Department of Justice

STATEMENT

OF

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BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

CONCERNING

MEDICAID FRAUD AND ABUSE BY PHARMACEUTICAL COMPANIES

PRESENTED ON

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Mr. Chairman, I appreciate the opportunity to appear before you to discuss some of the issues that are the focus of today's hearing. We are grateful for the Committee's leadership on this important topic and to you, Mr. Chairman, for allowing us this opportunity to discuss our enforcement efforts and to work with your staff to fashion solutions to some of the systemic problems we will discuss here today.

We work with the Medicaid programs across the country to identify Medicaid losses in the broad range of health care fraud cases we bring against health care providers. Successful cases brought by the Department include issues implicating illegal kickbacks, false claims, illegal diversion of prescription drugs, and failure of care. Today, I am focusing my remarks on pharmaceutical pricing schemes perpetrated against state Medicaid programs because that area, in pure dollar terms, has been the most significant seen by the Department. If the Chairman would find it useful, I will be glad to fully brief Committee staff on the efforts of the Department in these and other areas of Medicaid fraud. The Department of Justice remains committed to rooting out and punishing corporate wrongdoers and that commitment takes on even added urgency in the context of health care fraud, where the public dollars are so large and where fraud often has a direct impact on public health. And that is why the Department of Justice, through the Civil and Criminal Divisions and through the U.S. Attorney's Offices, continues to fairly and vigorously enforce the various laws at our disposal to deal with those companies and individuals that steal from the taxpayers.

By no means, however, is the Department of Justice, and its investigative component, the FBI, alone in the fight to combat fraud and preserve the integrity of the country's health care system. We work closely with our colleagues at the Centers for Medicare and Medicaid Services, at the Department of Health and Human Services and its Inspector General, and with our State law enforcement partners in their Offices of Attorneys General and Medicaid Fraud Control Units. Working with our colleagues, in the past six years the Department has obtained recoveries exceeding $2 billion in pharmaceutical fraud matters involving losses to federal and state programs.

This Committee now is considering ways to protect state Medicaid programs from schemes involving pharmaceuticals. It is clear from our experience that government healthcare programs continue to pay too much for prescription drugs. This is due to several factors, including, unfortunately, the illegal behavior of those who seek to manipulate the system. It is equally clear that the Medicaid program is facing abuses of its prescription drug program, compounded by the fact that it pays significantly more for prescription drugs than the Medicare program currently does. This fact is borne out by the successful investigations we have brought, many of which are initiated by *qui tam* relators possessing "inside" knowledge. The lessons learned from these cases may prove useful to you as you consider possible reforms.

Let me discuss a few of these cases:

Bayer Corporation entered into two settlements with the Department to resolve allegations arising from its sale of pharmaceuticals and biological products to government health care programs.

In a case settled in 2001, the initial allegations against Bayer came to the Department from a relator under the False Claims Act who alleged that Bayer improperly inflated its drug prices, causing government programs, including Medicaid, to pay inflated reimbursement. Infusable and injectable drugs that cannot be purchased over the counter by the public at a retail pharmacy were at issue, including biologics used to treat life-threatening illnesses, such as hemophilia and immune deficiency diseases.

As you may know, state Medicaid programs reimburse providers for the purchase of these drugs for covered beneficiaries and use either the Average Wholesale Price (AWP) or Wholesale Acquisition Cost (WAC). The Government alleged that Bayer artificially inflated its AWPs and WACs above the actual prices paid by the vast majority of its customers when purchasing directly from Bayer or through a wholesaler. We alleged that Bayer, in turn, reported those inflated prices to the national drug pricing reporting services used by the States to calculate Medicaid reimbursement. By setting and reporting these prices, and subsequently selling the product to doctors at a dramatic discount, Bayer induced physicians to purchase its products rather than its competitors' because of the profit they would realize from government reimbursement for Bayer purchases, a corrupt practice known as "marketing the spread." The Government also alleged that Bayer falsely reported that certain products were not sold to wholesalers to avoid reporting accurate wholesale or distributor price information, and that it misled Medicaid officials about the prices it charged to wholesale purchasers. Bayer agreed to pay a total of $14 million to settle these allegations, as well as claims that Bayer underpaid Medicaid rebates owed to the states by not factoring in certain price concessions.

In a second case settled with Bayer two years later, the Medicaid rebate statute was again at issue. Bayer paid $257.2 million to settle allegations of fraudulent "private labeling" of certain drugs for some of its HMO customers to evade Medicaid rebate liability, and derivative Public Health Service liability. As part of the Medicaid rebate program, as you may know, manufacturers such as Bayer enter into a rebate agreement with the Centers for Medicare and Medicaid Services (CMS). Under the rebate program, manufacturers such as Bayer agree to report their best price to CMS on a quarterly basis. This best price is defined as the lowest price available from the manufacturer to any "wholesaler, retailer, provider, health maintenance organization, nonprofit entity or governmental entity within the United States" with certain specified exclusions. This law requires that manufacturers determine best price "without regard to special packaging, labeling, or identifiers on the dosage form or product or package." 42 U.S.C. § 1396r-8(c)(1)(C)(ii)(II). It also requires that manufacturers pay rebates to each State Medicaid program each quarter, calculated as the product of (i) the total number of units of each dosage form and strength paid for under the State plan in the rebate period, and (ii) the greater of either the difference between average manufacturer price and best price, or a minimum rebate percentage of the average manufacturer. §§ 42 U.S.C. 1396r-8(c)(1)(A) and (B). The purpose of the rebate program is to ensure that the nation's insurance program for the poor receives the best price for drugs available in the marketplace.

We have determined through our investigations that such "private labeling" has been used by some manufacturers to affix the customer's label and, more importantly, the customer's National Drug Code (NDC) to the drug, in a fraudulent scheme to avoid the manufacturer's statutory reporting or payment obligations with respect to that drug. Although private labeling has legitimate uses in the industry, for example, where a chain pharmacy wants to offer a store brand in addition to a brand name product, the practice may run afoul of the Medicaid Rebate program, 42 U.S.C. §§1396r-8, where it is done to avoid the manufacturer's best price reporting or rebate obligations.

In the Bayer investigation, the United States Attorney's Office in Boston alleged that Bayer private labeled two of its most popular drugs, Cipro and Adalat CC. We alleged that Bayer's private label arrangements were intended to provide deeply discounted prices on these drugs to the HMOs while evading its statutory and contractual obligations to provide the same favorable prices to the Medicaid program. In addition, Bayer submitted false statements to the Office of Audit of the Inspector General for the Department of Health and Human Services (HHS-OIG) and to the Food and Drug Administration (FDA) to further conceal its obligation to pay additional Medicaid rebates in connection with private labeling.

The Government's investigation concluded that Bayer failed to pay rebates owed to the Medicaid program and overcharged certain Public Health Service entities at least $9.4 million. Bayer pled guilty in the District of Massachusetts to a one count criminal Information charging violation of the Federal Food, Drug and Cosmetic Act for failing to list the private label product with the FDA, in violation of 21 U.S.C. §§ 331(p), 333(a)(2), and 360(j), and it paid a criminal fine of nearly $5.6 million. Together with the agreed upon civil settlement amount of $251.6 million, the total resolution in this second Bayer matter was $257.2 million

In a related investigation, **GlaxoSmithKline (Glaxo)** paid $87.6 million to settle similar allegations based on its relationship with the HMO, Kaiser Permanente Medical Care Program (Kaiser). As I indicated earlier, federal law requires drug manufacturers participating in the Medicaid program to report their "best prices" to the Federal government, and to pay rebates to Medicaid to ensure that the nation's insurance program for the poor receives the same favorable drug prices offered to other large purchasers of drugs.

We learned that at the time of our investigation, Kaiser provided care and treatment to more than 6 million persons and often purchased drugs directly from drug manufacturers to save on costs for its members. That is perfectly legal. However, we learned also that Glaxo – much like Bayer had done – provided discounted prices to Kaiser for its drugs and engaged in "private labeling" for Kaiser, affixing different labels to its drug products to avoid reporting the low prices to CMS. Glaxo also repackaged and privately labeled Paxil, an anti-depressant, and Flonase, a nasal spray, at discounted prices for Kaiser and then failed to report these lower prices as part of its mandated "best price" calculation submitted to the government.

This settlement with Glaxo involved not only the federal government but also 49 States, the District of Columbia, and Public Health Service entities to address losses suffered by the Medicaid programs and the Public Health Service entities. When added to the previous Bayer settlement, Bayer and GSK paid over $344 million to resolve these related allegations.

Like Bayer, GSK also executed a corporate integrity agreement with HHS-OIG, designed to ensure that GSK (like Bayer) will accurately report its "best price" information to the Government.

In the largest settlement of its kind, **TAP Pharmaceutical Products Inc. (TAP),** a joint venture between Abbott Laboratories and Takeda Chemical Industries, paid $875 million to resolve criminal charges and civil liabilities in connection with its fraudulent pricing and marketing of the cancer drug Lupron. Under an agreement with the Department in 2001, TAP pled guilty in the District of Massachusetts to a conspiracy to violate the Prescription Drug Marketing Act and paid a $290 million criminal fine. To resolve its civil liability under the False Claims Act, TAP agreed to pay the United States $559.4 million for filing fraudulent claims with Medicare and Medicaid, and to pay $25.5 million for filing fraudulent claims with the States.

During the period at issue, many state Medicaid programs, and the Medicare program, reimbursed covered drugs at the lower of 95% of the AWP or the physicians' actual charge. The Government alleged that TAP set and controlled the price at which the government programs reimbursed physicians for the prescription of Lupron by misreporting its AWP as significantly higher than the average sales price TAP offered physicians and other customers for the drug. TAP allegedly "marketed the spread" between its discounted prices paid by physicians and the significantly higher Medicare and Medicaid reimbursement based on AWP as an inducement to physicians to obtain their Lupron business. The Government further alleged that TAP concealed from Medicare and Medicaid the true discounted prices paid by physicians, and falsely advised physicians to report the higher AWP rather than the real discounted price for the drug. The "marketing the spread" practice was recently addressed in the HHS-OIG's Compliance Guidance for Pharmaceutical Manufacturers. The government further alleged that TAP knowingly offered and paid illegal remuneration in various forms, including free drug samples, to physicians and other entities to induce them to purchase the drug.

Another component of this case concerned TAP's failure to include the costs of the free goods it offered to physicians in its "patient start program"(under which urologists received free goods for every patient they switched to Lupron) in the Best Price calculations it reported to CMS. Our investigation determined that TAP knew that free goods contingent on future purchases must be included in Best Price calculations, but undertook no effort to include those discounts. As a result, TAP falsely reported its Best Price to CMS and underpaid its rebates to the states for several quarters.

In a related matter, **AstraZeneca Pharmaceuticals LP (AstraZeneca)** pled guilty in the District of Delaware to violating the Prescription Drug Marketing Act and paid $355 million to

resolve criminal charges and civil liabilities in connection with its drug pricing and marketing practices arising from its sales of Zoladex, a drug used primarily for the treatment of prostate cancer and the main competitor product to TAP's Lupron.

AstraZeneca admitted it caused claims to be submitted for payment for the prescription of Zoladex which had been provided as free samples to urologists. As part of the plea agreement, AstraZeneca paid a $63.9 million criminal fine, paid $266.1 million to resolve allegations that the company caused false and fraudulent claims to be filed with the Medicare, TriCare and the Railroad Retirement Board Medicare programs, and paid $24.9 million to resolve allegations that its drug pricing and marketing misconduct resulted in false state Medicaid claims.

Our investigation revealed that AstraZeneca marketed Zoladex primarily for the treatment of prostate cancer, much like the drug Lupron produced by TAP. The United States alleged that from January 1991 through December 31, 2002, employees of AstraZeneca provided thousands of free samples of Zoladex to physicians, knowing and expecting that certain of those physicians would prescribe and administer the free drug samples to their patients and thereafter bill those free samples to the patients and to Medicare, Medicaid, and other federally funded insurance programs. In order to induce certain physicians, physicians' practices, and others to purchase Zoladex, AstraZeneca offered and paid illegal remuneration in various forms that included free Zoladex, unrestricted educational grants, business assistance grants and services, travel and entertainment, consulting services, and honoraria.

Also, to induce physicians to purchase Zoladex, the United States alleged that AstraZeneca marketed a "Return-to-Practice" program to physicians. In a scheme similar to that engaged in by TAP, AstraZeneca inflated the Average Wholesale Price used by Medicare and Medicaid for drug reimbursement, deeply discounted the price charged to physicians for the drug ("the discounted price"), and then marketed the spread between the AWP and the discounted price to entice physicians with the additional profit they stood to gain from Medicare and Medicaid. AstraZeneca set the AWP for Zoladex at levels far higher than what the majority of its physician customers actually paid. As a result, AstraZeneca's customers received reimbursement from Medicare and state Medicaid programs at levels significantly higher than the physicians' actual costs or the wholesalers' average price.

Much like in the TAP case, AstraZeneca also had an extensive free goods discounting program for urologists, including a program under which urologists received free goods for every patient switched to Zoladex, purportedly designed to familiarize office staff and patients with the delivery method of the drug. Many physicians reported in interviews with federal authorities that they understood these free samples and goods were an alternative way of giving additional pricing discounts for the drug. As I mentioned, free goods contingent on future purchases must be included in the calculation of the Medicaid Best Price reported to CMS, but AstraZeneca undertook no effort to include those discounts. Because it did not include free goods in its calculations of Best Price for Zoladex, AstraZeneca falsely reported its Best Price to CMS in each of the 24 quarters we examined and consequently underpaid its rebates to the states.

In 2004, Warrick, a division of **Schering Plough Corporation** (Schering) agreed to pay the United States and Texas $27 million to settle allegations that it had defrauded the Medicaid program by inflating its reported wholesale acquisition costs (WACs) to national reporting services, which are used to set Medicaid reimbursement. The government alleged that Warrick then marketed the spread between the Medicaid reimbursement and the actual lower purchase prices of the drugs in order to induce the purchasers to buy Warrick's products. In 2003, the state of Texas and the Department settled similar allegations with **Dey, Inc**. for $18.5 million.

In a significant matter resolved in 2004, Schering also paid $292.9 million to resolve allegations arising from its contracts with two managed care customers. The government alleged that contracts were entered into by Schering to ensure that Schering's drug, Claritin, stayed on the customers' formularies while evading its Medicaid rebate obligations and derivative Public Health Service liability. The government alleged that from 1998 through 2000, Schering provided additional "value" to PacifiCare to ensure that Claritin stayed on PacifiCare's formulary. Our investigation revealed that, with one exception, the value of these additional price concessions was not credited in Schering's calculation of the Medicaid "best price" reported to CMS and not used by the manufacturer in determining rebate obligations.

The investigation, conducted in the Eastern District of Pennsylvania, also determined that from 1999 through 2002, Schering provided additional "value" to Cigna to ensure that Claritin stayed on Cigna's formulary. Once again we concluded that none of the value of these additional price concessions was credited in Schering's calculation of its Medicaid best price reported to CMS and not used in determining rebate obligations. Schering paid more than $282.3 million to settle its Medicaid liability, and more than $10.6 million to resolve its liability to Public Health Service authorities.

A parallel criminal investigation was conducted against Schering and, as a result, Schering Sales Corporation, a Schering subsidiary, pled guilty to one count of offering and paying a kickback in violation of 42 U.S.C. §1320a-7b. The plea arose from Schering Sales Corporation's payment of a "data fee" for data already obtained in connection with Schering's efforts to maintain formulary status for Claritin at Cigna. Schering Sales Corporation paid a criminal fine in the amount of $52.5 million pursuant to the plea, over and above the $292.9 million paid to resolve its civil liability to date.

We commenced our investigation of **Parke-Davis,** a subsidiary of **Pfizer,** following the filing of a *qui tam* complaint by a relator who was a former executive for Parke-Davis and who worked on the account for the cholesterol-lowering drug, Lipitor. The relator alleged that Parke-Davis provided discounts to a large managed care account in Louisiana without properly reporting those discounts to CMS under the obligations created by the Medicaid Rebate program. Our investigation revealed that Parke-Davis provided discounts to the Louisiana managed care account in exchange for an agreement that the managed care account would extend unrestricted drug formulary status to Lipitor and sign a contract to buy Lipitor. The government alleged that these

discounts were not reported to the CMS as part of the best price calculations, nor to the states. The matter settled when Pfizer paid $49 million to settle state and federal Medicaid claims.

In another matter resolved last year, the government alleged that **Warner-Lambert**, which was acquired by Pfizer in 2000, acting through its wholly-owned pharmaceutical division, **Parke-Davis**, engaged in the illegal marketing and promotion of the prescription drug Neurontin for uses that were not approved by the Food and Drug Administration. This was another matter initiated by the filing of a *qui tam* that alleged that the drug Neurontin, which had been approved by the FDA as an adjunct therapy for epilepsy, had been marketed by Pfizer for numerous other "off-label" and unapproved uses, such as for the treatment of pain and psychiatric conditions.

As a general proposition, the federal law and regulations governing Medicaid reimbursement do not provide for reimbursement for off-label prescriptions where the use is not medically accepted. The government alleged that Parke-Davis' marketing scheme induced physicians to prescribe Neurontin for off-label uses through a variety of means, including the fraudulent practices of the payment of kickbacks to doctors and distribution of false statements to doctors about the safety, efficacy and approval status of Neurontin. Neurontin was launched into the marketplace in February of 1994; from mid-1995 to at least 2001, the growth of off-label sales was tremendous. While not all of these sales were the consequence of Warner-Lambert's illegal marketing, the marketing scheme was very successful in increasing Neurontin prescriptions for unapproved uses.

Under the terms of the settlement, Warner-Lambert pled guilty in the District of Massachusetts to a criminal information charging it with violations of the Federal Food, Drug and Cosmetic Act, 21 U.S.C. § 333(a)(2). Because Warner-Lambert was previously convicted of criminal violations under the Federal Food, Drug and Cosmetic Act in 1996, these misdemeanor offenses became felonies under 21 U.S.C. §333(a)(2). As part of the $430 million settlement amount, Warner-Lambert paid a criminal fine of $240 million and paid $190 million to resolve federal and state Medicaid claims, and to resolve state consumer protection claims.

Pfizer Inc., Warner-Lambert's parent company, has agreed to comply with the terms of a corporate compliance program, which will ensure that the changes Pfizer Inc. made after acquiring Warner-Lambert in June 2000, are effective in training and supervising its marketing and sales staff, and that any future off-label marketing conduct is detected and corrected on a timely basis.

In a recent matter handled by the United States Attorney's Office in Massachusetts and the Civil Division's Office of Consumer Litigation, on April 19, 2005, a Michigan medical device manufacturer and its president pled guilty to conspiring with others to disseminate adulterated computer software devices used to promote the diagnosis of AIDS wasting and to increase sales of an AIDS wasting drug. The drug, paid for by state Medicaid programs, cost more than $21,000 per twelve-week course of treatment, and thus more than $40,000 per patient per year for multiple courses of treatment.

The conspiracy involved **RJL Sciences**, its president, and others disseminating adulterated computer software devices for use in interpreting bioelectrical impedance analysis (BIA) for use in diagnosing AIDS wasting, without getting the necessary approvals from FDA. When required FDA approvals are not obtained for medical devices, the system for ensuring the safety and efficacy of devices is undermined, and the public is exposed to the risk that medical diagnoses and treatment decisions are based on diagnostic tools whose effectiveness have not been established. By circumventing the FDA approval process, the defendants and their co-conspirators put their desire to sell more drugs and devices over the interests of the public.

Demand for the AIDS wasting drug began to drop significantly immediately after it was launched as a result of a decline in the incidence and prevalence of AIDS wasting. AIDS wasting, the condition for which the drug was tested and approved by FDA, involves profound involuntary weight loss and loss of lean body mass in AIDS patients, and does not include loss of body cell mass. Use of computer software that purported to measure loss of body cell mass enabled RJL, and others, to expand the market for the drug beyond the disease state for which the drug was tested and approved. According to the Criminal Information, RJL and others engaged in various overt acts in furtherance of the conspiracy, including providing training and assistance to others in performing and interpreting BIA test results and obtaining reimbursement for the drug.

On April 14, 2005, in another investigation, four former top executives of the manufacturer of an AIDS wasting drug were indicted by a federal grand jury in the District of Massachusetts for conspiring to offer and pay kickbacks to doctors in the form of an all expense-paid trip for the doctors and their guests to attend a medical conference in Cannes, France in return for writing prescriptions for an AIDS wasting drug covered by Medicaid. The executives were also charged with offering to pay illegal remunerations.

The purpose of this conspiracy was also to increase the sale of an AIDS wasting drug by, among other things, achieving a sales goal of $6 million in six days, by inducing the writing of up to thirty prescriptions by each of the high prescribing doctors. Because the cost of each prescription of the AIDS wasting drug induced by the offer of the Cannes trip was for a twelve-week course of treatment valued at approximately $21,000, the market value of thirty prescriptions written by each doctor was $630,000.

In December, 2004, a former regional director for the manufacturer of the AIDS wasting drug pled guilty to three counts of offering to pay illegal remunerations to doctors in his sales territory in connection with his involvement in the kickback scheme. The investigation is continuing.

Now, I would like to quickly add here that under no circumstances are our attorneys attempting to inhibit the professional judgment of medical professionals who prescribe drugs for purposes not yet approved by the FDA. We know that physicians are permitted to prescribe medications for off label uses as they see fit in their medical judgment. A drug manufacturer's dissemination of reprints of medical journal articles, reference textbooks, and independent

continuing medical education regarding the safety and efficacy of drugs can be beneficial to health care practitioners and their patients. However, as we saw in the Parke-Davis case, certain companies may seek to vastly increase their market share by promoting their products for off-label purposes, by disseminating false and misleading evidence to support those unapproved uses, and by bestowing gifts and other remuneration on doctors to influence their prescription writing practices. Clearly, the law does not give drug manufacturers carte blanche to promote drugs for off-label uses by any means. Nor does the law create vast exceptions that render the Federal Food. Drug and Cosmetic Act or the Anti-Kickback Statute inapplicable to pharmaceutical manufacturers.

From the cases I have discussed, several lessons have emerged:

- By manipulating and then marketing the "spread" between the Medicare or Medicaid reimbursement rate and the amount the pharmacy or doctor actually pays for a drug, manufacturers are able to induce purchases of their drugs and obtain market share, all at the expense of government programs. Although the Medicare Modernization Act of 2003 addresses this problem on a going forward basis for Medicare Part B reimbursed drugs by using actual sales prices as the operative reimbursement benchmark, the Medicaid program remains vulnerable to such schemes at those at issue in the TAP, Bayer, AstraZeneca, Warrick, and Dey cases.

- Manufacturers have engaged in abuses of the Medicaid Rebate statute, a law that was designed to ensure that the Medicaid program obtains the savings that manufacturers offered to other customers, however those savings were passed along. A close examination of the authorities is timely and warranted by the issues that have arisen in our enforcement efforts.

- By providing free pharmaceuticals to physicians and then instructing them how to bill Medicare and Medicaid for the free products, manufacturers have surreptitiously caused the government to pay for the illegal kickbacks with which they induce physicians to prescribe their drugs. By disguising the true nature of these free products, manufacturers
obscure their best prices, facilitate payment of fraudulent claims by these cash strapped programs, and deny Medicaid the full benefit of the drug rebate program. Best price violations that affect Medicaid also directly impact Public Health Service entities, whose prices are based on a derivative formula.

- By inducing physicians to prescribe for uses that have not been approved by the Food and Drug Administration, either by promoting compromised "science" or offering financial incentives, manufacturers are subverting a healthcare system that necessarily relies on the sound medical judgment of practitioners, and perhaps harming the public health

- The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), remains a vital law enforcement tool in assuring that sound medical judgment is not subverted by the payment of inducements that sometimes cause medical professionals to prescribe drugs based on financial considerations and not medical need. Care must be taken to assure that any proposed amendments to the Anti-Kickback Statute designed to accommodate proposed electronic storage of medical records and interoperability of provider recordkeeping systems not result in a weakening of this important weapon in our defense against fraud, waste, and abuse.

The Department, working with its partners at CMS and HHS Office of Inspector General, has taken the lessons learned from these cases and applied them to safeguards for the new Medicare prescription drug benefit. Nevertheless, experience teaches us that manufacturer efforts to place their drugs in particular formularies will take many forms, some of which may be illegal or come at great cost to government health programs.

Conclusion

The cases that I have discussed, and many others, show that the Department has been very active in this area. We have been greatly assisted by industry insiders who have taken advantage of the *qui tam* provisions of the False Claims Act, but we also have been fortunate to be able to work alongside state prosecutors on these complex and difficult cases in a joint effort to protect the integrity of the nation's health system.

As you well know, our Medicaid program is struggling to provide health care to our nation's neediest citizens, and it is doing so at a time when resources are increasingly scarce. We simply cannot afford to let Medicaid be victimized by the schemes that I have discussed here today. Toward that end, the Department of Justice will continue to work with this Committee and its staff to identify problems and work toward formulating solutions.

Again, I thank the Committee for seeking the views of the Department of Justice on these issues. The Committee can be assured that the Department will continue to play a leading role in protecting the healthcare system for fraud and abuse, and will work with this Committee in addressing the myriad issues which I have briefly discussed this morning.