working groups formed to address specific cases and initiatives, often in conjunction with the Civil Division and Executive Office for United States Attorneys.

In FY 2006, the Fraud Section handled or was involved in cases and investigations of a defunct health maintenance organization; a financial service holding company that serviced hospitals, nursing facilities, and other health care providers; and of durable medical equipment (DME) suppliers and pharmacies. Along with the USAO for the Northern District of Ohio, Fraud Section attorneys indicted seven individuals in a scheme involving a financial service holding company. Through its subsidiary corporations, the company bought accounts receivable from hospitals, nursing homes and other health care providers and medical concerns, and company executives illegally diverted the money for other unrelated purposes. In another case, Fraud Section attorneys and the USAO from the Eastern District of Louisiana filed a superseding indictment of four corporate executives in a case involving the collapse of Louisiana's third largest HMO and its subsequent takeover and liquidation by the state Department of Insurance.

#### Civil Rights Division of the Department of Justice

The Civil Rights Division vigorously pursues the Department's goals of eliminating abuse and grossly substandard care in publicly-run Medicare (and Medicaid) funded nursing homes and other long-term care facilities. The Division undertakes this work pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA). CRIPA authorizes investigations of conditions of confinement at publicly operated nursing homes and other residential institutions and authorizes the initiation of civil action for injunctive relief from violations of federal rights. In performing this work, the Division often collaborates with United States Attorneys around the country and with the Department of Health and Human Services.

Division staff conducted preliminary reviews of conditions and services at 29 health care facilities in 12 states during Fiscal Year 2006. 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 Division 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 2006, the Division opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 45 health care facilities in 23 states, the District of Columbia, and the Commonwealth of Puerto Rico.

For example, in Fiscal Year 2006, the Division: (1) opened an investigation of a nursing home in South Carolina; (2) made findings that conditions and practices at another nursing home, Fort Bayard Medical Center, in Fort Bayard, New Mexico, violate its residents' federal constitutional and statutory rights; (3) entered a settlement agreement to remedy unlawful conditions at one of the largest public nursing homes in the country, A. Holly Patterson Extended Care Facility, in Uniondale, New York; and (4) monitored the implementation of remedial agreements for four nursing homes: Banks-Jackson-Commerce Medical Center and Nursing Home, in Commerce, Georgia; Nim Henson Geriatric Center, in Jackson, Kentucky; Reginald P. White Nursing Facility, in Meridian, Mississippi; and Mercer County Geriatric Center, in Trenton, New Jersey. More recently, in response to allegations of shocking mistreatment and neglect of elderly veterans, including an apparent homicide, the Division last month opened investigations of two veterans' homes in Tennessee.

The Division's recent findings regarding one nursing home are unfortunately illustrative. The investigation revealed a wide range of dangerously deficient medical and nursing care practices that not only failed to comply with federal regulations or meet professional standards, but were in fact aiding and contributing to the needless suffering and untimely deaths of residents. The Division found numerous situations where residents' last days of life were spent in misery, as they died from the effects of what appeared to be reckless and almost willful disregard to their health and safety. In fact, in virtually every record reviewed of deceased or current residents, the Division discovered life-threatening breakdowns of treatment that were substantial departures from the generally accepted standards in nursing home care. The Division is now negotiating an agreement to remedy these deficiencies.

#### Federal Bureau of Investigation

The FBI is the Department's primary investigative agency involved in the fight against health care fraud. The FBI leverages its resources in both the private and public arenas through investigative partnerships with agencies such as the HHS/OIG, the FDA/OCI, the Drug Enforcement Administration (DEA), the Defense Criminal Investigative Service, the Office of Personnel Management, the Internal Revenue Service, and various state and local agencies. In FY 2006, the FBI was allocated \$114 million in HCFAC funds for health care fraud enforcement. This yearly appropriation was used to support 775 positions (455 Agent, 320 Support) in FY 2006. The number of pending investigations has shown steady increase from 591 cases in 1992 to 2,423 cases through 2006. FBI-led investigations resulted in 535 criminal health care fraud convictions and 588 indictments and informations being filed in FY 2006.

The FBI initiates health care fraud cases from various sources of information. Information can come from such sources as Medicare contractors, private insurance company Special Investigations Units, the National Health Care Anti-Fraud Association, employees of businesses providing medical services (hospitals, doctor's offices, clinics, medical equipment suppliers, nursing homes, etc.), confidential sources or cooperating witnesses with access to information and complaints from public citizens which are often beneficiaries of the health care services.

## FRAUD SCHEMES

To give you a sense of the types of fraud schemes the Department has seen and the enforcement results the Department has achieved, I will outline below some of the significant Medicare fraud cases the Department pursued over the last year. This list is not meant to be exhaustive; it is meant to illustrate some of the fraud schemes we are seeing.

### Hospital Matters

- **Tenet Healthcare Corporation**, the nation's second largest hospital chain, agreed to pay \$920 million to settle allegations of fraud against Medicare and other federally insured health care programs. The settlement included \$806 million to resolve claims that Tenet billed Medicare for excessive "outlier" payments. Federal health insurance programs, including Medicare, typically reimburse hospitals a fixed amount for treating a patient with a specific condition or illness, but will reimburse extraordinary "outlier" costs when they are reasonably incurred. Congress enacted the supplemental outlier payment system to ensure that hospitals possess the incentive to treat inpatients whose care requires unusually high costs. The United States alleged that Tenet artificially inflated its charges to make it appear that many of its patients received extraordinary care when, in fact, the treatment that was given was fairly standard and far less costly. The settlement also included \$49 million to resolve claims that Tenet paid kickbacks to physicians for patient referrals, \$48 million to resolve claims that Tenet billed the government at a higher rate than was justified by the services performed, and \$20 million in pre-settlement interest.

Government-initiated claims accounted for nearly \$770 million of the settlement, with the remaining \$150 million attributable to six *qui tam* suits. The relators who filed those suits will share \$12 million of the settlement amount.

- **St. Barnabas Health Care System**, the largest health care system in New Jersey, paid \$265 million to resolve allegations that nine of its hospitals fraudulently increased charges to elderly patients to obtain enhanced Medicare reimbursement for outlier claims. The United States alleged that between October 1995 and August 2003, Saint Barnabas and nine of its hospitals purposefully inflated charges for inpatient and outpatient care to make these cases appear more costly than they actually were, and thereby obtained outlier payments from Medicare that they were not entitled to receive.

Saint Barnabas entered into a Corporate Integrity Agreement with the HHS-OIG. The Corporate Integrity Agreement contains measures to ensure compliance with Medicare regulations and policies in the future.

- Following a three-week trial, the former owner and chief executive officer of the now defunct **Edgewater Hospital** in Chicago was found liable under the False Claims Act for engaging in an illegal kickback scheme at Edgewater. The court found that the defendant paid physicians for Medicare and Medicaid patient referrals in violation of federal law. The court held that the hospital's cost reports and individual patient claims for patients referred in connection with the scheme were false claims and awarded treble damages and penalties on just over 1,800 claims.
- Two owners of a former San Diego psychiatric hospital were found liable after trial for more than \$15.7 million in damages and penalties for having included false claims in the hospital's cost report submitted to the Medicare program. Those cost reports sought reimbursement from the Medicare program for a variety of false costs, such as amounts for a fictitious lease, reimbursement for unused hospital space, and millions of dollars in costs that were actually attributable to the defendants' business enterprises unrelated to that hospital. The court awarded the United States \$15,688,585 for treble damages and \$31,000 in civil penalties.

### **Pharmaceutical Matters**

- **Schering-Plough Corporation**, together with its subsidiary, Schering Sales Corporation, agreed to pay a total of \$435 million to resolve criminal charges and civil liabilities in connection with illegal sales and marketing programs for its drugs Temodar, used in the treatment of brain tumors and metastasis, and Intron A, used in the treatment of superficial bladder cancer and hepatitis C. The resolution also pertained to Medicaid fraud involving Schering's drugs Claritin RediTabs, a non-sedating antihistamine, and K-Dur, used in the treatment of stomach conditions.

Schering Sales Corporation agreed to plead guilty to charges that it conspired with others to make false statements to the FDA in response to the FDA's inquiry concerning certain illegal promotional activities by the company's sales representatives at a national conference for oncologists. Schering Sales also agreed to plead guilty to charges that it conspired with others to give free Claritin Redi-Tabs to a major health maintenance organization (HMO) to disguise a new lower price being offered to the HMO to obtain its business.

- **Eli Lilly and Company** agreed to plead guilty and to pay \$36 million in connection with its illegal promotion of its pharmaceutical drug Evista. In pleading guilty to a criminal count of violating the Food, Drug, and Cosmetic Act by misbranding its drug Evista, the Indianapolis-based company agreed to pay a \$6 million criminal fine and forfeit to the United States an additional sum of \$6 million. In addition to the criminal plea, Lilly agreed to settle civil Food, Drug, and Cosmetic Act liabilities by entering into a consent

decree of permanent injunction and paying the United States \$24 million in equitable disgorgement.

Evista is approved by the FDA for the prevention and treatment of osteoporosis in postmenopausal women. The government alleged that the first year's sales of Evista in the U.S. were disappointing compared to Lilly's original forecast; the company reduced the forecast of Evista's first year's sales in the U.S. from \$401 million to \$120 million. In order to expand sales of the drug, it was alleged, Lilly sought to broaden the market for Evista by promoting it for off-label uses, such as for the prevention and reduction in risk of breast cancer, and the reduction in the risk of cardiovascular disease. Lilly promoted Evista as effective for reducing the risk of breast cancer, even after Lilly's proposed labeling for this use was specifically rejected by the FDA.

- **Serono**, one of the world's largest biotech manufacturers, paid \$704 million to resolve criminal charges and civil liabilities in connection with several illegal schemes to promote and sell its drug, Serostim, that resulted in the submission of false claims to Medicaid and Medicare. The FDA had granted accelerated approval for Serostim in 1996 to treat AIDS wasting, a condition involving profound involuntary weight loss in AIDS patients, then a leading cause of death in AIDS patients. Following the advent of protease inhibitor drugs, the incidence of AIDS wasting markedly declined, and Serono launched a campaign to redefine AIDS wasting to create a market for Serostim. Serono pled guilty to conspiring with RJI Sciences, a medical device manufacturer, to introduce on the market bioelectrical impedance analysis (BIA) computer software packages for use in measuring body cell mass and diagnosing AIDS wasting. The BIA software devices were adulterated medical devices in that FDA had not approved the devices for these uses. RJI and its owner also pled guilty to their roles in the conspiracy. In addition, Serono pled guilty to conspiring to offer doctors kickbacks in the form of free trips to Cannes, France, to induce them to prescribe Serostim.

### **Physicians**

- An Ohio physician was convicted by a jury of 56 counts of mail, wire, and health care fraud, as well as illegal drug distribution and sentenced to life for operating "pain management" clinics in which he treated all patients with weekly injections and Schedule II and III narcotic drug prescriptions during visits that lasted no more than a few minutes, and then claimed thousands of dollars in insurance reimbursements per visit. He saw upward of 100 patients per day and submitted \$60 million in fraudulent bills to the victim health care benefit programs. The physician was also convicted of health care fraud resulting in death in this case..
- A Tennessee oncologist was sentenced to over 15 years' imprisonment for defrauding Medicare, TennCare, and BlueCross BlueShield at the expense of cancer patients. The defendant mixed diluted versions of chemotherapy medications that were then given to patients, and instructed her nurses to draw up partial doses of one of the medications to administer to patients.

From 1996 through 2003, a physician employed an individual to work at the physician's medical practice in Connecticut. Although the individual was not licensed to practice medicine, he nonetheless treated patients in the physician's medical practice. During this time, he was referred to as "Doctor" by the physician and he wrote prescriptions. The physician then billed insurance companies for services that were rendered by the individual, representing them as services rendered by a physician. They both pled guilty to conspiracy to commit health care fraud. The physician also entered into a civil settlement with the government and paid \$160,000.

### **Hospice Care**

**Odyssey Healthcare, Inc.**, a Dallas, Texas-based hospice provider, agreed to pay the United States \$12.9 million to settle allegations that the company billed the Medicare program for services provided to hospice patients who were not terminally ill and hence were ineligible for the Medicare hospice benefit. Odyssey Healthcare has also entered into a Corporate Integrity Agreement with the HHS-OIG. The Corporate Integrity Agreement addresses the company's practices regarding compliance with applicable Medicare regulations.

**Faith Hospice, Inc.**, settled allegations that it submitted fraudulent claims to Medicare and Medicaid for ineligible hospice. The investigation was initiated when a review of a sample of its medical records showed that more than half of Faith Hospice's patients were ineligible for hospice care. Under the agreement, the owner and Faith Hospice forfeited \$599,165.29 to the United States, one half of the funds seized pursuant to the civil forfeiture action. The case occurred in Alabama.

### **Skilled Nursing Facilities**

**USA Healthcare, Inc.**, (USAH) the owner of several skilled nursing facilities based in Cullman, Alabama, settled allegations of mischarging the Medicare Program by agreeing to pay the United States \$1,217,808.00. The investigation arose out of an audit of cost reports filed by several of USAH's skilled nursing facilities which revealed that the company violated Medicare rules by failing to disclose that certain vendors were related to USAH by common ownership or control and therefore should have been reimbursed by Medicare at a lower rate based on actual costs and without inclusion of profit.

### **Medical Devices**

The owner and operator of **V&A Services**, a medical equipment supply company located in Stone Mountain, Georgia, was convicted by a federal jury of 11 counts of Medicare fraud in a motorized wheelchair fraud scheme. He was sentenced to 2 years and 3 months in federal prison to be followed by 3 years' supervised release. He was ordered to pay restitution of \$164,590 in connection with the scheme. The judge entered an order of forfeiture at sentencing by which the defendant forfeited \$36,416 from a seized bank account and durable medical equipment having a value of approximately \$11,000

- The owner of a power wheelchair store was sentenced to 63 months in prison and ordered to pay over \$4 million in restitution to the Medicare and Medicaid programs after he was convicted by a jury of paying recruiters to take beneficiaries to a medical clinic where a physician would perform medically unnecessary procedures and then sign false Certificates of Medical Necessity (CMN) forms authorizing the beneficiaries to receive motorized wheelchairs. The physician also was sentenced to 11 years and three months in prison for his participation in the scheme for receiving payment for signing the CMNs, and for submitting claims for services that either were not performed properly, or were not performed at all.
- The owner of a power wheelchair store pled guilty in Lynchburg, Virginia to conspiracy to commit health care fraud for his involvement in an intricate scheme involving power wheelchairs and “power chair scooters.” Among the allegations were that items not needed and not ordered by the physician, were simply added after the physician signed the Certificate of Medical Necessity.
- In the Southern District of Texas, the owner of a Houston-based DME company was sentenced to 63 months in prison for his role in a motorized wheelchair scam. His company fraudulently billed Medicare and Medicaid for almost \$5 million and defrauded these health care programs of at least \$1.6 million.

### **SOUTH FLORIDA INITIATIVES**

Because my colleagues at the HHS-OIG plan to discuss at the hearing the results of their investigation of South Florida DME vendors, I will discuss some of the initiatives being taken by the U.S. Attorney’s Office in SDFL in conjunction with the Criminal Fraud Section and the OIG.

In late 2005, through the leadership of U.S. Attorney Alex Acosta, SDFL formed the South Florida Health Care Fraud Initiative to bring together the health care fraud prosecution resources of SDFL prosecutors, HHS-OIG and the FBI agents and Florida Attorney General’s Office attorneys, cross-designated as Special Assistant United States Attorneys. Although still in its early phase, our Health Care Fraud Initiative has begun to pay dividends. Last fiscal year, we filed criminal charges against 111 defendants in 68 health care fraud cases, a 30% increase over the previous year. Our conviction rate was 97%. These cases typically involve at least one, and often several, million dollars in fraud.

Our prosecutors in South Florida are doing more than merely coordinating resources; they are developing and testing new law enforcement methods to add to our health care fraud litigation arsenal. I would like to describe two of these methods. The first concerns the use of civil complaints to freeze or seize money obtained through health care fraud as soon as our evidence will satisfy a civil standard.

“Operation Equity Excise” is an example. Working with HHS-OIG and the FBI, Operation Equity Excise identified clinics and DME companies that engaged in health care fraud. Often, these companies closed abruptly to avoid detection from law enforcement, and in that process abandoning their bank accounts, leaving behind substantial balances. Through this

Operation, federal agents attempted to locate the signatories on the bank accounts. Many of the signatories, who were also typically listed as the president of the company, denied knowledge of the operation of the company and denied having any claim or right to the funds in the accounts. Thirty-four individuals were located; they voluntarily surrendered the funds, resulting in approximately \$10.5 million returned to the United States Treasury. The signatories on twenty-three accounts, with a total balance of over \$30 million, have not been located. SDFL has filed civil health care fraud complaints against those individuals. We intend to provide notice through publication, proceed through default judgment, and return those funds to the Treasury as well. Importantly, our civil actions do not preclude a subsequent criminal prosecution. Where supported by facts, we continue to pursue criminal investigations of these companies. For now, at the very least, by seizing the bank accounts, we can recover some of the fraudulently paid moneys.

A second method is being refined through a recently-implemented short-term, proactive, surge operation that we are undertaking jointly with the Criminal Division, the FBI, HHS-OIG, and local law enforcement in Miami-Dade County. The surge operation uses proactive law enforcement methods adapted from experience fighting illicit drug trafficking along with real-time data review often used to fight credit card fraud. A typical health care fraud prosecution relies heavily on billing records and other historical evidence. In this operation, however, HHS-OIG agents are reviewing real-time billing patterns. In the few weeks of operation, our agents have identified patterns that standing alone reveal medically impossible claims. Our agents are visiting the offices and interviewing providers as the fraud is taking place. Such “caught-in-the-act” cases are often easier to prosecute than ones based solely on historical evidence.

Finally, to augment the cooperation between the prosecutors and agents, we have co-located the prosecutors and investigative agents in a “fusion center.” Modeled after similar arrangements more traditionally used in drug and organized crime prosecutions, we hope that the proximity of the investigators and prosecutors, working closely together, helps foster strong working relationships and a more proactive investigative technique.

In order for the Subcommittee to better understand some of the fraud schemes we are seeing in Miami, I will present the facts of a typical case involving kickbacks and durable medical equipment. On March 22, 2007, Ricardo R. Aguera, a/k/a Pichi, the owner of three Miami durable medical equipment companies, was found guilty on all counts, following a week-long jury trial, of defrauding the Medicare Program of millions of dollars. He was charged with one count of conspiracy and four counts of soliciting and receiving kickbacks. Sentencing is scheduled for June 12, 2007. Four other defendants, Ivan Aguera, Robert Berenguer, Aristides Berenguer, and Carlos Berenguer, entered guilty pleas to all counts in the indictment without plea agreements prior to trial. All five defendants are related and run health care companies that were involved in the fraud scheme.

Previously convicted co-conspirator pharmacy owners, Henry Gonzalez and Alfonso Rodriguez, billed the Medicare program for over \$20 million and reached agreements with DME owners, including the defendants, to kickback half of the money paid by Medicare in exchange for the DME owners bringing patients to the pharmacies. Testimony at trial revealed that the DME owners paid the patients to get access to their Medicare information so that the owners

could buy phony prescriptions from corrupt doctors to provide to the pharmacies. The heart of the conspiracy centered around three Miami pharmacies, Lily's Pharmacy, Unimed Pharmacy and Prestige Pharmacy, that illegally manufactured aerosol medications including albuterol, metaproterenol, and ipatropium bromide. These aerosol drugs are introduced into the lung through a piece of durable medical equipment known as a nebulizer. Medicare pays for such aerosol medication through the Part B program as it is taken through a nebulizer. Knowing this Medicare system rule, the pharmacy owners exploited the program by manufacturing the unnecessary, non-FDA approved medicine through a process known as "compounding." Evidence at trial established that at Lily's pharmacy, one of the men making the medicine was trained to repair air conditioners and was not a licensed pharmacist. The fraud scheme further relied on (1) paid patients who provided their Medicare cards and signed delivery receipts for medicine which the patients did not need and which they ultimately discarded, (2) doctors who signed fraudulent prescriptions which listed non-commercially-available medications, and (3) DME company owners that recruited and paid the patients to take the false prescriptions to the pharmacy owners.

At trial, evidence established that patients were paid \$100 to \$150 per month for the use of their Medicare cards. Pharmacy owners testified that the scheme of using "compounding" was designed from the beginning to defraud Medicare. Unwilling to buy FDA-approved medication to fill those prescriptions, pharmacies "compounded" the aerosol medications by the gallons and then billed Medicare. Patients testified at trial that they did not want the boxes of medicine and the only reason the patients visited the doctor with the DME owner was to receive cash kickbacks.

## **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 program, restoring funds illegally stolen from the Medicare program, 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 prosecute fraud and abuse in the Medicare program and restore the recovered proceeds of fraud to the Medicare trust fund. The HCFAC program pays for itself many times over and helps ensure the safety and availability of medical services to all beneficiaries.