Department of Justice

STATEMENT

OF

TONY WEST
ASSISTANT ATTORNEY GENERAL
CIVIL DIVISION
DEPARTMENT OF JUSTICE

BEFORE THE

COMMITTEE ON APPROPRIATIONS
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
UNITED STATES SENATE

ENTITLED

“Fighting Fraud and Waste in Medicare and Medicaid”

PRESENTED ON

FEBRUARY 15, 2011

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Chairman Harkin, Senator Shelby, and Members of the Committee: I am honored to appear before you today on behalf of the Department of Justice and I appreciate the opportunity to discuss the work of the Civil Division to combat fraud and secure the recovery of monies on behalf of American taxpayers. I also am pleased to be here today with our valued partner in these enforcement efforts, Deputy Administrator Peter Budetti from the Centers for Medicare & Medicaid Services.

The Civil Division represents the United States, its agencies and instrumentalities, Members of Congress, Cabinet officers and other Federal employees. The Division is made up of approximately 1,400 permanent employees, more than 1,000 of whom are attorneys. Each year, Division attorneys handle thousands of cases that collectively involve billions of dollars in claims and recoveries. In my capacity as Assistant Attorney General, I oversee much of the Federal Government's civil litigation across the country, including many of the Justice Department's efforts to protect consumers and recapture billions of taxpayer dollars lost to fraud, such as health care fraud, procurement fraud, and mortgage fraud.

OVERVIEW OF COMBATING FRAUD AND SECURING RECOVERIES ON BEHALF OF AMERICAN TAXPAYERS

The Department takes seriously its obligation to guard the United States Treasury. Over the last year, the Department has made significant strides in protecting taxpayer dollars – as well as the integrity of government programs that depend on those dollars – through aggressive civil enforcement actions aimed at rooting out waste, fraud, and abuse. For FY (FY) 2010, the Civil Division, working with our partners in United States Attorneys' Offices throughout the country, secured $3 billion in civil settlements and judgments in cases involving fraud against the government. Our primary tool in these fraud enforcement matters is the False Claims Act, which requires that wrongdoers repay the government three times the amount of their false or fraudulent claims and also imposes significant penalties. Although the False Claims Act dates back to the Civil War, it has been significantly strengthened in recent years to enhance its whistleblower provisions and to strengthen the government's ability to recover taxpayer dollars. I am glad to say that amounts recovered under the False Claims Act since January 2009 have eclipsed any previous two-year period, with $7 billion in taxpayer dollars returned to the Medicare Trust Fund, the Treasury, and others since 1986, when Congress substantially strengthened the civil False Claims Act, now total nearly $29 billion. These matters have consisted of fraud against a variety of federal agencies and programs. Our most significant recoveries, however, have been those alleging fraud and false claims schemes perpetrated against government health care programs, most notably the Medicare and Medicaid programs. It is this area to which I will devote the remainder of my testimony today.

HEALTH CARE FRAUD RECOVERIES

Fighting fraud committed against public health care programs is a top priority for the Administration. On May 20, 2009, Attorney General Eric Holder and Secretary of the Department of Health and Human Services (HHS) Kathleen Sebelius, announced the creation of a new interagency task force, the Health Care Fraud Prevention and Enforcement Action Team (HEAT), to elevate coordination in these matters to the cabinet level and to optimize criminal and civil enforcement. These efforts not only protect the Medicare Trust Fund for seniors and the Medicaid program for the country's neediest citizens, they also help to maintain the integrity of services and to prevent the costs of fraud from being passed on to patients and taxpayers. The evils of health care fraud are many: it undermines the judgment of health care professionals, deprives people of the treatment that they need, and, in some cases, can put patients' health and safety at risk.

The high-level, inter-agency collaboration made possible by HEAT has led to extraordinary results. Since January 2009, the Civil Division, working with HHS, our partners in U.S. Attorneys' Offices around the country, and our state and federal colleagues, has opened more health care fraud cases, secured larger fines and judgments, and recovered more than $8.5 billion for the taxpayers in healthcare fraud cases – more than in any other two-year period. That total includes more than $5.54 billion in taxpayer funds recovered from health care providers and others in the industry under the False Claims Act -- another two-year record. In FY 2010, the Department secured $2.5 billion in civil health care fraud recoveries – the largest single-year recovery in the Department's history.

Violations of the Food, Drug and Cosmetic Act (FDCA) are pursued by the Civil Division's Office of Consumer Protection Litigation (OCPL), which is authorized to bring both

civil and criminal actions for violations of that statute. Together with our partners in the United States Attorneys' Offices around the country, OCPL pursues the unlawful marketing of drugs and devices, fraud on the Food and Drug Administration, and the distribution of adulterated products, among other violations. Since January of 2009, the Department has secured more than $3.3 billion in fines, forfeitures, restitution, and disgorgement under the FDCA and we have convicted 28 defendants in criminal cases. In FY 2010, our efforts yielded more than $1.8 billion in criminal fines, forfeitures, restitution, and disgorgement -- the largest health care-related amount under the FDCA in a single year in the Department's history.

A significant component of the Department's health care fraud caseload consists of cases that allege misconduct by manufacturers of pharmaceutical and device products. For example, in December of last year, we announced settlements totaling more than $700 million with multiple pharmaceutical manufacturers resolving allegations that they had engaged in a scheme to report false and inflated prices for many of their pharmaceutical products, knowing that federal health care programs such as Medicare and Medicaid relied on those reported prices to set payment rates. In April of last year, we obtained a $520 million settlement with AstraZeneca LP and AstraZeneca Pharmaceuticals LP to resolve allegations that the marketing of the anti-psychotic drug Seroquel for uses that were not "medically accepted indications" and therefore, not covered by Medicare and State Medicaid programs which caused false claims to be submitted to federal health care programs. In 2009, the Department announced the largest health care fraud settlement in its history in a case that arose from Pfizer's illegal promotion of several pharmaceutical products. Pfizer pled guilty to misbranding the painkiller Bextra in violation of the FDCA and agreed to pay $2.3 billion in fines and civil recoveries. Last October, a subsidiary of GlaxoSmithKline pled guilty to violating the FDCA and the company paid fines and civil

recoveries totaling $750 million to resolve allegations that it manufactured and distributed certain adulterated drugs made at its now-closed plant in Cidra, Puerto Rico.

Health care fraud that affects the health, safety, and well-being of Medicare and Medicaid beneficiaries is of paramount concern to the Department. In January 2010, the Department negotiated a $24 million settlement to resolve allegations that a national chain of Small Smiles dental clinics was providing unnecessary dental services to children on Medicaid in order to maximize the company's Medicaid reimbursements. The services included unnecessary tooth extractions that resulted in healthy teeth being pulled and needless crowns and excessive root canals for baby teeth.

The Department also leads an Elder Justice and Nursing Home Working Group, which focuses on health care fraud involving elderly patients, such as when a skilled nursing facility bills Medicare or Medicaid for grossly deficient services. Such conduct not only wastes taxpayer dollars, but also threatens the health of some of our most vulnerable citizens. Last year, the Department announced criminal pleas and civil recoveries arising from our investigation of five nursing homes operated by Cathedral Rock, a Texas corporation, and its CEO. Our investigation found that these homes were staffed inadequately, that residents often did not receive their medications as prescribed, and that medical records were falsified to appear that the medications were given properly. The resolution of this case required that the homes institute a rigorous compliance program to ensure that this conduct is not repeated. Earlier this year, I personally launched a training program that involved over 50 attorneys and investigators intended to hone their skills in this difficult enforcement area. This training is part of our emphasis in ensuring that our most vulnerable citizens receive the care for which Medicare and Medicaid pay.

Finally, I should note that most of the cases resulting in recoveries were brought to the government by whistleblowers under the False Claims Act. In 1986, Congress amended the False Claims Act to revise the statute's *qui tam* (or whistleblower) provisions, which encourage whistleblowers to come forward with allegations of fraud. The changes enacted in 1986 made the record-setting recoveries of last year possible, and they also resulted in an increase of the number of *qui tam* complaints filed with the Department from a total of 30 in FY 1987 to 574 in FY 2010 – an increase of more than 1,800%. Indeed, just last year there was an increase in *qui tam* filings from the previous year of more than 32% -- from a total of 443 *qui tam* actions filed in FY 2009 to 574 filed in FY 2010. In the last three years, the number of these filings greatly contributed to our current caseload of pending matters. The False Claims Act requires the Attorney General to diligently investigate each one of these *qui tam* matters when they are filed and to obtain the court's consent to extensions of time to do so. We are now confronted with increasingly complex allegations that often implicate multiple defendants, and investigating these allegations in a limited timeframe is extremely challenging. This requires that we dedicate more resources to fully and effectively investigate our growing caseload.

In order to properly investigate these matters and prevail in any ensuing litigation, the Government is forced to expend considerable sums. A typical fraud case requires that we review massive amounts of documentation, interview countless witnesses, hire consultants to assist us in areas where we may lack in-house expertise, and engage experts who can testify for the government if the matter proceeds to trial. We must also develop databases to organize the documents and assist us in analyzing them. The Government's continuing obligation to preserve documents necessary for fraud litigation often requires agencies, most notably HHS in health care investigations, to incur additional expenses as they suspend routine document preservation

policies. Agencies such as HHS incur costs to provide their personnel as witnesses for depositions or trial and to produce reams upon reams of material requested by the other side during discovery. Once we have completed our investigation and allege fraud in a lawsuit, well-funded defendants are often able to mount a costly defense that includes teams of lawyers far in excess of the number we are able to devote to any particular case. They also are able to engage sophisticated (and costly) expertise to bolster their defenses, including state-of-the-art technology to manage and present extensive evidence. While we cannot match those costs dollar-for-dollar, and indeed often spend only a fraction of the amount our defense counterparts spend, we nevertheless have an obligation to pursue these matters with sufficient resources that permit us to maximize the potential for a recovery on behalf of the taxpayer.

FY 2010 HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM REPORT

Thus far, I have spoken of the efforts of the Civil Division and our partners in the United States Attorney community. However, HEAT has drawn together various other components of the Department of Justice, such as the Criminal Division, U.S. Attorneys' Offices, the Federal Bureau of Investigation, and those of the Department of Health and Human Services to produce record-breaking results. The Medicare Fraud Strike Force (Strike Force) – launched in 2007 and part of HEAT – is a recent example of the collaborative efforts now used to further combat health care fraud. The Strike Force is now operating in seven locations across the country and has successfully indicted hundreds of individuals and obtained substantial prison terms. In FY 2010 alone, the Strike Force filed 140 indictments involving charges against 284 defendants who collectively billed the Medicare program more than $590 million.

For example, in one of the largest Medicare Strike Force cases ever brought, Assistant Attorney General Lanny Breuer and I announced the unsealing of parallel criminal and civil enforcement actions against two Miami health care companies, American Therapeutic Corporation (ATC) and Medlink Professional Management Group, Inc., as well as ATC's owner and other senior executives in October 2010. The ATC prosecution, which alleges a $200 million fraud scheme against Medicare for purported mental health services, is the first Strike Force case that indicted a corporation and reflects the important coordination that is occurring between the Department's Criminal and Civil Divisions to hold fraudsters accountable who are stealing taxpayer dollars.

Last month, the Departments of Justice and Health and Human Services issued their annual Health Care Fraud and Abuse Control Program Report – the HCFAC Report – for FY 2010. The Report reflected historic accomplishments in FY 2010, including the fact that our collective efforts returned over $4 billion in health care fraud resources to the Medicare Trust Fund, victim programs, and others. This amount, consisting not only of our civil recoveries under the False Claims Act, but also criminal fines, civil monetary penalties and administrative recoveries, was the largest in the history of our collective efforts and was made possible in large part by funding provided by Congress through the Health Care Fraud Abuse and Control (HCFAC) program. In addition to the monetary results mentioned above, the report also noted that the Department of Justice opened 1,116 new criminal health care fraud cases involving 2,095 potential defendants. The Department filed criminal charges in 488 cases involving 931 defendants, and a total of 726 defendants were convicted for health care fraud-related crimes during the year. This represents the highest number of defendants charged and convicted in a single year in the history of the HCFAC program.

In 1996, Congress required the establishment of the HCFAC program under the joint direction of the Attorney General and the Department of Health and Human Services, acting through HHS's Inspector General, to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. Since its inception, the funds expended by HCFAC to provide oversight of the nation's health care expenditures have been dwarfed by the amounts returned to the Medicare Trust Fund as a result of those oversight efforts – more than $18.0 billion from 1997 through the end of FY 2010. Historically, the average Return on Investment (ROI) for the HCFAC program has been 4.90:1. That is, for every $1.00 spent by HCFAC to fund enforcement efforts, $4.90 is collected. In FY 2010, the three-year average ROI was $6.80 collected for every $1.00 expended – an increase of almost $2.00 over the historical average. Results such as these show the cost effectiveness of the HCFAC program and highlight the importance of additional investigative and prosecutorial resources. Of course, we also cannot lose sight of the fact that these efforts not only return money to the various health care programs, they also provide an effective and incalculable deterrence to those who would otherwise cheat the Nation's most vulnerable citizens, such as our elders and our disabled, who rely on these programs for their vital healthcare. HCFAC has been a resounding success in both regards and it is crucial to our continued success that we not only maintain our HCFAC resources, but that they grow to keep pace with increased government health expenditures and the growing caseload of *qui tam* matters.

As we move forward with the tough choices necessary to rein in our deficit and put the country on a sustainable fiscal path, we must balance those efforts with the investments and actions necessary to provide adequate oversight of such investments to ensure they are properly used for their intended purposes. The HCFAC program is one such investment that pays for

itself many times over. With the discretionary resources sought in the President's FY 2012 budget request, we can hire additional criminal prosecutors, civil attorneys, agents and professional support personnel who will help identify and seek redress for future fraud schemes. These funds also enable us to adequately support our investigations and litigation with the expertise and automated litigation support necessary to bring these actions to a resolution most beneficial to the taxpayers.

HEALTH CARE FRAUD RESOURCES

In FY 2012, the Department of Justice is requesting a total of $283.4 million in reimbursable funding to combat health care fraud. These funds are provided directly to both the Department of Justice and the Federal Bureau of Investigation, and represent an increase of $63.40 million over the FY 2011 Continuing Resolution level. Historically, the Department and the FBI received only mandatory reimbursable funding from the HHS. However, beginning in FY 2009, the Department of Justice began receiving discretionary reimbursable resources, and it is these funds which have allowed the Department to expand its workforce of attorneys, agents, and professional support staff to address health care fraud. As I have indicated, these funds are used to address the myriad of health care fraud schemes that afflict the Medicare and Medicaid programs, the Federal Employees Health Benefits Programs and other federally-funded health care plans and programs.

STRONGER TOOLS FACILITATED RECORD RECOVERIES

The enactment of the Fraud Enforcement and Recovery Act of 2009 (FERA) made additional improvements to the False Claims Act and other fraud statutes. Among other important changes, FERA authorized the delegation of the Attorney General's authority to issue

civil investigative demands (CIDs), which has substantially increased the use of this critical investigative tool in health care and other fraud matters.

FERA also has clarified and added important liability provisions to the False Claims Act. The statute now makes clear that it is a violation for a defendant knowingly to retain an overpayment, which is particularly important in the healthcare context. The Affordable Care Act adds a new section to the Social Security Act that addresses what constitutes such an overpayment under the FCA in the context of federal healthcare program and requires the reporting and returning of overpayments to Federal and state governments. Combined, these provisions enable the Government to more effectively pursue those who obtained money from Medicare and other federal healthcare programs to which they are not entitled.

I already have mentioned the *qui tam* provisions of the False Claims Act. Of the $3 billion in total False Claims Act settlements and judgments obtained in FY 2010, over $2.4 billion was recovered in lawsuits filed under the Act's *qui tam* provisions. Under these provisions, whistleblowers (known as "relators") – many of whom face considerable personal risk in coming forward with allegations of fraud – are entitled to recover between 15 and 30 percent of the proceeds of a successful suit. In FY 2010, relators were awarded $386 million. Since 1986, when the *qui tam* provisions were strengthened by Congress, recoveries in *qui tam* cases have exceeded $19.7 billion, and relators have obtained more than $3.2 billion in awards.

The enactment of the Affordable Care Act, which included the additional HCFAC resources to which I previously referred, also provided the Civil Division with additional tools to combat fraud. Among many other changes, the Affordable Care Act amended the False Claims Act's public disclosure provision and strengthened the provisions of the federal health care Anti-Kickback Statute. On a much broader scope, and as Dr. Budetti will testify in greater detail, the

Affordable Care Act also provided for enhanced provider screening and enrollment requirements, increased data sharing across government, expanded overpayment recovery efforts, and greater oversight of private insurance abuses. All of these tools are now in use in our efforts to combat health care fraud, and they will go a long way in facilitating our continued success.

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On behalf of the Department, let me again express my thanks for allowing me to highlight the Department's efforts in this important area. On behalf of the Attorney General, we welcome the opportunity to continue to work with you and your staffs as we find ways to more effectively safeguard government health care resources and, in so doing, protect taxpayers and consumers.