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EFFECTIVE STRATEGIES FOR PREVENTING HEALTH CARE FRAUD

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EFFECTIVE STRATEGIES FOR PREVENTING HEALTH CARE FRAUD

WEDNESDAY, OCTOBER 28, 2009

U.S. SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in room SD–226, Dirksen Senate Office Building, Hon. Patrick J. Leahy, Chairman of the Committee, presiding.

Present: Senators Leahy, Cardin, Klobuchar, Kaufman, Specter, Franken, Sessions, Hatch, Grassley, and Cornyn.

OPENING STATEMENT OF HON. PATRICK J. LEAHY, A U.S. SENATOR FROM THE STATE OF VERMONT

Chairman LEAHY. Good morning. Today the Committee will refocus on the problem of health care fraud. I think we all know we are engaged in a great national debate about health care reform. I would hope that those who, like myself, are in favor of the public option or those who feel that they should oppose the President on health care, whatever thing, I would hope both sides would agree on one issue: that health care fraud is an enormous problem and is something that cannot be tolerated. Whether it is Federal dollars or private dollars, fraud is draining billions and billions away from providing effective health care. We have to work together to ensure that we have tough and effective measures in place to prevent health care fraud and provide accountability.

I am pleased that we have with us today Deputy Secretary Bill Corr from the Department of Health and Human Services and Assistant Attorney General Tony West from the Department of Justice. Both are distinguished public servants; both are heavily engaged in the Government's efforts to combat health care fraud. We know health care fraud is wrong. It is insidious. It not only pushes up our health care costs and wastes taxpayer money, but also puts lives in danger.

As health care reform moves through the Senate, I want to make sure we do all we can to tackle the fraud that could undermine efforts to reduce the skyrocketing costs of health care.

The scale of health care fraud in America today is staggering. According to conservative estimates, about 3 percent of the funds spent on health care are lost to fraud; that is more than $60 billion dollars a year. In the Medicare program alone, the General Accounting Office estimates that more than $10 billion was lost to fraud last year.

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And there are specific incidents that illustrate the problem even more clearly than these astronomical numbers. In April, Quest Diagnostics settled a $300 million lawsuit filed by California businessman and biochemist Thomas Cantor. Quest continued to sell a certain kind of medical test kit from 2000 to 2006 despite complaints of inaccurate results. Now, the tests put the health of hundreds of thousands of dialysis patients at risk. Even though it was putting them at risk, the company continued to sell it. They were making a lot of money. The fact that people may die or have their health seriously injured did not bother them. They just made money. And the settlement covers claims that the bad tests led to unnecessary surgeries and overtreatment which risked causing deadly diseases.

Just last month, the Department of Justice settled a case against Pfizer for $2.3 billion, including more than $1 billion in recovered losses—the largest health care fraud settlement in the Department's history. Pfizer had promoted drugs for uses and at dosages that the Food and Drug Administration specifically declined to approve for safety reasons. Pfizer made a lot of money, but they placed millions of Americans at risk for serious health problems including heart attack, stroke, and pulmonary embolism.

That case was exposed by a whistleblower, and several whistleblowers who have come forward to expose outrageous instances of fraud are here today.

Incidentally, I want to applaud Senator Grassley who has worked so hard in bipartisan efforts on whistleblowers over the years. I have been pleased to join him in those.

Bruce Boice, a former sales representative for the pharmaceutical company Cephalon, blew the whistle at great cost to his career and livelihood on a similar scheme of marketing drugs for purposes for which they were not approved on which Cephalon made money. He helped the Government recover $425 million. Chuck Bates and Craig Patrick, two former employees of the medical device company Kyphon, are also here today. They blew the whistle on a practice aimed at inflating the bills sent to Medicare for a surgical procedure and helped the Government recover $86 million.

To stop the drain on our health care system caused by these types of fraud, we must make anti-fraud enforcement stronger and more effective. A lot has been done, but more can be done.

Much attention has been devoted to fraud in the Medicare and Medicaid programs. This fraud is significant. It undermines taxpayers, doctors and patients, and we have to do everything we can to stop it. But it is important to remember that health care fraud does not occur solely in the public sector. Private health insurers also see billions of dollars in fraud. That fraud is often harder for the Government to track. Private companies have less incentive to report it, but it is a grave problem that we need to address.

I am heartened by the significant and impressive steps the administration has taken to step up health care fraud prevention and enforcement. I am also pleased with the real progress represented by the anti-fraud provisions of the Finance and HELP Committee bills. I was glad to contribute to those efforts. But we have to make sure we are all working on that. I have been working closely with Senator Kaufman and Senator Specter and others to develop im-

portant additional anti-fraud measures. We will be introducing a bill soon that we hope will add to the already impressive anti-fraud efforts we are seeing this year.

We all agree that reducing the cost of health care for American citizens is a critical goal of health care reform. I hope we can find a way and a consensus in this area. We will hear the efforts of the Justice Department and the Department of Health and Human Services, and I think we are going to see what we can do in Congress to make sure that we help. One thing to unite all of us, we should be against crime, and fraud in the medical areas is crime.

Senator Sessions.

STATEMENT OF HON. JEFF SESSIONS, A U.S. SENATOR FROM THE STATE OF ALABAMA

Senator SESSIONS. Thank you. I would sincerely say that I appreciate what you are doing here today because I think it has potential to help us combat fraud.

We have a plan before us to massively increase the Federal involvement in health care. In 2007, we spent nearly $2.3 trillion on health care. According to the Centers for Medicare & Medicaid Services, by the year 2016 health care spending will reach $4.3 trillion, or 19 percent of gross domestic product. Medicare and Medicaid are considered one of the largest purchasers of health care really worldwide. In fact, over 13 percent of the Federal budget is allocated to Medicare alone. No wonder health care fraud is viewed as a lucrative business for criminals. Wasn't it Willie Sutton—they said, "Why do you rob banks?" And he said, "That is where the money is." And there is certainly a lot in health care. Estimates place the fraud from 3 to 10 percent of total health care costs.

When I was United States Attorney, we formed a medical care fraud task force, and I believe the estimates then were as high as 10 percent fraud. When you consider how much money is being spent, if you could reduce that in any significant way, it could be some of the biggest savings we could ever achieve in health care in America.

I would cite this cautionary fact. Periodically, Federal officials and others launch efforts against Medicare fraud, and I see the numbers still are a 3- to 10-percent rate out there, so it would suggest that we maybe have not been as effective as we should be, gentlemen, and hopefully we can talk about that.

A study conducted by George Washington University Medical Center pointed out that fraud cost Americans approximately $220 billion in 2007 alone. Other numbers are not that high, but that is a dramatic figure. And I am sure they had some basis for making that estimate.

CBS' "60 Minutes," I have already had a lot of calls over the show that aired Sunday night about some of the fraud in South Florida and other problems. They attributed $60 billion in cost to American taxpayers for Medicare fraud alone.

And I agree with you, Mr. Chairman, that whistleblowers can be a critical part of discovering frauds that may be of a massive nature, and I know you and Senator Grassley have really advocated this, and others have, and I think it is a legitimate part of our enforcement effort.

According to the FBI, defrauding Medicare is simple. A criminal simply has to "rent a cheap storefront office, find or create a front man to get an occupational license, bribe a doctor or forge a prescription pad, and obtain the names and ID numbers of legitimate Medicare patients." That is a statement that may be oversimplified, but it is, in fact, happening today, as we know.

Given the massive number of claims and the Government's inability to monitor these claims, Medicare has basically evolved into a pay-and-chase system—pay the claim and then later look to chase down the improper payments. For some companies, that may work. For others who are fly by-night, it does not. If Government has difficulty combating fraud in the current program, we know that if we expand those programs, it will be even greater.

So I look forward to working with you. I believe the private sector has an interest in containing this fraud also, that partnerships can be reached, and that is what we tried to achieve between the various Federal agencies on a collaborative basis along with private insurers and others who are taking losses, too. And they have computer programs and other ways to identify red flags, identify areas where claims exceed rationality or are disproportionate in others, and those can be the basis for commencing investigations.

I would like to see how you are doing on that. I think we need to do better, and thank you, Mr. Chairman.

Chairman LEAHY. Thank you very much.

Our first witness is William Corr. He is the Deputy Secretary of the Department of Health and Human Services. He was confirmed unanimously by the Senate on May 6th. Before joining the Department, Mr. Corr served as Executive Director of the Campaign for Tobacco-Free Kids. He has also spent significant time working on Capitol Hill, most recently as chief counsel and policy director for Senator Tom Daschle, previously in senior positions with Senator Howard Metzenbaum, Congressman Henry Waxman, and others. He has had prior experience at the Department of Health and Human Services where he served as chief of staff to Secretary Donna Shalala and before that as Deputy Assistant Secretary for Health as counselor to the Secretary. He received his undergraduate degree from the University of Virginia and his law degree from Vanderbilt University School of Law. And, of course, Mr. Corr is known to many of us. Many of us, myself included, have known him for years.

We are delighted to have you here.

STATEMENT OF BILL CORR, DEPUTY SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. CORR. Thank you, Chairman Leahy, for those gracious remarks, Senator Sessions and Members of the Committee. Thank you for the opportunity to testify today about the joint DOJ–HHS Task Force on Health Care Fraud and, in particular, Project HEAT, which was created by Secretary Sebelius and Attorney General Holder on May 20.

The President's creation of a Cabinet-level task force demonstrates his commitment to addressing fraud in our Federal health care programs. Our joint efforts have sped up prosecutions and increased recovery of funds lost to fraud.

As has been noted by both the Chairman and the Ranking Senator, health care fraud is a very serious challenge to the integrity of our Medicare and Medicaid programs. Our response to it needs to be strong and aggressive, and it will be, because we are in a better position today than ever before to fight health care fraud.

The collaboration between our two Departments has resulted in the use of new methods of data analysis that allows us to learn the profiles of criminals entering the programs, including the regions of the country where they are most prevalent and the types of payments that are most vulnerable to fraud. Using this new information, our strike forces are more effective, and we can pursue policy changes and develop innovative methods of preventing fraud.

For example, when the strike force in Miami focused on fraudulent claims for durable medical equipment and the Centers for Medicare & Medicaid Services instituted more rigorous reviews of claims and providers, the result was an over 60-percent reduction in DME claims in South Florida. That represents a decrease in claims of almost $2 billion in 1 year alone.

Fraud and abuse is not limited to Federal health insurance programs, as has been noted. Health care fraud is a national problem requiring collaboration among public and private health organizations. Our colleagues at DOJ tell us that they see the same fraud schemes in the private sector that we are seeing in Medicare and Medicaid. Criminals who commit health care fraud are becoming more sophisticated and are often parts of organized crime enterprises.

The best efforts of the public and private sectors will be required to substantially reduce health care fraud. Therefore, our joint Health Care Task Force is planning and will soon convene a national summit on health care fraud. We plan to invite participants from every affected group, including private insurers, beneficiaries, law enforcement, and providers. The summit will bring fresh ideas and collaborations that we believe will result in more effective methods of preventing, detecting, and prosecuting fraud.

The collaboration between our Departments is primarily funded through the Health Care Fraud and Abuse Control Program, known as HCFAC. Since its inception, HCFAC-funded activities have resulted in the return of over $13 billion to the Medicare Trust Fund. The investigative and prosecutorial activities performed by the HHS Office of Inspector General and the Department of Justice with HCFAC resources have returned well over dollar per dollar for all the expenses, as high as $8 to $1 for every investment in 2008 alone.

The success of the HCFAC program would not have occurred without the outstanding efforts of the HHS Office of the Inspector General, which has provided essential investigative and auditing services, and the work of the Department of Justice with its prosecutors.

Experts agree that the most effective way to eliminate fraud is to stop it before it starts. Some of the most important work of the HEAT task force and its partners is focused on enhancing the fraud prevention programs in Medicare and Medicaid.

Our focus on durable medical equipment is an example. DME fraud appears to be the most prevalent type of criminal activity in

Medicare and Medicaid, particularly in hot spots like South Florida. Using authorities provided by Congress, we are requiring DME providers to post surety bonds; be certified by nationally recognized accreditation organizations, which includes onsite review of the supplier; and submit to new rigorous competitive bidding processes. This unprecedented level of pre-enrollment screening will be complemented by onsite inspections of new providers and greater scrutiny of suspicious claims. DME is the first step in our strategy to add more rigor to the fraud prevention efforts across the board.

CMS is instituting other prevention measures as well. For the first time in Medicare's history, by year's end CMS will bring all Medicare claims data together into one centralized data repository. CMS, the Inspector General, and the Department of Justice strike forces will be able to use sophisticated new technology to review claims data for aberrations anyplace across the country.

In summary, Chairman Leahy, we are adding resources to existing programs and evaluating funding needs for the future. We are coordinating efforts across the Government, led by the joint DOJ-HHS HEAT task force, with great initial success. HHS is building new prevention programs to stop fraud before it happens and using new analytical techniques to identify and then strike against individuals and criminal organizations that have targeted Medicare and Medicaid.

While this task ahead of us is enormous, the commitment is very strong, and with the continued support of the President, this Committee, and the entire Congress, and joining forces with the private sector, we can continue our success in the war against health care fraud.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Corr appears as a submission for the record.]

Chairman LEAHY. Thank you very much, Mr. Corr. What I am going to do is have you both testify and then we will open it to questions.

Tony West is the Assistant Attorney General for the Civil Division in the Department of Justice. He was confirmed to that position on April 20th. But prior to his time in the Civil Division, Mr. West worked as a partner at Morrison & Foerster, LLP, where he represented individuals and companies in civil and criminal matters. Mr. West also spent 5 years working as Assistant U.S. Attorney for the Northern District of California, 2 years working as a special assistant for the Justice Department on crime policy issues, and served as a State Special Assistant Attorney General in California. He earned his bachelor's degree from Harvard University, and his J.D. from Stanford University Law School, where he was elected president of the Stanford Law Review.

Mr. West, delighted to have you here.

STATEMENT OF TONY WEST, ASSISTANT ATTORNEY GENERAL, CIVIL DIVISION, U.S. DEPARTMENT OF JUSTICE

Mr. WEST. Thank you, Mr. Chairman.

Mr. Chairman, Senator Sessions, and members of the Committee, thank you for inviting me here today to testify on the Department of Justice's efforts in fighting and deterring health care

fraud. Under the leadership of the Attorney General, Deputy Attorney General David Ogden is supervising the Department's day-to-day efforts to marshal our resources in combating health care fraud, recovering Medicare funds stolen through fraud and abuse, and coordinating with the Department of Health and Human Services. The Deputy Attorney General very much wanted to be here today, but was unable to attend because of a prior commitment. He asked me to relay to you the important work that DOJ is doing in close coordination with HHS and our other law enforcement partners to deter, detect, and defend against health care fraud and to express how important this issue is to both him and the Attorney General.

Mr. Chairman, every year hundreds of billions of dollars are spent to provide health security for American seniors, children, and the disabled. While most medical or pharmaceutical providers are doing the right thing, we know that when Medicare and Medicaid fraud occurs, it costs the American taxpayers billions of dollars.

While there is no official Federal estimate of the level of fraud in Medicare or Medicaid or the health care sector more generally, external estimates project the amount at 3 to 10 percent of total spending, and this fraud affects public and private insurers alike.

It is those wrongdoers who we must stop. Those billions represent health care dollars that could otherwise be spent on services for Medicare and Medicaid beneficiaries, on seniors, children, and families, but instead are wasted on fraud and abuse. This is unacceptable.

We have a duty to our citizens who receive treatment paid for by the Medicare, Medicaid, and other Government programs to see to it that the integrity and quality of their care is not undermined by fraud, because when Medicare and Medicaid fraud occurs, it can corrupt the medical decisions health care providers make with respect to their patients and thereby put the public health at risk.

The Department of Justice recognizes both the urgency and the need to recover funds that are lost to fraud as well as to ensure that such fraud does not reoccur. That is why the Department of Justice, through its Civil, Criminal, and Civil Rights Divisions, along with the U.S. Attorneys' Offices and the FBI, have prioritized much of our enforcement efforts on protecting the integrity of health care that is provided to patients.

However, we must also recognize that we cannot combat this problem alone. Coordination across agencies is an integral part of preventing and prosecuting health care fraud, which is why Secretary Sebelius and Attorney General Holder announced in May 2009 the creation of the Health Care Fraud Prevention and Enforcement Action Team, or HEAT. And with the creation of the HEAT team, as Deputy Secretary Corr put it, fighting Medicare and Medicaid fraud became a Cabinet-level priority for both DOJ and HHS.

HEAT, through its emphasis on agency coordination and resource and data sharing, is helping to solidify a partnership between DOJ and HHS begun by the Health Care Fraud and Abuse Control Program, or HCFAC.

Since HCFAC's inception, our two Departments have returned more than $15 billion to the Federal Government, of which over

$13 billion went back to the Medicare Trust Fund. These efforts have resulted in more than 5,600 criminal convictions for health care fraud offenses, with the average return on the public's investment being $4 for every $1 spent.

During fiscal year 2008, the Department of Justice's vigorous efforts to combat health care fraud accounted for more than $1 billion in civil settlements and judgments. During that same time period, the Department opened 849 new civil health care fraud matters and filed complaints or intervened in 226 civil health care fraud cases. During that same time period, Federal prosecutors filed criminal charges in more than 500 health care fraud cases involving charges against nearly 800 defendants and obtained 588 convictions for health care fraud offenses. And they opened over 950 new criminal health care fraud investigations involving more than 1,600 defendants.

Now, in addition to strengthening exist programs to fight illegal conduct, we have also worked cooperatively to prevent health care fraud before it happens, through increased compliance training for providers and expanded public education so that the American people can be part of the solution by reporting suspected fraud to the HEAT task force.

Mr. Chairman, we hope that you will look at the Department's successes thus far in combating waste, fraud, and abuse and recognize the role we continue to play and can continue to play with the help of our Federal and State government partners in making sure taxpayers' funds are protected and patient safety is preserved.

As we have seen time and again, the only way we can truly be effective in protecting the integrity of our public health care programs is by combining the full panoply of our Federal resources, our expertise, and our information across agency and jurisdictional lines.

The Department of Justice looks forward to working with Congress as we continue to prevent, deter, and prosecute health care fraud.

Mr. Chairman, this concludes my prepared statement, and I am happy to answer any questions you or the Committee have.

[The prepared statement of Mr. West appears as a submission for the record.]

Chairman LEAHY. Well, thank you very much, Mr. West.

You know, I thought it was a good sign when the Obama administration launched the Health Care Fraud Prevention and Enforcement Action Team, the HEAT initiative. Several of us on this Committee once had the opportunity to be prosecutors, and we know how important it is if you can combine forces when you want to go after fraud of any sort, and the high-level joint agency task force sends a pretty strong message you are going to do that. And I think the sharing of information is extremely important, especially as some of these frauds become more and more complex. People make a lot of money out of them, and if we cannot share the information, we are never going to find them, especially for those who think that the only cost of getting found out is that it may cost them some money. I would like to think the cost of them being found out is some of them will go to jail. That might actually prove a deterrent.

Now, it is my understanding the HEAT team is using new technology to improve real-time data sharing and analysis between HHS and DOJ. Is that what is happening, Mr. Corr?

Mr. CORR. Senator Leahy, one of the most important results of the collaboration that has developed so far has been not only a commitment but the realization of providing real-time access to the Department of Justice, to its investigators, and to the Office of the Inspector General. By the end of the year, we will have a single data base for all Part A, Part B, and Part D of Medicare, and the investigators will be able to review claims as they come into the Centers for Medicare & Medicaid Services.

That means that at the earliest possible moment our investigators can be evaluating whether there are trends that indicate fraud in a particular area or a particular field, a particular category of service. It enables CMS to do additional and tougher claims review. So the collaboration has been extremely valuable in making sure that—one of the most important things we heard from day one from the Justice Department and our Inspector General was that we have to have access to the data, to the claims as they come into CMS, and we are doing everything we can to make sure that happens.

Chairman LEAHY. Mr. West, are you finding that this is helpful to the Department of Justice?

Mr. WEST. Yes, Senator. Mr. Chairman, when you look at the strike forces, for instance, the strike forces have on them representation by CMS. I think that underscores how important it is to not only share data and information, but to make sure that we are using that information to identify trends early on, to communicate that back to CMS, as well as use that data to drive our enforcement decisions. It is helpful both in the civil investigations of health care fraud as well.

Chairman LEAHY. I have found over the years that so many times these areas of fraud, whether in this area or in military contracting or any other area, the most important information often comes from an insider, from a whistleblower through the False Claims Act. I mentioned Senator Grassley's work in this, and he and I and Senator Kaufman and others worked over many years to strengthen this anti-fraud tool, and we passed the Fraud Enforcement and Recovery Act of 2009. That amended the False Claims Act for the first time in nearly a quarter century, and the day the President signed it, I was there, and a number of law enforcement people seemed pretty excited that we had this.

Will this help under the False Claims Act? And I ask the question not just seeking affirmation of it, but I want to know: Is it working? Will it work? Are there other things we should do?

Mr. WEST. Mr. Chairman, yes, the False Claims Act, and particularly the FERA amendments that were passed earlier this year, have been an important tool in our ability to continue to combat health care fraud. And we are very much appreciative of this Committee's work, and the Senate, for passing those amendments.

The vast majority of cases that we pursue under the False Claims Act come from qui tam relators. They originate with whistleblowers. And so making sure that we have the tools that allow us to use information that is provided by qui tam relators, to be

able to investigate those cases, to make sure we will not be unduly restricted in our ability to bring false claims actions, all of those have proven to be quite important in our efforts.

Chairman LEAHY. Well, I notice also we had reference to studies by George Washington University. There was one that showed the kind of fraud that is also perpetrated by the private health insurance industry. When I first saw these numbers, I asked if they were correct, and they are. In 2009, United Health, a leading insurance company, paid $350 million to settle losses by the American Medical Association and other physician groups for overcharging patients and physicians for medical services, a 28-percent cost increase for some doctors and patients. Private insurance companies have no requirement to report fraud, and some studies suggest they have strong initiatives to hide fraud and simply pass on the cost to consumers.

Why don't we hear more about this fraud in the private sector?

Mr. WEST. Well, Mr. Chairman, I think when you are talking about fraud, of course, and a covert activity, it is always difficult to get a handle on what the actual numbers are. I can say that through the use of the False Claims Act, and particularly the qui tam provisions, I think we have a valuable tool in allowing us to ferret out fraud where it is occurring.

I would also say that an important part of the approach is making sure that we are talking with private insurers who are also victims of fraud. I would say about 6 weeks after I was confirmed, I addressed the board of the Coalition Against Insurance Fraud, and what became quite clear is the private sector as well as the public sector are victims of fraud. And so coordinating, sharing information where permitted by law, sharing strategies, I think all of these are important efforts to augment our abilities to combat fraud.

Chairman LEAHY. Thank you very much, and I apologize. I went over my time. I was not paying attention.

Senator SESSIONS. Thank you, Mr. Chairman. I would just say that you raise an important issue. You can count on my strong support in moving forward to make progress. I think you will have bipartisan support.

I would just ask, Mr. Corr, will you be the person that is going to head this task force? Or will someone else be assigned the specific duties? Both of you are good witnesses, but I would like to know who is going to head this effort.

Mr. CORR. The Secretary and the Attorney General organized the task force, and the Deputy Attorney General, David Ogden, and I are the co-chairs of the task force. I wanted to just mention that—and I do not want to sound bureaucratic, but the fact that we have this task force—it is meeting regularly. We have organized committees. We are going to stay with this every day, every month, every year, until we get a handle on it.

So I will be the one responsible for working with Deputy Attorney General Ogden to make sure that the task force performs.

Senator SESSIONS. And, Mr. West, on DOJ's side, the Department of Justice, who is the point person for these task forces?

Mr. WEST. Well, as the Deputy Secretary indicated, Deputy Attorney General David Ogden is heading up the day-to-day responsibilities for our task force. But I can assure you that it has the

attention of all of the—at the highest levels of the Department of Justice. Not only is it a key priority for me in the Civil Division, Assistant Attorney General Lanny Breuer, who heads the Criminal Division, it is a key priority for him.

So this issue has the absolute full attention of the highest levels of the Department of Justice.

Senator SESSIONS. Have you selected people? Mr. Ogden I do not think is a prosecutor. You are not, Mr. Corr. You came from a different background. You have, Mr. West. You have tried some cases, but you have got the whole Civil Division to run. Mr. Ogden is Deputy for the whole Department of Justice. Have you empowered some really capable people who know about these cases, have experience in it, to actually ensure the effectiveness of these efforts?

Because I just want to tell you, I have been at this business since 1981 when I was appointed U.S. Attorney, and every President that has ever held the office has announced a fraud task force on health care. That has just been the way it is. And that is not bad, but it takes sustained effort and support from the top—probably not so much the management from the top, but support from the top.

Do you think you have made that commitment, Mr. Corr? Do you have the people selected that have had experience in this that can help make it work?

Mr. CORR. Absolutely. The senior leadership of CMS, the senior leadership in the Inspector General's office, the Secretary herself will be involved in this. We believe we have the right people, and we will be holding them accountable, and the Secretary will certainly be holding me accountable—and I think the President will expect both of our Departments to make sure that we are not just more talk—and we believe we have a record so far that our collaboration is paying results. And we expect to continue that.

Senator SESSIONS. You also recognize, Mr. West, do you not, that the fraud schemes impact the private sector, the Veterans Administration, the Department of Defense, State Medicaid programs and other programs, disability claims, and Indian health care claims? Are those persons going to be—do you have people from each one of those and they will be working together? And are you attempting to coordinate the data that they may have in their systems that could identify aberrational charging levels in certain areas that could help you identify criminal activity?

Mr. WEST. You are quite right, Senator, that this involves a number of public agencies and data that perhaps we can get from a number of public agencies. And the answer is yes, we are actively seeking to try to coordinate that information through the HEAT task force.

And I should mention that the HEAT task force not only has, as you have pointed out, support from the top, from the Attorney General, from the Secretary, and then the actual chairing by the Deputy Secretary and the Deputy Attorney General, but there are a number of subcommittees that are a part of HEAT. One of them, in fact, is a data-sharing committee, and there is where you have the real expertise, the line lawyers from my Division, from the Criminal Division, the professionals from the HHS side, who are meeting regularly and talking regularly and figuring out the best

ways to share the data, to share the information, to go out and figure out what we do not have, so that we can make the most informed law enforcement decisions we can.

Senator SESSIONS. Well, thank you, Mr. West, and both of you. I think we can do better. I hope and believe that you can do better.

I would just say the "60 Minutes" program caused quite a lot of national discussion. People do not like that. They do not appreciate their tax money being stolen. And it has been going on for years. We have been hearing about the South Florida problem for years.

Let me just ask it simply. Do you guys intend to address the abuses in other areas, but in particular South Florida that we have been hearing about and seen so much about?

Mr. WEST. Yes, Senator. And, in fact, we have a strike force that is there. In fact, I think it was featured in the "60 Minutes" program. And one of the great advantages of that—and just last week I think we had one disposition down in South Florida. You are right, it is a hot spot, and it has a lot of attention from our Criminal Division as well as our Civil Division.

Senator SESSIONS. Thank you.

Chairman LEAHY. Well, thank you.

As Senator Sessions said, on rooting out fraud you are going to have strong bipartisan support here in the Senate, certainly in the Congress, and one of the reasons we put the tools in here, both in the fraud bill and the whistleblower bills, is to help you on that. But we will count on you if you find that the tools are inadequate or contradictory, to let us know so we can change it.

I am going to turn the chair over to Senator Kaufman, who has joined me in all these, and I apologize for leaving for a doctor's appointment. Take care.

Senator KAUFMAN. [presiding]. Good luck.

Mr. West, can you tell us about the role of kickbacks in health care fraud? Who pays them to whom and why?

Mr. WEST. Well, yes, Senator. What we find when we find fraud in this area is sometimes physicians will be paid by providers to refer patients to a particular provider. That is illegal. We will sometimes find that a physician who has a financial relationship with a provider will try to refer patients to that provider or that provider will try to refer patients to the physician. That, too, is illegal. So when we see the kickback activity, it is an indication that there is fraud going on.

Senator KAUFMAN. In your view, what is the impact of the payment of such kickback on not just health care costs but also the quality of care?

Mr. WEST. Well, we think it really corrupts the quality of care because patients have a right to depend upon the integrity of advice that they get from their physicians, and they have a right to believe that that advice is not tainted by any financial interest or any other inducement that a physician may get. It ought to be advice that is given in the best interest of the patient. And so we believe it harms public health.

Senator KAUFMAN. Mr. Corr.

Mr. CORR. I would certainly agree with those remarks.

Senator KAUFMAN. OK. One significant form of health care fraud is off-label marketing, Mr. West. Please tell us what form of fraud,

what problems it creates, and what the Department is doing to fight it.

Mr. WEST. Well, off-label marketing usually involves, Senator, a situation when a pharmaceutical company will market a drug for a use that it has not been approved by the FDA for. So, for instance, if there is a drug that is designed to fight headaches and that company were to market it as a weight loss drug, that would be an off-label marketing purpose.

The problem is, of course, that, again, patients and purchasers have a right to depend upon the integrity of the FDA process, and if the FDA has approved a drug for a specific process and then that drug is marketed for something else, that corrupts the ability for a patient or a consumer to make an informed choice.

Senator KAUFMAN. Great. Mr. Corr, as we discussed, Medicare has a statutory mandate to pay out claims quickly. Can you talk about how the mandate works and how it interacts with anti-fraud efforts?

Mr. CORR. Thank you, Senator. It is a very important question as we grapple with trying to improve our prevention efforts.

When a claim comes into the Centers for Medicare & Medicaid Services, we are obliged to pay within 14 to 30 days—no early than 14, but by 30 days. So the review that has to be done of those claims is immediate. We get 4.4 million claims each day, so there is a huge volume, and providers rely upon Medicare to be paying in accordance with that schedule.

So there is pressure for us to move those claim forms along. We do do claims review, and some of those, about 3 percent, are pulled out and go through further medical review. But it just indicates the difficulty of spotting fraud early and recognizing it, but not undermining the medical practice that needs to go forward.

Senator KAUFMAN. Ranking Member Sessions asked a really good question about we have been doing about this for years and how difficult it is. Do we have enough resources directed toward fighting fraud, in your opinion?

Mr. CORR. Senator, what I can tell you is that we believe we have identified practices that are making a difference and that are successful. We need to do more enrollment review. We need to do more stricter claims review. We know that the strike forces have been quite successful in identifying fraud and reducing it.

All of those activities could be expanded and would have a significant impact.

Senator KAUFMAN. OK. Thank you.

Senator Grassley.

Senator GRASSLEY. Thank you, Senator Kaufman.

I want to thank Senator Leahy for holding this hearing, trying to get to the bottom of this, although I think it is a never-ending job. There are always so many sophisticated crook out there who are always going to sit around and laugh at us in Government that we cannot get ahead of them. I think in the years that Senator Baucus and I worked together on the Finance Committee, we have had at least 20 oversight hearings, investigative hearings on such fraud. So I compliment the expansion of that through Senator Leahy and this Committee as well.

In the 1986 law, we set up something that we call CIDs, civil investigative demands, and the idea was to get investigations during the investigative stage. Now, where we evidently made a mistake in 1986 was that the law then required the Attorney General to sign all those CIDs himself, so earlier this year in the bill that Senator Leahy referred to, the FERA legislation, we permitted the Attorney General to delegate CID authority to a designee. That provision allows the Department to share CID information with qui tam relators and Federal and State and local agencies. These provisions will help streamline CIDs and speed up the inventory decisions by the Department. However, nearly 6 months after FERA was signed into law, I have heard that there has been no decision from the Attorney General regarding who the authority is delegated to.

So update me on this, if you can, Mr. West. What is the status of the CID delegation authority? And has the Attorney General decided who will have final delegated CID authority? And if not, why not? Because we made a mistake in 1986. An Attorney General is so busy, any Attorney General is so busy and maybe overlooks this. We want to get it so it can be used.

Mr. WEST. Well, thank you, Senator. That is exactly right, and we welcomed that amendment to FERA to allow the CID authority to be sub-delegated. And I have taken steps to ensure that that happens. It is within the Department's internal process right now. Hopefully within fairly short order we will have that sub-delegation, so that is moving through the internal DOJ process.

Senator GRASSLEY. Do you have kind of a deadline to getting that decision made?

Mr. WEST. We do not have a deadline per se, Senator, but I can tell you that there is a great deal of desire to see that effected sooner rather than later. It is something that I talk regularly with U.S. Attorneys around the country about, and it is something that we are moving through as quickly as we can the internal process at DOJ.

Senator GRASSLEY. Well, do we have any problems in that process with whether or not the Attorney General is considering adding additional requirements prior to allowing delegated authority to CIDs? And if so, what might those conditions be? Or maybe that is not a problem.

Mr. WEST. I do not think that that is a problem, Senator. I appreciate it, but I do not think that is an issue.

Senator GRASSLEY. OK. Will that delegation go down to the U.S. Attorneys, or would it stay at Main Justice?

Mr. WEST. Well, that is one thing that we are looking into, and part of the reason is we want to make sure we get that right. But that is one of the questions that we are currently considering.

Senator GRASSLEY. OK. On another point—and this may sound—I hope I am considered an equal opportunity oversight person and I am not—you know, you folks are new to me, so these questions go to Republicans or Democrats. And so I am going to bring up a problem that we have had around for a while.

There are 1,040 false claim cases that are under seal in Federal courts waiting on the Department of Justice to make a decision to join the lawsuit. This is on top of the 130 pending cases the Department has joined and the 340 that it has declined. Of the cases

awaiting a decision, 985 of them allege allegations of health care fraud, so overwhelmingly, you know, this whole False Claims Act is going after health care fraud. You know, when we first wrote it, it was to go after defense industry fraud. But wherever it is used, it is important.

This number of 1,040 is higher than the 1,000 cases under seal when I asked the same question a year ago, which, of course, I was asking of another administration. Averaged out, it takes about 12.3 months for the Justice Department to make a decision. Twelve months is a long time for the Government to figure out if it is willing to pursue fraud.

As the author of the 1986 amendments, I wanted to attest that Congress indeed intended that the Department make an intervention decision in a timely manner. So I find it troubling that some cases are lingering for 36 months.

Questions—and this will be the last series of questions, and they will go pretty quickly. Does the Justice Department have a plan to clear this backlog in a timely manner? If so, what is it? And if you do not have a plan, you know, I would just want to know that.

Mr. WEST. Yes, thank you, Senator, and I appreciate the concern. This is actually something that I asked my folks in the Civil Division not long after I arrived to look into because I was curious about it as well. And here is what I have learned.

Those cases that you have identified, the 1,000, they are indeed cases which are actively being investigated, not just in my Division in the Civil Division, but throughout the country in all of the U.S. Attorneys' Offices throughout the country. So that represents 1,000 cases that are actively in various stages of investigation throughout the country.

What we also know is that one of the reasons it may take time to investigate these cases, not only are they complex, as I know you appreciate, and we have a duty to thoroughly investigate the allegations of wrongdoing, which we take seriously, but oftentimes they involved parallel criminal as well as civil allegations or investigations. And we always want to make sure that we are not doing anything in the civil case that might adversely impact a potential criminal case and vice versa.

The other thing that I think is important to point out is that when these cases are under seal, oftentimes there is an active negotiation to globally resolve the case. So in the majority of cases that are unsealed, what you see is not only an announcement of allegations, but you also see an announcement of a settlement. And we believe that actually serves everybody's interest best.

Senator GRASSLEY. Could I make a statement? I am done asking questions. Maybe for the benefit of my colleagues, as much as anybody else.

Now, I understand there are 1,000 cases, and if the Federal Government is involved, there is more money going to go to the Federal Treasury. If the private litigator goes ahead themselves, they get a higher percentage. But, on the other hand, if there are 1,000 cases there, it would seem to me that some of those decisions can be made, to get the private litigator moving ahead, we would accomplish at least more for the Federal Treasury than maybe waiting so long to make such a decision.

Thank you very much.

Mr. WEST. Thank you, Senator.

Senator KAUFMAN. Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman. I will go to Mr. West first.

Historically, Federal anti-fraud efforts have focused on Medicare and Medicaid, but criminals do not distinguish—or do they?—between public and private health insurance when they engage in fraudulent activity, right?

Mr. WEST. You are quite right, Senator. They do not distinguish.

Senator FRANKEN. So are we doing enough to go after private health care fraud? And what would be the benefit of jointly addressing fraud in the public and private sectors? And how can we best create a coordinated strategy for fraud across the entire health care system?

Mr. WEST. Well, I think the point you raise, Senator, of trying to coordinate is very important. It is one reason why I met with the Coalition Against Insurance Fraud early on in my tenure to talk about coordination, sharing strategies, sharing information where permitted by law. And, in fact, I should say that that has led to an ongoing dialog with my office where we hold meetings with private insurers to talk about ways in which we can better coordinate.

I would also point out something that Deputy Secretary Corr mentioned in his testimony about the summit that is being planned which would involve the participation of private insurers just for that very point that you raise, that it is important to look at this problem of fraud in health care as a holistic problem, not just a public problem or not just a private sector problem.

Senator FRANKEN. And do you feel that private insurers really feel that they have been reached out to by the Department of Justice?

Mr. WEST. Well, I can only tell you that the letter that I received from the Coalition Against Insurance Fraud—and I should mention that that is a coalition of private insurers, along with some participants from the public sector—was very complimentary and one which appreciated the fact that the Department of Justice is making an active effort to reach out to private insurers. So I was heartened by that, and I think they have been heartened by the ongoing dialog that we have had with them, and the ongoing dialog that we are having with them through HEAT.

Senator FRANKEN. But there is no statutory requirement to collaborate between public and private. Correct?

Mr. WEST. That is correct. You are right.

Senator FRANKEN. I would like to take a little time—for either of you, we have been hearing about the fraud, and we do not hear—I would just like to get some examples of it, because we just hear these numbers and incidents.

There was one that I saw which was in Florida where these—infusion therapy, fake infusion therapy. Can one of you explain that? Mr. Corr.

Mr. CORR. It would be an example of someone with HIV/AIDS that needed intravenous treatment. But infusion therapy, home

health care, and durable medical equipment are three areas where the——

Senator FRANKEN. Explain, though. Explain the fraud. I mean, you are——

Mr. CORR. What I was going to say is that in each of those three areas, we have a similar problem where the barriers to entry for providers are quite low; where a criminal could, as Mr. West was pointing out earlier, get a physician to agree to prescribe certain treatments for a kickback. The criminal could very well take a provider's billing number as well as get beneficiaries' billing numbers and bill Medicare for services that have never been rendered or bill for services that were unnecessary.

Senator FRANKEN. So kickbacks, billing for procedures that were never done, OK. Now, in your testimony you mentioned 189 convictions. What are the penalties? Are these people in prison?

Mr. WEST. Many of them do go to prison. In fact, when you look at the average length of prison sentence and you include the strike force activity, it is about 37 months for a health care fraud offense. And I should note that the strike force activities or enforcement activity, that is in addition to what is already going on in U.S. Attorneys' Offices around the country. But this is a very serious crime, and it is being treated that way by the Department of Justice, and we seek serious penalties.

Senator FRANKEN. OK. I think the biggest fraud was by Pfizer. Is that right? And they paid a fine of over $2 billion.

Mr. WEST. That was the biggest fraud in connection with misbranding or off-label marketing, yes.

Senator FRANKEN. OK. Is anyone in prison for that?

Mr. WEST. No, Senator. What happened there is you had two individuals who were charged criminally, and through a plea agreement, as to one, and a conviction after trial, as to the other, those individuals—those cases were resolved.

Senator FRANKEN. Because people go to prison for having, you know, a bag of marijuana. These are people who are responsible for ripping off Medicare to the tune of a couple billion dollars, and they are not in prison. Now, how are we going to deter this? How are we going to deter people doing this if they can plea bargain and stay out of prison? Why don't we send them to prison?

Mr. WEST. Well, there are two things I would say in response to that, Senator.

First is that I can assure you that when we have the evidence, and the facts and the law allow us to pursue criminal cases against individuals such that we can put them in prison for these offenses, we will do that. That is the commitment that the Department of Justice has, and that is how seriously we take it.

Unfortunately, the evidence is not always as clear-cut as one would like it to be, particularly when you are talking about large organizations in which the decisionmaking is quite diffuse, it is very difficult to find out exactly who made what decision.

So we have to be vigilant, on the one hand, and aggressive, and we are that. But at the same time, we want to be responsible to make sure that we are actually targeting those individuals who are responsible as opposed to simply going out and capturing activity that may not be warranted by the facts or the law.

Senator FRANKEN. Thank you.

Thank you, Mr. Chairman.

Senator KAUFMAN. Senator Cornyn.

Senator CORNYN. Thank you, Mr. Chairman. I would like to express my appreciation to the witnesses for being here today, and thank you for serving your country in your capacities that you are holding now. I have to confess, though, that the bad guys outnumber the good guys, and I agree with Attorney General Holder that the lack of resources is a real problem, and I have some personal experience as a former State Attorney General in the Medicaid fraud area where we work with the Federal and State authorities to try to deal with this.

But I would like to—so I know you are doing as well as you can with the resources you have, and I want to do everything I can to be supportive of that, and that is one reason why earlier this year I reintroduced a bill called the STOP Act, which I think addresses this problem of pay and chase and would change it to detect and prevent when it comes to Medicaid fraud.

But, Mr. Corr, I do not know how we can expect CMS to do a much better job when they are only able, out of the 4.4 million claims they get a day, to review 3 percent of them. So that is why I would like to work with you to try to figure out how we can change the paradigm to one that will actually work, because I am not sure we will ever have enough good guys to outnumber the bad guys in this area.

But I do want to explore, because there is a lot of difference about public options in health care reform and public plans, we obviously have two prominent Government-run health care plans—Medicare and Medicaid. And I just want to contrast and get your reaction to some statistics, because I think, Mr. West, you pointed out that anywhere between 3 to 10 percent of what is spent on these Government plans now is stolen by fraud.

And just for example, I would note that in recent testimony about the credit card industry, which has $2 trillion in transactions per year, which is nearly the size of the health care sector, there are more than 700 million credit card transactions and circulations, millions of vendors, and yet their total fraud is roughly 1 percent compared to 3 to 10 percent for Medicare and Medicaid—1 percent for credit card transactions.

According to a chapter on Medicare fraud in a book called "Stop the Crooks" that I want to cite to you here, one statistics that intrigues me is that in private health insurance claims, fraud is roughly 1.5 percent or less, 1.5 percent compared to the Federal Government 3 percent to 10 percent. And that is why I think we have to change our paradigm and how we deal with these issues to go from a pay-and-chase system to a detect and prevent system.

But I would like to ask you, other than resources, what else can we do to make sure that the Government-run health care plans we have now, Medicare and Medicaid, what is in the vernacular of today the public option that is being discussed more generally to create yet another Government plan, what can we do to reduce the fraud and the theft in the current Government plans to more closely approximate what we see both in the credit card industry at 1

percent or in the private health care claims, which is about 1.5 percent? Do you have any thoughts about that?

Mr. CORR. Senator, we currently have under review the additional authorities, particularly at the enrollment period, that would benefit CMS as these 4.4 million claims come in. We have around 18,000 new providers seeking provider numbers from Medicare every month. We have about 900 durable medical equipment providers seeking new numbers every month. So there is not only a flood of claims coming in but also providers, and we are taking a very careful look at what additional authorities to review without undermining the ability of the Medicare program and Medicaid program to pay claims to providers who are rendering quality care and deserve to be paid quickly, how we can better identify the bad guys as they start into our system. And we will be bringing that to the Congress as soon as we can.

Senator CORNYN. Mr. West.

Mr. WEST. Senator, thank you. First I would say that with the FERA amendments, that has been a very big help to our efforts, and we appreciate that.

I think one other way in which you can be quite supportive is to support the HEAT priorities. What that task force represents is really an unprecedented level of coordination between DOJ and HHS, and supporting the data-sharing initiatives that are underway there, supporting the dual criminal and civil enforcement efforts that we are undertaking there, and I will note that I recall when I was here for my confirmation hearing, you asked both Assistant Attorney General Breuer and myself if we would work together to combat health care fraud and at least, you know, do a few things. I think you said, "We know you cannot get it all, but if you do at least a few things, you can at least begin to deter some of the bad guys." And I am happy to report that in the last 6 months we have taken that suggestion and we have done that. And so your help and the Senate's help in continuing to support our efforts through HEAT I think will be quite helpful.

And then I would simply say that we are always open to a dialogue and hearing your suggestions, the suggestions of your colleagues on how we might better enhance the enforcement tools and prevention tools that are available to us when it comes to dealing with health care fraud.

Senator CORNYN. Mr. Chairman, I want to just say that one of the reasons why I think it is so important to have False Claim Act authority and the qui tam process that you and Senator Leahy and Senator Grassley—and I have made some minor contribution to, because we need more good guys on the field investigating and prosecuting these claims because, frankly, the Federal Government and the State government is outnumbered, and we need to get more resources on the front lines to deal with this.

But I think we also have to look at this pay-and-chase system and realize that we are never going to be able to catch up with all the fraud, particularly, as Mr. Corr points out, under a situation where you have to pay those claims within 14 to 30 days, and you are getting 4.4 million of them a day and can only review 3 percent of them. I mean, we have to change the game, I think, in order to win.

Thank you very much.

Senator KAUFMAN. Thank you.

Senator Klobuchar.

Senator KLOBUCHAR. Thank you very much. Thank you, Mr. Chair, and thank you to our witnesses. I think we have discussed this before, but when I was a prosecutor, I made a high priority out of prosecuting these types of white-collar cases, and particularly these fraud cases involving Medicare and Medicaid, because the saddest part of these cases was the money. Ultimately, the people ripped off are the most vulnerable people in our society. And I saw firsthand how these crooks would cheat the system, so I really appreciate the work that you have done.

A bill that I introduced with former Senator Martinez, which I think would be somewhat helpful here, focuses on—it is called the IMPROVE Act, which improves the payment policy for reimbursement through oversight and efficiency by requiring direct deposits of all payments made to providers under Medicare and Medicaid. And we know of several recent incidences involving the use of check-cashing facilities.

For example, in November of 2007, a woman was indicted for billing Medicare for motorized wheelchairs that beneficiaries did not need. According to the indictment, the woman then laundered the money through a Houston check-cashing business, cashing several Medicaid checks each for more than $10,000.

So my first question, I guess of you, Mr. Corr, is: Does CMS have the capacity to administer payment electronically? And do you think this would be an effective way to prevent fraud?

Mr. CORR. Senator, I apologize for not being more up to speed on the pros and cons of what you are proposing. We certainly want to consider every avenue that gives us and gives the Department of Justice a greater chance to track down who is ripping off Medicare and Medicaid.

Where the checks are sent I think is not as big an issue. Paying electronically as opposed to paying by check is not as big an issue for Medicare. But what I would prefer to do, if you do not mind, is talk with our experts about any issues that we have, and also talk with the Justice Department about how that would assist in tracking down the criminals.

Senator KLOBUCHAR. Very good. We think it would be a good idea. Patrick Murphy has a bill in the House, and we are hoping to get it included in this health care reform.

The other thing that I have found interesting, Mr. Corr, in your testimony is that you mentioned that the strike force prosecutions in Miami have focused on fraudulent claims for durable medical equipment and that new prevention efforts have resulted in a 63-percent reduction in these claims, which is something to be proud of.

Can you talk about these prevention efforts? And why is this type of product more susceptible to these fraud claims?

Mr. CORR. It is more susceptible because it is easier for a criminal to become a durable medical equipment supplier, to put in to CMS fake claims for individuals who are not receiving the equipment, or to bill for a more sophisticated, more expensive piece of equipment than they actually have provided.

We oftentimes see criminals who will set up several corporations with different family members, so we are trying to track down individuals who are very smart about our payment limits and they understand how much we pay for certain things and when certain bills get kicked out of the system, caught with our computer checks. So what we have to do is be more focused, and we are, and the durable medical equipment is the best example.

On screening these providers before they get into the system. We have just instituted surety bonds for all durable medical equipment suppliers. We now require accreditation of those providers, which includes an onsite visit to be sure that there actually is a provider there that is legitimate. We look at their staffing, at their licenses. We are improving our claims review so that it is more sensitive. And as I mentioned earlier when you were not here, by the end of the year CMS will have a single integrated data base of all Part A, Part B——

Senator KLOBUCHAR. No, I actually came in for that part.

Mr. CORR. I apologize.

Senator KLOBUCHAR. I remember you saying Part A, Part B. That will be helpful.

Another area I thought was interesting when we look at all these statistics is the Homeland Security Committee found that Medicare claims contained the identification numbers of an estimated 16,500 to 18,200 deceased physicians, which involved something like 385,000 to 572,000 claims for medical equipment. In every case study cited by the Senate Committee, the deceased physicians were merely unwitting instruments—or their names were—in transactions that meant easy money for these crooks.

What is CMS doing to combat criminals from using these deceased physicians' identification numbers?

Mr. CORR. One of the most important is to create a single integrated data base for the entire country that allows us to avoid criminals using a physician's name or number in multiple jurisdictions where we have separate contractors and separate data bases. We also are improving our compromised—we call it a compromised provider number and compromised beneficiary number data base so that when we have the first indication that a claim has been filed for someone and it should not have been, that number then triggers a rejection of all future claims or at least a review of all future claims.

So as you heard, with so many claims coming in and with the requirement to pay quickly, we are trying our best to get much better control on the front end of who is in the program so that we do not run into these situations.

Senator KLOBUCHAR. Very good. We will probably have time for a second round, but just quickly, Mr. West, we have been talking a lot about resources here. And as you know, it is more than just prosecutors; it is also accountants and other people that are needed to work on cases like this. And I was a strong supporter of our recent legislation, the FERA legislation. But, again, there may be more needed in this area given the amount of money at stake.

But one thing we have not talked about is I would assume that it would be helpful for the tools in the toolbox to have U.S. Attor-

neys confirmed to actually prosecute these cases. Would that be correct?

Mr. WEST. Well, I think that is right, Senator. I think clearly the U.S. Attorneys around the country are an important force, frontline force in prosecuting fraud—all crimes, not just fraud, but fraud—and we rely on them heavily to help us combat Medicare fraud.

Senator KLOBUCHAR. Would it also help to have judges confirmed and marshals confirmed?

Mr. WEST. Well, the criminal justice system works well when it is fully complemented.

Senator KLOBUCHAR. Thank you very much, Mr. West.

Mr. WEST. Thank you, Senator.

Senator FRANKEN. Senator Specter, would you like to question or would you like to wait a couple minutes?

Senator SPECTER. Thank you, Mr. Chairman. I just walked in, having attended the hearing on——

Senator KAUFMAN. Your "talk" button.

Senator SPECTER. I said I just walked in, having attended the hearing in Environment and Public Works, and I know our hearing today is on the issue of fraud, waste, and abuse on the health care legislation. And I think it is important that the final bill will include a provision for mandatory jail sentences.

Under our current system, jail sentences are discretionary with the trial judges. They may follow the recommendations of the guidelines, or they may not. But we have seen an increasing number of sentences, fines, where there is very egregious, reprehensible, serious conduct involved. And the fines are simply added into the cost of doing business.

A jail sentence is different. Senator Graham and I have taken the lead in introducing a bill which would provide a mandatory sentence of 6 months for fraud in the medical field, whether it is Medicare, Medicaid, or against private insurance companies in excess of $100,000. There is an aversion in many quarters to having any mandatory sentences, and I think there is something to that if you deal with the crack cocaine issue, the disparity. And there is legislation pending there which Senator Durbin has championed and others have introduced.

But where you deal with white-collar crime, it is especially susceptible to deterrence. If you talk about a bar-room homicide on a Saturday night when people are intoxicated, you are not going to deter anybody by a jail sentence there. But if you are dealing with Medicare and Medicaid fraud or insurance company fraud, people are going to go to jail, and any jail, even 6 months—one of the concerns that we have had in trying to structure what a sentence should be—kind of looks too light if you have a multi-million-dollar fraud scheme.

So I just wanted to make that comment. If I knew what had gone on, if I knew how to formulate a relevant question, I would do so. [Laughter.]

Senator SPECTER. But since I do not, that customarily is not any standard around the U.S. Senate, but occasionally I follow it. Thank you, Mr. Chairman.

Senator KAUFMAN. Senator Specter, you always ask relevant questions. I have watched you for a long time.

To follow up on that and what Senator Franken said, Mr. West, you have done both criminal and civil work. What kind of deterrence do you think jail time is?

Mr. WEST. Well, I think jail time is certainly a strong deterrent, and I think that when we have the evidence and we have the law and we have the ability to seek jail sentences, we certainly do that, and we do that aggressively. In fact, it is the policy, the sentencing policy of the Department of Justice to recommend sentences that fall within the applicable guideline range. Only in extraordinary cases do we depart from that. But, clearly, we take health care fraud very seriously. We will seek the most serious penalties that we can, given the law and the facts of every specific case.

Senator KAUFMAN. Mr. Corr, do you have any comments you want to make on that?

Mr. CORR. Nothing to add. Thank you.

Senator KAUFMAN. Let us talk about CRIPA for a minute, if we can, Mr. West. Tell us how the act relates to health care.

Mr. WEST. Well, CRIPA is an act—Civil Rights of Institutionalized Persons Act, and this really is a tool that we use with the Civil Rights Division responsible for enforcing to ensure that the rights of individuals who are institutionalized in some way, shape, or form are not being abused and are not being eclipsed. And it is an important part of the full panoply of Federal enforcement tools that we have at our disposal.

Senator KAUFMAN. Now, right now you do not have the authority to subpoena institutions being investigated, but you have to rely on their cooperation. Is that right?

Mr. WEST. That is absolutely correct.

Senator KAUFMAN. And what impact does that have on investigating and doing the work that you should be doing?

Mr. WEST. Well, I do think, Mr. Chairman—I believe that the situation involving investigations, as we have seen by analogy in the CID context, certainly can be facilitated with the ability of making either civil investigative demands or administrative subpoenas where that is appropriate.

I think I would invite further conversation with you and with others who are interested in this as to what the exact correct mix of tools is in the CRIPA context.

Senator KAUFMAN. Mr. Corr, what technologies or techniques would help HHS better leverage existing personnel to engage in anti-fraud opportunities?

Mr. CORR. The Justice Department and our Inspector General look to us to manage the enormous data that comes into the Department in a way that promotes oversight and investigation. And I think one of our challenges is in making that data base most usable. It might seem remarkable, but it will take us until the end of this year to create a single data base, and it will be an enormous benefit. And I think we need to continue to make improvements in the accessibility of that data for review for purposes of fraud.

As we identify new techniques and new systems that we need, we will be the first to let you know.

Senator KAUFMAN. A number of commentators, including the head of the Medicare Program Integrity Director Kimberly Brandt, assert that prescreening of Medicare providers could substantially reduce fraud. Is that correct? Do you believe that?

Mr. CORR. That is certainly our view.

Senator KAUFMAN. OK. Thank you.

Senator Franken.

Senator FRANKEN. Mr. Corr, we have heard the statistic today, and I have heard several times the statistic that fraud in private health insurance occurs at 1.5 percent. Do we have good data to verify this statistic?

Mr. CORR. Unfortunately, we do not. We have estimates from a number of different organizations, but it is sometimes very hard to distinguish fraud from unnecessary care that is simply wasteful. So getting a clear reading on fraud, we know it is substantial and way too large, but we do not have a clear sense of exactly how much.

Senator FRANKEN. So when that statistic is trotted out, it is sort of trotted out especially when it is trotted out to compare the fraud rate in private insurance to Medicare, it is really maybe not—there might be, I do not know, some reason that someone is doing that other than——

Mr. CORR. There is no requirement——

Senator FRANKEN [continuing].—Trying to get at the facts? Could that——

Mr. CORR. There is no requirement for private insurance companies to report fraud rates. As you know, in Medicare and Medicaid we do report an annual error rate that is more than just fraud. It also includes mispayments over at——

Senator FRANKEN. We are here trying to figure out what is really going on. It is probably maybe not useful to use something that has no data behind it. Would that be fair to say?

Mr. CORR. I am sorry. The estimates, you mean?

Senator FRANKEN. Never mind.

[Laughter.]

Senator FRANKEN. I just have a question—first of all, to speak to Mr. Cornyn's concerns, I was very impressed with the sort of return on investment. I would like either of you to speak to that—or maybe, Mr. Corr, you can speak to that—on increases in spending in your work and what it yields. Can you speak to that a little bit?

Mr. CORR. The numbers that we provided to you involve the work of our strike forces in areas where we have concentrated our time and energy. In 2008 alone, there was a return of $8 for every $1 we spent from our HCFAC fund, which is the basic source of revenue for our prevention and enforcement efforts. The prepayment restrictions and claims audits that we have instituted we believe have returned $13 for every $1 we have spent over the last 3 years. And these are lessons learned. We are trying our best to identify those techniques that most quickly and most effectively identify when fraud is occurring.

Senator FRANKEN. I imagine at some point the investment and the yield would reach a point of diminishing returns. But is it fair to say that it has not yet?

Mr. CORR. That is fair to say.

Senator FRANKEN. OK. Thank you.

This is for both of you. This is just a curiosity of mine. How many of these people who end up doing fraud start out doing this legally and say, "Hmm, you know, I could have billed for a more expensive wheelchair. I think I will do that"? And then they do that and they get away with it, and now they are doing it routinely, and they buy a nicer condo. And then they start doing it. Is that common? Is that a common thing?

Mr. WEST. Unfortunately, we do not have very precise numbers on fraud generally or on how many individuals who might start out as legitimate providers migrate.

Senator FRANKEN. You do not collect stories.

Mr. WEST. We do not have that, unfortunately, Senator.

Senator FRANKEN. OK. And it is fair to say, is it, Mr. Corr, that electronic records, electronic health records, really is an area—because you are talking about the data base you are getting together. That is a place where we can really start increasing our efficiency in attacking fraud. Is that right?

Mr. CORR. Absolutely, as well as improving the quality of medical care.

Senator FRANKEN. So it is a tremendous investment. It is a win-win, right?

Mr. CORR. It is an investment that Congress has made and that we are doing our best to implement.

Senator FRANKEN. OK. I want to thank both you guys for the work you do.

Mr. CORR. Thank you.

Mr. WEST. Thank you.

Senator FRANKEN. Thank you, Mr. Chairman.

Senator KAUFMAN. Senator Klobuchar.

Senator KLOBUCHAR. Thank you very much, Mr. Chairman.

I know, Mr. West, that you talked about—when you talked about the HEAT team—how you have been able to analyze this data and, in coordination with HHS, identify fraud hot spots and then focus on those hot spots. So what are the factors that determine whether a place is a hot spot?

Mr. WEST. Well, I think one of the key things we look for are patterns of activity. If we see patterns of, say, overutilization or if we see patterns of overbilling, if you have a particularly small provider and they are a large percentage of claims that are made in a particular area, that is an indicator that there may be fraudulent activity going on. So there are a number of data points that we look at.

Senator KLOBUCHAR. So hot spots are parts of an area, is what you are looking at?

Mr. WEST. When I talked about hot spots, I was referring geographically. I think we know that—and I think the deployment of our law enforcement resources as manifest by the strike forces indicates where we see——

Senator KLOBUCHAR. And where are—can you tell me where these hot spots are?

Mr. WEST. I think you will see it in South Florida——

Senator KLOBUCHAR. Are they places that are hot? Florida.

Mr. WEST. Houston.

Senator KLOBUCHAR. I just knew it.

Mr. WEST. And Houston where it is also warm, but you also have Los Angeles, where I guess it is warm most of the year, and Detroit, where you have 50–50.

Senator KLOBUCHAR. I think what would be interesting with this is that we are very focused on the highest quality, low-cost areas of the country in terms of putting incentives into this bill to get Medicare reimbursement rates to reward that kind of behavior. And I find it interesting that the places that you mention tend to be some of the places, particularly Florida, Texas, that have some of the higher-cost, lower-quality care, and that is nothing to say about these States, but sometimes it is because there is a lack of organization in their health care systems. Sometimes it is because they just have had a culture of medicine delivery that just is not the same as the way a place like Mayo clinic would do it. And I find it so interesting you mentioned two of the areas that tend to have—I think most people would think it is like a hotel. You pay more and you get a better room. Not true with health care. For the most part, you pay more and you get a worse room, whether it is in a hospital or whether it is the treatment you get.

So I just wonder if you have any thoughts on the interrelationship between disorganized health care systems and the propensity for fraud.

Mr. WEST. Well, I think whenever you have—I think Senator Sessions actually said it best. Whenever you have large amounts of money, you have the propensity for fraud. I think that is why we have efforts to combat not only health care fraud at the Federal level, but also financial fraud in all of its forms. And so I do not know if I am the best person to comment on the interrelationship between disorganized health systems and fraud, but I do know that where we see it, it is usually because we see patterns that are occurring.

Senator KLOBUCHAR. And then are you able with this hot-spot analysis to learn from that and then prevent certain locations from being hot spots, you kind of put the word out on the kind of fraud you are seeing?

Mr. WEST. Well, the data flows both ways. Not only is it important for us to share data with HHS to try to identify where we are going to deploy our law enforcement resources, what we pick up in the field and the information we pick up in the field, it is very important for the Department of Justice to share that with HHS so they can in turn identify providers who may be falling into these patterns. Absolutely, it flows both ways.

Senator KLOBUCHAR. Did you want to add anything, Mr. Corr.

Mr. CORR. Simply to say that that is exactly right, and it is the reason the collaboration is paying off.

Senator KLOBUCHAR. I found that interesting, and what I would hope then also would come out of it is some suggestions about how to, you know, organize the systems and put in place these protections to prevent fraud. And it is just no surprise to me that there is a pattern.

Mr. CORR. Senator, just as one example, the lack of accountability within a disorganized health care system does open the possibility for fraud. For example, if you bundled payments for certain

kinds of services and one aspect of that bundled payment was durable medical equipment, it would be more difficult for a fly by-night criminal to set up a corporation and start billing Medicare than if they had to participate as a part of a more organized system where there was a single payment for all the services that were rendered.

Senator KLOBUCHAR. Because the other providers would have an interest, and there would be a double-check for you, not just the Government checking.

Mr. CORR. Yes.

Senator KLOBUCHAR. I would think the other people that want to get paid have an interest in not getting ripped off by some fly by-night criminal that comes in and takes part of their money when they do not get the durable medical equipment. That is very interesting, because I am a big fan of these bundled payments. So thank you very much.

Senator KAUFMAN. Well, I want to thank you both for your excellent testimony on what obviously is a critical subject. As we move toward meaningful health care reform, we must ensure that criminals who engage in health care fraud and those who contemplate doing so understand that they face swift prosecution and substantial punishment. I look forward to working with the Department of Health and Human Services and with the Justice Department and with Chairman Leahy and others on the Committee to promote this goal.

Thank you very much, and the hearing is adjourned.

[Whereupon, at 11:34 a.m., the Committee was adjourned.]

[Questions and answers and submissions for the record follow.]

QUESTIONS AND ANSWERS

Additional Written Question for the Record

HHS Deputy Secretary Bill Corr

Senate Judiciary Committee Hearing

"Effective Strategies for Preventing Health Care Fraud"

October 28, 2009

Senator Coburn

10. The new government plan proposed by Democrats is supposed to control costs by reducing the profits of insurance companies. Fortune Magazine found that the top 14 insurers earned a combined $8.61 billion in 2008. That may seem like a lot of money, but consider that Medicare lost an estimated $60 billion – seven times as much money – to fraud as those insurers earned in profits.

Moreover, GAO labeled Medicaid a "high risk" program, finding $32.7 billion in improper payments in 2007 alone – 10 percent of the program's total spending. So the Medicare and Medicaid "public plans" lose more than $90 billion dollars to fraud each year – ten times the profits of the major insurers.

Question: If the new government plan is anywhere close to the size of either Medicare or Medicaid, experience demonstrates that taxpayers will lose far more to fraud than they will save in eliminating insurer profits. Is that a good investment for taxpayers?

Answer:

As you know, the public option would be one option among numerous private options within the health exchange. According to an analysis by CBO, 30 million Americans would participate in the exchange but only 6 million would participate in the public plan, meaning that 4/5 of people enrolled in the exchange would opt for private coverage. Medicare and Medicaid have a combined enrollment of roughly 98 million Americans, significantly greater than the 6 million estimated to participate in the public option. Fraud is an issue the Administration is addressing in both Medicare and Medicaid, but the public option will have significantly fewer participants than other public programs.

The Administration has been clear that cracking down on Medicare and Medicaid fraud is a top priority. In providing health care to 98 million Americans, CMS expends over $700 billion per year on health care expenditures for Medicare, Medicaid, and the Children's Health Insurance Program. Medicare alone pays $431 billion in claims a year and processes 4.6 million claims each working day. In programs of this size and scale, even a small fraction of dishonest people

can cost the taxpayers a significant amount of money. We will not allow a few unscrupulous individuals to be the reason millions of Americans are denied access to health care.

Keep in mind that fraud and abuse is not limited to federal health insurance programs. In fact, the $60 billion figure you cite is from the National Health Care Anti-Fraud Association and it relates to the health care system overall, both private and public. It is not a Medicare-only fraud number. The Administration does not currently calculate a "fraud rate" for Medicare or Medicaid. We do know that health care fraud is a national problem that requires collaboration among private and public entities. Experts agree that the most effective way to eliminate fraud is to stop it before it ever starts. The Administration is making program integrity and fiscal oversight a high priority at CMS.

The health reforms under discussion in Congress, accomplished through a partnership of private insurance plans and public programs, give new authorities for fighting fraud in Medicare and Medicaid, and provide opportunities for ongoing collaboration between the public and private sectors. The Administration takes our responsibility as a steward of taxpayer funds very seriously and are working to ensure that neither Medicare, Medicaid, nor any future public program is an easy target for unscrupulous individuals and criminal elements whose intent is to perpetrate fraud.

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Questions for Bill Corr, Deputy Secretary
U.S. Department of Health and Human Services
Submitted by Senator Specter

1. Mr. Corr, you note that "The Health Care Fraud Prevention and Enforcement Action Team (HEAT)" was "established by Secretary Sebelius and Attorney General Holder on May 20, 2009." I chaired a Crime and Drugs Subcommittee hearing on "Criminal Prosecution as a Deterrent to Health Care Fraud" that very same day. On May 21, 2009, I wrote to General Holder and Secretary Sebelius to encourage their consideration of recommendations we received from Dr. Malcolm Sparrow, a criminologist from Harvard. Dr. Sparrow recommended that HHS "Require a review of the adequacy of the Medicare and Medicaid programs' operational responses to claims submitted that are clearly implausible. Auto-rejection of claims involving dead patients, dead doctors, or previously deported persons is a terribly weak response . . . ." On July 24, 2009, HHS Inspector General Daniel R. Levinson responded to my letter that OIG "will consider for inclusion in our fiscal year 2010 work plan a review of CMS's[[1]] operational response to implausible claims." **To your knowledge, Mr. Corr, has the OIG included a review of CMS's operational response to implausible claims in its FY 2010 work plan? Do you agree with Dr. Sparrow that it should?**

Response:

Yes, OIG has several audits and evaluations in its FY 2010 work plan that relate to CMS payments for and operational responses to implausible claims. These audits and evaluations will identify possible overpayments and vulnerabilities in internal controls and recommend safeguards to avoid these types of incorrect payments in the future. OIG's planned and ongoing work in this area includes reviews of:

- Medicare and Medicaid payments for claims for services ordered or referred by:
    - deceased physicians,
    - excluded providers, and
    - other providers with invalid or inactive provider identification numbers;
- Medicare payments for claims involving deceased beneficiaries;

[1] CMS stands for the Centers for Medicare and Medicaid Services.

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- Medicare payments for physician claims with inaccurate information about the setting in which the service was provided. Medicare reimburses physicians at a lower rate for services provided in an outpatient facility such as an ambulatory surgical center than in the physician's office, so inappropriate coding for place of service on a claim can result in overpayments. If a physician submits a claim indicating that a service was provided in his/her office and an outpatient facility submits a claim for the same beneficiary for the same date indicating that the service was provided at the facility, this could indicate an inaccurate claim.

2. Mr. Corr, you testified that "We are putting criminals who fraudulently billed Medicare for equipment like wheelchairs behind bars, while at the same time ensuring our beneficiaries get the right services and the ones they pay for." (Corr Stmt. at 12). **Do you think that jail time is the best deterrent when it comes to highly profitable white collar frauds?**

Response:

Criminal prosecution is a critical component of an overall law enforcement strategy designed to detect and prevent health care fraud – a strategy that also includes civil fines and penalties, administrative sanctions such as exclusion from participation in Federal health care programs, periodic financial audits, industry guidance, beneficiary outreach, and evaluations that identify and recommend corrective action for program vulnerabilities. Recently, an OIG investigation resulted in convictions of three executives of the Purdue Frederick Company based on their positions of responsibility at Purdue during the time of the fraudulent misbranding of OxyContin. After these convictions, OIG excluded the three executives from participation in Federal health care programs. The exclusions have been upheld administratively and are on appeal in Federal court.

We believe that criminal prosecutions (and subsequent exclusion) have a marked sentinel effect. Though deterrence is difficult to quantify, we have empirical evidence that our Strike Force model for investigating and prosecuting health care fraud has resulted in reductions in improper claims to Medicare. Medicare claims data showed that during the first 12 months of the Strike Force (March 1, 2007, to February 29, 2008), claim amounts submitted for Durable Medical Equipment (DME) in south Florida decreased by 63 percent to just over $1 billion from nearly $2.76 billion during the preceding 12 months.

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3. Mr. Corr, you mention that HHS is "using new methods of data analysis and intelligence gathering to detect patterns of criminal activity, including regions of the country where they are most prevalent, and the types of payments from Medicare and Medicaid that are most vulnerable to fraud." (Corr Stmt. at 2). **What types of new methods of data analysis is HHS generally, and CMS in particular, using to detect fraud? For the Record, what is the "Integrated Data Repository" (Corr Stmt. at 7) and what are "Benefit Integrity Contractors"? How do these new tools facilitate beneficiary and physician interviews to nail down suspect claims?**

Response:

CMS has been working to consolidate claims information, with the first phase of an integrated data repository (IDR) already complete and targeted for initial use by the end of the year. An integral part of the CMS data warehouse strategy, the IDR ensures a consistent, reliable, secure, enterprise-wide view of data supporting CMS and its partners in more effective delivery of quality health care at lower cost to CMS' beneficiaries through state-of-the-art health informatics.

The IDR will allow CMS to:

- Transition from a claim-centric orientation to a multi-view orientation that includes beneficiaries, providers, health plans, claims, drug data, clinical data and other data as needed.
- Create an analytic and reporting platform.
- Retain operational data stores such as Common Working File (CWF) and those in shared systems.
- Provide database scalability to meet current and expanding volumes of CMS data.
- Provide uniform privacy and security controls.
- Provide users the capability to analyze the data in place instead of relying on data extracts.
- Integrate claims data from diverse sources such as Medicare and Medicaid in a meaningful way.

The vision of the IDR includes providing greater information sharing, broader and easier access, enhanced data integration, increased security and privacy and strengthened query and analytic capability by building a unified data repository for reporting and analytics.

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Benefit integrity activities at CMS are performed by designated benefit integrity contractors, the Program Safeguard Contractors (PSCs) which are being replaced by new Zone Program Integrity Contractors (ZPICs), who identify and track fraud, waste & abuse in the Medicare program, impose administrative actions such as suspensions, overpayment collections and sanctions, and work as a liaison to make referrals to CMS' law enforcement partners. Within the last two years, CMS' benefit integrity contractors have suspended nearly $23 million in payments, referred nearly $2 billion in overpayments for collection, and made more than 700 referrals to law enforcement.

As part of the HEAT initiative, the OIG and DOJ have formed a cross-discipline, cross-department data intelligence team to examine Medicare claims for fraud and aberrant patterns in claims and billing. The team is comprised of Investigators, Auditors, and Evaluators from OIG as well as a Senior Health Care Program Analyst from DOJ. Together the team brings a wealth of experience in utilizing sophisticated data analysis tools combined with criminal intelligence gathered directly from OIG Investigators in the field in order to more quickly identify ongoing health care fraud schemes and trends.

The HEAT initiative has also expanded the Medicare Fraud Strike Forces. Strike Forces are law enforcement specialty teams that conduct criminal investigations and prosecutions and execute enforcement operations in areas identified as being at high risk for and having high concentrations of health care fraud. DOJ and HHS are implementing a new paradigm in fighting fraud by using data analysis to swiftly identify, investigate, and prosecute health care fraud perpetrators. Strike Force investigations are data driven and target individuals and groups that are actively involved in ongoing Medicare fraud schemes.

OIG is also capitalizing on cutting edge electronic discovery tools to maximize investigative efficiency in the processing and review of electronic evidence obtained during the course of our health care fraud investigations. This technology allows OIG Investigators and Computer Forensics Examiners to cull through Gigabytes, or even Terabytes, of electronic mail and other documents in a matter of days as opposed to months of manual investigative analysis. The OIG is also providing access to these tools to our law enforcement partners allowing a much more collaborative approach to reviewing electronic evidence than has been done up to now.

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HHS Deputy Secretary Bill Corr

Senate Judiciary Committee Hearing

"Effective Strategies for Preventing Health Care Fraud"

October 28, 2009

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Questions of Senator Tom Coburn, M.D.
"Effective Strategies for Preventing Health Care Fraud"
United States Senate Committee on the Judiciary
October 21, 2009

1. What criminal statutes are used to prosecute health care fraud?

DOJ Response: The following table presents the criminal statutes used most frequently in the Department's health care fraud cases and matters in fiscal year 2009.

Rank Frqcy	United States Code Title and Section "Short Title"	U.S. Code Title & Section	Pct Total FY 2009
1	Health Care Fraud	18 U.S.C. 1347	24.1%
2	Conspiracy to Commit Offense or Defraud United States	18 U.S.C. 371	16.8%
3	Criminal Forfeiture	18 U.S.C. 982	10.9%
4	Attempt and Conspiracy	18 U.S.C. 1349	8.3%
5	Mail Fraud and Swindles	18 U.S.C. 1341	5.1%
6	Laundering of Monetary Instruments	18 U.S.C. 1956	4.1%
7	False Statements Relating to Health Care Matters	18 U.S.C. 1035	3.4%
8	Criminal Penalties for Acts Involving Federal Heath Care Programs	42 U.S.C. 1320	2.7%
9	Prohibited Acts - Food, Drug and Cosmetic Act	21 U.S.C. 331	2.7%
10	Engaging in Monetary Transactions in Property Derived from Specified Unlawful Activity	18 U.S.C. 1957	2.0%
11	Fraud by Wire, Radio, or Television	18 U.S.C. 1343	2.0%
12	False Statements or Entires	18 U.S.C. 1001	1.5%
13	Fraud and Related Activity in Connection with Identification Documents, Authentication Features, and Information	18 U.S.C. 1028	1.4%
14	Principals - Crimes	18 U.S.C. 2	1.2%
15	False, Fictious or Fradulent Claims	18 U.S.C. 287	1.1%
16	Prohibited Acts - Drug Abuse Prevention and Control	21 U.S.C. 841	1.0%
17	Title 18 Civil Forfeiture	18 U.S.C. 981	1.0%
18	Attempt and Conspiracy	21 U.S.C. 846	0.9%
19	Theft or Embezzlement in Connection with Health Care	18 U.S.C. 669	0.9%
20	Prohibited Acts - Drug and Abuse and Prevention Control	21 U.S.C. 843	0.8%
21	Criminal Forfeiture	21 U.S.C. 853	0.5%
22	Public Money, Property or Records	18 U.S.C. 641	0.4%
23	Authorized Sentences	18 U.S.C. 3551	0.4%
24	Penalties - Food, Drug, and Cosmetic Act	21 U.S.C. 333	0.4%
25	Obstruction of Criminal Investigatins of Health Care Offenses	18 U.S.C. 1518	0.3%
26	Attempt to Evade or Defeat Tax	26 U.S.C. 7201	0.3%
27	Penalty for Failure to Appear	18 U.S.C. 3146	0.3%
28	Smuggling Goods into the United States	18 U.S.C. 545	0.3%
29	Destruction, alteration, or falsification of records in Federal Investigations and Bankruptcy	18 U.S.C. 1519	0.2%
30	All Other Statutes		5.0%
	Total		**100.0%**

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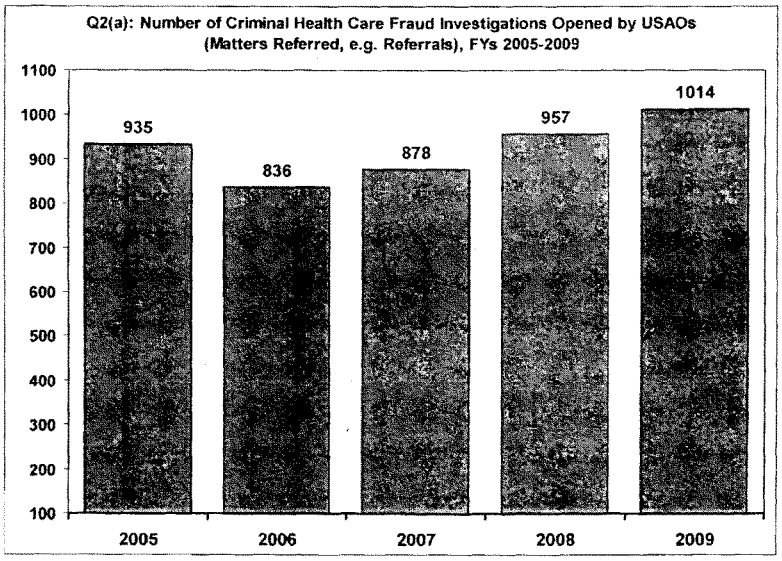
2. How many criminal health care fraud investigations have been opened in the last five years? How many criminal health care fraud prosecutions have been brought in the last five years? How many criminal health care fraud convictions have been secured in the last five years?

a. How many criminal health care fraud investigations have been opened in the last five years?

DOJ Response: Over the past five years, the Department of Justice has opened a total of 4,620 criminal health care fraud investigative matters. The following chart presents the number of new investigative matters opened during each fiscal year, 2005-2009.



b. How many criminal health care fraud prosecutions have been brought in the last five years?

DOJ Response: Over the past five years, the Department of Justice has filed or opened a total of 2,154 criminal cases charging 3,617 individual defendants with health care fraud violations. The following chart presents the number of cases filed and defendants charged during each fiscal year, 2005-2009.

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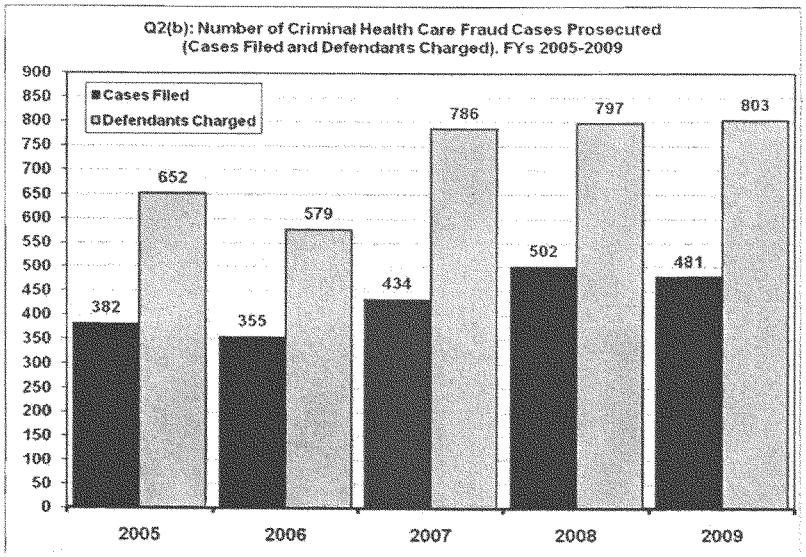

c. How many criminal health care fraud convictions have been secured in the last five years?

DOJ Response: Over the past five years, the Department of Justice has secured 2,801 convictions in criminal health care fraud cases prosecuted. The following chart presents the number of convictions in criminal health care fraud cases during each fiscal year, 2005-2009.

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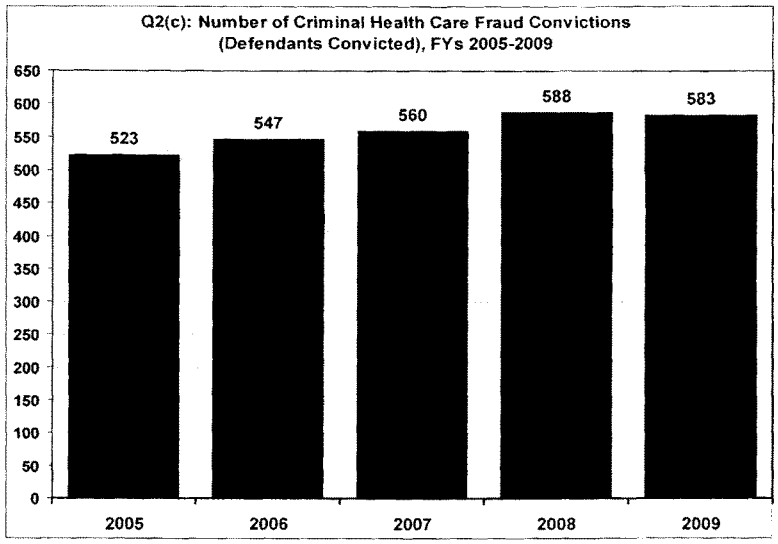

3. Which criminal statutes are used most often to prosecute criminal health care fraud?

DOJ Response: The criminal health care fraud statute, Title 18 U.S.C. §1347, is the most frequently used statute in criminal health care fraud prosecutions. Other criminal statutes that are frequently used include: conspiracy to defraud the United States, Title 18 U.S.C. §371, and attempt and conspiracy, Title 18 U.S.C. §1349; mail fraud, Title 18 U.S.C. §1341, and wire fraud, Title 18 U.S.C. §1343; money laundering, Title 18 U.S.C. §1956, and engaging in monetary transactions in property derived from specified unlawful activity, Title 18 U.S.C. §1957; false statements relating to health care matters, Title 18 U.S.C. §1035, and false statements, Title 18 U.S.C. §1001; and Food, Drug and Cosmetic Act violations, Title 21 U.S.C. §331 and §333. Collectively, these ten criminal statutes were charged in 70 percent of all health care fraud cases last year. The criminal penalty provisions of Title 42 U.S.C. §1320a-7b (Medicare Anti-Kickback Statute) were also charged in another 3 percent of health care fraud cases.

4. Is existing criminal law sufficient to reach the kind of health care fraud that you are seeing today?

a. If not, please give examples of the types of conduct you need to prosecute, but cannot reach with existing law.

DOJ Response: As demonstrated by the Department's response to Question 1, there are a substantial number of criminal statutes available for prosecuting numerous forms of health care fraud. However, we regularly evaluate whether additional statutes may be helpful as changes to

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health care financing and delivery systems occur. For example, in the private sector, the marketing and sale of fraudulent group health coverage to employee group health plans can be difficult to detect and prosecute. Additional enforcement tools may enhance efforts to curtail such abuses. .

5. What percentage of health care fraud can you not prosecute because of inadequacies in existing law?

DOJ Response: The Department is not aware of a significant amount of health care fraud schemes that cannot be prosecuted because of inadequacies in existing law.

6. How many prosecutors are currently assigned to health care fraud? How many of these prosecutors work health care fraud cases full time? On average, what is the health care fraud caseload for each of these prosecutors?

DOJ Response: The Department's health care fraud component agencies track attorney time by recording the amount of hours worked on health care fraud cases and matters. A single attorney full-time equivalent (FTE) equals 2,080 hours worked by any number of attorneys on health care fraud cases and matters. Therefore, the Department can only provide statistics for the number of attorney FTEs who recorded time worked on criminal and/or civil health care fraud cases and investigations.

In fiscal year 2009, approximately 125 FTE among criminal Assistant United States Attorneys and DOJ criminal attorneys were devoted to criminal health care fraud prosecutions and investigations. On average, each criminal health care fraud attorney FTE handled about 10 cases (which included new cases filed during the fiscal year and pending cases filed in previous years that were still being litigated in fiscal year 2009). In addition, each criminal health care fraud attorney FTE, on average, handled approximately 21 investigative matters (which included new matters opened during the fiscal year, plus matters pending from prior years that remained under investigation in fiscal year 2009).

Last year, approximately 140 FTE civil Assistant United States Attorneys and DOJ Civil Division attorney work years were devoted to civil health care fraud cases and investigative matters. On average, each civil health care fraud attorney FTE's case load was about 7 cases (which included new cases filed during the fiscal year and pending cases filed in previous years that were still being litigated in fiscal year 2009). In addition, each civil AUSA or DOJ attorney FTE, on average, handled approximately 15 civil investigative matters (which included new matters opened during the fiscal year, plus matters pending from prior years that remained under investigation in fiscal year 2009).

7. In your opinion, are the sentences available under existing law and Sentencing Guidelines sufficient to punish and deter health care fraud?

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DOJ Response: The Department believes that prison sentences have an important deterrent effect on health care fraud. The Department also believes that the Sentencing Guidelines generally provide an adequate framework for achieving tough, fair and consistent sentences in the federal criminal justice system.

8. Do improvements need to be made to any existing criminal laws to make them more useful in health care fraud prosecutions? If so, what are your suggested improvements?

DOJ Response: Although the Department is not in a position to offer any specific proposals at this time, we look forward to working with the Committee and with Congress on effective strategies for prosecuting health care fraud in all of its forms.

9. How much of the rampant health care fraud that we are experiencing is the result of lax enforcement of existing criminal law?

DOJ Response: The Department of Justice is vigorously enforcing criminal law to prevent, deter, and prosecute health care fraud to the fullest extent possible with our current levels of attorney, investigative, and support staff funded by the Health Care Fraud and Abuse Control (HCFAC) program. Between fiscal years 2003 and 2009, mandatory HCFAC program funds provided to the Department were largely fixed by statute at 2003 levels. The Tax Relief and Health Care Act of 2006 provided annual inflationary increases in HCFAC funding for fiscal years 2007-2009. The Department used the annual inflationary increases to launch the Medicare Fraud Strike Force. Last year, the Department also received an additional $19 million in discretionary funding through the HCFAC program for health care fraud enforcement. The Department used the added discretionary funding, in part, to expand the Strike Force from two to four sites, and for civil enforcement. In 2010, the Department received an additional $29.8 million in discretionary funding through the HCFAC program. During the seven-year period when health care fraud enforcement resources were increased only by annual inflation, the Department *increased* the number of criminal health care fraud cases filed annually by 34 percent from 362 cases in 2003 to 481 cases in 2009. Over this same period, however, the number of criminal health care fraud cases pending (e.g., awaiting settlement or resolution by trial) increased by nearly 45 percent from 551 to 798 cases (see following chart).

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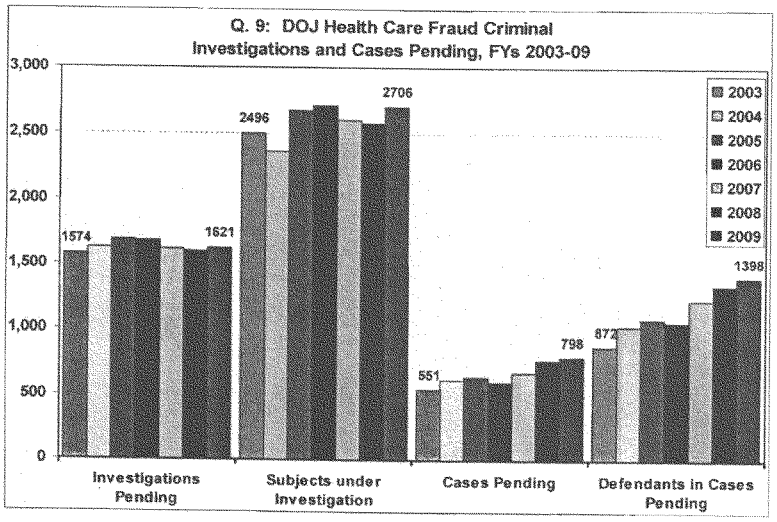

10. The new government plan proposed by Democrats is supposed to control costs by reducing the profits of insurance companies. Fortune Magazine found that the top 14 insurers earned a combined $8.61 billion in 2008. That may seem like a lot of money, but consider that Medicare lost an estimated $60 billion - seven times as much money - to fraud as those insurers earned in profits.

Moreover, GAO labeled Medicaid a "high risk" program, finding $32.7 billion in improper payments in 2007 alone -10 percent of the program's total spending. So the Medicare and Medicaid "public plans" lose more than $90 billion dollars to fraud each year - ten times the profits of the major insurers.

Question:
If the new government plan is anywhere close to the size of either Medicare or Medicaid, experience demonstrates that taxpayers will lose far more to fraud than they will save in eliminating insurer profits. Is that a good investment for taxpayers?

DOJ Response: A precise measure of the amount of fraud in Medicare and Medicaid does not exist. The Department's experience, from years of criminal and civil enforcement is that private health insurers suffer losses from fraud and abuse similar to those suffered by government health care programs. Because health care fraud drives up both public and private health care costs, the Department is committed to vigorously combating health care fraud in all of its forms.

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We think it is important to note that the improper payment rate should never be confused with the rate of fraud in any federal government program. OMB Circular A-123 defines "improper payment" as any payment that should not have been made or that was made in an incorrect amount. Incorrect amounts are overpayments and underpayments (including inappropriate denials of payment or service). An improper payment in the Medicare program means that the documentation provided with a claim does not support a claim payment. The reason for a determination of improper payment could be poor record-keeping, a mistake by the provider or supplier, or a decision by a supplier or provider that not contesting a finding of improper payments is the less costly avenue. Therefore, the fact that a payment has been ruled improper does not mean that the service should not have been provided. Fraud, on the other hand, implies intent to steal from the program.

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Senator Specter – Questions for Assistant Attorney General Tony West

Senate Judiciary Committee:
Effective Strategies for Preventing Health Care Fraud

October 28, 2009

1. Mr. West, you mention the historic and groundbreaking prosecution of "Pfizer Inc. and its subsidiary Pharmacia & Upjohn Company Inc." in which they "agreed to pay $2.3 billion to resolve criminal and civil liability arising from the illegal promotion of" Bextra. (West Stmt. at 2). I understand two individuals were prosecuted in related cases but that, to date, no individual has been sentenced to jail time. **Do you think that white collar criminals who commit – or assist their corporations in committing – multi-billion dollar health care frauds would be better deterred if they were sentenced to a period of incarceration?**

Response:

The Department is committed to vigorously prosecuting those responsible for committing health care fraud. In determining whether charges should be brought against corporations and their executives, the prosecutors weigh all of the factors normally considered in the sound exercise of prosecutorial judgment: the sufficiency of the evidence; the likelihood of success at trial; the probable deterrent, rehabilitative, and other consequences of conviction; and the adequacy of noncriminal approaches.

In the Pfizer/Pharmacia matter, we have charged and obtained convictions for the most serious, readily provable offenses that were supported by the facts of the case. The prosecutors made those determinations based on an "assessment of the extent to which particular charges fit the specific circumstances of the case, [were] consistent with the purposes of the Federal criminal code, and maximize[d] the impact of federal resources on crime." *See* U.S.A.M. § 9-28.1200B. Also, "[a] charge is not 'readily provable' if the prosecutor has a good faith doubt, for legal or evidentiary reasons, as to the Government's ability readily to prove a charge at trial." Department Policy Concerning Charging Criminal Offenses, Disposition of Charges, and Sentencing (Sept. 22, 2003) ("Ashcroft Memorandum"). "[C]harges should not be filed simply to exert leverage to induce a plea." *Id.*

Two individuals were charged and convicted in connection with that matter based on the evidence the Government was able to develop in the course of its investigation. One individual was convicted of a misdemeanor offense, and a probationary term was appropriate. In the case of a second individual, the Government advocated for a term of imprisonment, but the court sentenced the defendant to a term of probation with six months of home confinement. Neither individual was a senior executive in the company.

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To obtain a felony conviction of a corporate executive of a pharmaceutical or medical device company engaged in health care fraud, the United States is required to prove, beyond a reasonable doubt, that the individual had the requisite intent to commit the crime. Corporate executives are not vicariously liable for the felonious conduct of employees within the corporation. Therefore, a conviction of the company for feloniously misbranding a prescription drug product, for example, would require proof beyond a reasonable doubt that the executive had personal knowledge of the felonious misbranding activity *and intended to defraud or mislead.* In large organizations it can be very difficult to prove, beyond a reasonable doubt, that high level executives had knowledge of the illegal activity of their subordinates. It is especially challenging to prove the criminal intent necessary to sustain a felony conviction that could lead to a sentence of imprisonment.

Frequently, we learn of the allegations of criminal activity from the filing of a *qui tam* lawsuit by a company insider. The allegations are often about conduct that has occurred years before the lawsuit is filed. Therein lies another problem of pursuing individuals. We have limited time and resources to develop the facts and, as a result, the charging decisions are affected by the approaching statute of limitations.

2. Mr. West, you also mention the Department's prosecution of Eli Lilly and that the company "pled guilty to violating the Food, Drug, and Cosmetic Act (FDCA) for its illegal marketing of the anti-psychotic drug Zyprexa for uses that were not approved by the FDA." (West Stmt. at 4). That settlement in January 2009 "totaled $1.415 billion and included a $515 million criminal fine, $100 million in forfeiture and $800 million in civil recoveries . . . ." **To your knowledge, was anyone sentenced to jail time for the FDCA fraud perpetrated by Eli Lilly in its marketing of Zyprexa?**

   Response:

   No one was sentenced to jail in connection with the Eli Lilly matter.

3. Finally, Mr. West, you testified that "just last week, Mylan Pharmaceuticals, Inc. paid $118 million to resolve allegations that it had sold innovator drugs that were manufactured by other companies and had classified those drugs as non-innovator drugs for Medicaid rebate purposes." **Are you aware of whether any corporate actor or individual agent of Mylan Pharmaceuticals is expected to be targeted for the conduct that resulted in that prosecution and, if so, will the Department seek to have a sentence of incarceration imposed?**

   Response:

   We do not expect any criminal prosecution of any corporate actor or individual agent of Mylan Pharmaceuticals as a result of this conduct.

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4. **Mr. West, do you think that if individuals were incarcerated that would tend to have a general deterrent effect upon other corporate executives tempted by the profits associated with health care fraud?**

Criminal prosecution is a critical component of an overall law enforcement strategy designed to detect and prevent health care fraud. Consistent with Department policy, upon conviction, we advocate for sentences of imprisonment within the advisory Sentencing Guidelines range in all but extraordinary cases. This policy reflects the Department's belief that the Sentencing Guidelines provide the best framework for achieving tough, fair and consistent sentences in the federal criminal justice system.

Despite the challenges of bringing charges against individuals, the Department of Justice has charged and obtained convictions of senior corporate executives and others engaged in illegal activity in connection with the sale and marketing of pharmaceuticals and devices. In several recent cases, such as Purdue Pharma discussed below, responsible corporate officers were prosecuted where they did not implement measures to ensure that violations would not occur and, as a result, widespread violations were committed by individuals within the company. In other cases, we charged individuals whom we could prove were directly involved in the criminal conduct.

Recent Charges Against Senior Executives Engaged in Health Care Fraud at Major Pharmaceutical and Device Companies

- **InterMune (N.D. Cal.)**. On September 29, 2009, a jury in San Francisco returned a guilty verdict for wire fraud against the former CEO of InterMune, Inc., a biopharmaceutical company in Brisbane, California. The CEO was acquitted of a misbranding charge brought under the Federal Food, Drug and Cosmetic Act. The charges stemmed from an August 28, 2002 InterMune press release that described the results of a clinical trial that tested InterMune's drug Actimmune as a treatment for the fatal lung disease, idiopathic pulmonary fibrosis (IPF). Despite the trial failing completely, the CEO wrote the press release to falsely portray the trial results as showing that Actimmune helped IPF patients live longer, claiming in his defense that a "subgroup analysis" of the test results justified the claim. In addition to distributing the press release to the public generally, InterMune's sales force used the press release with doctors to increase sales of Actimmune. The annual cost of Actimmune for one IPF patient was $50,000. The vast majority of InterMune's sales of Actimmune were for the purpose of treating IPF even though Actimmune was not approved by the Food and Drug Administration as a treatment for IPF. Sales of Actimmune made up 90% of InterMune's revenues. The guilty verdict followed a seven-week jury trial. Sentencing will take place early next year. Dr. Harkonen is facing a potential sentence of imprisonment.

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- **Synthes, Inc./Norian Corp. (E.D. PA)**: In June 2009, four senior executives at a medical device manufacturer, Norian Corp., and its wholly owned subsidiary Synthes, Inc., were charged with offenses related to the off-label promotion of Norian XR, an unapproved bone cement developed by defendants. The defendants developed Norian XR by adding barium sulfate to Norian SRS, a device that was approved by FDA. The However, Norian SRS was approved only to fill bony voids that were not intrinsic to the stability of the bony structure, and the FDA specifically warned that SRS should not be mixed with any other substance. Despite the approved indications and FDA warnings, defendants mixed SRS with another substance and promoted it for off-label uses. The individuals pled guilty to misdemeanor offenses as "responsible corporate officers" in July and are awaiting sentencing.

- **Serono Labs (D. Mass.)**: In 2008, a medical director for Serono Laboratories, a subsidiary of Swiss drug manufacturer Serono, S.A., pled guilty to three counts of causing the dissemination of adulterated computer software devices used to interpret bioelectrical impedance analysis (BIA) test results, in order to diagnose AIDS wasting and to increase sales of an AIDS wasting drug. The device in question, a software package used to diagnose "AIDS wasting" (a profound involuntary loss of weight and lean body mass which was once a leading cause of death among AIDS patients), was adulterated because FDA had not approved or cleared it for this use. The President of the medical device manufacturer, RJL Sciences, also pled guilty to conspiracy in connection with the crime.

- **Purdue Pharma (W.D. Va.)**: In May 2007, three Purdue Pharma senior executives pled guilty to misdemeanor misbranding offenses, as responsible corporate officers, relating to misrepresentations the company made to health care providers that Purdue's drug OxyContin was less addictive, less subject to abuse and diversion, and less likely to cause withdrawal problems than other pain medications. As a result of their misconduct, the Department of Health and Human Services' Office of Inspector General excluded the three officers from participation in federal health care programs for 15 years. The exclusions have been upheld administratively and are on appeal in federal court.

- **Stryker Biotech (D. Mass.)**: In October 2009, four executive officers at medical device manufacturer Stryker Biotech were charged along with the company with multiple felony counts related to an illegal marketing scheme to promote off-label the unapproved use of the firm's medical devices, OP-1 and Calstrux. OP-1 is a putty implant that is used for repairing and regenerating bone. Calstrux was a Stryker product approved to fill voids in bones. The charges allege that the executives at Stryker, however, promoted OP-1 and Calstrux together, and directed physicians to mix Calstrux with OP-1, a use not approved by FDA. The case is ongoing and no one named in the October 2009 indictment has been convicted. Four sales managers from Stryker were charged by separate Informations in late 2008 through spring 2009. Those four individuals pled guilty but have not yet been sentenced.

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Senator Grassley – Questions for Assistant Attorney General Tony West

Senate Judiciary Committee:
Effective Strategies for Preventing Health Care Fraud

October 28, 2009

1) False Claims Act: Civil Investigative Demands (CIDs):

Please provide a specific date when the Department will implement and delegate the Attorney General's authority to sign off on Civil Investigative Demands (CIDs) as authorized by the Fraud Enforcement Recovery Act of 2009. In order for the Committee to properly exercise oversight responsibilities, please provide a specific time frame for implementation and to whom the authority will be delegated.

Response:

On May 20, 2009, the President signed the Fraud Enforcement and Recovery Act of 2009 (FERA), which included amendments authorizing the Attorney General to delegate his authority to issue civil investigative demands (CIDs) under the False Claims Act. On January 15, 2010, the Attorney General delegated to the Assistant Attorney General for the Civil Division all authority of the Attorney General under 31 U.S.C. sec. 3733. That authority is re-delegable by the Assistant Attorney General to other Department officials, including United States Attorneys. On March 8, 2010, the Assistant Attorney General issued a directive re-delegating this authority to United States Attorneys in cases that are delegated or assigned as monitored to their respective offices. For cases that are jointly handled by the Civil Division and a United States Attorney's Office, the directive provides that the Civil Division will issue a CID only after requesting the United States Attorney's recommendation.

2) False Claims Act: Public Disclosure Bar:

In the last Congress, the Department provided views and supplementary materials to the Committee that stated the Department would not object to removing the jurisdictional component of the public disclosure bar of the False Claims Act, given certain modifications to the bill then pending. Has the Department changed it views on this issue? If so, please provide an update as to what the official position of the Department is related to Section 4 of S.458 (111th Congress).

Response:

Since the October 28, 2009 hearing, Congress and the President have acted to amend the False Claims Act's public disclosure bar. On March 23, 2010, the President signed into law P.L. 111-148, the Affordable Care Act (ACA). Section 10104(j)(2) of ACA revised the public disclosure bar in several respects, including removing the

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reference to "jurisdiction" from the bar. As amended, the public disclosure bar provides as follows:

(4)(A) The court shall dismiss an action or claim under this section, unless opposed by the Government, if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed--

(i) in a Federal criminal, civil, or administrative hearing in which the Government or its agent is a party;

(ii) in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation; or

(iii) from the news media,

unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, 'original source' means an individual who either (i) prior to a public disclosure under subsection (e)(4)(a), has voluntarily disclosed to the Government the information on which allegations or transactions in a claim are based, or (2) who has knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions, and who has voluntarily provided the information to the Government before filing an action under this section.

3) Working Capital Fund and the 3% Fund:

In 2002, Congress authorized the Attorney General to collect "up to 3 percent of all amounts collected pursuant to civil debt collection litigation activities of the Department of Justice." This authorization allows the Attorney General to retain 3% of all civil debt collections and place those funds in the Department's Working Capital Fund.

As civil settlements by the Department of Justice continue to grow in size, especially under the False Claims Act, I'm concerned with the size of this fund. I want to ensure that the expenditures are done in accordance with the law.

I have concerns regarding the 3% fund and how monies recovered from health care fraud cases that are supposed to be returned to the Medicare trust fund are diverted to the Department. The trust fund is ultimately back-filled by the Treasury Department, but this begs the question: Could this process could be simplified?

Do you agree it would be easier for Congress to provide an annual appropriation to DOJ equal to a percentage of civil debt collections instead of this system of moving money from the Trust Fund and refilling it? Why or why not?

Response:

The Department does not agree that it would be easier for Congress to provide an annual appropriation to DOJ equal to a percentage of civil debt collections for a number of reasons. At this time, the 3 % offset is available to the Department upon disbursement.

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Disbursement usually takes place within a week after the funds are received by the Department. These funds are then available for expenditure as authorized. Therefore, this funding is not subject to the enactment of continuing resolutions or other full-year funding vehicles. Further, the 3 % fund is "no year" money, which means that balances may be carried over to subsequent years.

There are important reasons why Congress designed the 3 % fund in this manner. (*See* 28 U.S.C. § 527 (note)). The 3 % fund was established in order to provide the Department with additional resources to improve civil debt collection and to generate increases in revenue to the United States Treasury. The Department uses 3 % funds to advance critical financial recovery and collection efforts throughout the Department -- not just in the health care fraud area. Thus, Medicare Trust Fund deposits constitute only a part of the total 3 % fund. Large cases for the prior fiscal year which have contributed to the 3 % fund include cases in the areas of defense procurement fraud (*Walanpatrias Stiftung*), tax fraud (*UBS*), fire recovery (*Union Pacific Railroad*), and mortgage fraud (*RBC Mortgage*). The Department does not believe that it is reasonable to change the mechanism by which the entire 3 % fund is provided to the Department, because a portion of the offset relates to the Medicare Trust Fund.

With respect to your comments concerning the Medicare program, we note that the Department has a process in place under which documentation is provided to the Treasury's Bureau of Public Debt (BPD) each time a collection is transferred to the Medicare Trust Fund. The documentation shows the total amount of the collections and the amounts retained for the 3% offset in accordance with Public Law 107-273. The BPD is responsible for transferring from the Treasury General Fund to the Medicare Trust Fund the amounts due back to the Trust Fund as reimbursement, and the Department is not involved in those transactions. Therefore, we would respectfully refer you to the Department of the Treasury and the Department of Health & Human Services to determine the accuracy of your statement that "The trust fund is ultimately backfilled by the Treasury Department. . . ".

Would you object to Congress placing new restrictions on the 3% fund to ensure that Medicare funds are returned directly to the trust fund and not diverted to DOJ?

Response:

The Department would object strenuously to Congress placing restrictions on the 3% fund in the manner described above. The Department uses 3% funds to support financial recovery and collection efforts throughout the Department on behalf of the United States Government, not just in the health care fraud area. Many cases have substantial resource needs, and the 3% fund has been used to provide a portion of the resources needed, in addition to other appropriated resources.

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Moreover, the Treasury Department reimburses the Medicare Trust Fund for all Medicare fraud recoveries allocated to DOJ as 3% offsets, which ensures that the Medicare Trust Fund receives 100% of civil recoveries for Medicare fraud litigation. Thus, the Medicare Trust Fund is made whole. The monthly deposits can be seen on the Financial Statements provided by the Treasury Department.

4

SUBMISSIONS FOR THE RECORD

Statement of the American Orthotic and Prosthetic Association
Concerning Effective Strategies for Combating Health Care Fraud
October 28, 2009

On behalf of the American Orthotic and Prosthetic Association, I appreciate this opportunity to describe to you some fundamental steps we think could reduce fraud in Medicare. AOPA was founded in 1917, and is the largest national trade association representing the interests of patient care facilities, distributors and manufacturers of orthoses (orthopedic braces) and prostheses (artificial limbs). With nearly 2,000 member companies, the association is dedicated to raising awareness of the profession and advocating for policies that impact the future of the orthotic and prosthetic field and the patients we serve.

The American Orthotic and Prosthetic Association has long advocated for steps to protect Medicare patients from fraud and abuse and from poor quality care. Legitimate businesses, and organizations that represent bona fide providers in the prosthetic and orthotic field have petitioned, cajoled and met with Medicare officials for years, complaining about these problems, and proposing ways the Centers for Medicare and Medicaid Services (CMS) could combat the problem. Last Sunday, "60 Minutes" aired a report concerning fraud in this area that highlighted the cost of inaction.

Crooks apply for and receive a Medicare provider number for their "business" even though no medical equipment or supplies are ever sold. They buy names, addresses and social security numbers of Medicare beneficiaries, steal or fraudulently secure physician prescriptions, and start billing Medicare for a range of items, often including prosthetics—artificial limbs and electric arms are specifically cited in the "60 Minutes" story—because they are relatively high priced items. No one confirms the medical necessity or the legitimacy of the practitioner. As shown in the "60 Minutes" story, patients with all four natural limbs are surprised when they see their Medicare Explanation of Benefits for 'their' prosthetic legs and arms.

There are fundamental steps that should be taken immediately to reduce fraud. The first step should be to ensure Medicare payment goes to only those practitioners of orthotics and prosthetics who are licensed to do so, if a state requires licensure.

Ironically, The Centers for Medicare and Medicaid Services issued "Transmittal 656" in August, 2005 to require that only those individuals licensed in states requiring licensure for the provision of orthotics and prosthetics were reimbursed by Medicare. However, and tragically for Medicare and the people the program serves, this transmittal was never implemented. To implement this requirement, the contractor responsible for processing claims for orthotics and prosthetics would have to make an "edit" in their system to acknowledge that the practitioner is licensed. No explanation has ever been given about why this Transmittal although issued, was never implemented. This fundamental step would prevent those who simply want to rip off the system from being able to do so.

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Currently 12 states have licensure laws. Surely the time it would take to initially verify licensure would be well worth the effort and save Medicare millions over time.

The corollary to state licensure for those practitioners in states that do not require licensure would be accreditation. No practitioner should receive Medicare payment unless the individual is accredited according to a strict standard that includes specific education and training (residency) requirements. To be eligible as an accrediting organization, the organization should be either (1) be the American Board for Certification in Orthotics and Prosthetics, Inc. or the Board for Orthotist/Prosthetist Certification or (2) use standards essentially equivalent to those used by one of these Boards. This is completely consistent with legislation already enacted by Congress in Section 427 of Beneficiary Improvement and Protection Act 2000. We believe that accrediting bodies should have a history in this area and that there not be so many accrediting bodies that credentialing and therefore quality is driven to the lowest common denominator.

AOPA members believe that qualifications standards should be established so these bad actors couldn't bill for the more complicated (and costly) services, unless they had demonstrated they had the skills needed to do the job right. While most people are familiar with prosthetics, they are not as familiar with complex orthotics needed by children and adults with debilitating diseases. For children with cerebral palsy and adults with MS, complex orthotics are often custom made and can help them with activities of daily living, like sitting up right.

Legislation has been introduced in the House of Representatives that would implement the strategies we have highlighted. The Medicare Orthotics and Prosthetics Improvement Act, HR 2479, would require CMS to take the two steps we have outlined to reduce fraud in Medicare and it also creates strong standards for the professionals providing care to people with limb loss or in need of complex orthotics. It will save money and ensure the highest level of care in the prosthetic and orthotic profession. We believe that these steps could save at least $100 million in Medicare.

CMS could act upon these recommendations and tighten up the loopholes that allow crooks to take advantage of the Medicare system. However, that has not happened. AOPA members urge this Congress to act upon these recommendations now.

Tom Fise
Executive Director
The American Orthotic and Prosthetic Association
330 John Carlyle Street
Alexandria, VA 22314
571-431-0876

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63186.026

Testimony for Effective Strategies for Preventing Health Care Fraud

Testimony of United States citizen named:
David M. Carlin
4111 Decatur Ave
Kensington, MD 20895
(301)300-7079 cell
(301) 962-7291 msg

United States Senate Committee on the Judiciary
Testimony for hearing dated Oct. 28, 2009
On Effective Strategies for Preventing health Care Fraud

My name is David M. Carlin and I was a stay at home dad and I am a victim. The following Mosquito report is an outline of what many parents are currently going through in the United States. We have asked for justice and we find ourselves fighting the people that have created the problem. Namely attorneys and abused person lobby groups. These powerful groups have created a system within our state family law systems that is fundamentally unfair and biased. The system routinely violates civil rights of American citizens and is funded by public money.

The attached Mosquito report was compiled by thousands of parents that have struggled to make corrections at the State level it is time for a change at the Federal level and we want these issues investigated. We seek a Judicial Oversight investigation for the prevention of health care fraud in regards to family health and wellbeing. We ask this committee to investigate the common practices of the legal profession to strip assets of at risk American families. This fraud is widespread and has a huge negative economic impact on the at risk American family.

We seek the investigation into this fraud that preys on the very basic instincts of parents to be with their children. We ask that absent abuse, neglect and abandonment the Senate propose federal legislation for the presumption of shared parenting. We ask the Senate investigate and use the attached case law and state statutes that have been established in the Majority of states to complete the task and make presumption of shared parenting federal law. It is in the best interest of the children of America to have a strong family no matter what form it takes. This requires strong penalties for attorneys that escalate domestic situations for profit. We need to preserve the assets of the family within the family not our judicial system. As a federal agency the Health and Human Services oversees the enforcement of family matters. We need fundamental changes to protect the children of the United States and remove profit seeking professionals from the conflict of at risk families.

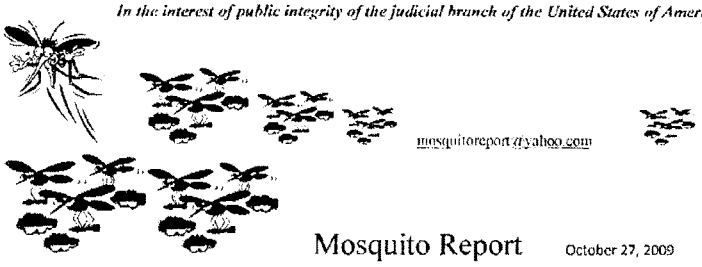
Please include the Mosquito report as part of my testimony and investigate the issues outlined in the report. The report outlines a common pattern of racketeering that strips American families of financial resources. This creates negative economic impact in every state and place a financial burden on social programs. Please investigate these issues and act on the changes we request to implement an "**Effective Strategies for Preventing health Care Fraud**" in our family court system.

David M. Carlin 10/27/09

10/27/2009 12:12PM

Mosquito Report Parent's Information Report

In the interest of public integrity of the judicial branch of the United States of America



Wise Old American Indian saying: Be like the mosquito small, fast, annoying, persistent, inflicts pain, and swarms. Join us in building a swarm to bring back integrity and accountability to our justice system.

James Madison quotes:

"The accumulation of all powers, legislative, executive, and judiciary, in the same hands, whether of one, a few, or many, and whether hereditary, self-appointed, or elective, may justly be pronounced the very definition of tyranny" (James Madison, Federalist No. 48, Feb. 1, 1788). **What this means: Stop voting for attorneys entering public service.**

Thomas Paine video: http://www.youtube.com/watch?v=jeYscnkp6yA

Acknowledgements

The Mosquito report represents the struggle and achievements of thousands of parents and organizations that have paved the way for changes in our family law system across the United States. Sadly many parents have taken their own lives for having no place to turn for help. We want to express our deepest regret to their families and friends for their loss. We pray that this report will aid in preventing this from happening in the future. The Mosquito report has been assembled to provide the resources needed to provide hope and support and gain access to children. We thank each and every parent and organization for their input to this public effort. We want to give them our highest praise for protecting the children's rights. We want to thank them for exposing Judicial Misconduct and Professional Misconduct of attorneys profiting from parents struggle to access their children. We want to thank them for taking the time to make legislative changes that are needed to protect the future of our children and American Family.

Mosquito Report Objective

The objective of this report is to educate the public about peaceful alternatives to litigation and the traps set by profit seeking legal professionals. This report addresses the key issues that both parties need to keep in mind. **Both parties must control** their anger **towards the opponent** and come to a reasonable settlement and preserve assets. The information in this report will help to avoid escalation of your issues by the legal profession. Remember the **legal profession is a business and seeks to profit** from your conflict. Let me state this again the legal profession is a business and seeks to profit from your conflict. Did you get the point they want your assets. We have assembled important information, case laws, and statutes and provided legal forms within this report. Our objective is to **take the profit out of conflicts and preserve family assets for the benefit of your children.**

The negative economic impact to yourself and family assets will be great if you enter litigation. Avoid this at all costs your children need your assets not the legal profession. One of the largest causes for foreclosure and bankruptcy is divorce. You will be told by attorneys that you can sell everything you own to pay legal expenses to continue the conflict. Remember you have a choice to escalate the conflict or find a cost effective settlement path. Think of the needs of your children. How would your **paying attorneys**, court appointed experts, social workers benefit your children. I want to make this clear IT **DOES NOT IN ANY WAY BENEFIT YOUR CHILDREN**. Science has proven absent neglect, abuse, abandonment children need both parents. Do not allow attorneys to twist normal conflicts into abuse. An attorney might "suggest" the use of domestic violence as a tactic. Do not fall into this trap. "Never stir up litigation. A worse man can scarcely be found than one who does this." (Abraham Lincoln, 16th President) Attorney will not tell you that this tactic blocks mediation. Your focus is to resolve your conflict with your opponent and not involve the children. Keep them out of the conflict and provide the best possible solution you can that meets the needs of both parties.

Remember someone always gets hurt in a divorce or custody battle. Know if you are hurt or mad and seek revenge against your opponent do not involve the children. Do not drain financial resources to the legal profession that could be used to benefit yourself and your children. Think of the children and remember you once loved your opponent to the point of having a child in the first place. Any issues can be resolved without the involvement of litigation. Seek to preserve your assets from profit seeking legal professionals and protect your children's rights to both parents. Know if you are fighting or fleeing (fight or flight). Calm down and take a breath.

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Your Children's Rights

The most important issue is the Children. The children have a fundamental right to see both parents. The court uses the term "in the best interest of the children" as a smoke screen to promote parental alienation tactics to strip parents access to children. Protect your children from the legal system. Parental alienation will damage the children for the rest of their lives. **We need every parent to keep the children out of their fight.** What is said and what is practiced by the legal system are two separate things. It is becoming routine for facts about normal parental relationships to be twisted into abuse, these false accusations must be documented. Early statistics are showing that 80% of accusations are unfounded, or worse, planned and executed. "Never stir up litigation. A worse man can scarcely be found than one who does this." (Abraham Lincoln, 16th President) When a plan is executed the sole purpose is to circumvent due process of law and gain control of custody of children and assets. This creates an unfair advantage, a violation of Rules of professional misconduct by the party that executed the plan. Courts will routinely overlook this misconduct due to the "political nature" of these cases. What happens in these cases is a parent is stripped of their access to their children. Seek to modify the determination of child custody and support a presumption of shared parenting. Let's keep the children away from the lawyers and legal system. "Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them how the nominal winner is often a real loser – in fees, expenses and waste of time. As a peacemaker, the lawyer has a superior opportunity of being a good man. There will still be business enough." (Abraham Lincoln, 16th President)

Reasons for Support:

1. A custody decision should focus upon the U.S. constitutional custody rights and responsibilities of parents first and the unfitness of parents afterwards. The "Best interests of children" are typically served by encouraging and facilitating maximum involvement among *both* parents and children.

2. Since courts currently award joint custody as it relates to the decision-making abilities of parents, the courts are rarely presented with a true and accurate picture due the contentiousness of divorces, the adversarial climate of family courts, and their historically biased custody rulings favoring a single parent (mothers) in 88% of cases.

3. Current law requires trial courts to make findings on requests for joint custody. Instead there should be a statutory presumption of joint physical custody. Trial courts should make findings on reasons for *not* awarding joint physical custody.

4. Where trial courts must determine custody under existing child custody factors, mothers receive sole physical custody in the overwhelming majority of cases. Fathers are required to separate motion separately for visitation (parenting time) in order to exercise their parental responsibilities.

5. Joint custody awards should not necessarily reflect the voluntary distribution of parental involvement in an intact household prior to divorce. The environment of a two-household, non-intact family will place new demands upon parents and children alike.

6. A joint physical custody award will practically guarantee a greater involvement of both parents in the lives and activities of their children. Typical visitation (parenting time) awards hamper the involvement of both parents in their child's development post divorce. Custody awards to unmarried mothers seldom involve adequate child visitation of fathers.

7. The definition of an unfit parent is easily defined by the U.S. constitution and upheld by the U.S. Supreme Court. This definition is limited to physical, psychological, or child abuse. If parental unfitness were to be defined by current Maryland domestic violence statutes, it would be so broad that few parents (married or otherwise) would be deemed fit to parent.

8. There are indeed times when joint physical/legal custody is not in the best interest of the children, but these times are the exceptions and involve actual physical, psychological, or child abuse.

9. These changes will dramatically reduce the documented bias of custody awards by state trial courts. Further it will reduce litigation and its associated costs. Further it will preserve the marital assets for the minor children.

10. These changes will encourage both parents to remain accessible to their children. Court discretion can be utilized to determine specific physical custody durations based upon circumstances. Presumption of 50/50 for physical custody.

11. MARYLAND CASE LAW: In Maryland there is case law already established Kimberly Boswell v. Robert G. Boswell (Boswell v. Boswell, 352 Md. 204, 721 A.2d 662(1998)) quoted from court clarifying the best interest standard:(b) in making a determination of legal and physical custody under this subtitle, the court shall give primary consideration to the best interest of the child. Reasonable maximum exposure to each parent is presumed to be in the best interest of the child. The Maryland Court of Appeals overruled this decision and stated as part of their decision, "We seek to clarify that only one standard is used in determining whether to restrict parental visitation in the presence of non-marital partners, bests interests of the child, but we also want to emphasize that when a court is engaging in a best interests analysis, reasonable maximum exposure to each parent is presumed to be in the best interests of the child." (352 Md. 204, at 214.) This language was important as it was the first time a Maryland state court has mentioned any presumption towards both parents, at least in any published opinion.

    Some have claimed that Boswell was really a case about gay rights, and only nominally discussed this issue of a presumption towards maximum reasonable exposure. For a time, it seemed that the courts were also treating Boswell in such a manner. However, we have recently found a 2007 Court of Special Appeals case applying Boswell. In Gordon v. Gordon (174 Md.App. 583, 923 A.2d 149 (Md.App., 2007).), the Court of Special Appeals took up the case of a father who was attempting to modify a custody order to have the time split 50-50. While the court ruled that 50-50 was not the meaning of maximum reasonable exposure, the court did report favorably on the presumption first articulated is Boswell and did not rule that this presumption was just dicta. Furthermore, the court noted that the custody arrangement currently in place for the Gordons afforded Mr. Gordon every other weekend from Thursday night through Monday morning and Wednesday morning through Thursday morning on alternate weeks. It should not go without noting that the one published case citing Boswell's presumption language had a custody arrangement that was much more equitable than most.

Economic impact

Many Studies have been conducted on the economic benefits to the child of joint custody and we ask you to research this subject on the World Wide Web and not depend on individuals who make their living from Family law. We ask that you review the United States Department of Health and Human Services Fatherhood Initiative programs and the various foundations that are now funding and promoting the strong positive impact of fathers in the best interest of the children of America. These programs express the need to help low income families and father to obtain the training they need to be the best parents they can be. We have attached two reprinted articles that outline the truth about economic impact of custody. THE WALL STREET JOURNAL article included below "The Myth of Deadbeat Dads" outlines percentages of mothers and fathers payments of child support. The Washington Times article "Child-support-law amendment comes to attention of Hill" outlines how custody becomes an incentive to pay child support. This article also shows the economic impact of driving child support payers into the underground economy. Reports of statistics of parents with joint custody pay their child support obligations at a much higher rate providing a reduction in Child-support enforcement. To expand on the negative economic impact you just need to look deeply at how the justice system of the United States has removed resource from our productive citizens. I call any industry that doesn't product anything a parasitic industry. As

the parasitic industries grow our society will not be able to support their greed. Think about their unjust fees and reputations.

Parental Access to Children

Listed below is a section of case law that has been established in support of constitutional right to have access to your children. These cases have established parental rights from a constitutional stand point. However be aware that state appointed judges will violate your rights to add expense to your conflict and meet their funding requirements. The family court system is basically a divorce industry that prays on parent's anger for profit. Remember this fact a system has been developed to take your money.

Do not fall into the trap of allowing legal professionals to exploit your parental instincts to protect and nurture your children. Both parties have these instincts. The best way for both parties to win is to allow equal access to children when possible. This should be in the form of joint physical custody. Legal custody is a term used by the legal profession to confuse the public. It has been proven that parents that pay child support that have access continue to pay. Again do not allow legal professionals to exploit your parental instincts to protect and nurture your children. Fight for the presumption of shared parenting and seek the best interest of your children is to have access to both parents and preserve family assets.

Flight or Fight

The legal system has developed a system that prays on your basic parenting instincts. What they do is exploit a parent's anger toward the other parent. This takes the form of a custody battle over the children. No consideration is given to the rights of the children to see both parents. **Absent abuse, neglect and abandonment every child deserves both parents.** As a parent we have all heard the stories of parents going "nuts" and killing their children and families. These are the stories that the media love to play on and are relatively very few. However their exposure creates the fear and ultimately the bias the courts exploit. This is one form of the **"fight"** we ask that if you intend to fight expose the injustice of the predatory practices of the judicial system.

It is normal to get angry or depressed when you are removed from your children. When good parents are backed up against a wall some fight back with force. There is a book called "Kill the Attorneys" and a sad fact is many people are turning their anger towards biased judges. This has become a problem for this movement because judges are being killed. Harsh legislation against parents rights is starting to be past into law because key committees are dominated by attorneys. Their motive is simple protect their profit making industry and cover up their wrong doing. What seems to be happening is people are starting to take the time to plan military style assaults with diversions and routes to execute their plans. These tactics take time to plan and this level of anger is a direct result of parents having no place to turn for justice. This is due to legal professionals ignoring civil rights of parents. These sworn legal professionals strip families of resources and place financial burdens on parents to meet federal funding requirements. We need to get to the root of the problem and use the pen and change legislation to take the profit out of these predatory practices.

What doesn't get the media's attention is how many parents use "flight" to escape these legal attacks for profit. The CDC studies show how parents are committing suicide at an alarming rate. The studies show men have a higher success rate at committing suicide. These suicides are a direct result of predatory practices and place a negative economic impact on our society. The justice system has built in controls to protect them from being accused. These controls take the form of publicly funded social programs or crisis centers. Depression is a very powerful emotion and victims sometimes seek help from these programs. The truth is parents seeking help from social programs for their depression are labeled. They later find the very organization they went for help from are used against them in a court of law. This sometimes triggers a negative response and the person now feels they have no place to turn and they commit suicide. The legal system always terms their victims as unstable or mentally unstable for the media. These simple examples outline how when parents have no place to turn for justice their emotions kick in and becomes basic instincts of **fight or flight.** The trigger the legal profession doesn't what you to know about is the following section. Parental alienation is currently being suppressed in legislation by legal professionals and abused person funded organizations.

Parental Alienation

Avoid this behavior the long term damage to your children cannot be repaired. The basic trust between child and parents should remain intact for both parents. It is the child's right to have this trust of both parents. **Stop this form of child abuse.**
What is Parental Alienation Syndrome (PAS)? This is the definition of PAS as described by R.A. Gardner: http://www.paskids.com/
"The parental alienation syndrome (PAS) is a disorder that arises primarily in the context of child-custody disputes. Its primary manifestation is the child's campaign of denigration against a parent, a campaign that has no justification. It results from the combination of a programming (brainwashing) parent's indoctrinations and the child's own contributions to the vilification of the target parent." (Excerpted from: Gardner, R.A. (1998). The Parental Alienation Syndrome, Second Edition, Cresskill, NJ: Creative Therapeutics, Inc.)

Maryland law has only marginally addressed the issue in the case of Barton v. Hirshberg 137 Md.App. 1, 767 A.2d 874 Md.App., 2001. Courts outside of Maryland have reviewed the issue in greater detail listed below.

http://www.metacafe.com/watch/2117396/the_gregory_mantell_show_parental_alienation_part_2/
http://www.dailymotion.com/video/x8nfdc_the-gregory-mantell-show-parental-a_shortfilms
http://www.hostile-aggressive-parenting.com/
http://www.paawareness.org/
http://www.stopparentalalienation.org/
Frye v Gardner in the Family Courts (Part 1)
http://expertpages.com/news/parental_alienation_syndrome.htm
Frye v Gardner in the Family Courts (Part 2)
http://expertpages.com/news/parental_alienation_syndrome2.htm
Expert:
Jayne A. Major, Ph.D., Executive Director
Stop Parental Alienation of Children
Breakthrough Parenting Services, Inc
12405 Venice Boulevard, #172, Los Angeles, CA 90066 (Map)
Telephone: (310) 823-7846
Fax: (310) 388-0700
jaynemajor@gmail.com
www.stopparentalalienation.org
www.breakthroughparentingservices.org

Court Rulings Relevant to Parental Alienation UNITED STATES (22 States)

The Frye Test is the standard by which a court can determine whether a scientific contribution has gained enough general acceptances in the scientific community to be admissible in a court of law. The Frye Test criteria for admissibility were applied to The Parental Alienation Syndrome in the following cases:

- Kilgore v. Boyd, 13th Circuit Court, Hillsborough County, FL, Case No. 94-7573, 733 So. 2d 546 (Fla. 2d DCA 2000) Jan 30, 2001.
  - Boyd v. Kilgore, 773 So. 2d 546 (Fla. 3d DCA 2000) (*Prohibition Denied*)
  - Court ruling that the Parental Alienation Syndrome has gained general acceptance in the scientific community and thereby satisfies ***Frye Test*** criteria for admissibility.
- Bates v. Bates 18th Judicial Circuit, Dupage County, IL Case No. 99D958, Jan 17, 2002.
  - Court ruling that the Parental Alienation Syndrome has gained general acceptance in the scientific community and thereby satisfies ***Frye Test*** criteria for admissibility. [excerpt]

Court Rulings

Alabama

- Berry v. Berry, Circuit Court of Tuscaloosa County, AL, Case No. DR-96-761.01. Jan 06, 2001

Alaska

- Pearson v. Pearson, Sup Ct. of AK., No. S-8973, No. 5297, 5 P.3d 239; 2000 Alas. Lexis 69. July 7, 2000.

Arkansas

- Chambers v. Chambers, Ct of App of AR, Div 2; 2000 Ark App. LEXIS 476, June 21. 2000.

California

- Coursey v. Superior Court (Coursey), 194 Cal.App.3d 147,239 Cal.Rptr. 365 (Cal.App. 3 Dist., Aug 18, 1987.
- John W. v. Phillip W., 41 Cal.App.4th 961, 48 Cal.Rptr.2d 899; 1996.
- Valerie Edlund v. Gregory Hales, 66 Cal. App 4th 1454; 78 Cal. Rptr. 2d 671.

Colorado

- Oosterhaus v. Short, District Court, County of Boulder (CO), Case No. 85DR1737-Div III.

Connecticut

- Case v. Richardson, 1996 WL 434281 (Conn. Super.,Jul 16, 1996).
- Metza v. Metza, Sup. Court of Connecticut, Jud. Dist. of Fairfield, at Bridgeport, 1998 Conn. Super. Lexis 2727 (1998).

Florida

- Schutz v. Schutz, 522 So. 2d 874 (Fla. 3rd Dist. Ct. App. 1988).
- Blosser v. Blosser, 707 So. 2d 778; 1998 Fla. App. Case No. 96-03534.

- Tucker v. Greenberg, 674 So. 2d 807 (Fla. 5th DCA 1996).
- Berg-Perlow v. Perlow, 15th Circuit Court, Palm Beach County, FL,Case no. CD98-1285-FC. Mar 15, 2000.
  - An exceptionally strong family court decision in which five experts testified to the diagnosis of PAS.
- Loten v. Ryan, 15th Circuit Court, Palm Beach County, FL., Case No. CD 93-6567 FA. Dec 11,2000.
- Kilgore v. Boyd, 13th Circuit Court, Hillsborough County, FL., Case No. 94-7573, 733 So. 2d 546 (Fla. 2d DCA 2000) Jan 30, 2001.
  - Boyd v. Kilgore, 773 So. 2d 546 (Fla. 3d DCA 2000) (*Prohibition Denied*)
  - Court ruling that the Parental Alienation Syndrome has gained general acceptance in the scientific community and thereby satisfies ***Frye Test*** criteria for admissibility.
- McDonald v. McDonald, 9th Judicial Circuit Court, Orange County, FL. Case No. D-R90-11079, Feb 20, 1001.
- Blackshear v. Blackshear, Hillsborough County, FL 13th Jud. Circuit: 95-08436.

Illinois

- In re Violetta 210 Ill.App.3d 521, 568 N.E2d 1345, 154 Ill.Dec. 896(Ill.App. 1 Dist Mar 07, 1991).
- *In re* Marriage of Divelbiss v. Divelbiss, No. 2-98-0999 2nd District, Ill.(Appeal from Circ Crt of Du Page Cty No. 93-D-559) Oct 22, 1999.
- Tetzlaff v. Tetzlaff, Civil Court of Cook County, Il., Domestic Relations Division, Cause No. 97D 2127, Mar 20, 2000.
- Bates v. Bates 18th Judicial Circuit, Dupage County, IL Case No. 99D958, Jan 17, 2002.
  - Court ruling that the Parental Alienation Syndrome has gained general acceptance in the scientific community and thereby satisfies ***Frye Test*** criteria for admissibility.[excerpt]

Indiana

- White v. White, 1995 (Indiana Court of Appeals) 655 N.E.2d 523. (Ind. App., Aug 31, 1995).

Iowa

- In re Marriage of Rosenfeld, 524 NW 2d 212, 214 (Iowa app, 1994).

Louisiana

- Wilkins v Wilkins, Family Court, Parish of East Baton Rouge, La., Civ. No. 90792. Nov. 2, 2000.
- White v Kimrey, Court of Appeal, Second Circuit, LA, No. 37,408-CA. May 14, 2003.Click here for the Court's decision.

Michigan

- Spencley v. Spencley, 2000 WL 33519710 (Mich App).

Nevada

- Truax v. Truax, 110 Nev. 437, 874 P. 2d 10 (Nev., May 19, 1994).

New Hampshire

- Lubkin v. Lubkin, 92-M-46LD Hillsborough County, NH. (Southern District, Sept. 5, 1996).

New Jersey

- Lemarie v. Oliphant, Docket No. FM-15-397-94, (Sup Crt NJ, Ocean Cty:Fam Part-Chancery Div) Dec. 11, 2002.

New York

- Rosen v. Edwards (1990) Tolbert, J. (1990), AR v. SE. New York Law Journal, December 11:27-28.
  The December 11, 1990 issue of *The New York Law Journal* (pages 27-28) reprinted, in toto, the ruling of Hon. J. Tolbert of the Westchester Family Court in Westchester Co.
- Karen B v. Clyde M., Family Court of New York, Fulton County, 151 Misc. 2d 794; 574 N.Y. 2d 267, 1991.
- Krebsbach v. Gallagher, Supreme Court, App. Div., 181 A.D.2d 363; 587 N.Y.S. 2d 346, (1992).
- Karen PP. v. Clyde QC. Sup Ct of NY, App Div, 3rd Dept. 197 A.D. 2d 753; 602 N.Y.s. 2d 709; 1993 N.Y. App. Div. LEXIS 9845.
- In the matter of J.F. v. L.F., Fam. Ct. of NY, Westchester Cty, 181 Misc 2d 722; 694 N.Y.S. 2d 592; 1999 N.Y. Misc. LEXIS 357.
- Oliver V. v. Kelly V., NY Sup. Ct. Part 12. New York Law Journal Nov. 27, 2000.
- Sidman v. Zager, Family Court, Tompkins County, NY: V-1467-8-9-94.

Ohio

- Sims v. Hornsby, 1992 WL 193682 (Ohio App. 12 Dist., Butler County, Aug 10 1992).
- Zigmont v. Toto, 1992 WL 6034 (Ohio App. 8 Dist Cuyahoga County, Jan 16, 1992).
- Pisani v. Pisani, Court of Appeals of Ohio, 8th App. Dist. Cuyahoga Cty. 1998 Ohio App. Lexis 4421 (1998).
- Pathan v. Pathan, Case No. 96-OS-1. Common Pleas Court of Montgomery County, OH, Div. of Dom Rel.
  - Pathan v. Pathan, C.A. Case No. 17729. Ct. of App. of OH, 2d Dist., Montgomery County; 2000 Ohio App. Lexis 119. Jan. 21, 2000
- Conner v. Renz, 1995 WL 23365 (Ohio App. 4 Dist., Athens County, Jan 19, 1995).
- State v. Koelling, 1995 WL 125933 (Ohio App. 10 Dist., Franklin County, Mar 21, 1995).

Pennsylvania

- Popovice v. Popovice, Court of Common Pleas, Northampton Cty, PA. Aug 11, 1999, No. 1996-C-2009.

Texas

- Ochs et al. v. Myers, App. No. 04-89-00007-CV. Ct. of App. of TX, 4th Dist., San Antonio; 789 S.W. 2d 949; 1990 Tex App. Lexis 1652, May 16, 1990.

Virginia

- Ange, Court of Appeals of Virginia, 1998 Va. App. Lexis 59 (1998).
- Waldrop v. Waldrop, in Chancery No. 138517. Fairfax County Circuit Court,(Va., April 26, 1999).

Washington

- Rich v. Rich, Sup Ct, 5th Dist. Case No. 91-3-00074-4 (Douglas County) June 11, 1993.

Wisconsin

- Janelle S. v. J.R.S., Court of Appeals of Wisconsin, District 4. 1997 Wisc. App. LEXIS 1124 (1997).
- Fischer v. Fischer, Ct. of App. of WI, Dist. Two, No. 97-2067; 221 Wis. 2d 221; 584 N.W.2d 233; 1998 Wisc. App. Lexis 1534.

Wyoming

- In re Marriage of Rosenfeld, 524 N.W. 2d 212 (Iowa App., Aug 25 1994) McCoy v. State 886 P.2d 252 (Wyo.,Nov 30, 1994).
- McCoy v State of Wyoming, 886 P 2d 252, 1994.

Violence Against Woman Act (VAWA)

We need to protect both sexes and this act is fundamentally unfair and flawed. The Center for Disease Controls (CDC) has conducted studies that clearly show men and woman are just about equal when it comes to violence against a domestic partner. Health and Human Services (HHS) and the Fathers Initiative programs have conducted numerous studies that also prove the positive value to have both parents involved with the raising of children.

The problem with this act is it is being misused by woman groups (woman caucuses) to establish unfair advantages in child custody domestic situations. Misinformation is routinely used to conceal the truth. The problem is this is a very profitable industry that extends deep into many aspects of our society. What we need is a simple change to Stop Child Abuse for Profit. Absent abuse neglect and abandonment no court should be allowed to strip the rights of the children to see both parents. We need several issues addressed 1) Anger management for both adult parties 2) Mediation 3) Presumption of shared parenting; requiring courts to justify why they strip one parent or the other. 4) Judicial oversight by the public 5) Stiffer Misconduct penalties for abuse of domestic violence statutes 6) Public reporting of Misconduct abuses

Miss appropriation of public funding has become routine with this act and a large percentage of funding is used in a biased discriminatory fashion in violation of the first amendment. Funding is also misused to pay high priced executives that routinely lobby against the American family on the state and federal level.

Bradley Amendment

The enforcement of child support clause ties the hands of judges to suspend payments. This has effectively created a new debtors prison system here in the United States of parents. Their only crime was having a child with the wrong life partner. What happens is the court imposes child support payments and interest and fees that can never be repaid. The debtor's debt continues to go up even when they are imprisoned for non-payment. There are many stories of good parents being stripped of everything they own to see their children only to end up in prison. When a child is removed from the parents instincts kick in and the judicial fraud takes place. This document clearly shows the case laws and the crimes being committed on a routine bases against the public interest and American family. So what was the problem with the Bradley amendment?

In United States law, , the **Bradley Amendment** is the common name given to any of a number of amendments offered by Senator Bill Bradley the most notable of which is the amendment to 42 U.S.C. § 666(a)(9)(c) which requires state courts to prohibit retroactive reduction of child support obligations. The Amendment was passed in 1986 to automatically trigger a non expiring lien whenever child support becomes past-due.

- The law overrides any state's statute of limitations.
- The law disallows any judicial discretion, even from bankruptcy judges.
- The law requires that the payment amounts be maintained without regard for the physical capability of the person owing child support (the *obligor*) to make the notification or regard for their awareness of the need to make the notification.

The amendment was intended to correct a perceived imbalance between the power of the obligee (usually the mother) and the obligor (usually the father) during subsequent child support disputes.

It had been alleged that a significant number of men were running up large child support debts and then finding a sympathetic judge, often in another state, to erase them. Recent studies have shown that most woman do not pay their obligations. Often a

woman of means simply claims abuse and deadbolts the father away from the child or children. This is starting to become the norm or status quo many law enforcement officers and abused person programs are now suggesting the misuse of domestic violence statutes for this purpose. This alarming trend is creating a systematic way to increase funding for enforcement merely by prosecuting a party. Many parties are stripped of marital assets and resources to defend themselves properly or worst denied their right to representation all together.

The issue is how do we correct the problem created with the Bradley Amendment. Simply make an amendment to allow judge to suspend the debt. The argument of increased collections of child support payments has failed and is offset by the negative economic impact of enforcement based on debts that cannot be collected from a growing prison population in the new Debtor Prisons.

Federal Racketeering Violations being covered up

A simple fact is when an attorney or judge does not report misconduct it is MISCONDUCT. It is a simple fact that when an attorney or judges conceals a crime it is a CRIMINAL ACT against the public. *WE THE PEOPLE* have laws in place that are meant to protect the public's interests. What takes place in the family law system is criminal racketeering by legal professionals. They simply escalate a domestic situation with their "off the record" advice. At this point the party will pay for additional services that the attorneys have created. The attorneys create a bigger conflict therefore bigger fees that can be extracted from at risk families. Each family can have all assets stripped to pay attorney fees. How can this be "in the best interest of the child". The justice department has gone as far to recommend the abuse of domestic violence statutes to increase enforcement and other funding in violation of Federal accounting regulations (FAR). The outline of federal crimes being committed is pursuant to: US Code: Title 18 Part 1 Chapter 96 §1962 and other sections. These criminal acts will be expanded upon later in this report.

Tape or Record All Hearings

If you have to go to court, the MOST important thing to do is file a WRITTEN motion to video or audio record all hearings to insure you have an accurate ELECTRONIC record of your hearings. This helps keep everyone honest, therefore decreases the need for appeals and expensive court reporters and transcripts. Court transcripts and audio recordings have been altered or "lost" to protect a corrupt family law system. Watch the videos: "Deconstructing America" to learn from disbarred attorneys about altered court records and transcripts. These attorneys got disbarred for speaking out against the system.

Deconstructing America, Part 1 http://www.youtube.com/watch?v=TBzUywM2ENo

Deconstructing America, Part 2 http://www.youtube.com/watch?v=vB2msm45ex8&feature=related

Protect yourself from misconduct and file a motion to have in the record. The point is to get your motion in the record file. Courts wish to avoid the APPEARANCE of being unfair. But if they do deny your motion, you want any denial in the record file of your case. Make sure you file the WRITTEN motion well ahead of time. Don't wait until you get before the judge to motion orally or let your attorney do the same.

SAMPLE MOTION TO RECORD ALL HEARINGS (Modify to fit your case and if you use an attorney remove #1.)

YOUR STATE:
IN THE (J & DR or CIRCUIT) COURT OF (WHATEVER) COUNTY

JANE DOE, Plaintiff

v

JOHN DOE , Defendant

Case No. $$$$$$$$

MOTION TO VIDEO RECORD, OR ALTERNATIVELY, AUDIO RECORD ALL HEARINGS

COMES NOW JOHN DOE to make this motion to be allowed to video record, or alternatively, audio record all hearings in this matter for the following reasons:

1. I am a pro se litigant and cannot afford an attorney.

2. I cannot afford a court reporter and cannot make accurate notes while attempting to represent myself in court.

3. I need accurate notes in the event of an appeal from this proceeding.

4. I need the court's authorization to bring a recording device into the court house past the security screeners.

WHEREFORE, Mr. DOE requests the court allow him to video or audio record all hearings in this matter.

Respectfully submitted.

John/Jane Doe, pro se

_____

John Doe
1234 Bankrupt Lane
Upthecreek, SlaveState 00000

Know the "Enemy"

1. Your anger and being hurt by your opponent can be your biggest enemy. Do not allow yourself to destroy years of assets over a conflict. Look to preserve your assets to benefit your children. If both parties have assets the children win. When assets are drained by the legal profession the children lose. It is that simple.
2. In litigation your ex will lie. Their attorney will lie. The facts will be twisted. False accusations will be made. Your civil rights will be violated. Judges will use their discretion against facts. Your marital assets will be drained by the system. Make no mistake your ex and the system is your family's enemy. Your objective should be to seek a mediation channel outside the court system before entering the system. Only involve attorneys at the last possible minute to review agreements before signing. Look at sample agreement and forms available on internet. Use third party mediators like clergy, rabbi, etc. find the common platform to save marital assets from the legal profession.
3. The Judicial system has created an entrenched system that is structured to take funds from at risk families. The system results in a huge negative economic impact based on predatory practices of the legal profession. The fees charged by attorneys, courts, copies, experts and paid public social workers are funded by your conflict. It is common knowledge that the Family Court system is biased toward woman and represented clients. Judicial misconduct and professional misconduct are rarely enforced with less than 1% prosecution. Expect dishonesty by your opposition to go unpunished by a corrupt system. Expose attorney grievances in public record before filing them.
4. The abused person program is funded by the Federal government (2009 $1.8 billion). This funding is misused by various shelters and nonprofit organizations to pay for studies and lobby efforts against children's rights and equal rights. These organizations promote the misuse of domestic violence as a tactic to gain control in a divorce. These organizations discriminate against the under privileged, men and provide useless information for men demonstrating their bias and discriminations. These groups are actively on a misinformation campaign. Expose and document it. Lobby against these groups funding by sending letters to your delegates.
5. The United States and various state constitutions grant every person the right to participate in government and civic affairs, speak freely on public issues, and petition government officials for redress of grievances. A retaliatory tactic used by the legal profession is called **SLAPP = Strategic Lawsuit against Public Participation** intended to intimidate and silence critics by burdening them with the cost of legal defense until they abandon their opposition. These issues must have public interest or social significance.
6. Exposing organized racketeering violations in the interest of the integrity of the legal profession should be the focus and civic duty of the public. The need for more public over site of the judicial branch exists. The public must have clear defined enforcement and audit abilities to control corruption and misconduct in the judiciary. US CODE TITLE 18 PART 1 CHAPTER 96§1951 is a great place to start your research. Protect your family assets and expose these actions.
7. Know your Delegates and Senators position on shared parenting and do not vote for representatives that are against this issue. Do not vote for members of the judicial branch (Lawyers, Judges) for state or federal offices. They do not belong in the legislative branch. This creates corruption at the highest level of our government. Lawyer campaigns are funded by other lawyers and law firms to obtain power and influence. "James Madison" hit the nail on the head for this issue. "The accumulation of all powers, legislative, executive, and judiciary, in the same hands, whether of one, a few, or many, and whether hereditary, self appointed, or elective, may justly be pronounced the very definition of tyranny" (James Madison, Federalist No. 48, Feb. 1, 1788).
8. Collect and document all information about your enemy.

Suggestions

"Stand up for your Children's Rights" "Unite these efforts" "*Know your enemy*" "Be active"

1. If you are falsely accused of Domestic Violence read below information and act quickly to build your defense. Make sure the court does not award custody of children to opposition. Avoid bad agreements with this action they will effect a divorce. Any agreement with a domestic violence case will have impact on mediation of a divorce avoid them. The court will enforce them for the victim but not for the respondent "Known Bias". Expose and document false accusations to the Court. The court knows the political nature of these cases and rules on their risks of exposure.

2. If you have been accused of Domestic violence your life has been changed forever even if not convicted. Welcome to the "*Domestic Violence Registry*". Your name has been entered and it is maintained by the FBI and other States. You character has been damaged forever by your accuser. This information will impact your ability to get jobs etc. We have been informed you must prove fraud to be removed but it is very difficult and made costly. http://www.thebostonchannel.com/video/18047516/index.html

3. You must file counter-complaints of any accusation or file false accusation charges quickly. Know that the court has strict timeframes and you must seek legal assistance quickly. **Do not wait on any subject get on the offensive go on the attack.** Get the proof and witnesses you need. Expose any civil rights violations by the judicial system.

4. Attorneys will not tell you that a simple defense of obtaining a risk assessment report and various other tests from a licensed psychologist will aid with your defense. There are experts in defense against false accusations. Dean Tong is one such expert and has been successful for many years. www.deantong.com/ or http://www.abuse-excuse.com/

5. Seek any means of resolution other than entering the judicial system which will drain family assets. Seek mediation with third parties to resolve the issues to protect the family's assets. Protect your assets from the legal profession. They will escalate issues for their profit and job justification.

6. The Department of Justice "DOJ" promotes and disseminates misinformation about studies to law enforcement, social works and Judges. Question everything they supply and look for the true facts and science. The DOJ has created a penal colony of parents that cannot meet their debts. Even if a person is place in jail for failure to pay child support the debt continues to grow making it in possible to pay. This drives many good parents into the underground economy. The US outlawed debtor prisons in the 18th century (1833 President John Quincy Adams) and yet our largest prison population is for failure to pay child support.

7. Mediate everything you can to lower costs to both parties. So you don't exhaust family assets in the form of legal fees. Only hire attorney's that support Parent's Rights and practice family law. Provide direction in writing to avoid conflict with what you want your attorney to accomplish.

8. Interview your perspective attorney. Don't go for initial consultation if it cost you money. You're looking to hire them only if they meet your needs. Otherwise move to the next one. Do not pay them for a job interview. Remember they will be working for you. Know that attorneys are in business and look for ways to make more money with your conflict.

9. Know that the justice systems objective is to place a financial burden on a parent for "child support" this can be abused and used to create debts that never can be erased or paid. When a judge uses a heavy hand and assesses child support payments retroactive to the filing date. The results is a good parent is place in the new "debtor prison system". The only benefit is obtained by the justice system funding objective. The justice system contracts prisoner workers to various companies at nearly slave wages? This has become a big business and the justice system is building more prisons in remote locations only accessible by train. Does this remind you of anything like how NAZI Germany handled prisoners? A change is needed to the **Bradley Amendment a 1986** federal law that prohibits retroactive reduction of alleged "child support". The change that is needed to this Amendment is to allow the courts judges to use their discretion to suspend in the arrears obligations of parents. The financial burden the current Bradley amendment places on our society drives good parents into the underground economy or worst places them in prison. How can this be in the best interest of the children of America?

10. Know your State Representatives Delegates (3) and Senator (1) and do not vote for them if they do not support Children's Rights to both parents and or Parent's Rights. Call and ask how they stand on these issues. In Maryland General Assembly (301) 858-3000 Maryland: http://www.msa.md.gov/msa/mdmanual/07leg/html/ga.html#senate

11. Know your Federal Representatives, 1 Congressman and 2 Senator: http://www.congress.org/congressorg/home/

12. **Do not vote for any member of the Judiciary,** Lawyers, and judges etc. that seeks to be a member of the legislative branch. (Delegate or Senator, etc.) "The accumulation of all powers, legislative, executive, and judiciary, in the same hands, whether of one, a few, or many, and whether hereditary, self-appointed, or elective, may justly be pronounced the very definition of tyranny" (James Madison, Federalist No. 48, Feb. 1, 1788).

13. Study the rules for Judicial Misconduct and Professional Misconduct for your state: http://michie.lexisnexis.com/ http://www.courts.state.md.us/attygrievance/index.html http://www.mdcourts.gov/mdatjc/about.html

Attorneys

Stop voting for Attorneys to enter public office. Take a look at their funding and you will find they self promote each other into office. The campaign funding trail demonstrates how this takes place. Learn about free legal clinics and pro se projects in your state. Learn how to represent yourself in order to make sure your attorney is your advocate. The "right to counsel" is your right under the sixth and fourteenth amendment. What you need to know is that you have the right to timely hearings so get to know the assignment office of the court. Attorneys will schedule hearings so you have to pay additional fees. Keep your hearings within your needs not the needs of the attorney or courts. Know the basic appeal period for your area. Always interview your attorney for free do not pay a fee for the interview. Yes they have to make a living but do not sign retainers that allow them to charge for large blocks of time. Review the fee structure carefully and negotiate items to make them reasonable. Most attorneys charge their hourly rate when they make copies and phone calls and research etc. So be very careful what you sign and always keep track of calls and time spent with the attorney and check there records against yours. Always provide a 1099 to them for tax purposes and get receipts for each payment you make. Read the rules of professional misconduct and expose any violations. Your attorney is your advocate so keep informed and get copies of all motions and filings as they are completed.

A common tactic used by the legal profession is to discredit parents and suppress opposition with expensive litigation. The objective is to get a list of assets quickly so they know how much they can strip with legal fees and associated experts. This might sound like a movie script but the normal pattern is to single out a parent and discredit them the main tool they use is the children. The negative economic impact to our country is huge for predatory a practice which has extended to all aspects of law. Think about how our society is being stripped by a layer that provides nothing to our citizens. What I mean by this is the legal profession does not produce a product. They provide a service that in many cases for something they have created. This is the very definition of extortion used to create a conflict for the increased fees for their services. We need to have more citizen based oversight of the judiciary branch and its members. Less than 1% of attorney grievances are prosecuted and a recent study shows that if a citizen files a law suit against a state or the government most are not even heard a violation of the victims civil rights.

Divorce information and Internet Links

Books: Divorce Poison by: Richard A. Warshak Parental Alienation Syndrome by: Richard A. Gardner
Children's Rights Council: www.crckids.org (301)459-1220 promotes the proposed Bill "Children's Rights" to "presumption of shared parenting" for the children of Maryland get active and help with this issue. **Mothers for Shared Parenting for Children:** supports this Bill and functions as collection point for names please send to: Erica Sansbury, 1001 Fairview Ave., Takoma Park, MD 20912. (301)891-3849
The **Women's Law Center** lobbies against presumption of shared parenting but publishes a free informative reference guide on Legal Rights of Marriage & Divorce in Maryland http://www.wlcmd.org/pdf/LegalRightsMarriageDivorce.pdf
Maryland Judiciary Case Search: Track your case docket (Court documents filed make a notebook!) Check to make sure no errors are entered. Get certified copies of important docket entries in your case they could get "Lost". Get copies of Transcripts also. http://casesearch.courts.state.md.us/inquiry/inquiry-index.jsp
Michies's Legal Resources: List by State Rules and Codes of law. Read about family law and professional rules of conduct to keep attorneys from escalating issues. http://michie.lexisnexis.com/
Respecting Accuracy in Domestic Abuse Reporting (RADAR): Third party studies & statistics http://www.mediaradar.org/
The **National Fathers Resource Center: http://www.fathers4kids.com/html/DomesticViolence.htm** Domestic violence facts and information.
Fathers United for Equal Rights Foundation: "Father Support group that provides free attorney at meetings". (Meetings 1st and 3rd Tuesdays of each month Rockville, MD) Has a list of suggested local father's rights attorneys.
http://www.marylandfathers.org**Fathers Rights:** "Father's Rights Survival Guide" Provides low cost Advocate plans to guide you on divorce issues a great low cost second opinion on your legal issues. http://www.fathersrightsinc.com
Fathers and Dads for equal custody rights: Pro Se books and guides that can be used to guide your attorney. Litigate a divorce

yourself on a Pro Se basis. http://www.fathersrights.org
Fathers4 justice: National event calendar "Stop the War on Fathers" http://www.f4j.com
American Coalition for Fathers and Children (ACFC): Shared parenting. http://www.acfc.org
Dadsdivorce.com: Information and forums. http://www.dadsdivorce.com
Alliance for Non-Custodial Parents Rights: Books and Downloads. http://www.ancpr.org
Baby Center: Information on babies Books and Downloads. http://www.babycenter.com https://www.fatherhood.org/fathers.asp
Men and Father Resource Center: http://www.fathers.org/
http://fatherhood.hhs.gov/regions/region06.shtml
http://www.kofc.org/un/eb/en/convention_2008/newsroom/fathers.html
http://www.nhsa.org/program/fathers/index.htm
http://www.memory-of.com/Public/article9.aspx
http://www.truefatherhood.org/
http://www.plennsacks.com/national_fatherhood_initiative_ads.htm
http://www.fatherhood.gov
http://www.fatherhood.com Travel packages
HHS Agencies that provide Funding. (Fatherhood Initiatives) https://www.fatherhood.org/fathers.asp
HHS Improving Research and Data collection on Fathers
SAMHSA (Substance Abuse and Mental Health Services Administration)
CDC (Centers for Disease Control and Prevention)
OPA (Office of Population Affairs)
OMH (Office of Minority Health)
NIH (National Institutes of Health) Institutes: NICHD, NIMH, NIDA, NIAAA
HRSA (Health Resources and Services Administration)
ASPE (Office of the Assistant Secretary for Planning and Evaluation)
ACF (Administration for Children and Families)

Supporting Reference Statutes

Maryland is one of the last 13 States that do not have a presumption or strong preference for joint custody. Thirty-seven states plus the District of Columbia have statutes that explicitly authorize joint custody as a presumption or strong preference. The following are some of the best relevant statues from States that provide a presumption.

- DELAWARE
- DISTRICT OF COLUMBIA
- FLORIDA
- IDAHO
- LOUISIANA
- MONTANA
- NEW MEXICO
- TEXAS

The following are some of the best relevant statutes from states which provide a strong preference for joint custody:

- ALASKA
- CALIFORNIA
- KANSAS
- MICHIGAN
- MINNESOTA
- MISSISSIPPI
- NEW HAMPSHIRE

The following two states have case law which makes joint custody a preference:

- GEORGIA
- KENTUCKY

Statutes Supporting Shared Custody

DELAWARE:

Title 13, Chapter 7, Subchapter I, 701. Rights and responsibilities of parents; guardian appointment.

(a) The father and mother are the joint natural custodians of their minor child and are equally charged with the child's support, care, nurture, welfare and education. Each has equal powers and duties with respect to such child, and neither has any right, or presumption of right or fitness, superior to the right of the other concerning such child's custody or any other matter affecting the child. If either parent should die, or abandon his or her family, or is incapable, for any reason, to act as guardian of such child, then the custody or such child devolves upon the other parent. Where the parents live apart, the Court may award the custody of their minor child to either of them and neither shall benefit from any presumption of being

better suited for such award.

DISTRICT OF COLUMBIA:

D.C. Code 16-911. Alimony pendente lite; suit money; enforcement; custody of children. (a)(5) and 16-914. Retention of jurisdiction as to alimony and custody of children. (a)(2) ... Unless the court determines that it is not in the best interest of the child, the court may issue an order that provides for frequent and continuing contact between each parent and the minor child or children and for the sharing of responsibilities of child-rearing and encouraging the love, affection, and contact between the minor child or children and the parents regardless of marital status. There shall be a rebuttable presumption that joint custody is in the best interest of the child or children, except in instances where a judicial officer has found by a preponderance of the evidence that an intrafamily offense as defined in D.C. Code section 16-1001(5), an instance of child abuse as defined in section 102 of the Prevention of Child Abuse and Neglect Act of 1977, effective September 23, 1977 (D.C. Law 2-22; D.C. Code 6 (2101), an instance of child neglect as defined in section 2 of the Child Abuse and Neglect Prevention Children's Trust Fund Act of 1993, effective October 5, 1993 (D.C. Law 10-56; D.C. Code 6-2131), or where parental kidnapping as defined in D.C. Code section 16-1021 through section 16-1026 has occurred... To determine the best interest of the child, for the purpose of making a joint or sole custody determination, the court shall consider all relevant factors, including but not limited to:

- the willingness of the parents to share custody;
- the sincerity of each parent's request;
- the parent's ability to financially support a custody arrangement;
- the impact on Aid to Families with Dependent Children and medical assistance;
- the benefit to the parents;

D.C. Code 16-911(2)(A) In any custody proceeding under this chapter, the court may order each parent to submit a detailed parenting plan which shall delineate each parent's position with respect to the scheduling and allocation of rights and responsibilities that will best serve the interest of the minor child or children....

(D) The court may also order either or both parents to attend parenting classes.

(3) Joint custody shall not eliminate the responsibility for child support in accordance with the applicable child support guideline as set forth in section 16-916.1.

FLORIDA:

Title VI, Chapter 61, 61.13. Custody and support of children; visitation rights; power of court in making orders.

5(2)(b)...It is the public policy of this state to assure that each minor child has frequent and continuing contact with both parents after the parents separate or the marriage of the parties is dissolved and to encourage parents to share the rights and responsibilities of childrearing....

2. The court shall order that the parental responsibility for a minor child be shared by both parents unless the court finds that shared parental responsibility would be detrimental to the child....

3.(3) For purposes of shared parental responsibility and primary residence, the best interests of the child shall include an evaluation of all factors affecting the welfare and interests of the child, including but not limited to:

(a) The parent who is more likely to allow the child frequent and continuing contact with the nonresidential parent.

(c) The capacity and disposition of the parents to provide the child with food, clothing, medical care or other remedial care recognized and permitted under the laws of this state in lieu of medical care, and other material needs.

(j) The willingness and ability of each parent to facilitate and encourage a close and continuing parent-child relationship between the child and the other parent.

(4)(c) When a custodial parent refuses to honor a noncustodial parent's visitation rights without proper cause, the court may:

1. After calculating the amount of visitation improperly denied, award the noncustodial parent a sufficient amount of extra visitation to compensate the noncustodial parent, which visitation shall be taken as expeditiously as possible in a manner which does not interfere with the best interests of the child: or
2. Award the custody or primary residence to the noncustodial parent, upon the request of the noncustodial parent, if the award in the best interests of the child.

IDAHO: Title 32, Chapter 7, 32-717B. Joint custody.

(1) "Joint custody" means an order awarding custody of the minor child or children to both parents and providing that physical custody shall be shared by the parents in such a way as to assure the child or children of frequent and continuing contact with both parents... If the court declines to enter an order awarding joint custody, the court shall state in its decision the reason for denial of an award of joint custody.
(2) "joint physical custody" means an order awarding each of the parents significant periods of time in which a child resides with or is under the care and supervision of each of the parents or parties.
(4) Except as provided in subsection (5), of the section, absent a preponderance of the evidence to the contrary, there shall be a presumption that joint custody is in the best interest of a minor child or children.
(5) There shall be a presumption that joint custody is not in the best interests of a minor child if one (1) of the parents is found by the court to be a habitual perpetrator of domestic violence as defined in section 39-6303, Idaho Code.

Section 1 of S.L. 1982. ch. 311 read: "Policy statement. It is the policy of this state that joint custody is a mechanism to assure children of continuing and frequent care and contact with both parents provided joint custody is in the best interest of said children."

LOUISIANA: Civil Code, Section 3,

Article 131. Court to determine custody. A. If there are children of the marriage whose provisional custody is claimed by both husband and wife, the suit being yet pending and undecided, custody shall be awarded in the following order of preference, according to the best interest of the children:
(1) To both parents jointly. The court shall, unless waived by the court for good cause shown, require the parents to submit a plan for implementation of the custody order, or the parents acting individually or in concert may submit a custody implementation plan to the court prior to issuance of a custody decree. A plan of implementation shall allocate the time periods each parent shall enjoy physical custody of the children and the legal authority, privileges and responsibilities of the parents....
(2) To either parent. In making an order for custody to either parent, the court shall consider, among other factors, which parent is more likely to allow the child or children frequent and continuing contact with the noncustodial parent, and shall not prefer a parent as custodian because of that parent's sex or race. The burden of proof that joint custody would not be in a child's best interest shall be upon the parent requesting sole custody.
D. For purposes of this Article, "joint custody" shall mean the parents shall, to the extent feasible, share the physical custody of children of the marriage... Physical care and custody shall be shared by the parents in such a way as to assure a child of frequent and continuing contact, with both parents. An award of joint custody obligates the parties to exchange information concerning the health, education, and welfare of the minor child; and, unless allocated, apportioned, or decreed, the parents or parties shall confer with one another in the exercise of decision- making rights, responsibilities, and authority.
E. The court shall state in its decision the reasons for modification or termination of the joint custody order if either parent opposes the modification or termination order.

ARTICLE 132. AWARD OF CUSTODY TO PARENTS
In the absence of agreement, or if the agreement is not in the best interest of the child, the court shall award custody to the

parents jointly; however, if custody in one parent is shown by clear and convincing evidence to serve the best interest of the child, the court shall award custody to that parent.

SUBPART B. JOINT CUSTODY

335 Joint custody decree and implementation order. A. (1) In a proceeding in which joint custody is decreed, the court shall render a joint custody implementation order except for good cause shown.

(2)(a) The implementation order shall allocate the time periods during which each parent shall have physical custody of the child so that the child is assured of frequent and continuing contact with both parents.

(b) To the extent it is feasible and in the best interest of the child, physical custody of the children should be shared equally... B. (1) In a decree of joint custody the court shall designate a domiciliary parent....

(2) The domiciliary parent is the parent with whom the child shall primarily reside....

(3) The domiciliary parent shall have authority to make all decisions affecting the child unless an implementation order provides otherwise....

C. If a domiciliary parent is not designated in the joint custody decree and an implementation order does not provide otherwise, joint custody confers upon the parents the same rights and responsibilities as are conferred on them by the provisions of Title VII of Book I of the Civil Code.

MONTANA: Title 40, Chapter 4, Part 2. Support, Custody, Visitation, and Related Provisions

40-4-224. Joint custody -- modification -- consultation with professionals

(1) Upon application of either parent or both parents for joint custody, the court shall presume joint custody is in the best interest of a minor child unless the court finds, under the factors set forth in 40-4-212, that joint custody is not in the best interest of the minor child. If the court declines to enter an order awarding joint custody, the court shall state in its decision the reasons for denial of an award of joint custody. Objection to joint custody by a parent seeking sole custody is not a sufficient basis for a finding that joint custody is not in the best interest of a child, nor is a finding that the parents are hostile to each other. However, a finding that one parent physically abused the other parent or the child is a sufficient basis for finding that joint custody is not in the best interest of the child.

(2) For the purposes of this section, "joint custody" means an order awarding custody of the minor child to both parents and providing that the physical custody and residency of the child shall be allotted between the parents in such a way as to assure the child frequent and continuing contact with both parents. The allotment of time between the parents must be as equal as possible; however;

(a) each case shall be determined according to its own practicalities, with the best interest of the child as the primary consideration; and

(b) when allotting time between the parents, the court shall consider the effect of the time allotment on the stability and continuity of the child's education.

NEW MEXICO:

Chapter 40, 40-4-9.1 Joint custody; standards for determination; parenting plan.

A. There shall be a presumption that joint custody is in the best interest of a child in an initial custody determination....

F. When joint custody is awarded, the court shall approve a parenting plan for the implementation of the prospective custody arrangement prior to the award of joint custody. The parenting plan shall include a division of a child's time and care into periods of responsibility for each parent....

G. Where custody is contested, the court shall refer that issue to mediation if feasible.

I. Whenever a request for joint custody is granted or denied, the court shall state in its decision its basis for granting or denying the request for joint custody. A statement that joint custody is or is not in the best interest of the child is not sufficient to meet the requirements of this subsection.

J. An award of joint custody means that:

(1) each parent shall have significant, well-defined periods of responsibility for the child;
(2) each parent shall have, and be allowed and expected to responsibility for the child's financial, physical, emotional and developmental needs during that parent's periods of responsibility;
(3) the parents shall consult with each other on major decisions involving the child before implementing those decisions; that is, neither parent shall make a decision or take an action which results in a major change in a child's life until the matter has been discussed with the other parent and the parents agree. If the parents, after discussion, cannot agree and if one parent wishes to effect a major change while the other does not wish the major change to occur, then no change shall occur until the issue has been resolved as provided in this subsection.

TEXAS: 153.131 Presumption that Parent to be Appointed Managing Conservator

(a) Unless the court finds that appointment of the parent or parents would not be in the best interest of the child because the appointment would significantly impair the child's physical health or emotional development, a parent shall be appointed sole managing conservator or both parents shall be appointed as joint managing conservators of the child.
(b) It is a rebuttable presumption that the appointment of the parents of a child as joint managing conservators is in the best interest of the child.

<u>The following are some of the best relevant statues from States which prove a strong preference for joint custody:</u>

ALASKA: Title 25, Chapter 20
Sec. 25.20.100 Reasons for denial to be set out.
If a parent or the guardian ad litem requests shared custody of a child and the court denies the request, the reasons for the denial shall be stated on the record.

CALIFORNIA: Family Code Section
3040. Order of preference.
(a) Custody should be granted in the following order of preference according to the best interest of the child as provided in 3911: (1) To both parents jointly pursuant to Chapter 4 (commencing with 3080) or to either parent. In making an order granting custody to either parent, the court shall consider, among other factors, which parent is more likely to allow the child frequent and continuing contact with the noncustodial parent, subject to 3011, and shall not prefer a parent as custodian because of that parent's sex.
3080. Presumption of joint custody.
There is a presumption, affecting the burden of proof, that joint custody is in the best interest of a minor child, subject to 3011, where the parents have agreed to joint custody or so agree in open court at a hearing for the purpose of determining the custody of the minor child.
3082. Statement of reasons for grant or denial.
When a request for joint custody is granted or denied, the court, upon the request of any party, shall state in its decision the reasons for granting or denying the request. A statement that joint physical custody is, or is not, in the best interest of the child is not sufficient to satisfy the requirements of this section. IOWA: Title XV, Subtitle 1, Chapter 598
598.41 Custody of children
1.a. The court, insofar as is reasonable and in the best interest of the child, shall order the custody award, including liberal visitation rights where appropriate, which will assure the child the opportunity for the maximum continuing physical and emotional contact with both parents after the parents have separated or dissolved the marriage, and which will encourage parents to share the rights and responsibilities of raising the child unless direct physical harm or significant emotional harm to the child, other children, or a parent is likely to result from such contact with one parent.
c. The court shall consider the denial by one parent of the child's opportunity for maximum continuing contact with the other parent, without just cause, a significant factor in determining the proper custody arrangement.

2.b. If the court does not grant joint custody under this subsection, the court shall cite clear and convincing evidence, pursuant to the factors in subsection 3, that joint custody is unreasonable and not in the best interest of the child to the extent that the legal custodial relationship between the child and the parent should be severed.

KANSAS: Chapter 60, Article 16

60-1610. Decree; authorized orders. Neither parent shall be considered to have a vested interest in the custody or residency of any child as against the other parent, regardless of the age of the child, and there shall be no presumption that it is in the best interests of any infant or young child to give custody or residency to the mother.

(4) Types of custodial arrangements. Subject to the provisions of this article, the court may make any order relating to custodial arrangements which is in the best interests of the child. The order shall include but not be limited to, one of the following, in the order of preference:

(A) Joint custody. The court may place the custody of a child with both parties on a shared or joint-custody basis. In that event, the parties shall have equal rights to make decisions in the best interests of the child under their custody. When a child is placed in the joint custody of the child's parents, the court may further determine that the residency of the child shall be divided either in an equal manner with regard to time of residency or on the basis of a primary residency arrangement for the child. The court, in its discretion, may require the parents to submit a plan for implementation of a joint custody order upon finding that both parents are suitable parents or the parents, acting individually or in concert, may submit a custody implementation plan to the court prior to issuance of a custody decree. If the court does not order joint custody, it shall include in the record the specific findings of fact upon which the order for custody other than joint custody is based.

(B) Sole custody....

(C) Divided custody.... (two or more children)

(D) Nonparental custody....

MICHIGAN:

Chapter 722 Sec. 6a. (1) In custody disputes between parents, the parents shall be advised of joint custody. At the request of either parent, the court shall consider an award of joint custody, and shall on the record the reasons for granting or denying a request.

MINNESOTA: Chapter 518

518.17 Custody and support of children on judgment

The court must make detailed findings on each of the factors and explain how the factors led to its conclusions and to the determination of the best interests of the child.

The court shall use a rebuttable presumption that upon request of either or both parties, joint legal custody is in the best interests of the child.

MISSISSIPPI: Title 93, Chapter 5

93-5-24. Types of custody awarded by court; joint custody; access to information pertaining to child by noncustodial parent.

(1)Custody may be awarded as follows according to the best interests of the child:

(a)Physical and legal custody to both parents jointly pursuant to subsections 2 through 7.

(b) Physical custody to both parents jointly pursuant to subsections 2 through 7 and legal custody to either parent.

(c) Legal custody to both parents jointly pursuant to subsections 2 through 7 and physical custody to either parent.

(d) Physical and legal custody to either parent.

NEW HAMPSHIRE: Title XLIII, Chapter 458

458:17 Support and Custody of Children
II. Except as provided in subparagraph (c), in the making of any order relative to such custody there shall be a presumption, affecting the burden of proof, that joint legal custody is in the best interest of minor children:
(a) Where the parents have agreed.... If the court declines to enter an order awarding joint legal custody, the court shall state in its decision the reasons for denial of an award of joint legal custody.
(b) Upon the application of either parent....
The following two states have case law which make joint custody a preference:

GEORGIA: Court of Appeals of Georgia, Case No. A93A0698, 7/2/93 IN the INTEREST of A.R.B., a child
In a unanimous opinion, presiding Judge Dorothy T. Beasley stated: Although the dispute is symbolized by a 'versus' which signifies two adverse parties at opposite poles of a line, there is in fact a third party whose interests and rights make of the line a triangle. That person, the child who is not an official party to the lawsuit but whose wellbeing is in the eye of the controversy, has a right to shared parenting when both are equally suited to provide it. Inherent in the express public policy is a recognition of the child's right to equal access and opportunity with both parents, the right to be guided and nurtured by both parents, the right to have major decisions made by the application of both parents' wisdom, judgment and experience. The child does not forfeit these rights when the parents divorce.
The A.R.B. case was subsequently heard by the Supreme Court of Georgia, which upheld the Court of Appeals' finding that, according to public policy of Georgia, joint custody was in the best interests of children when both parents are fit.

KENTUCKY: Chalupa v. Chalupa, Kentucky Court of Appeals, No. 90-CA-001145-MR; (May 1, 1992).
Judge Schroder, writing for the majority:
A divorce from a spouse is not a divorce from their children, nor should custody decisions be used as a punishment. Joint custody can benefit the children, the divorced parents, and society in general by having both parents involved in the children's upbringing.... The difficult and delicate nature of deciding what is in the best interest of the child leads this Court to interpret the child's best interest as requiring a trial court to consider joint custody first, before the more traumatic sole custody. In finding a preference for joint custody is in the best interest of the child, even in a bitter divorce, the court is encouraging the parents to cooperate with each other and to stay on their best behavior. Joint custody can be modified if a party is acting in bad faith or is uncooperative. The trial court at any time can review joint custody and if a party is being unreasonable, modify the custody to sole custody in favor of the reasonable parent. Surely, with the stakes so high, there would be more cooperation which leads to the child's best interest, the parents' best interest, fewer court appearances and judicial economy. Starting out with sole custody would deprive one parent of the vital input.

Parental rights a fundamental right

Each parent has a right to access their children. If one parent denies the other parent access to visit the children that parent can be held in contempt of court. Some states have case law that now permits one parent to sue the other for interfering with visitation.

Studies:
Anything other than shared parenting is economically inadvisable from a child support perspective for the children and for the State.

1. **"90.2% of fathers with joint custody {shared parenting} pay the child support due."** (pg. 7, col. 1, ¶ 2, lines 1 - 2) U.S. Bureau of the Census: 1988

2. Child Support & Alimony: 1989 Series P-60, No.173, 1989 Census - Current Population Report, Issued September 1991

Case Law

The rights of parents to the care, custody and nurture of their children is of such character that it cannot be denied without

violating those fundamental principles of liberty and justice which lie at the base of all our civil and political institutions, and such right is a fundamental right protected by this amendment (First) and Amendments 5, 9, and 14. Doe v. Irwin, 441 F Supp 1247; U.S. D.C. of Michigan, (1985).

The several states has no greater power to restrain individual freedoms protected by the First Amendment than does the Congress of the United States. Wallace v. Jaffree, 105 S Ct 2479; 472 US 38, (1985).

The U.S. Court of Appeals for the 9th Circuit (California) held that the parent-child relationship is a constitutionally protected liberty interest. (See; Declaration of Independence –life, liberty and the pursuit of happiness and the 14th Amendment of the United States Constitution – No state can deprive any person of life, liberty or property without due process of law nor deny any person the equal protection of the laws.) Kelson v. Springfield, 767 F 2d 651; US Ct App 9th Cir, (1985).

The parent-child relationship is a liberty interest protected by the Due Process Clause of the 14th Amendment. Bell v. City of Milwaukee, 746 f 2d 1205, 1242-45; US Ct App 7th Cir WI, (1985).

The Due Process Clause of the Fourteenth Amendment requires that severance in the parent-child relationship caused by the state occur only with rigorous protections for individual liberty interests at stake. Bell v. City of Milwaukee, 746 F 2d 1205; US Ct App 7th Cir WI, (1984).

A parent's right to the preservation of his relationship with his child derives from the fact that the parent's achievement of a rich and rewarding life is likely to depend significantly on his ability to participate in the rearing of his children. A child's corresponding right to protection from interference in the relationship derives from the psychic importance to him of being raised by a loving, responsible, reliable adult. Franz v. U.S., 707 F 2d 582, 595-599; US Ct App (1983).

A parent's right to the custody of his or her children is an element of "liberty" guaranteed by the 5th Amendment and the 14th Amendment of the United States Constitution. Matter of Gentry, 369 NW 2d 889, MI App Div (1983).

Even when blood relationships are strained, parents retain vital interest in preventing irretrievable destruction of their family life; if anything, persons faced with forced dissolution of their parental rights have more critical need for procedural protections than do those resisting state intervention into ongoing family affairs. Santosky v. Kramer, 102 S Ct 1388; 455 US 745, (1982).

The right of a parent not to be deprived of parental rights without a showing of fitness, abandonment or substantial neglect is so fundamental and basic as to rank among the rights contained in this Amendment (Ninth) and Utah's Constitution, Article 1 § 1. In re U.P., 648 P 2d 1364; Utah, (1982).

The liberty interest of the family encompasses an interest in retaining custody of one's children and, thus, a state may not interfere with a parent's custodial rights absent due process protections. Langton v. Maloney, 527 F Supp 538, D.C. Conn. (1981).

Parents have a fundamental constitutionally protected interest in continuity of legal bond with their children. Matter of Delaney, 617 P 2d 886, Oklahoma (1980). <Verify citation>.

Parent's interest in custody of her children is a liberty interest which has received considerable constitutional protection; a parent, who is deprived of custody of his or her child, even though temporarily, suffers thereby grievous loss and such loss deserves extensive due process protection. In the Interest of Cooper, 621 P 2d 437; 5 Kansas App Div 2d 584, (1980).

Legislative classifications which distributes benefits and burdens on the basis of gender carry the inherent risk of reinforcing stereotypes about the proper place of women and their need for special protection; thus, even statutes purportedly designed to compensate for and ameliorate the effects of past discrimination against women must be carefully tailored. The state cannot be permitted to classify on the basis of sex. Orr v. Orr, 99 S Ct 1102; 4340 US 268 <check cite>, (1979).

The U.S. Supreme Court implied that "a (once) married father who is separated or divorced from a mother and is no longer living with his child" could not constitutionally be treated differently from a currently married father living with his child. Quilloin v. Walcott, 98 S Ct 549; 434 US 246, 255-56, (1978).

Parent's right to custody of child is a right encompassed within protection of this amendment which may not be interfered with under guise of protecting public interest by legislative action which is arbitrary or without reasonable relation to some purpose within competency of state to effect. Reynold v. Baby Fold, Inc., 369 NE 2d 858; 68 Ill 2d 419, appeal dismissed 98 S Ct 1598, 435 US 963, iL, (1977).

Loss of First Amendment Freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury. Though First Amendment rights are not absolute, they may be curtailed only by interests of vital importance, the burden of proving which rests on their government. Elrod v. Burns, 96 S Ct 2673; 427 US 347, (1976).

No bond is more precious and none should be more zealously protected by the law as the bond between parent and child." Carson v. Elrod, 411 F Supp 645, 649; DC E.D. VA (1976).

The United States Supreme Court held that the "old notion" that "generally it is the man's primary responsibility to provide a home and its essentials" can no longer justify a statute that discriminates on the basis of gender. No longer is the female destined solely for the home and the rearing of the family, and only the male for the marketplace and the world of ideas. Stanton v. Stanton, 421 US 7, 10; 95 S Ct 1373, 1376, (1975).

Father enjoys the right to associate with his children which is guaranteed by this amendment (First) as incorporated in Amendment 14, or which is embodied in the concept of "liberty" as that word is used in the Due Process Clause of the 14th Amendment and Equal Protection Clause of the 14th Amendment. Mabra v. Schmidt, 356 F Supp 620; DC, WI (1973).

The Court stressed, "the parent-child relationship is an important interest that undeniably warrants deference and, absent a powerful countervailing interest, protection." A parent's interest in the companionship, care, custody and management of his or her children rises to a constitutionally secured right, given the centrality of family life as the focus for personal meaning and responsibility. Stanley v. Illinois, 405 US 645, 651; 92 S Ct 1208, (1972).

Judges must maintain a high standard of judicial performance with particular emphasis upon conducting litigation with scrupulous fairness and impartiality. 28 USCA § 2411; Pfizer v. Lord, 456 F 2d 532; cert denied 92 S Ct 2411; US Ct App MN, (1972).

A parent's right to care and companionship of his or her children are so fundamental, as to be guaranteed protection under the First, Ninth, and Fourteenth Amendments of the United States Constitution. In re: J.S. and C., 324 A 2d 90; supra 129 NJ Super, at 489.

The Constitution also protects "the individual interest in avoiding disclosure of personal matters." Federal Courts (and State Courts), under Griswold can protect, under the "life, liberty and pursuit of happiness" phrase of the Declaration of Independence, the right of a man to enjoy the mutual care, company, love and affection of his children, and this cannot be taken away from him without due process of law. There is a family right to privacy which the state cannot invade or it becomes actionable for civil rights damages. Griswold v. Connecticut, 381 US 479, (1965).

State Judges, as well as federal, have the responsibility to respect and protect persons from violations of federal constitutional rights. Gross v. State of Illinois, 312 F 2d 257; (1963).

Reality of private biases and possible injury they might inflict were impermissible considerations under the Equal Protection Clause of the 14th Amendment. Palmore v. Sidoti, 104 S Ct 1879; 466 US 429.

The rights of parents to parent-child relationships are recognized and upheld. Fantony v. Fantony, 122 A 2d 593, (1956); Brennan v. Brennan, 454 A 2d 901, (1982). State's power to legislate, adjudicate and administer all aspects of family law, including determinations of custodial; and visitation rights, is subject to scrutiny by federal judiciary within reach of due process and/or equal protection clauses of 14th Amendment...Fourteenth Amendment applied to states through specific rights contained in the first eight amendments of the Constitution which declares fundamental personal rights...Fourteenth Amendment encompasses and applied to states those preexisting fundamental rights recognized by the Ninth Amendment. The Ninth Amendment

acknowledged the prior existence of fundamental rights with it: "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." The United States Supreme Court in a long line of decisions has recognized that matters involving marriage, procreation, and the parent-child relationship are among those fundamental "liberty" interests protected by the Constitution. Thus, the decision in Roe v. Wade, 410 US 113; 93 S Ct 705; 35 L Ed 2d 147, (1973), was recently described by the Supreme Court as founded on the "Constitutional underpinning of ... a recognition that the "liberty" protected by the Due Process Clause of the 14th Amendment includes not only the freedoms explicitly mentioned in the Bill of Rights, but also a freedom of personal choice in certain matters of marriage and family life." The non-custodial divorced parent has no way to implement the constitutionally protected right to maintain a parental relationship with his child except through visitation. To acknowledge the protected status of the relationship as the majority does, and yet deny protection under Title 42 USC § 1983, to visitation, which is the exclusive means of effecting that right, is to negate the right completely. Wise v. Bravo, 666 F 2d 1328, (1981).

The United States Supreme Court noted that a parent's right to "the companionship, care, custody and management of his or her children" is an interest "far more precious" than any property right. May v. Anderson, 345 US 528, 533; 73 S Ct 840, 843, (1952).

Parent's rights have been recognized as being "essential to the orderly pursuit of happiness by free man." Meyer v. Nebraska, 262 or 426 US 390 <check cite>; 43 S Ct 625, (1923).

Law and court procedures that are "fair on their faces" but administered "with an evil eye or a heavy hand" was discriminatory and violates the equal protection clause of the Fourteenth Amendment. Yick Wo v. Hopkins, 118 US 356, (1886).

Family Court Abuses of the Public

What the court system doesn't want the public to know is that it is an entire industry that has developed a system to escalate conflict to strip families of resources. This is a pattern of racketeering that has been repeated across the country. The tactic is to use children as the primary weapon between parents. What takes place is attorneys "suggest" a tactic that one party executes the domestic violence allegations is the most effective way to escalate a divorce into "high conflict". The attorney is protected because they hide behind the anger of one party's actions and have created a plausible deniability. They play on the executing party's fear of being exposed for false allegations which is a criminal offence. By the way the attorney is guilty of furtherance of a criminal act. We need to stop the promotion of this tactic by the judicial branch and publicly funded abused person programs. When publicly funded abused person programs promote the use of domestic violence they are also aiding the commission of criminal acts. What needs to be investigated is how much public funding is being misused to promote domestic violence. How much public funding is being used to Lobby against parent's right. How much of the federal accounting regulations are being violated by social programs misappropriation of funding. The misappropriation can be based on sex discrimination of judicial bias and civil rights violations. Each of the following sights can provide insight into this complex issue.

http://www.exiledfathers.org/
http://www.liamsdad.org/
www.parentingandpolitics.org
www.acfc.org
www.crispe.org
www.ancpr.com
http://www.facebook.com/group.php?gid=314667245456 (Veterans for Child support reform- FACEBOOK)
http://www.freewebs.com/vacriminaljustice/
http://groups.yahoo.com/group/VaEQUALParents/

THE WALL STREET JOURNAL.

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The Myth of Deadbeat Dads

by Stuart A. Miller

Child-support collection has recently become a big issue in Washington. President Clinton issued an executive order this week requiring all federal agencies to facilitate the payment of father's debts. And Health and Human Services Secretary Donna Shalala testified that if we collect all of the child support owed by Americans, we would reduce the $200 billion welfare cost by 25%. In fact, Republicans and Democrats alike count on increased child support collections as a cornerstone of their welfare reform plans.

You don't have to be a member of the world champion U.S. Math Olympiad team to see that there is something wrong with those calculations. Even under the rosiest projections of the government's Annual Child Support Report, in 1992 (the last year for which data is available), there was about $10.9 billion in court-ordered child support owed by all Americans and, of that, a little more than $6 billion was paid. This leaves $4.9 billion in unpaid child support in 1992 -- far short of the $50 billion Ms. Shalala hopes to raise.

But it's virtually impossible even to collect the smaller amount of child support obligations. We've tried many times over the past 10 years, yet no effort has increased the percentage of collections for welfare mothers (the biggest target group) by more than 1%.

This is due to a number of factors. First, of the 30% of child support payments not collected, a significant number are owed by fathers who are imprisoned. A high percentage of prisoners have child support obligations, and as many as one-third of the inmates in many county jails are there in the first place because of child support noncompliance.

Many of the other delinquent fathers are addicts, alcoholics, disabled, mentally incapacitated, unemployed, or otherwise unable to pay pre-set child support amounts. But the largest number of all delinquents are those who simply don't exist.

Recently, the Florida Department of Revenue, the agency responsible for child support enforcement in that state, sent out 700,000 notices of allegedly delinquent fathers. The summonses demanded immediate payment or the recipient would be incarcerated.

Subsequently, officials acknowledged that probably 500,000 of those notices were sent to individuals who actually did not owe child support. One of those recipients, Daniel Wells, died eight years ago in a traffic accident, but the state still wanted him to cough up $160,000 in past due support! (About the same amount of money Florida wasted on postage for the notices.)

Nor is this an isolated case. The General Accounting Office found in 1992 that as many as 14% of fathers who owe child support are dead. The report further stated that 66% of fathers who owe support "cannot afford to pay the amount ordered."

The easiest way, then, to increase the figures on child-support collections is simply for the government to make an accurate tally. Until this happens, it's impossible to discuss remedies for the child-support problem.

Once a serious discussion gets under way, one of the first items on the agenda should be the inherent unfairness in taking something away from people and then making them paying for it. Most fathers are deeply committed to their children, yet a 1991 Census Bureau study found that about half of fathers receive no court-ordered visitation. When fathers do receive visitation, almost 80% pay all of their child support on time and in full. When fathers receive joint custody, the child support compliance rate jumps to more than 90%.

Joint Custody is the cure to the child support problem and is the closest thing to a two-parent family that we can give a child. Unfortunately, more than 90% of litigated divorces result in an award of sole custody to the mother.

Even when fathers do receive court-ordered access to their children, their visitation attempts are often met with interference by the mothers. Joan Berlin Kelley and Judith Wallerstein, in "Surviving the Break-Up" (Basic Books, 1980), found that almost half of all mothers see no value in the father's continued contact with his children following separation or divorce. Sanford Braver, a University of Arizona psychologist, confirmed these figures and found that up to 40% of mothers interfere with the dad's relationship with his kids.

Given this documented connection between a father's access to his children and the payment of child support, why does Washington seem intent on punishing the father? What about the mother who creates a climate encouraging non-compliance?

One way around this problem may be to make child-support obligations more equitable. At the moment, child support is almost exclusively the burden of fathers. The federal Office of Income Security Policy found in 1991 that less than 30% of custodial fathers receive a child support award, whereas almost 80% of custodial mothers do.

Yet, about 47% of those mothers who are ordered to pay support totally default on their obligation. In the interest of fairness, if nothing else, policy makers should make an effort to collect child support from both delinquent fathers and mothers.

But of course the only real long-term answer is to support the two-parent family -- preferably in marriage and, if that doesn't work, through joint custody arrangements. We need to re-engage fathers in their children's lives. Draconian transfer-of-wealth schemes will continue to be as ineffective in the future as they have proved to be in the past, no matter how aggressively they are enforced.

Mr. Miller is the senior legislative analyst for the American Fathers Coalition in Washington, D. C.

10/27/2009 12:12PM

Reference Studies

Support reps.:
Sens. Susan Collins (R-ME) and Ben Nelson (D-NE) will be introducing an amendment that would cut by 50% funding already included in the economic recovery package that would provide $400 million for VAWA and VOCA programs. American Recovery and Reinvestment Act of 2009, also known as the Economic Recovery bill.

Support Studies:

In 1999, the Harvard Injury Control Center launched the National Violent Injury Statistics System (NVISS) In 2000, CDC started planning for the implementation of the National Violent Death Reporting System (NVDRS) NVDRS began operation in 2003 with seven states (Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, and Virginia) participating; six states (Colorado, Georgia, North Carolina, Oklahoma, Rhode Island, and Wisconsin) joined in 2004 and four more (California, Kentucky, New Mexico, and Utah) in 2005, for a total of 17 states (Figure). Funding for state participation is provided by CDC. CDC anticipates that NVDRS will expand to include all 50 states, the District of Columbia, and U.S. territories.
http://www.cdc.gov/Women/pubs/violence.htm

The One Hundred Billion Dollar Man: The Annual Public Costs of Father Absence
https://www.fatherhood.org/research.asp
National Fatherhood Initiative research
Summary:

- The federal government spends $99.8 billion dollars every year on programs - such as child support enforcement and anti-poverty efforts - that support father-absent homes.

The Father Factor: Facts of Fatherhood
https://www.fatherhood.org/father_factor.asp
Summary:

- Many facts to support father's involvement with children. Data on the Consequences of Fathers Absence.
- According to a U.S. Census Bureau report, over 25 million children live apart from their biological fathers. That is 1 out of every 3 (34.5%) children in America. Nearly 2 in 3 (65%) African American children live in father-absent homes. Nearly 4 in 10 (36%) Hispanic children, and nearly 3 in 10 (27%) white children live in father-absent homes.
- **Employment, Economic Stability & Father Involvement**
  https://www.fatherhood.org/doclibrary/NRFC_EconomicStability_FatherInvolvement.pdf
- **Fathers and Domestic Violence**
  https://www.fatherhood.org/doclibrary/NRFC_FathersDomesticViolence.pdf

Understanding Intimate Partner Violence Fact sheet 2006
http://www.cdc.gov/ViolencePrevention/pdf/IPV-FactSheet.pdf
Summary:
Intimate partner violence (IPV) is abuse that occurs between two people in a close relationship. The term "intimate partner" includes current and former spouses and dating partners. IPV exists along a continuum from a single episode of violence to ongoing battering. IPV includes four types of behavior:

- **Physical abuse** is when a person hurts or tries to hurt a partner by hitting, kicking, burning, or other physical force.
- **Sexual abuse** is forcing a partner to take part in a sex act when the partner does not consent.
- **Threats** of physical or sexual abuse include the use of words, gestures, weapons, or other means to communicate the intent to cause harm.
- **Emotional abuse** is threatening a partner or his or her possessions or loved ones, or harming a partner's sense of self-worth. Examples are stalking, name calling, intimidation, or not letting a partner see friends and family.

Often, IPV starts with emotional abuse. This behavior can progress to physical or sexual assault. Several types of IPV may occur together.

Restoring Fathers to Families and Communities, Social Policy Action Network, Kathleen Sylvester and Kathy Reich, 2000, ph 202-434-4770.
http://www.nccf.org/upload/publicationfiles/restoring%20fathers.pdf
Summary:
Across the country, states and communities are mobilizing to increase fathers' involvement in the lives of their children. The strategies they are choosing vary widely, reflecting the philosophical differences about the definition of "responsible fatherhood." Some efforts focus on teaching men the skills they need to be good fathers; others concentrate on child support enforcement; still others promote marriage and two-parent family formation. But other states are still doing less than they could to promote father involvement. *Map and Track*, a 1999 survey of state responsible fatherhood efforts, reported that few states had begun new efforts to help fathers in the previous two years. One reason: There isn't enough specific information available for state and local officials about what they can do, legislatively or administratively, to help fathers help their children. This guide tries to fill that gap. It lays out a detailed six-step strategy for promoting father involvement, especially among low-income, unwed men. The guide will be most useful for state legislators, governors, and agency officials looking for ways to better serve fathers. But local government officials, businesses, community-based organizations, and the faith community will find ideas they can use as well. Each of the six steps includes a menu of policy options from which policymakers can choose. Each step also includes detailed examples of what states, communities, and non-profits nationwide are doing to promote responsible fatherhood, along with contacts and resources for policymakers who want to learn more.

The Importance of Fathers in the Healthy Development of Children
Jeffrey Rosenberg and W. Bradford Wilcox , 2006
http://www.childwelfare.gov/pubs/usermanuals/fatherhood/fatherhood.pdf

U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau Office on Child Abuse and Neglect
Summary:
OVERVIEW OF THE SCOPE OF CHILD MALTREATMENT AND CHILD PROTECTION:
Prior to delving into the discussion of fathers and their role in both preventing and perpetrating child maltreatment, it is useful to understand the scope of the problem. The following findings from the National Child Abuse and Neglect Data System (NCANDS) for 2003 provide a snapshot of reported child victimization:

- During 2003, an estimated 906,000 children were victims of abuse or neglect.
- An estimated 2.9 million referrals of abuse or neglect concerning approximately 5.5 million children were received by CPS agencies. More than two-thirds of those referrals were accepted for investigation or assessment.
- Nationally, 60.9 percent of child victims experienced neglect (including medical neglect), 18.9 percent were physically abused, 9.9 percent were sexually abused, and 4.9 percent were emotionally or psychologically maltreated. **Approximately two-fifths (40.8 percent) of child victims were maltreated by their mothers acting** alone, another 18.8 percent were maltreated by their fathers acting alone; and 16.9 percent were abused by both parents.

In most jurisdictions, CPS is the agency mandated to conduct an investigation into reports of child abuse or neglect and to offer services to families and children where maltreatment has occurred or is likely to occur. Of course, any intervention into family life on behalf of children must be guided by State laws, sound professional standards for practice, and strong philosophical underpinnings. The key principles guiding State laws on child protection are
based largely on Federal statutes, primarily the Child Abuse Prevention and Treatment Act (CAPTA) as amended by the Keeping Children and Families Safe Act of 2003 (P.L. 108-36) and the Adoption

RESEARCH ON THE ROLE OF FATHERS:
In the last decade, the social sciences have begun recognizing and examining the crucial role that fathers play in child development and family dynamics. Nevertheless, relatively little attention has been paid to the role fathers play in the dynamics of child maltreatment. A 1997 review of research on child abuse and neglect concluded that this research was characterized by a "conspicuous absence of information from and about fathers in violent families. The research that does exist on the link between fathers and maltreatment suggests that:

- Fathers are directly involved in 36.8 percent (acting alone in 18.8 percent and with others in 18.0 percent of the cases) of maltreatment cases;
- The presence of fathers in the home is tied to lower rates of maltreatment;

- Unrelated male figures and stepfathers in households tend to be more abusive than biological, married fathers;
- The quality of the relationship between the mother and father has an important indirect effect on the odds of maltreatment.

Not much is known, however, about the specific role that fathers play in preventing, causing, or contributing to child maltreatment. In addition, relatively little energy has been invested in training CPS caseworkers to work with fathers in cases of maltreatment. A number of studies indicate that caseworkers may overlook fathers in connection with their investigations and interventions regarding child maltreatment. This is not surprising since working with fathers in social services is relatively new—the first national meeting dedicated solely to issues concerning fathers did not occur until 1994. In addition, American families today represent a range of fatherhood models, some of which lend themselves to productive involvement with the caseworker and others which may not. While research and training directly related to fathers and child maltreatment have been limited, there have been significant efforts over recent years devoted to research on the role of fathers in child development and the creation of programs to strengthen the capacity of fathers. This manual highlights both the findings from the available research and examples of fatherhood programs. By equipping CPS caseworkers with a solid introduction to the fatherhood research, the manual should foster a sense of empathy and knowledge that will enable them to work effectively with fathers. Further, the exploration of each stage of the child protection process—from investigation to case closure—will help caseworkers work with fathers in a way that increases the likelihood of achieving the ultimate goal: safety and permanency for the child.

The Parenting of Adolescents and Adolescents as Parents: A Developmental Contextual Perspective
http://parenthood.library.wisc.edu/Lerner/Lerner-bib.html

Richard Lerner, PhD, Anita L. Brennan Professor of Education Director, Center for Child, Family and Community Partnerships Boston College, E. Ree Noh, Clancie Wilson

Summary:

- This report contains a huge list of reference material and cases to support parenting by both parents.

"Surveillance for Violent Deaths -- National Violent Death Reporting System, 16 States, 2005" (SVD) An April 2008 report by the CDC
http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5703a1.htm

Summary:

- The report provides revealing data collected by the NVDRS. While approximately twice as many females as males attempt suicide, the rate of completed suicide in the SVD report is nearly 4 times greater for males than females. In 2005, 32,637 suicides were reported. The SVD reports 30% of the suicides are precipitated by intimate partner problems.
- Hence, it is possible that approximately 7,832 male and 1,958 female suicides were precipitated by intimate partner problems. These intimate partner problem suicides far exceed the number of intimate partner homicides. The online literature review Domestic Violence-Related Deaths exams how many of these intimate partner problem deaths may have a direct or indirect association with domestic violence.
- **Results:** For 2005, a total of 15,495 fatal incidents involving 15,962 violent deaths occurred in the 16 NVDRS states included in this report. The majority (56.1%) of deaths were suicides, followed by homicides and deaths involving legal interventions (29.6%), violent deaths of undetermined intent (13.3%), and unintentional firearm deaths (0.7%). Fatal injury rates varied by sex, race/ethnicity, age group, and method of injury. Rates were substantially higher for males than for females and for American Indians/Alaska Natives (AI/ANs) and blacks than for whites and Hispanics. Rates were highest for persons aged 20--24 years. For method of injury, the three highest rates were reported for firearms, poisonings, and hanging/strangulation/suffocation.

REFERENCES EXAMINING ASSAULTS BY WOMEN ON THEIR SPOUSES OR MALE PARTNERS: AN ANNOTATED BIBLIOGRAPHY

Martin S. Fiebert, Department of Psychology, California State University, Long Beach
Last updated: February 2009 **http://www.csulb.edu/~mfiebert/assault.htm**

Summary:

- This bibliography examines 247 scholarly investigations: 188 empirical studies and 59 reviews and/or analyses, which demonstrate that women are as physically aggressive, or more aggressive, than men in their relationships with

their spouses or male partners. The aggregate sample size in the reviewed studies exceeds 240,200.

WASHINGTON STATE CENTER FOR COURT RESEARCH ADMINISTRATIVE OFFICE OF THE COURTS, July, 2008
Residential Time Summary Reports Filed in Washington from July 2007 – March 2008
Summary:

- This report analyzed 4,354 Residential Time Summary Reports filed in Washington courts from July 2007 through March 2008. Overall, 93% of all Parenting Plans were by agreement of the parties and 86% involved no risk factors on the part of the parents that limited residential time of children. The most common residential schedule for children was for the mother to have 66-99% of the residential time and the father to have 1-34% of residential time. This schedule occurred for approximately half of all cases and was more than three times more likely than any other arrangement.
- Residential time, however, was impacted by a number of factors. First, when it was established that one parent had a risk factor that could limit his or her residential time (e.g., abused or neglected a child, had chemical dependency, committed domestic violence), the other parent received all, or almost all, of the residential time (provided he or she had no risk factors). Second, the combination of representation statuses had a significant impact on residential time. When both parties had the same type of representation (either self or attorney), the outcomes were similar. However, when one party had an attorney and the other party was self represented, the attorney-represented party received more residential time in comparison to cases which had the same type of representation for both parties. Finally, although the vast majority of cases were agreed, when a case was contested, fathers tended to receive more residential time in comparison to other types of decisions (provided the father had an attorney).

Father Facts, 3rd ed., The National Fatherhood Initiative, Wade F. Horn, Ph.D, 1999, ph 301-948-0599

Parenting Our Children, Department of Health and Human Services, 1996

Opposition Studies:
National Network to End Domestic Violence, Domestic Violence Counts
http://nnedv.org/resources/census/67-census-domestic-violence-counts/232-census2008.html
Summary:

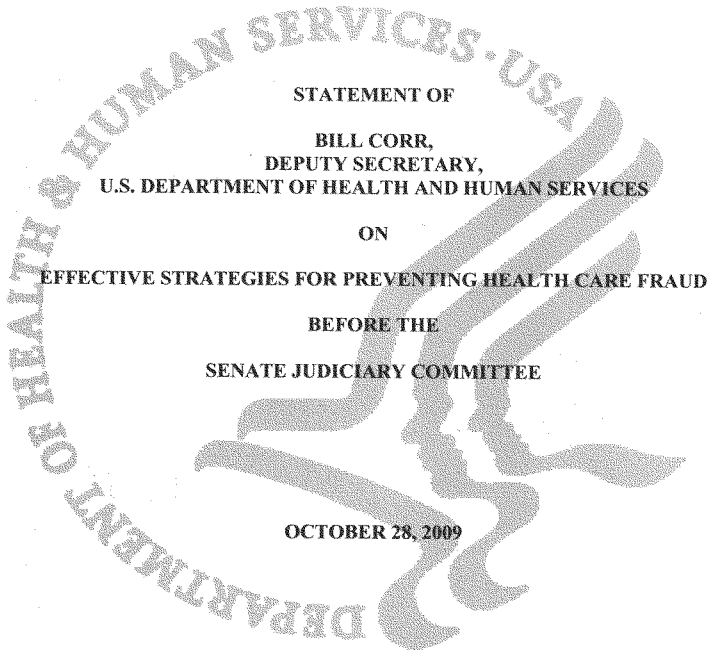
- The **National Census of Domestic Violence Services (Census)** is an annual non invasive, unduplicated count of adults and children who seek services from U.S. domestic violence shelter programs during a single 24-hour survey period. Conducted annually by NNEDV since 2006, this Census takes into account the dangerous nature of domestic violence by using a survey designed to protect the confidentiality and safety of victims.
- This is a commissioned report (paid for) that demonstrates the bias generated by women groups around the country. Upon examination of the numbers in the reports every man woman and child in the United States based on total population annualized has gone to a shelter in the last 2 years and or received services.
- Our current efforts are to expose how Federal funding is being used to promote the miss use of domestic violence statutes to circumvent due process and equal protection of parties of a divorce.
- A study of the organizations outlined in this report will reveal that some funding provided for abused persons is being used to lobby and promote the miss use of domestic violence statutes. A miss use of Federal funding.

Conclusion

We want to thank everybody that has aided in the creation of this report. This is an organic public document and we look for input from anybody. If you have information that should be added to the report send it to: mosquitoreport@yahoo.com we will try our best to add it.

If you have found this report useful we have done our public service. We ask that you do your part every letter helps; every phone call helps remember the mosquito. Help build a swarm and take back the American children and families.

STOP CHILD ABUSE FOR PROFIT



STATEMENT OF

BILL CORR,
DEPUTY SECRETARY,
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

EFFECTIVE STRATEGIES FOR PREVENTING HEALTH CARE FRAUD

BEFORE THE

SENATE JUDICIARY COMMITTEE

OCTOBER 28, 2009

Chairman Leahy, Senator Sessions and Members of the Committee. I am Bill Corr, the Deputy Secretary of the Department of Health and Human Services (HHS). Thank you for the opportunity to join with my colleague from the Department of Justice (DOJ) to testify about the joint DOJ-HHS Task Force on Health Care Fraud, and in particular, HEAT, one of the Administration's signature initiatives. The Health Care Fraud Prevention and Enforcement Action Team (HEAT) is a joint effort by HHS and DOJ to marshal our resources, expertise and authorities to prevent fraud and abuse in Medicare and Medicaid. The HEAT task force was established by Secretary Sebelius and Attorney General Holder on May 20, 2009.

As a result of the priority given to combating health care fraud by President Obama, the government has been able to achieve a more rapid response to fraudulent schemes and increase its recovery of more funds lost to fraud than in previous years. For example, HHS Office of Inspector General investigations have resulted in $4.0 billion in receivables for FY 2009, an increase from $3.2 billion in OIG investigative receivables in FY2008.[1] Strike force cases typically are indicted and litigated faster than traditional criminal health care fraud cases.

[1] OIG investigative receivables, include monies resulting from criminal and civil judgments, settlements, forfeitures, and administrative recoveries. The number includes restitution, fines, penalties, forfeitures, and administrative recoveries. The figures are recorded at the time of judgment or settlement and do not represent the amount collected.

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Since March 2007 strike force cases that included HHS agents have obtained 189 convictions, 443 indictments, and total an estimated $227 million in expected recoveries.[2] During this time, the Department of Justice also secured the largest health care fraud settlement in history against a pharmaceutical company for Medicare and Medicaid fraud and for violating the Food, Drug and Cosmetic Act. I refer to the $2.3 billion settlement with Pfizer to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products.

We are identifying perpetrators of fraud, recovering the money they stole, and removing them from federal health programs providing health care coverage to elderly, low income, and disabled beneficiaries. In the process, we are using new methods of data analysis and intelligence gathering to detect patterns of criminal activity, including regions of the country where they are most prevalent, and the types of payments from Medicare and Medicaid that are most vulnerable to fraud. Using this new information, we are pursuing policy changes and developing innovative methods of preventing fraud.

[2] This conviction figure includes only those subjects who have been sentenced. There may be additional subjects who have pled guilty or been convicted at trial but have not yet been sentenced and are not reflected in this figure. Expected recoveries include payments that have been court-ordered or agreed to be paid upon sentencing, settlement, or seizure.

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For example, as a result of the strike force prosecutions in Miami focusing on fraudulent claims for durable medical equipment (DME), the Centers for Medicare and Medicaid Services (CMS) detected the potential for fraud and initiated new efforts to prevent fraudulent claims. These prevention efforts, together with the deterrent effect of the strike force prosecutions, resulted in a 63 percent reduction in DME claims in South Florida during the first 12 months of the strike force (March 2007 to February 2008). This represents a decrease in claims of $1.75 billion compared to the year before the intervention of the strike force.

HHS has a multi-faceted role in the HEAT task force, involving three of our most important components: the Office of Inspector General (OIG), CMS and the Food and Drug Administration (FDA). The OIG provides essential support by analyzing data for patterns of fraud, conducting independent investigations, supporting federal prosecutions of providers who commit criminal and civil fraud and pursuing administrative remedies, including civil monetary penalties and program exclusions. In FY 2009 alone, OIG investigations resulted in $4 billion in receivables, 671 criminal actions, 394 civil actions, and 2556 exclusions.

Since 2004, CMS has had field offices in high fraud areas of the country such as Miami, New York City and Los Angeles, providing an "on-the-ground" presence

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to fighting fraud in the Medicare program. In addition to conducting its own data analysis to identify fraud trends, CMS provides significant data and analytical support to OIG and DOJ investigators and refers potential fraud cases for investigation to law enforcement entities.

FDA supports investigations of Food, Drug and Cosmetic Act violations and false claims act cases involving the illegal use of medicines for unapproved promotion. The aforementioned case against Pfizer involved significant support from FDA.

Fraud and abuse is not limited to federal health insurance programs. Health care fraud is a national problem that requires collaboration among public and private health entities. While there is no hard number for the costs of health care fraud, the National Health Care Anti-Fraud Association estimates that approximately 3 percent of total health care expenditures, or $60 billion, is lost to fraud by both the private and public sectors each year. Criminals who commit health care fraud are becoming more sophisticated and are often organized crime enterprises. They are preying on both providers and beneficiaries by illegally obtaining their provider or enrollment information and using it to submit fraudulent billings to Medicare and Medicaid. They are sullying the reputation of the overwhelming majority of providers, who are not only honest, but are providing essential health care to

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Medicare and Medicaid beneficiaries. Strike forces are aggressively pursuing these criminal organizations and individuals.

The best efforts of the public and private sectors will be required to substantially reduce health care fraud. Therefore, one of the initiatives being considered by the HEAT task force is a national summit on health care fraud that would include participants from every affected group, including private insurers, beneficiaries, law enforcement and providers. A summit of this nature will bring fresh ideas and collaborations that we believe will result in more effective methods of preventing and detecting fraud. Collaboration and innovation are essential in the fight against fraud. They are the key factors in the success of HEAT. The collaboration between HHS and DOJ is rooted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which established a joint Health Care Fraud and Abuse Control (HCFAC) Program. HCFAC activities are supported by a dedicated funding stream within the Hospital Insurance Trust Funds as well as annual discretionary appropriations.

Since its inception, HCFAC has resulted in the return of $13.1 billion to the Medicare Trust Fund. The investigative and prosecutorial activities performed by OIG and DOJ with HCFAC resources have a return on investment averaging over

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$6 for each $1 spent from 2006 to 2008. In fact, their work yielded a nearly $8 to $1 return in FY 2008 alone, as shown in the FY 2008 HCFAC Annual Report which was published on-line just last week. The cost avoidance activities performed by the Medicare Integrity Program under HCFAC, such as prepayment edits and claims audits, have a return on investment averaging $14 for each $1 spent over the last three years.

Experts agree that the most effective way to eliminate fraud is to stop it before it ever starts. Some of the most important work of the HEAT task force and its partners is focused on enhancing the fraud prevention programs in Medicare and Medicaid.

The Administration is making program integrity and fiscal oversight a high priority at CMS. We will build on existing prevention activities at CMS, such as enrollment and claims review processes, to detect and prevent fraud and abuse. We will provide more rigorous screening of new provider applications and greater scrutiny of existing providers. Our goal is to ensure that Medicare and Medicaid are not easy targets for unscrupulous individuals and criminal elements whose intent is to perpetrate fraud.

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CMS is currently in the final stages of building an integrated data repository (IDR) which will for the first time in Medicare's history bring all Medicare claims data together in one centralized data repository. Using the IDR, CMS will go beyond the current practices of application and claims review by using sophisticated new technology to identify aberrations in claims data, such as unusual, clinically inconsistent, or high volume billings. This will allow CMS to go beyond the current standard of reviewing just the paperwork. For example, using the CMS field offices and benefit integrity contractors, CMS conducts additional inspections of providers, interviews beneficiaries and visits physicians to ensure that services are being provided in accordance with Medicare laws and regulations. The IDR will enhance these existing program integrity activities.

The President has made increased HCFAC funding a strong priority by requesting $311 million in total discretionary resources in his FY 2010 Budget Request. This request represents a $113 million increase over the $198 million in new discretionary funding Congress provided for HCFAC in the Omnibus Appropriations Act of 2009. As indicated in our budget request, we will use this funding to strengthen HHS and DOJ efforts to combat health care fraud and abuse, predominantly in the Part D drug benefits program, Medicare Advantage, and the Medicaid program. In addition, this funding will be used to improve real-time data

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analysis between HHS and DOJ, as well as increase our on-the-ground field presence across the country to more quickly detect and investigate fraud and abuse.

A complement to HCFAC is the Medicaid Integrity Program (MIP) created by the Deficit Reduction Act of 2005 (DRA). The Deficit Reduction Act provided dedicated federal funding to enhance Medicaid integrity efforts through four defined activities: 1) the review of provider actions; 2) the auditing of claims; 3) the identification of overpayments; and 4) the education of providers, managed care entities, beneficiaries, and others on payment integrity and healthcare quality.

CMS has completed the process of awarding Medicaid Integrity review and audit contracts, which now cover the entire country. Over 600 provider audits are now underway. In addition, we have identified over $120 million of potential overpayments through data analysis and mining for five states. The states involved are now verifying these findings. We continue to identify further potential overpayments and errors through our national program of algorithm development and testing.

The Deficit Reduction Act also supports the national expansion of the Medicare-Medicaid (Medi-Medi) Data Match Pilot Program. Matching Medicare and

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Medicaid claims data to find patterns of fraud, previously undetectable to the programs individually, has provided State and Federal law enforcement and program integrity units with dramatic insights into the overall practices of providers who are exploiting both programs. In FY 2008, 30 Medi-Medi cases were referred to law enforcement, over $27 million in overpayments were referred for collection, and $7 million in improper payments were caught before erroneous payments were made.

We recognize that preventing health care fraud and abuse will require relentless effort and constant dedication to protect Medicare and Medicaid. Through the joint task force, DOJ and HHS are training lawyers to have the necessary skills to prosecute health care fraud, and training FBI and OIG agents and local law enforcement personnel on methods of investigation. We are investing in data analysts, to identify patterns of fraud so that we can target our efforts for maximum effectiveness.

Additional training is being provided directly to state governments by the Medicaid Integrity Institute (MII), which was established in September 2006 to provide quality education on program integrity to State Medicaid employees free of cost. Through an interagency agreement with the National Advocacy Center of the DOJ

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Office of Legal Education, CMS supports training in all aspects of program integrity. Since February of 2007, more than 1,300 State employees have been trained at the MII.

In addition to the MII, CMS conducts comprehensive management reviews of each State's Medicaid program integrity procedures and processes on a triennial basis. Through these reviews, CMS assesses the effectiveness of State program integrity efforts and determines whether a State's policies and procedures comply with Federal regulations. CMS also uses the reviews to identify and disseminate effective practices.

The most common performance problems cited in these reviews include: the failure to collect required ownership, control, and criminal conviction disclosures; the failure to require disclosure of business transaction information; and the failure to report adverse actions on providers to the HHS' Office of Inspector General (OIG). The most common vulnerabilities, which can place State program integrity at greater risk than performance violations include: inadequate protections in the provider enrollment process; lack of exclusion checking after initial enrollment; undocumented program integrity procedures; failure to disenroll inactive

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providers; inadequate oversight of Medicaid managed care organizations; and ineffective relationships with State Medicaid Fraud Control Units (MFCU).

The States have responded positively to the reviews, indicating that they will implement corrective actions in response to the findings identified in the reviews. CMS has posted an annual summary of effective practices, findings, and vulnerabilities on its website.[3] CMS has also identified States with effective practices by name so State Medicaid agencies may consult each other and collaborate on what may work in their State.

Home medical equipment—Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS or "DME")—is an industry that has historically high risk for fraud. In South Florida and Los Angeles, where Medicare billing is disproportionately high, the number of DME suppliers spiked by increasing nearly 20 percent between 2005 and 2007.

This is an example where our efforts have culminated in a successful approach to addressing fraud in federal health programs. As I briefly mentioned earlier, we are employing new methods of analysis by personnel trained to use claims data to

[3] http://www.cms.hhs.gov/FraudAbuseforProfs/Downloads/2008pireviewannualsummaryreport.pdf

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identify fraud, using investigators trained in health care fraud, working with DOJ prosecutors, and implementing new prevention techniques.

We are putting criminals who fraudulently billed Medicare for equipment like wheelchairs behind bars, while at the same time ensuring our beneficiaries get the right services and the ones they pay for. We are vigilant when we see spikes in DME claims. We are screening DME providers and keeping bad actors out of the Medicare program. As a result, we are seeing substantial drops in DME claims in high-risk pockets of the country.

One important tool to help fight DME fraud is competitive bidding for suppliers, first authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Bidding began for DME suppliers recently and we anticipate the competitive bidding program to be implemented in Round 1 for suppliers in nine areas of the country by January 1, 2011.

In conjunction with the move to competitive bidding, effective in early October 2009, most DME suppliers participating in the Medicare program were required to have both a surety bond and accreditation from a deemed accrediting organization. Most non-physician suppliers of durable medical equipment are required to obtain

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a $50,000 or higher surety bond, thus deterring illegitimate suppliers from enrolling in Medicare. The combination of the surety bond and accreditation requirements is an important step to ensure that CMS is only doing business with legitimate and high quality partners and will allow CMS to expel fraudulent suppliers from the program and keep them out.

The new accreditation requirements include onsite visits, detailed reviews of staff credentials, business records, insurance and license requirements, and other information necessary to ascertain that the supplier is a valid business entity that meets Medicare requirements. The combined impact of these two policies is expected to decrease significantly the number of unscrupulous DME suppliers participating in the Medicare program, even before competitive bidding is launched.

Until DME competitive bidding is fully operational, CMS is focusing on Medicare fraud in seven high-risk areas across the country. This "stop-gap program" increases pre-payment reviews of medical equipment suppliers and will also single out the highest-billed claims—continuous positive airway pressure (CPAP) devices, oxygen equipment, glucose monitors and test strips, and power wheelchairs—which are the most lucrative items for suppliers and thus, at the

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greatest risk of fraud. The program adds background checks on new suppliers and increases scrutiny of claims submitted by the highest ordering physicians and the highest utilizing beneficiaries.

We are supporting our efforts against fraud and abuse by adding staff in high fraud risk areas of the country. CMS has opened program integrity field offices in Los Angeles, Miami and New York to coordinate our fraud and abuse efforts at the local level. They conduct data analysis to proactively identify targets, connect the dots among various contractors and agencies to identify local, field level issues and vulnerabilities with national or regional impact and to serve as CMS' "eyes & ears" in the field. They implement administrative actions such as suspensions, auto-denial edits, deactivations, and revocations.

In our Miami field office, CMS has worked with law enforcement to address a Medicare drug infusion scam that involves sham clinics recruiting HIV/AIDS patients, paying them kickbacks and then billing Medicare for astronomical amounts of infusion services. To curb these fraudulent practices, CMS pursued front-end prevention strategies including more vigorous claims review and editing. Simultaneously, on the back-end, law enforcement is prosecuting cases. To date these efforts have resulted in more than $1.8 billion dollars in Medicare savings

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based on cumulative efforts by CMS, OIG, DOJ in South Florida to address infusion therapy fraud, and in 20 criminal cases being made against 42 defendants. Overall field office efforts for the three offices, excluding the infusion scam, have resulted in combined savings of billions of dollars.

Our work in Florida includes a new pilot program initiated in August, 2008, to test the effectiveness of sending out monthly, rather than quarterly Explanation of Benefits (EOBs) to beneficiaries and providing them with a regional fraud hotline to call in order to report problems identified while reviewing those EOBs. To date the Florida hotline alone has received more than 5,200 calls, and 840 of those calls have led to open investigations. In addition, the following actions have been taken:

- Eight providers have been suspended from the Medicare program;
- Nineteen providers have been placed on prepayment edits;
- Seven provider numbers have been revoked from Medicare; and
- Over $6.3 million in overpayments have been requested.

We will remain steadfast in our efforts and continue to find new ways to fight fraud, waste, and abuse. In addition to the programs I have described in my testimony, CMS has just completed two promising demonstrations involving strengthening initial provider and supplier enrollment and revalidation of

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enrollment to prevent unscrupulous DME and HHA providers from entering the program. The demonstrations also incorporated criminal background checks of providers, owners and managing employees into the provider enrollment process. Additionally, CMS has completed a third demonstration that waived authorities related to the payment of claims for infusion therapy.

Preliminary reporting has shown proven results. Over 1,139 suppliers' billing privileges have been revoked as of January 2009 and total reimbursement to the L.A. demonstration suppliers has decreased significantly. Other demonstration results indicate that thirty-seven HHAs' provider numbers have been revoked. These providers had received approximately $6.1 million in Medicare payments in CY 2007.[4]

Results of the infusion therapy demonstration include 24 referrals to law enforcement, 138 provider deactivations/revocations and $254 million in savings based on edits that resulted in claims denials between November 2007 and January 2009, with a cumulative savings and costs avoided totaling $327.6 million.

[4] Both DME and HHA demonstration figures are based on internal communications with CMS contractor, National Supplier Clearinghouse.

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The health reform bills moving through Congress all include substantial new requirements and authorities to aid in our efforts to reduce fraud. The bills include provisions such as: (1) Requiring the Secretary of Health and Human Services to institute an enhanced screening process for all providers and suppliers before granting Medicare billing privileges, which can include criminal background checks and licensure checks; (2) Requiring providers and suppliers to implement compliance programs as a condition of enrolling in Medicare and Medicaid; and (3) Establishing new penalties for submitting false data on applications, false claims for payment, or for obstructing audit investigations related to Medicare and Medicaid.

I have described a reinvigorated and focused Federal Government that is taking measured steps to prevent health care fraud. .In summary, we are adding resources to existing programs and evaluating funding needs for the future; coordinating efforts across the government, led by the joint DOJ-HHS HEAT task force, with great initial success; building new prevention programs to stop fraud before it happens; and using new analytical techniques to identify and then strike against individuals and criminal organizations who have targeted Medicare and Medicaid. With the continued support of the President, this Committee and the

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entire Congress, and joining forces with the private sector, we will continue our success and ultimately prevail in the war against health care fraud.

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Statement of

The Honorable Patrick Leahy

United States Senator
Vermont
October 28, 2009

Statement Of Senator Patrick Leahy,
Chairman, Senate Judiciary Committee,
On "Effective Strategies For Preventing Health Care Fraud"
October 28, 2009

Today, the Committee refocuses on the problem of health care fraud. We are now engaged in a great national debate about health care reform. Whether you support the public option as I do, or oppose the legislative effort as so many Republicans have lined up to do in order to deal the President a political blow, I would hope that one thing on which we all can agree is that health care fraud is an enormous problem, and something that cannot be tolerated. Whether it is Federal dollars or private dollars, fraud is draining billions and billions away from providing effective health care. We must work together to ensure that we have tough and effective measures in place to prevent health care fraud and provide accountability.

I am pleased that we have with us today Deputy Secretary Bill Corr from the Department of Health and Human Services, and Assistant Attorney General Tony West from the Department of Justice. Both are distinguished public servants, and both are heavily engaged in the Government's efforts to combat health care fraud. Health care fraud is wrong. It is insidious. It not only pushes up our health care costs and wastes taxpayer money, but also puts lives in danger.

The Health and Human Services Department and the Justice Department have been working hard and more closely together than ever before to address this problem. I look forward to hearing today about those efforts and the progress they are making.

For more than three decades, I have fought in Congress to combat fraud and protect taxpayers' dollars. This spring, I introduced with Senator Grassley and Senator Kaufman the Fraud Enforcement and Recovery Act, the most significant anti-fraud legislation in more than a decade. When that legislation was enacted, it provided law enforcement with new tools to detect and prosecute financial and mortgage fraud. Now, as health care reform moves through the Senate, I want to make sure we do all we can to tackle the fraud that could undermine efforts to reduce the skyrocketing cost of health care.

The scale of health care fraud in America today is staggering. According to conservative estimates, about three percent of the funds spent on health care are lost to fraud -- more than $60

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billion dollars a year. In the Medicare program alone, the Government Accountability Office estimates that more than $10 billon dollars was lost to fraud just last year.

Of course, there are specific incidents that illustrate the problem even more clearly than these astronomical numbers. In April, Quest Diagnostics Inc. settled a $300 million lawsuit filed by California businessman and biochemist, Thomas Cantor. Quest continued to sell a certain kind of medical test kit from 2000 to 2006, despite complaints of inaccurate results. These tests put the health of hundreds of thousands of dialysis patients at risk. The settlement covers claims that the bad tests led to unnecessary surgeries and overtreatment which risked causing deadly diseases.

Just last month, the Department of Justice settled a case against Pfizer for $2.3 billion, including more than $1 billion in recovered losses – the largest health care fraud settlement in the Department's history. Pfizer had promoted drugs for uses and at dosages that the Food and Drug Administration specifically declined to approve for safety reasons. Pfizer not only defrauded American taxpayers; it placed millions of Americans at risk for serious health problems including heart attack, stroke and pulmonary embolism.

That case was also exposed by a whistleblower, and several whistleblowers who have come forward to expose outrageous instances of fraud are here today. Bruce Boice, a former sales representative for the pharmaceutical company Cephalon, blew the whistle at great cost to his career and livelihood on a similar scheme of marketing drugs for purposes for which they were not approved. He helped the Government recover $425 million. Chuck Bates and Craig Patrick, two former employees of the medical device company Kyphon, are also here today. They blew the whistle on a practice aimed at inflating the bills sent to Medicare for a surgical procedure, and helped the Government recover $86 million.

To stop the drain on our health care system caused by these types of fraud, we must make anti-fraud enforcement stronger and more effective. Much has been done to improve enforcement since the late 1990s, but we can and must go further.

Much attention has been devoted to fraud in the Medicare and Medicaid programs. This fraud is significant, it undermines taxpayers, doctors and patients, and we must do everything we can to stop it. I hope today we will hear that real progress is being made in that area. But it is important to remember that health care fraud does not occur solely in the public sector. Private health insurers also see billions of dollars in fraud. That fraud is often harder for the Government to track. Private companies have less incentive to report it, but it is a grave problem that we need to address.

The Finance Committee and the HELP Committee both worked hard to develop health care reform legislation. I worked with leaders from both Committees on fraud provisions, and I have encouraged both Committees to include the strongest possible anti-fraud measures. I am gratified that their legislative proposals incorporate important provisions focused on fraud, waste, and abuse.

I am glad that pending legislation would expand the Health Care Fraud and Abuse Control program, which funds our Federal anti-fraud efforts. This program has been a great success over

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the years, but it needs additional investigators and prosecutors to continue to fight health care fraud effectively. Since its creation in 1996, the program has recovered and restored to the Medicare Trust Fund more than $11 billion dollars lost to fraud. According to the Justice Department, every dollar spent on health care fraud enforcement returns four dollars to the U.S. Treasury. Estimates by independent, non-government entities suggest that the return is even greater. Investing more money in health care fraud enforcement is good policy and good economics.

I am also glad that pending legislation includes provisions allowing for more access by law enforcement to essential information. The fight against health care fraud requires Federal investigators to have appropriate access to the data and information needed to root out fraud.

I am heartened by the significant and impressive steps the administration has already taken to step up health care fraud prevention and enforcement, and I am also pleased with the real progress represented by the anti-fraud provisions of the Finance and HELP Committee bills. I was glad to contribute to those efforts. But I believe that we must do everything we can to ensure that those responsible for rooting out health care fraud have the tools they need. That is why I have been working closely with Senators Kaufman and Specter, and others, to develop important additional anti-fraud measures. We will be introducing a bill soon that we hope will add to the already impressive anti-fraud efforts we are seeing this year.

We all agree that reducing the cost of health care for American citizens is a critical goal of health care reform. I hope we can reach a consensus that stopping health care fraud and the many billions of dollars it drains from the system each year is a vital part of that effort. I look forward to hearing about the efforts of the Justice Department and Health and Human Services to more effectively combat fraud. We in Congress can do our part to ensure that, when we pass a health care reform bill, it includes all the tools and resources needed to crack down on the scourge of health care fraud.

# # # # #

Quest Diagnostics Incorporated

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November 30, 2009

The Honorable Patrick J. Leahy
Chairman, Committee on the Judiciary
United States Senate
224 Dirksen Senate Office Building
Washington, DC 20510

Dear Senator Leahy:

I am writing to correct several incorrect or misleading comments concerning Quest Diagnostics made at a Senate Judiciary Committee hearing on October 28, 2009. The comments in dispute are found in two written statements submitted to the Committee:

- "In April, Quest Diagnostics, Inc. settled a $300 million lawsuit filed by California businessman and biochemist, Thomas Cantor. Quest continued to sell a certain kind of medical test kit from 2000 to 2006, despite complaints of inaccurate results. These tests put the health of hundreds of thousands of dialysis patients at risk. The settlement covers claims that the bad tests led to unnecessary surgeries and overtreatment which risked causing deadly diseases." (Statement of Senator Patrick Leahy).

- "In the Eastern District of New York, Quest Diagnostics Incorporated ("Quest") and its subsidiary, Nichols Institute Diagnostics ("NID"), entered into a global settlement with the United States to resolve criminal and civil claims concerning various types of diagnostic test kits that the company manufactured, marketed and sold to laboratories throughout the country that allegedly provided inaccurate and unreliable results. The global resolution of $302 million was one of the largest recoveries ever in a case involving a medical device." (Statement of Tony West, Assistant Attorney General).

In fairness, and for the sake of accuracy, it is important to correct the record. With regard to the first statement, we have the following clarifications:

- There was no finding of patient harm and we do not believe that any patients were harmed. Nor was there any finding that the health of any dialysis patients, let alone "hundreds of thousands" of patients, was at risk.

- There was no finding that the products of Nichols Institute Diagnostics "led to unnecessary surgeries and overtreatment which risked causing deadly disease."
- The products referred to in the statement were manufactured and sold by a subsidiary of Quest Diagnostics Incorporated known as Nichols Institute Diagnostics and not by Quest Diagnostics itself.

With regard to the statement of Tony West, the use of "the company" implies that Quest Diagnostics manufactured, marketed, and sold the products, when in fact the company that made, marketed, and sold the products was actually Nichols Institute Diagnostics.

When Quest Diagnostics became aware of the issues regarding Nichols Institute Diagnostics, it diligently sought to ensure the quality of NID's products. It should also be noted that NID voluntarily withdrew several of the products from the market during its internal investigation. Quest Diagnostics ultimately voluntarily closed the subsidiary and fully cooperated with all federal agencies involved in a sincere effort to resolve all of the allegations.

We ask that you make this letter part of the record of your hearing to reflect our position with regard to the comments noted above.

Respectfully submitted,

Charles J. Silverman
Director, Government Affairs and Regulatory Policy

Department of Justice

STATEMENT OF

TONY WEST
ASSISTANT ATTORNEY GENERAL

BEFORE THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

ENTITLED

"EFFECTIVE STRATEGIES FOR PREVENTING HEALTH CARE FRAUD"

PRESENTED

OCTOBER 28, 2009

TONY WEST
ASSISTANT ATTORNEY GENERAL
Before the U.S. Senate Committee on the Judiciary – October 28, 2009

INTRODUCTION

Chairman Leahy, Senator Sessions, and Members of the Committee, thank you for inviting me here today to testify on the Department of Justice's efforts in fighting and deterring health care fraud. Under the leadership of the Attorney General, Deputy Attorney General David Ogden is supervising the Department's day-to-day efforts to marshal our resources in combating health care fraud, recovering Medicare funds stolen through fraud and abuse, and coordinating with the Department of Health and Human Services. Deputy Attorney General Ogden very much wanted to be here today but was unable to attend because of a prior commitment. He asked me to relay the important work that the Department of Justice, in close coordination with the Department of Health and Human Services and our other law enforcement partners, is doing to deter, detect and defend against health care fraud and express how important this issue is to him and the Attorney General.

We have a duty to the taxpayers. Every year, hundreds of billions of dollars are spent to provide health security for American seniors, children, and the disabled. While most medical or pharmaceutical providers are doing the right thing, when Medicare or Medicaid fraud occurs, it costs the American taxpayer real dollars. Every year, billions of dollars are lost to Medicare and Medicaid fraud.

It is those wrongdoers who we must stop. Those billions represent health care dollars that could be spent on services for Medicare and Medicaid beneficiaries – on seniors, children and families in need – but instead are wasted on fraud and abuse. This is unacceptable. We have a duty to our citizens who receive treatment paid for by the Medicare, Medicaid, and other government programs to see to it that their care meets acceptable medical standards. We know that when Medicare and Medicaid fraud occurs, it can corrupt the medical decisions health care providers make with respect to their patients and thereby put the public health at risk. For these reasons, the Department of Justice, through its Civil, Criminal, and Civil Rights divisions, along with U.S. Attorneys' Offices and the FBI – the entities responsible for enforcing laws against all forms of health care fraud – has prioritized much of our enforcement efforts on protecting the integrity of health care that is provided to patients.

FIGHTING HEALTH CARE FRAUD IS A PRIORITY OF THE DEPARTMENT OF JUSTICE

Federal and state spending on Medicare and Medicaid exceeds $800 billion per year. While there is no official federal estimate of the level of fraud in Medicare, Medicaid, or the healthcare sector more generally, external estimates project the amount at three to ten percent of total spending. The Department of Justice, in coordination with the Department of Health and Human Services, and other federal and state law enforcement agencies, recognizes both the

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urgency in the need to recover those funds and the need to ensure that such fraud does not reoccur.

Because coordination across agencies is an integral part of preventing and prosecuting health care fraud, Secretary Sebelius and Attorney General Holder together have pledged to fight waste, fraud and abuse in Medicare and Medicaid and in May 2009 announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT). With the creation of the HEAT team, fighting Medicare and Medicaid fraud became a Cabinet-level priority for both DOJ and HHS.

The HEAT initiative, which is supervised by Deputy Attorney General David Ogden and the Deputy Secretary of the Department of Health and Human Services William Corr, has had some remarkable successes thus far. We have already expanded the Medicare Fraud Strike Force to Houston and Detroit, bringing the total number of cities and or regions where the Strike Force is operating to four: South Florida, Los Angeles, Detroit and Houston. These expanded efforts have already shown results. On June 24, 2009, the Criminal Division and United States Attorney's Office for the Eastern District of Michigan announced seven indictments charging 53 people in schemes involving physical, occupational, and infusion therapy to defraud Medicare of more than $50 million in the Detroit metropolitan area. Since the Detroit announcement, the Criminal Division and United States Attorneys' Offices in Houston and Los Angeles have conducted two additional arrest takedowns indicting another 52 defendants for allegedly submitting $42 million in fraudulent billings to the Medicare program.

We are actively analyzing Medicare data in unprecedented coordination between our two agencies, and in as real-time as possible, to identify fraud "hot spots" and expand strike force operations to those areas where there is the most need. We have enhanced training programs on enforcement measures for prosecutors and investigators, and we have increased compliance training for providers to prevent honest mistakes and help stop potential fraud before it happens. Because health care fraud drives up the cost of health care for all of us, we also are actively engaged in efforts to educate the public about ways they can assist us to detect, prevent and prosecute fraud. HEAT's website – www.stopmedicarefraud.gov – is an easy way for beneficiaries to report suspected fraud to the HEAT task force.

The HEAT initiative also has focused on misconduct by pharmaceutical companies and device manufacturers. Last month, Pfizer Inc. and its subsidiary Pharmacia & Upjohn Company Inc. agreed to pay $2.3 billion to resolve criminal and civil liability arising from the illegal promotion of certain pharmaceutical products. This is the largest health care fraud settlement in the history of the Department of Justice, the largest criminal fine of any kind imposed in the U.S., and the largest ever civil fraud settlement against a pharmaceutical company.

While the HEAT Initiative is new, the collaborative efforts between the Department of Justice and the Department of Health and Human Services are not. In 1997, Congress established the Health Care Fraud and Abuse Control (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.

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Since the inception of the program, our Departments have returned more than $15 billion to the federal government, of which $13.1 billion went back to the Medicare Trust Funds. These efforts have resulted in more than 5600 criminal convictions for health care fraud offenses. With $13.1 billion returned to the Medicare Trust Funds, the average return on investment to the Trust Fund for funding provided by the 1996 law that created the program, HIPAA, to law enforcement agencies is $4.02 per dollar spent.

During fiscal year 2008, the Department of Justice's vigorous efforts to combat health care fraud accounted for $1.12 billion in civil settlements and judgments. During that same time period, the Department opened 849 new civil health care fraud matters and filed complaints or intervened in 226 civil health care fraud matters. Also, during that time period, federal prosecutors filed criminal charges in 502 health care fraud cases involving charges against 797 defendants and obtained 588 convictions for health care fraud offenses. In addition, they opened 957 new criminal health care fraud investigations involving 1641 defendants. Our monetary recoveries in fiscal year 2009 have already exceeded those of the previous year, and we appear on track to soon report over $1.6 billion in settlements and judgments in health care fraud matters.

The litigating components of the Department of Justice, as well as the FBI, are actively engaged in investigating and litigating a wide range of civil and criminal health care fraud cases, and we work closely with the Department of Health and Human Services and other federal and state agencies.

CIVIL DIVISION'S HEALTH CARE FRAUD EFFORTS

The primary enforcement tool possessed by the Department of Justice to pursue civil remedies in health care fraud matters is the False Claims Act (FCA), 31 U.S.C. §§ 3729-3733. The Department of Justice worked closely with Congress on the recently enacted Fraud Enforcement and Recovery Act (FERA) to amend the FCA to strengthen the government's ability to combat fraud. In addition to the Department of Justice being able to go after false claims directly, lawsuits are often brought by private plaintiffs, known as "relators," under the *qui tam* provisions of the FCA. The *qui tam* provisions allow private citizens to sue, on the government's behalf, companies and others that defraud the government. The government then can intervene in appropriate cases to pursue the litigation and recovery against the defendant. Since the False Claims Act was substantially amended in 1986 and through FY 2008, the Civil Division, working with United States Attorneys, has recovered $21.6 billion on behalf of the various victim federal agencies. Of that amount, $14.3 billion was the result of fraud against federal health care programs – primarily the Medicare program. These totals do not include the significant recoveries in the fiscal year just ended.

This calendar year, the Department settled a matter with Pfizer Inc. in which Pfizer agreed to pay $2.3 billion, the largest health care fraud settlement in the history of the Department of Justice, to resolve criminal and civil liability arising from illegal promotion of certain pharmaceutical products. Pfizer's subsidiary, Pharmacia & Upjohn Company Inc., pled guilty to a felony violation of the Food, Drug, and Cosmetic Act for its off-label promotion of

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Bextra, an anti-inflammatory drug, with the intent to defraud or mislead. Pfizer promoted the sale of Bextra for several uses and dosages that the FDA specifically declined to approve due to safety concerns. Bextra was withdrawn from the market in 2005 after studies confirmed an increased cardiovascular risk in certain types of uses for which Pfizer had marketed the drug. The company was ordered to pay a criminal fine of $1.195 billion, the largest criminal fine ever imposed in the United States. Pharmacia & Upjohn was also ordered to forfeit $105 million, for a total criminal resolution of $1.3 billion. Further, Pfizer paid $1 billion to resolve allegations under the civil False Claims Act that the company illegally promoted four drugs – Bextra; Geodon, an anti-psychotic drug; Zyvox, an antibiotic; and Lyrica, an anti-epileptic drug – and caused false claims to be submitted to government health care programs for uses that were not medically accepted indications and therefore not covered by those programs. The civil settlement also resolved allegations that Pfizer paid kickbacks to health care providers to induce them to prescribe these, as well as other, drugs. The federal share of the civil settlement is $668.5 million and the state Medicaid share of the civil settlement is $331.5 million.

The Department completed another substantial settlement in January 2009 when Eli Lilly pled guilty to violating the Food, Drug, and Cosmetic Act for its illegal marketing of the anti-psychotic drug Zyprexa for uses that were not approved by the FDA. The global settlement totaled $1.415 billion and included a $515 million criminal fine, $100 million in forfeiture, and $800 million in civil recoveries to federal and state governments under the False Claims Act. And just last week, Mylan Pharmaceuticals, Inc. paid $118 million to resolve allegations that it had sold innovator drugs that were manufactured by other companies and had classified those drugs as non-innovator drugs for Medicaid rebate purposes.

In addition to these matters, the Civil Division, as a part of our health care fraud enforcement efforts, investigates and pursues False Claims Act matters that are predicated on claims that doctors and others were paid kickbacks or other illegal remuneration to induce referrals of Medicare or Medicaid patients in violation of the Physician Self-Referral laws, commonly referred to as the "Stark" laws, the Anti-kickback Statute, and the civil monetary penalties statute. These statutes have been extremely important in protecting the integrity of our health care system and have proven useful in going after fraudsters.

Another way the Civil Division fights health care fraud is through the criminal prosecutions by the Office of Consumer Litigation (OCL). OCL, under the statutory authority of the Federal Food, Drug and Cosmetic Act, investigates and prosecutes drug and device manufacturers and responsible individuals believed to be illegally promoting and distributing misbranded and adulterated drugs or devices. Unlawful conduct by pharmaceutical and device manufacturers subverts our healthcare system which relies on the sound medical judgment of practitioners, and puts patients at risk. OCL works with the United States Attorneys on these complex criminal matters in conjunction with law enforcement agencies like the Federal Bureau of Investigation, the Department of Health and Human Services Office of Inspector General and the Food and Drug Administration's Office of Criminal Investigations.

Finally, the Civil Division houses the Elder Justice and Nursing Home Initiative to coordinate and support law enforcement efforts to combat elder abuse, neglect and financial exploitation of this population. Too often, our most vulnerable citizens are the ones that are

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taken advantage of, so special attention is needed to prevent and prosecute these crimes. Each year Medicare and Medicaid spend over $120 billion on long-term care services, including nursing homes. At the same time, research shows that 11 percent of our seniors report experiencing at least one form of abuse, neglect, or exploitation. The Department created the Elder Justice and Nursing Home Initiative to focus on preventing this abuse and protecting our seniors. The Initiative has invested significant dollars to study elder abuse risk factors so that we can develop systems to prevent abuse before it occurs.

But when abuse and/or neglect does occur, the Elder Initiative coordinates the Department's litigation against long-term care providers, including nursing homes that fail to provide the quality of care to which our Medicare and Medicaid beneficiaries are entitled. Over the years, the Department, through the Elder Initiative, has worked with the HHS Inspector General and his office to recover fraudulently received money from long-term care facilities and to force these nursing homes to improve the care they provide to their residents.

The Department recognizes that the face of health care fraud is ever-changing and that it is therefore critical for law enforcement to be properly trained to identify, investigate, and prosecute the fraud. To accomplish this, the Department provides substantial training to its attorneys and agents and it includes all our law enforcement partners in those efforts. The Civil Division provides specific training and guidance in connection with pharmaceutical and device fraud matters. Given the nationwide scope of the defendants' conduct, as well as the complex legal and factual issues raised in these cases, the Civil Division plays a critical role in coordinating extensive trainings for representatives of various federal and state enforcement and regulatory agencies.

CRIMINAL DIVISION'S ENFORCEMENT EFFORTS IN FIGHTING FRAUD, WASTE AND ABUSE

The Department of Justice's efforts to fight health care fraud have succeeded in part because of strategic thinking about how to respond to this growing problem. The Medicare Fraud Strike Force (Strike Force) – launched in 2007 – is a recent example of the Department's latest strategic thinking about how to further combat health care fraud.

The Strike Force's mission is to supplement the criminal health care fraud enforcement activities of the United States Attorneys' Offices by targeting emerging or migrating schemes along with chronic fraud by criminals operating as health care providers or suppliers. The Strike Force is now operating in South Florida, Los Angeles, Detroit, and Houston, and is the perfect example of how federal, state, and local law enforcement working together can strike back against crime in our communities. The Strike Force analyzes Medicare data to identify hot spots of unexplained high-billing levels in concentrated areas. Teams of federal, state, and local investigators then work together to investigate fraudulent activity, and where appropriate, to bring criminal and civil cases against the most serious perpetrators. Our goal is to bring these cases as quickly and responsibly as possible once the fraud is identified to assure that viral fraud schemes do not spread between regions within our country.

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The Criminal Division and the United States Attorney's Office for the Southern District of Florida launched the Strike Force in Miami to target durable medical equipment (DME) and HIV infusion fraud in March 2007. In March 2008, the Criminal Division expanded the Strike Force to a second phase, partnering with the United States Attorney's Office for the Central District of California and HHS to combat DME fraud in the Los Angeles metropolitan area. The Strike Force model for criminal health care fraud prosecutions has now become a permanent component of the United States Attorneys' Office in both the Southern District of Florida and the Central District of California.

We have already seen significant success since the Strike Force was expanded in May in connection with the HEAT initiative. In addition to the Detroit indictments described above that were announced in June, on July 29, the Department and United States Attorney's Office for the Southern District of Texas announced 32 people were indicted in Houston for schemes to submit more than $16 million in false Medicare claims for durable medical equipment involving "arthritis kits," power wheelchairs and enteral feeding supplies. According to the indictments, the defendants, which include physicians, company owners and executives, are charged with participating in a scheme to submit claims for products that were medically unnecessary and oftentimes, never provided. In some cases, indictments allege that beneficiaries were deceased at the time they allegedly received the items.

On October 21, the Department and United States Attorney's Office for the Central District of California announced indictments of another twenty defendants, most of them residing in the Los Angeles area, who are charged in seven cases for allegedly participating in Medicare fraud schemes that resulted in more than $26 million in fraudulent bills to the Medicare program. The charging documents outline criminal schemes involving the fraudulent ordering of power wheelchairs, orthotics (devices designed to assist with orthopedic problems) and hospital beds.

Since its inception over two years ago through the end of fiscal year 2009, the Strike Forcehas:

- filed 130 cases charging 313 defendants who collectively billed the Medicare program more than $690 million dollars;
- taken 149 guilty pleas;
- handled 15 jury trials resulting in convictions of 21 defendants. [1]

The Strike Force also has the potential to have a powerful deterrent effect. Strike Force operations in the Miami area contributed to estimated reductions of $1.75 billion in durable medical equipment (DME) claim submissions and $334 million in DME claims paid by Medicare over the 12 months following the Strike Force's inception, compared to the preceding 12-month period.

[1] These figures exclude recent health care fraud prosecutions initiated by the Southern District of Florida and Central District of California since the Strike Force model for criminal health care fraud prosecutions became a permanent component of each office. The Department is working to develop a comprehensive Strike Force prosecution tracking system that will capture and track all DOJ Criminal Division initiated cases and USAO follow-on litigation under the auspices of the Strike Force and Health Care Prevention and Enforcement Action Team (HEAT) Initiative.

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As the Attorney General stated, "The Department believes that a targeted civil and criminal enforcement strategy in key geographic locations will have a substantial impact on deterring fraud and abuse, protecting patients and the elderly from scams, and ensuring that taxpayer funds are simply not stolen."

The Strike Force is just one tool designed to fight the most aggressive criminal schemes. We maintain 93 United States Attorney's Offices throughout the nation with criminal and civil prosecutors who work on health care fraud cases along with attorneys in the Department's Criminal, Civil and Civil Rights Divisions, and are aided significantly by FBI field offices around the country.

UNITED STATES ATTORNEYS' ENFORCEMENT EFFORTS

The 93 United States Attorney's Offices are an integral part of our commitment to go after health care fraud wherever it occurs. Each district has a designated Criminal Health Care Fraud Coordinator and a Civil Health Care Fraud Coordinator. The U.S. Attorneys' Offices play a major role in health care fraud enforcement by bringing affirmative civil cases with our colleagues in the Civil Division, and criminal cases to recover funds wrongfully taken from the Medicare Trust Fund and other taxpayer-funded health care systems as a result of fraud. Civil and criminal AUSAs litigate a wide variety of health care fraud matters including false billings by doctors and other providers of medical services, overcharges by hospitals, Medicaid fraud, kickbacks to induce referrals of Medicare or Medicaid patients, fraud by pharmaceutical companies, and failure of care allegations against nursing home owners. The USAOs have partnered with the Civil Division in the landmark Eli Lilly and Pfizer, Inc. global settlements resulting in multi-billion dollar recoveries detailed above. Other notable health care fraud successes of U.S. Attorneys' Offices include:

- In the Northern District of Illinois, ten people were charged and convicted with a health care fraud scheme that affected thousands of patients and victimized numerous health care plans. The defendants were paid approximately $2.6 million by insurers based on fraudulent claims. Nine of the defendants pled guilty. The one defendant, a doctor, who went to trial, was convicted. The leader of the scheme, John Froelich, who was a nurse, was sentenced to 9 years incarceration.

- In the Eastern District of New York, Quest Diagnostics Incorporated ("Quest") and its subsidiary, Nichols Institute Diagnostics ("NID"), entered into a global settlement with the United States to resolve criminal and civil claims concerning various types of diagnostic test kits that the company manufactured, marketed and sold to laboratories throughout the country that allegedly provided inaccurate and unreliable results. The global resolution of $302 million was one of the largest recoveries ever in a case involving a medical device.

- In the Central District of California, a former anesthesiologist and pain management specialist pled guilty to criminal conspiracy and health care fraud for allowing his

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Medicare provider numbers to be used to bill the Medicare program for fraudulent respiratory treatments. The defendant entered into a $2.1 million civil settlement in resolution of these allegations, and he is barred from participating in the Medicare program for 15 years.

The U.S. Attorneys' Offices are assisted in their efforts through Health Care Fraud and Abuse Control allocations (HCFAC). The funding supports attorneys, paralegals, auditors and investigators, as well as litigation of resource-intensive health care fraud cases. HCFAC funding is supplemented by Executive Office of U.S. Attorneys discretionary appropriations. IN FY 2009, EOUSA allocated $36.2 million in discretionary funds to target health care fraud. In FY 2008, it allocated $24.5 discretionary dollars to that effort.

The Executive Office for United States Attorneys' Office of Legal Education (OLE) also recognizes the importance of the continuing education of AUSAs and other DOJ attorneys, as well as paralegals, investigators, and auditors in the investigation and prosecution of health care fraud. In 2009, OLE offered a Health Care Fraud Seminar for AUSAs and DOJ attorneys, which was attended by over 100 attorneys, and offered an Affirmative Civil Enforcement Conference, which include health care fraud issues, for paralegals, auditors, and investigators.

FBI'S HEALTH CARE FRAUD INVESTIGATIONS

Health care fraud investigations are among the highest priority investigations within the FBI's White Collar Crime Program, along with Public Corruption and Corporate Fraud. Through national initiatives focusing on Internet pharmacy, durable medical equipment, and infusion therapy fraud, the FBI is utilizing sophisticated investigative techniques—from undercover operations to wiretaps—not only to collect evidence for prosecution, but also to find and stop criminals before they take action.

The FBI is actively pursuing health care fraud in every region. It has task forces and working groups to address health care fraud in every one of its 56 field offices, and it is shifting resources to regions where increased fraud trends are detected. FBI's field office-level task forces and working groups are comprised of HHS-OIG, U.S. Attorneys' Offices, state and local law enforcement agencies and, in many districts, private insurance company special investigative units and Medicare contractors that refer suspected fraud activity that is investigated jointly by the law enforcement agencies that are involved in the task force or working group. These task forces and working groups, which meet regularly, provide a structure to address the unique health care fraud in each region.

The FBI's Headquarters-based Health Care Fraud Program supports these field offices and serves as a veritable fusion center, sharing information on inter-region trends and providing training to include lessons learned and best practices.

In the past few years, the number of pending FBI health care fraud investigations have steadily increased. In FY 2008, alone, FBI-led investigations resulted in over 800 indictments and informations, and nearly 700 convictions, for health care fraud in federal and state courts

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collectively. In FY 2009, the FBI recorded over 840 indictments and informations, and 555 convictions for health care fraud.

In late July, working in concert with our partners, the FBI arrested more than 30 suspects in a major Medicare anti-fraud operation that spanned the country. In New York, Louisiana, Boston, and Houston, more than 200 agents worked on a $16 million fraud that ensnared several physicians. In short, the FBI and its partners are uniquely positioned to combat this particular crime problem every step of the way.

CIVIL RIGHTS DIVISION'S WORK TO FIGHT FRAUD, WASTE AND ABUSE

The Civil Rights Division plays a critical role in the Department's protection of the nation's health care system. The Special Litigation Section of the Civil Rights Division is the Department component responsible for the Civil Rights of Institutionalized Persons Act (CRIPA) and its role is to ensure that the civil rights of residents in public, state or locally-run, institutions (including facilities for persons with developmental disabilities or mental illness, and nursing homes) are fully protected. CRIPA authorizes the Department to seek injunctive relief to remedy a pattern or practice of violations of the Constitutional or federal statutory rights possessed by residents in such facilities. The review of conditions in facilities for persons who have mental illness, facilities for persons with developmental disabilities, and nursing homes comprises a significant portion of the program.

The Americans with Disabilities Act requires that services be provided to residents of such facilities in the most integrated setting appropriate to their needs. It is through that prism that the Department's Civil Rights Division evaluates residential placements in each of its investigations under CRIPA and seeks to eliminate the unjustified institutional isolation of persons with disabilities. The Department recognizes that unnecessary institutionalization is discrimination that diminishes individuals' ability to lead full and independent lives and, as a result, our CRIPA enforcement activities have enabled thousands of unnecessarily institutionalized individuals to live safely in the community with adequate supports and services.

As part of the Department's Institutional Health Care Abuse and Neglect Initiative, the Civil Rights Division conducts reviews of conditions in health care facilities. In FY2009, it pursued 19 CRIPA investigations regarding conditions in 23 healthcare public facilities. Also in FY 2009, the Division addressed conditions and practices at 13 state facilities for persons with intellectual and developmental disabilities, eight state facilities for persons with mental illness, and three state operated nursing homes. The Division entered five settlement agreements regarding these 24 facilities. The Division was unable to settle one case involving a facility for persons with developmental disabilities, and that case is currently in contested litigation.

CRIPA investigations require cooperation of jurisdictions to allow investigators access to facilities under investigation or to produce requested documents. Absent this cooperation, it is difficult for the Department to gain sufficient information to make the requisite findings to initiate litigation.

CONCLUSION: LOOKING FORWARD

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We hope you will look at the Department's successes thus far in combating waste, fraud and abuse and recognize the role we can continue to play, with the help of our federal and state government partners, in protecting both taxpayers' funds and patient safety. As we have seen time and time again, the only way we can be truly effective in protecting the integrity of our public health programs is by combining the full panoply of our federal resources, our expertise, and our information across agency and jurisdictional lines. The Department of Justice looks forward to working with Congress as we continue to prevent, deter, and prosecute health care fraud.

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