STATEMENT OF STUART E. SCHIFFER
ACTING ASSISTANT ATTORNEY GENERAL
CIVIL DIVISION
U.S. DEPARTMENT OF JUSTICE

Mr. Chairman, I appreciate the opportunity to appear before you to discuss some of the important issues which are the focus of today's hearing. We are grateful for this Committee's leadership on the important topic of fraud and abuse and its impact on our elder citizens and government health care programs. I also would like to thank this Committee's former Chairman, Senator Grassley, for his continuing work on the False Claims Act and for promoting quality health care for older Americans.

At its core, fraud and abuse of the Medicare program is an aging issue. When the Medicare trust fund is illegally depleted, its beneficiaries - today's and tomorrow's Americans over 65 - lose. Similarly, Medicaid fraud and abuse harms our frailest and most impoverished older citizens. Those who defraud programs intended to benefit older Americans steal from all those who contribute to and rely on those programs.

Health care fraud remains a serious problem that has an impact on all health care payers, and affects every person in this country. Health care fraud cheats taxpayers out of billions of dollars every year. But it does not only harm beneficiaries. It also harms the majority of honest providers by decreasing the potential pool of funds as demand grows, necessitating increased scrutiny, and giving the industry generally a black eye. Tax dollars alone do not show the full impact of health care fraud on the American people. Beneficiaries must pay the price for health care fraud in their copayments and contributions. Fraudulent billing also may disguise or lead to inadequate or improper treatment for patients, posing a threat to the health and safety of countless Americans, particularly the most vulnerable. The funds that we recoup through our efforts to combat fraud and abuse of the healthcare programs then can be used properly - to fund the requisite care for those who need it.

Thus, given the burgeoning demand on our healthcare programs caused by the aging of our population, stopping those who prey on the health care system and the losses they cause remains one of the Department's top law enforcement priorities. The types of schemes uncovered by the Department, in conjunction with the Department of Health and Human Services, the US Postal Service, the Defense Criminal Investigative Services, the Defense Department's TRICARE program, and other entities range from physicians billing the government for services never rendered, to corporate entities engaging in complex and sophisticated fraud in submitting claims to the Medicare system. Other examples of fraudulent schemes include: health care providers who exaggerate the level of care they provide to their patients or bill for services not provided; medical supply companies that falsify records to obtain payment for supplies that are not medically necessary; nursing homes that bill for nonexistent or grossly substandard care leading to harm or death of residents; and providers of home health services that employ unqualified and untrained personnel to render medical care.

As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Department is involved in a number of activities aimed at coordinating our health care fraud enforcement efforts with other investigative agencies and the health care program agencies, such as the Centers for Medicare and Medicaid Services (CMS). These activities involve both exchange of information and consultation on the development of legislation, rules and policies. They concern prevention of health care fraud, as well as the detection, investigation, and use of legal tools to remedy health care fraud. Department attorneys who specialize in various health care related areas often are asked to speak to outside groups about the Department's activities in those areas. Similarly, the Department participates with other federal and state agencies, such as the Office of Inspector General, Department of Health and Human Services (OIG), CMS, the Department of Defense's TRICARE

program, the National Association of Medicaid Fraud Control Units, and the National Association of Attorneys General on numerous committees and Task forces, such as the Executive Level Healthcare Working Group chaired by the Deputy Attorney General, the Healthcare Fraud Working Group, the Nursing Home Steering Committee, and an Interagency Elder Justice Workgroup.

Our health care fraud coordination activities include the following, among others:

- focusing resources and working with the CMS and the OIG, State and other entities on several high priority areas for the Department, including fraud and abuse by nursing homes and by managed care organizations;

- administering the systemic weakness reporting program, pursuant to which Department attorneys and investigators report vulnerabilities in federal health care programs that create opportunities for fraud and abuse;

- proposing and commenting on legislation and regulations aimed at preventing health care fraud and abuse, or relating to the legal tools used to address health care fraud and abuse;

- developing training and other instructional materials for Department attorneys, federal government investigators, and others;

- developing policies on issues such as disclosing quality of care allegations to regulatory and licensing authorities, and protecting the confidentiality of patient records; and

- providing advice and information to federal program agencies to assist them to develop policies designed better to prevent and detect health care fraud and abuse.

As members of this Committee know, the nation's healthcare system operates largely on an "honor system," trusting health care providers and suppliers of goods and services to submit honest claims for payment. Quite simply, and despite our best effort to work collaboratively, the government is simply not able to closely audit each claim submitted to assure that the care or service has been provided and was "reasonable and necessary for the diagnosis or treatment of illness or injury." Government enforcement efforts, therefore, provide a necessary and unquantifiable (but very real and oft-cited) deterrence to those who would cheat the system, and serve as a reminder that there will be serious consequences for fraudulent conduct. These consequences may include incarceration, debarment from federal health care programs, administrative fines and penalties, and damages or restitution in an amount two or three times that which was obtained through fraud.

These enforcement efforts also are instructive to the nation's policy makers, illustrating weaknesses in current payment systems and illuminating the need to take proactive measures in certain areas the future. Also, these efforts form a basis for extensive training offered to government attorneys, auditors, investigators, and others charged with the task of enforcing the rules and regulations of the nation's health care delivery system. In the past 18 months, the Department's Office of Legal Education conducted 8 training courses related to health care fraud and use of the False Claims Act and trained over 600 Assistant United States Attorneys, Department Attorneys, and Auditors/Investigators. This training takes place primarily at the Department's National Advocacy Center in Columbia, South Carolina, and includes lessons gleaned from past experiences in these cases and the types of allegations that are coming to the forefront.

In addition, health care fraud working groups and/or task forces meet in many of the 94 federal districts and are composed of representatives of the United States Attorneys' offices, the FBI, HHS/OIG, DCIS,

and state and local officials charged with the task of coordinating health care fraud enforcement efforts.

The Department and CMS also are launching new interagency efforts to enhance our use of technology and high-tech tools to combat health care fraud and abuse. Advanced technologies provide yet another mechanism to ensure that no provider is prosecuted for simple billing errors or mistakes lacking any evidence of fraudulent intent and, conversely, that providers whose billings reflect enduring and consistent patterns of fraudulent or abusive behavior receive further scrutiny from law enforcement. In June 2000, CMS and the Department of Justice co-sponsored a national conference on the use of technology to combat fraud and abuse in health care programs. Recently, our agencies formed a National Technology Group to help implement key recommendations from last year's conference.

Examples of Achievements

HCA: In December, we announced the $840 million criminal and civil settlement with HCA - The Healthcare Company (formerly Columbia/HCA), the largest for-profit hospital chain in the United States. That settlement, for $95 million in criminal fines and $745 million in civil recovery, is the largest health care fraud settlement ever reached by the government and reflects the coordination of resources and collaboration we have brought to bear in investigating health care fraud. This was the largest investigation of a health care provider ever undertaken, involving a multi-agency investigation by attorneys, investigators, auditors and agency personnel, over the course of several years. There are yet additional issues unresolved by the civil settlement.

In FY 2000, before the HCA settlement, the Department's extensive health care fraud efforts, in partnership with other federal and state enforcement agencies, won or negotiated more than $1.2 billion in judgments, settlements in health care fraud proceedings and cases. The Department collected and disbursed more than $674 million in connection with health care fraud cases and matters, with $535 million either deposited directly into the Medicare Trust Fund, or returned to the Trust Fund as amounts equal to other health care fraud collections. These funds now can be used properly - to fund the requisite care for those who need it. Some of the schemes brought to light by our investigations in the last fiscal year include the following:

- The world's largest provider of kidney dialysis products and services, Fresenius, Inc., agreed to pay the United States government $486 million to resolve a sweeping investigation of health care fraud. This investigation revealed that an acquired subsidiary of Fresenius submitted false claims seeking payment for nutritional therapy provided to patients during their dialysis treatments, for services that were provided to patients as part of clinical trials, for hundreds of thousands fraudulent blood testing claims, for kickbacks, and for improper reporting of credit balances. The criminal fine and the civil settlement were, at the time, the largest ever recovered by the United States in a healthcare fraud investigation.

- The nation's largest operator of nursing homes, Beverly, Inc., resolved allegations that it fabricated records to make it appear that nurses were devoting more time to Medicare patients than they actually were. The settlement required the company to pay $170 million in civil settlement -- a figure negotiated based on the chain's limited ability to pay.

- Anthem Blue Cross and Blue Shield of Connecticut, a former Medicare fiscal intermediary (a contractor who processes Medicare claims for the government), agreed to pay $74 million to resolve claims that it falsified interim payments on settled hospital cost reports in order to meet CMS's Contractor Performance Evaluation standards.

- A $53 million settlement with GAMBRO Healthcare resolved allegations of false billings for

laboratory services primarily provided to dialysis clinics treating patients with end-stage renal disease (ESRD).

- Community Health Systems (CHS) paid $31 million to resolve allegations improperly assigning diagnostic codes for the purpose of increasing reimbursement amounts. Seven states received a portion of the settlement for losses to their Medicaid programs.

- More than 70 entities that provided, or assisted in the provision of, radiation oncology services to cancer patients, as well as their billing companies, agreed to pay almost $10 million to settle allegations of false claims to federally-funded health care programs. These providers often billed Medicare for services that were not provided, billed twice for the same service, or sought a higher rate of reimbursement than that to which they were entitled.

- In the first settlement with a Medicare managed-care company, Humana, Inc., paid $14.5 million to settle allegations that the company provided inaccurate payment information from 1990 through 1998. Humana incorrectly listed beneficiaries as eligible for both Medicare and Medicaid, thus securing the higher reimbursement afforded such dually eligible beneficiaries.

- The United States recovered $2.6 million from clients of the Oklahoma-based Emergency Physician Billing Services (EPBS) to settle claims of overpayments based on false claims submitted by EPBS. These settlements follow on the heels of a September 1999 settlement with EPBS and its physician founder for $15 million for fraudulent billing to Medicare, Medicaid, TRICARE, and the Federal Employees Health Benefit Program.

National Projects

Through working groups composed of experienced Assistant United States Attorneys and Attorneys from the Department's Civil Division, the Department maintains four so-called "national projects" to recover the government's losses from similar types of false claims submitted by hundreds of hospitals around the country. These four projects are referred to as the "DRG 72-Hour Window Project," the "Hospital Laboratory Unbundling Project," the "Pneumonia Upcoding Project," and the "PPS Transfer Project." The projects stem from analyses of national claims data by the Office of Inspector General of the Department of Health & Human Services. These working groups were established as part of the Department's "Guidance on the Use of the False Claims Act in Health Care Cases," which was issued by the Deputy Attorney General on June 3, 1998, in response to concerns expressed by some in the provider community. The guidance memorializes existing policies requiring allegations of False Claims Act liability to be based on an adequate factual and legal predicate, and institutes new procedures for "national projects," including coordination and oversight by the working groups discussed above, and the use of "contact letters" that offer health care providers an opportunity to discuss the government's allegations before a demand for payment is made. The guidance was updated by a February 3, 1999, memorandum from the Deputy attorney General.

In a March, 2001, GAO issued its Report to Congress titled "Medicare Fraud and Abuse: DOJ Has Improved Oversight of False Claims Act Guidance." In its report, GAO specifically found that the Department has an evaluation process that provides meaningful assessment of compliance with the guidance, that United States Attorneys' offices certify compliance with the guidance, and that interaction with hospitals was consistent with the guidance. GAO also found that the Department has taken substantive steps to strengthen oversight of compliance with the guidance and that the two most recent national initiatives (PPS Transfer and the Pneumonia Upcoding projects) are being handled in a manner consistent with the guidance. GAO concluded that the Department "has demonstrated its continued commitment to promoting the importance of compliance with the False Claims Act guidance at its U.S.

Attorneys' Offices."

Elder Abuse and Neglect

In my testimony before this Committee on June 14, 2001, I highlighted the Department's continuing efforts to protect our nation's most vulnerable citizens - its older people through our Nursing Home Initiative and Elder Justice efforts. At that time I explained that the Department's efforts to combat elder abuse, neglect and exploitation have been multi-faceted, and include: (1) stepped up prosecution, (2) education and training, (3) broad-based interagency and multi-disciplinary coordination, (4) promotion of medical forensics, and (5) funding, research, programs, and statistics, to fight elder victimization.

The majority of the Department's cases alleging institutional abuse and neglect - failures of basic care leading to profound malnutrition, dehydration, pressure ulcers, scalding, and other illness, injury or death - have been pursued under the civil False Claims Act, a financial fraud statute. The theory in these cases is straightforward - the United States paid for requisite care and services that the defendant knowingly did not provide, but for which it sought reimbursement. Two courts have affirmed this theory, and approximately ten failure of care cases have settled in the last five years. Settlement terms in the majority of these cases have required imposition of a temporary monitor and implementation of specific protocols and training to improve care -- for example in wound care or diabetes management -- if that is where the entity demonstrated problems.

The last two and one-half years have presented new challenges, with the financial decline and bankruptcy filings of five of the nation's seven largest nursing home chains - owning approximately 300 to 450 facilities each. For five such substantial entities to file for bankruptcy in such a short a period (in addition to many smaller entities) was extraordinary (and the subject of a hearing by this Committee last September). The Department's False Claims Act investigations against some of these entities involved monetary claims of tens or hundreds of millions of dollars, in addition to troubling failure of care claims.

The precarious financial state of these chains required that the Department of Health and Human Services closely monitor the care offered by the facilities and formulate "contingency plans" in the event any of the chains suddenly closed or liquidated. The Department of Justice worked closely and productively with both CMS and OIG to negotiate appropriate settlements that balanced the interests of the residents of these facilities with the need to make restitution to government health programs.

Telemarketing Schemes Against Older People

The Department has detected a major trend in telemarketing fraud against consumers in this country (including Internet fraud) where the schemes are directed both within and from outside the United States. These schemes often target our nation's older citizens. Older people in declining health, mobility, and varying cognitive capacity, are not only more vulnerable to physical and psychological abuse and neglect, but also to financial exploitation. Indeed, there appears to be a correlation between the two, with victims of financial exploitation appearing to be at higher risk for other forms of abuse and neglect. The Department's United States Attorneys' offices and its Criminal and Civil Divisions have successfully pursued both civil and criminal cases to redress these schemes.

One method available to the Department for combating this problem is the filing of civil proceedings by our Civil Division's Office of Foreign Litigation in the foreign jurisdiction where the fraudulent telemarketing activities are based. In appropriate civil cases, we can seek to shut down boiler rooms, enjoin con-artists from telemarketing into the United States, and freeze corporate and individual assets for eventual restitution to victims of the fraud. For example:

- In United States v. Fortuna Alliance, LLC, et al, we filed an action in the High Court of Antigua, freezing all trust accounts in an offshore bank controlled by Fortuna Alliance, which was involved in a pyramid scheme that operated over the Internet. $2.8 million was eventually returned from those accounts and distributed to victims of the scheme by the Federal Trade Commission.

- In United States v. Euro-Can-Am, et al., Canadian telemarketers recently paid $1 million to the United States in settlement of a suit filed in Canada. The funds provided partial restitution to victims of a cross-border telemarketing scheme involving the sale of fake gemstones. The Canadian action was parallel to a criminal case brought in the Middle District of Pennsylvania and effectively froze defendants' assets until the settlement. As part of the global resolution of the matter, defendants plead guilty to criminal charges and were sentenced to 12 months in prison.

Other cross-border fraud civil cases are presently pending in Canadian courts. These suits arise from Canadian telemarketing fraud operations directed at consumers in this country, with proceeds of the fraud going to other countries in the Caribbean and Europe. We anticipate filing additional suits in those countries in which assets are located in order to repatriate them for restitution to injured consumers in the United States.

Similarly, the Department's Criminal prosecutors -- using mail fraud, wire fraud, credit card fraud, conspiracy, money laundering, and other federal criminal charges - have successfully prosecuted many people who defraud older people through telemarketing, Internet, credit card, and advance-fee fraud. Three major undercover operations directed at telemarketing fraud, for example, resulted in prosecution of more than 1,400 persons for telemarketing-fraud charges. Sentences in these cases have ranged as high as 14 and 18 years. In one very recent case, a telemarketer who preyed upon elderly victims -- including an 82-year-old woman who told the defendant that her husband was in the hospital dying of cancer -- was sentenced in the Central District of California to 115 months imprisonment.

Conclusion

In conclusion, I assure the Committee, as I did in June, that the Department of Justice will continue to play a lead role and to work with this Committee in addressing fraud and abuse committed against the nation's health care programs as well as those committed against our nation's older citizen's. I welcome your comments and questions.