Department of Justice

STATEMENT

OF

PETER F. NERONHA
UNITED STATES ATTORNEY
DISTRICT OF RHODE ISLAND

BEFORE THE

SUBCOMMITTEE ON CRIME AND TERRORISM
COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ENTITLED

"EFFORTS TO PREVENT, INVESTIGATE, AND PROSECUTE MEDICARE AND MEDICAID FRAUD"

PRESENTED ON

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Statement of
Peter F. Neronha
United States Attorney
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INTRODUCTION

Chairman Whitehouse, 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, along with my colleague Ted Doolittle, Deputy Director for Policy the Center for Program Integrity within the Centers for Medicare & Medicaid Services, and Peter F. Kilmartin, the Attorney General for the state of Rhode Island. The Department is grateful to the Subcommittee for its leadership in this area, and we appreciate the opportunity to appear before you here today.

Health care fraud is a serious law enforcement problem facing our country today. It threatens the long term 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, and while most medical providers and health care companies are doing the right thing, there are some health care providers, as well as criminals, that target Medicare and other

government and private health care programs for their own financial benefit. This fraud has the potential to corrupt the medical decisions made by these few health care providers, placing patients at risk of harm from unnecessary or unapproved treatments. With the rising cost of medical care, every dollar stolen from our health care programs is one dollar too many. For these reasons, fighting health care fraud is a priority of the Department of Justice. Together with our colleagues at the Department of Health and Human Services ("HHS"), we are fighting back. With HHS' assistance, we investigate, prosecute, and secure prison sentences for hundreds of defendants every year, and we are recovering billions of dollars in stolen funds. With the additional resources provided to us by Congress over the past 3 years, we are making significant strides in this battle. Through its United States Attorneys' Offices, Civil and Criminal Divisions, Civil Rights Division, and the Federal Bureau of Investigation ("FBI") – the entities responsible for enforcing laws against all forms of health care fraud – the Department has significantly enhanced its efforts to protect the public from health care fraud and to help ensure the integrity of patient care.

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

Because coordination across agencies is an integral part of preventing and prosecuting health care fraud, Attorney General Holder and Secretary Sebelius together have pledged to strengthen our fight against waste, fraud and abuse in Medicare and Medicaid. As you know, to improve that coordination, in May 2009, they announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a senior level, joint task force, designed to marshal the combined resources of both agencies in new ways to combat all facets of the health care fraud problem. With the creation of HEAT, we re-committed to making the fight against health care fraud a Cabinet- level priority for both DOJ and HHS. By joining forces to

coordinate federal, state and local law enforcement activities to fight health care fraud, our efforts have seen unprecedented success. In FY 2011, the government's health care fraud and prevention efforts recovered nearly $4.1 billion in taxpayer dollars stolen from federal health care programs, and returned these funds to the Medicare Trust Funds, the U.S. Treasury, other federal agencies, and individuals. This is the highest annual amount ever recovered from doctors and companies who attempted to defraud seniors and taxpayers or who sought payments to which they were not entitled.

The Justice Department has a multi-faceted litigation approach to fighting health care fraud, with the U.S. Attorneys' Offices, the FBI, the Criminal Division, the Civil Rights Division, and the Civil Division all contributing substantial resources to the effort. Additionally, as you know, the 93 United States Attorneys and their assistants, or AUSAs, are the principal prosecutors of federal crimes, including health care fraud, representing the Department of Justice and the interests of the American taxpayer in both criminal and civil cases in the federal courts in the 94 judicial districts across the country.

FEDERAL BUREAU OF INVESTIGATION

The Justice Department's primary investigative and enforcement arm in the area of health care fraud is the FBI. Working closely with U.S. Attorneys' Offices across the country and DOJ litigating components, the FBI serves to identify, investigate, and aid in the prosecution of health care fraud. With its large presence and extensive investigative authority, the FBI is uniquely positioned to investigate a broad spectrum of health care fraud activity. First, by leveraging its 798 FBI personnel dedicated to health care fraud investigations, the FBI is able to aggressively address fraud not only in Strike Force locations, but also in any of the 56 FBI field offices nationwide. Second, the FBI is the primary investigative agency involved in the fight against

health care fraud that has jurisdiction over both the federal and private health care programs. The FBI not only collaborates with HHS-OIG investigative personnel and other government agencies, but has built established partnerships with Special Investigative Units from many of the country's major private insurance companies. Third, the FBI leverages its intelligence across its multiple investigative programs to identify and attack criminal enterprises that are turning to health care fraud as a mechanism to fund additional activity. Some recent successes involving the FBI include:

- In November 2011, American pharmaceutical company Merck, Sharp & Dohme agreed to pay $950 million to resolve criminal charges and civil claims related to its promotion and marketing of the painkiller Vioxx® (rofecoxib).
- In September 2011, the Medicare Fraud Strike Force – a partnership between the Department of Justice and the Department of Health and Human Services – charged more than 91 defendants in eight cities, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving more than $295 million in false billing.
- Also in September 2011, Lawrence Duran and Marianella Valera, the owners of a mental health care company, American Therapeutic Corporation (ATC), were sentenced to 50 and 35 years in prison, respectively, for orchestrating a $205 million Medicare fraud scheme.

The FBI is a key component of the Justice Department's efforts to combat health care fraud and is a vital piece in the increasing return on investment to the Medicare Trust Funds and the Treasury.

U.S. ATTORNEYS' OFFICES' WORK WITH THE CIVIL DIVISION

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 recover funds stolen in health care fraud schemes, often through the use of the False Claims Act, ("FCA") 31 U.S.C. §§ 3729-3733, one of the Department's most powerful civil tools. Through its Consumer Protection Branch, ("CPB"), the Civil Division also invokes the Food, Drug and Cosmetic Act ("FDCA"), which authorizes both civil and criminal actions. CPB pursues the unlawful marketing of drugs and medical devices, fraud on the Food & Drug Administration, and the distribution of adulterated products, among other violations. In FY 2011, CPB, working together with the U.S. Attorneys' Offices around the country, pursued cases under the FDCA that resulted in more than $1.5 billion in fines, forfeitures, restitution and disgorgement.

Since 2000, the U.S. Attorneys' Offices, working with our colleagues in the Civil Division, as well as with the FBI, HHS-Office of Inspector General ("OIG"), and Centers for Medicare & Medicaid Services (CMS), and other federal, state and local law enforcement agencies, have recovered over $1 billion nearly every year on behalf of defrauded federal health care programs. CMS has actively collaborated with DOJ and the OIG by providing improved access to Medicare data to help identify criminals and fight fraud while protecting patient privacy. CMS and the OIG have partnered to train more than 600 law enforcement agents in Medicare data analysis using CMS systems. In FY 2011, the Department secured approximately $2.4 billion in civil health care fraud recoveries. This marks two years in a row that more than $2 billion has been recovered in FCA health care matters, and since January 2009, the Department has used the FCA to recover more than $6.7 billion in federal health care dollars.

U.S. ATTORNEYS' OFFICES' WORK WITH THE CRIMINAL DIVISION

Working with our colleagues in the Criminal Division, the U.S. Attorneys' Offices' criminal health care fraud efforts have also been a tremendous success. Since 2009, the Departments of Justice and HHS have enhanced their coordination through HEAT, steadily increasing the number of Medicare Fraud Strike Force ("MFSF") teams, which supplement the Department's criminal health care fraud enforcement efforts. In FY 2011, the total number of cities with strike force prosecution teams was increased to nine, all of which have teams of investigators and prosecutors from the Justice Department, the FBI, HHS-OIG, and our state and local partners, dedicated to fighting fraud. Each United States Attorney's Office in the strike force cities has allocated several AUSAs and support personnel to this important initiative. The MFSFs use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes along with chronic fraud by criminals masquerading as health care providers or suppliers. This model is working. The strike forces have been an unqualified success.

Today, our criminal enforcement efforts are at an all time high. In FY 2011, strike force operations charged a record number of 323 defendants, who allegedly collectively billed the Medicare program more than $1 billion. Strike force teams secured 172 guilty pleas, convicted 26 defendants at trial and sentenced 175 defendants to prison. The average prison sentence in strike force cases in FY 2011 was more than 47 months. Including strike force matters, federal prosecutors filed criminal charges against a total of 1,430 defendants for health care fraud related crimes. This is the highest number of health care fraud defendants charged in a single year in the Department's history. Including strike force matters, a total of 743 defendants were convicted for health care fraud-related crimes during the year.

Typical strike force cases 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 identification information to providers so that those providers could submit false Medicare claims using the beneficiary identification information. Just last month, the Departments announced the arrest of a Dallas physician and the office manager of his medical practice, along with five owners of home health agencies, on charges related to their alleged participation in a nearly $375 million health care fraud scheme involving fraudulent claims for home health services. The conduct charged in this indictment represents the single largest fraud amount orchestrated by one doctor in the history of HEAT and the MFSF operations. In addition to the indictment, the Centers for Medicare & Medicaid Services ("CMS") announced the suspension of payments to 78 home health agencies ("HHA") associated with the physician, based on credible allegations of fraud against them. This enforcement action was made possible by the historic partnerships we've built to combat health care fraud, and sends a clear message that the government is serious about prosecuting health care fraud to the fullest extent of the law.

During FY 2011, HEAT and the MFSFs also helped educate Medicare beneficiaries about how to protect themselves against fraud. The Departments hosted a series of regional fraud prevention summits around the country, provided free compliance training for providers and other stakeholders and sent letters to state attorneys general urging them to work with HHS and federal, state and local law enforcement officials to mount a substantial outreach campaign to educate seniors and other Medicare beneficiaries about how to prevent scams and fraud.

U.S. ATTORNEYS' OFFICES' WORK WITH THE CIVIL RIGHTS DIVISION

The U.S. Attorney's Offices also work collaboratively with the Civil Rights Division to support their litigation activities related to health care fraud and abuse. The Civil Rights Division vigorously pursues the Department's goals of eliminating abuse and substandard care in public, residential health care facilities. The Civil Rights Division undertakes this work pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 (CRIPA.) CRIPA authorizes the investigation of conditions of confinement at state and local residential institutions, including facilities for persons with developmental disabilities or mental illness, and nursing homes. CRIPA also authorizes the Department to seek injunctive relief to remedy a pattern or practice of violations of the Constitution or Federal statutory rights. The Civil Rights Division also has established an initiative to eliminate abuse and grossly substandard care in public, Medicare and Medicaid funded nursing homes and other long-term care facilities.

Civil Rights Division staff conducted preliminary reviews of conditions and services at 16 health care facilities in 13 states during Fiscal Year 2011. 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 Civil Rights 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 2011, the Civil Rights Division opened or continued formal investigations, entered remedial agreements, or monitored existing remedial agreements regarding 79 health care facilities in 25 states, the District of Columbia, the Territory of Guam, and the Commonwealth of Puerto Rico.

For example, in Fiscal Year 2011, the Civil Rights Division: commenced investigations of 12 Mississippi facilities for persons with intellectual and developmental disabilities and/or mental illness, including the Boswell Regional Center, in Magee, Mississippi, and the Ellisville State School, in Ellisville, Mississippi; found that conditions and practices at the Delaware Psychiatric Center, in New Castle, Delaware, violated its residents' federal constitutional and statutory rights; entered settlement agreements to resolve its investigations of eight Georgia state-operated facilities for persons with mental illness, and of the William F. Green Veterans Nursing Home, in Bay Minette, Alabama; and monitored the implementation of remedial agreements for 20 facilities for persons with intellectual and developmental disabilities ,including the Clover Bottom Developmental Center, in Nashville, Tennessee, the Woodbridge Developmental Center, in Woodbridge, New Jersey, and the Lubbock State Developmental Center, in Lubbock, Texas.

U.S. ATTORNEY'S OFFICE FOR THE DISTRICT OF RHODE ISLAND

The attorneys in my own district, the District of Rhode Island, 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 are recent examples of the district's health care fraud efforts:

Rhode Island Hospital

In February 2011, Rhode Island Hospital agreed to reimburse federal health care programs approximately $2.6 million dollars and will pay the federal government approximately $2.7 million in double and triple damages for ordering medically unnecessary overnight patient

hospital stays and then submitting claims for payment to federally funded Medicare and Medicaid programs. An investigation by the United States Attorney's Office for the District of Rhode Island; Office of Inspector General of the U.S Department of Health and Human Services (OIG-HHS); and the Federal Bureau of Investigation determined that during the period from January 1, 2004, through December 31, 2009, medically unnecessary overnight hospital admissions were ordered for approximately 260 patients who underwent stereotactic radiosurgery, otherwise known as Gamma Knife treatment. The investigation also revealed that Rhode Island Hospital's claims for reimbursement for the overnight admissions to Medicare and Medicaid falsely represented that the admissions were medically necessary when, in fact, they were not.

Planned Eldercare

In February 2012, the owner of Planned Eldercare, a nationwide supplier of durable medical equipment was sentenced to 37 months in federal prison for defrauding the Medicare program of more than $2.2 million. The defendant pled guilty to two counts of health care fraud, and one count each of money laundering and the introduction of an adulterated and misbranded medical device into interstate commerce. The defendant admitted to targeting arthritic and/or diabetic Medicare beneficiaries through telemarketing, then ensuring that his company ordered and shipped medical equipment and supplies to the beneficiaries contacted that they did not order and/or were not medically necessary. The Court also ordered the payment of restitution in the amount of $2,210,152 to the Medicare Program.

At the time of his guilty plea, the defendant admitted to the Court that from 2005 through early 2009, he instructed Planned Eldercare employees, upon successfully reaching individuals as a result of unsolicited telemarketing calls, to inquire if they suffered from diabetes or arthritis.

Once call recipients identified themselves as suffering from either ailment, as an inducement for recipients to provide their Medicare and physician information, employees were instructed to inform recipients that Planned Eldercare could provide them with products to help with their ailments "at no cost to you." Once employees obtained Medicare beneficiaries' agreement to receive certain products, the defendant instructed employees to order as many products as possible, whether or not the beneficiaries requested them or had a medical need for the equipment. Medicare was billed for thousands of products that beneficiaries did not order.

Med Care Ambulance LLC

In November 2011, the owner and president of a Warwick, R.I. ambulance company was sentenced to 24 months in federal prison, three years supervised release and 1,000 hours of community service for defrauding health care programs administered by Medicare and Blue Cross Blue Shield of Rhode Island of more than $700,000. The owner and president of Med Care Ambulance LLC, was also ordered by the Court to make full restitution in the amount of $625,825.31 to the Medicare Program and $78,292.25 to Blue Cross Blue Shield.

The defendant pleaded guilty in June 2011 to two counts of health care fraud, and one count each of obstruction of a federal audit and making false statements. At the time of his guilty plea, he admitted to the Court that beginning in March 2008 and continuing until December 2010, he obtained payments in excess of $700,000 from Medicare and Blue Cross Blue Shield, by improperly submitting claims for reimbursement that falsely and fraudulently represented that Med Care had provided medically necessary Specialty Care ambulance transportation.

The defendant admitted that he routinely solicited Medicare beneficiaries to be transported on a routine basis to renal care facilities for dialysis treatments, the majority of which was routine in nature and did not require advanced or specialty care. He also admitted that he

actively solicited Medicare beneficiaries to agree to be transported for dialysis treatments by waiving the co-payment that the beneficiary would be liable for once Medicare or Blue Cross determined the amount that they would pay for services. By waiving co-payments, Med Care removed the monetary obstacle a patient might have had, and thus would agree to be transported by Med Care.

CONCLUSION

In 1996, the Health Insurance Portability and Accountability Act ("HIPAA") established a national Health Care Fraud and Abuse Control Program ("HCFAC") under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services ("HHS"). The program was designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. In its fifteenth year of operation, and reaffirmed by the commitment of the HEAT initiative to improve that 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 and Criminal Divisions, the Civil Rights Division, FBI and HHS-OIG agents, as well as other federal, state and local law enforcement partners are working together across the country with unprecedented success. Since the HCFAC Program was established, working together, the two Departments have returned over $20.6 billion to the Medicare Trust Funds and the Federal Treasury. 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.

Thanks you for the opportunity to provide this overview of the Department's health care fraud efforts and successes.