**Testimony of Patrick Burns**

**Co-Executive Director**

**Taxpayers Against Fraud**

**Hearing on HR 4001, the West Virginia False Claims Act**

**Tuesday, January 28, 2014**

## Summary of Testimony

The State of West Virginia spends billions of dollars to fund various governmental programs, and it is essential that these funds are not lost to fraud, but are spent on their intended purposes. Federal and state false claims acts have proved to be critical tools for exposing fraud and helping to recover taxpayer money.

We applaud this effort to pass a West Virginia False Claims Act, and urge this committee to reject weakening amendments which would result in the state not receiving millions of dollars back from the federal government under the Deficit Reduction Act of 2005.

## Introduction

Taxpayers Against Fraud and its sister organization, Taxpayers Against Fraud Education Fund, are nonprofit organizations dedicated to combating fraud against the federal government and state governments through the promotion of the whistleblower provisions of false claims acts ("FCA's").

I am pleased to be invited to submit testimony concerning HR 4001, the West Virginia False Claims Act.

Enactment of strong anti-fraud laws should be an integral part of any debate over addressing budget challenges. As states struggle with rising deficits and looming budget shortfalls, programs that assist children, the elderly, and the infirm, as well as programs that strengthen infrastructure, such as roads, bridges and schools, are often put on the chopping block even as anti-fraud tools remain weak or unused. At a time when citizens may be asked to pay more, or get less, it's critical to send a clear signal that fraudsters will be pursued with vigor.

**The False Claims Act Model**

The False Claims Act contains "*qui tam*" provisions, which allow people with evidence of fraud against the government to sue on behalf of the Government. People who sue under the FCA are called "relators" or "whistleblowers," and are eligible for 15 to 30 percent of the amount recovered. Whistleblower awards are paid out of the treble damages levied on fraudster companies. If there is no recovery, there is no award.

Historically, *qui tam* provisions were created as a way of keeping government small by empowering citizens to come to the aid of law enforcement and bring civil actions on behalf of the government against those who violate our laws.

The core idea behind the False Claims Act is simple and straightforward: if federal and state governments incentivize integrity, they will get more of it.

For more than 25 years, this idea has worked remarkably well. The Federal False Claims Act has returned over $45 billion to the U.S. Treasury, and nearly $10 billion back to the states.

The reason False Claims Act laws work is that whistleblower incentives serve as a counterbalance to the fear of job loss, unemployment, and bankruptcy which otherwise prevents good, honest people from coming forward to report wrong doing.

This point cannot be overstated.

We all know what companies do to employees who report lying, stealing and cheating to federal and state governments; they move to isolate, humiliate, and terminate those employees as quickly as they can.

The False Claims Act is designed to encourage whistleblowers to come forward, but it is also cleverly crafted to discourage frivolous lawsuits and to relieve litigation burdens from innocent companies.

Whistleblower lawsuits are filed under seal. The procedural and evidence burdens of filing a False Claims Act lawsuit generally require a whistleblower to hire an attorney, most of whom work on contingency.

Because False Claims Act cases generally take 2-4 years or more to resolve themselves, experienced false claims act attorneys are difficult to retain, as they only get paid if they are successful at recovering money back to the federal government and the states.

What this means is that private attorneys not only screen cases for federal and state governments, they also organize, investigate and develop whistleblower claims so that the defrauded agencies understand how they were ripped off, and the extent to which they were defrauded.

Because so much of the work is done on the front end by the whistleblower and his or her attorney, the government generally saves years of effort and millions of dollars in investigation costs. Just as importantly, the government can read the complaint before investigating in order to rather quickly determine if a case meets evidence burdens that must be met under state and federal false claims acts.

Among other reasons *qui tam* cases may be dismissed is if:

- The whistleblower bases his complaint on public information available from the news media, the courts, or the government;
- The whistleblower cannot plead clear and specific evidence of fraud;
- Another *qui tam* complaint alleging the same fraud is already pending;
- The whistleblower cannot show that the defendant knowingly submitted a false claim to the government or did so with reckless disregard or indifference to the truth;
- The case is filed outside of the statute of limitations, or;
- The whistleblower engaged in criminal activity in connection with the fraud.

Because whistleblowers and their lawyers only get paid if a case is successful, they are dis-incentivized to bring frivolous cases; in fact, FCAs contain a fee-shifting provision that requires relators to pay defendants' costs and attorneys' fees if they bring a *qui tam* suit that is clearly frivolous. The result is a tremendous bang for the buck. A recent study done by Taxpayers Against Fraud Education Fund concluded that the federal government recovers $20 back for every $1 invested in False Claims Act prosecutions and investigations.

**Replicating Success at the State Level**

Cash incentives have worked so well to get whistleblowers to come forward to help in the war on fraud, that the federal government has extended the cash incentive idea to the states.

Under the Deficit Reduction Act of 2005, if a state passes a state False Claims Act that is at least as strong as the federal version of the law, the Federal Government will increase the state's share of a Medicaid False Claims Act award by 10 percentage points.

This is actually a far larger percentage share than it first appears. For example, if a Federal-State Medicaid split is 72-28, as it was for West Virginia in 2013, then the

State share would rise from 28 percent to 38 percent – a 35% increase in the State's award in a settled or positively litigated case.

In order to win this increased incentive, however, the West Virginia False Claims Act has to be at least as strong as the federal act. Weakening amendments will result in the U.S. Department of Health and Human Services disqualifying West Virginia from the Deficit Reduction Act incentives, and the result will be millions of dollars lost to West Virginia.

Today, 29 states, and the District of Columbia have enacted their own state False Claims Act laws.

If West Virginia is looking for a state model of success in the war on fraud, it need look no farther than neighboring Virginia.

The key to Virginia's success has been the one-two punch of a Virginia False Claims Act, combined with a proactive Medicaid Fraud Control Unit.

Since the Virginia General Assembly passed the Virginia Fraud Against Taxpayers Act in 2002, the Commonwealth's Medicaid Fraud Control Unit has returned an average of $228 million per year, or more than $3.1 million per fraud unit employee per year.

Two big cases stand to illustrate the power of a state law.

The first was a civil prosecution against Purdue Frederick, the maker of Oxycontin, a painkilling drug which is one of the most addictive drugs ever legally sold in this country, and one which has devastated Appalachia as a consequence.

Not only was Purdue Frederick forced to pay the federal government and the states over $634 million to settle off-label marketing charges, but the president, general counsel, and chief medical officer of the company also pled guilty to criminal charges, were forced to pay millions out of their own pockets, and were then excluded from doing business with the U.S. Government.

As part of the Purdue Frederick settlement, the Virginia Medicaid Fraud Control Unit was paid $5.3 million to fund future health care fraud investigations, and an additional $20 million was paid to fund a Virginia Prescription Monitoring Program to help curtail the misuse, abuse, and diversion of prescription drugs.

With money in hand to fight forward in the war against fraud, Virginia was able to take the lead in the civil prosecution of Abbott Laboratories for the off-label marketing of the mood-control drug Depakote. This whistleblower-initiated case was settled for $1.5 billion, and remains the largest Medicaid fraud case ever led by a state.

Virginia's aggressive Medicaid Fraud Control Unit has been so successful that the state portion of its budget is now funded solely by recoveries made in criminal and civil settlements.

In short, the bad guys are now paying for their own investigations and prosecutions, not Virginia taxpayers.

Clearly, Virginia's Medicaid Fraud Control Unit is a winning program.

But health care is only part of Virginia's budget, and Virginia is moving to recover funds across the board. For example, in the construction arena, a jury recently found pipe manufacturer JM Eagle guilty of knowingly selling defective plastic water pipes to municipalities across the nation, including those in Virginia. The damages part of this litigation lies ahead, but it's clear Virginia is likely to recover millions of taxpayer dollars in this case.

Virginia is not alone in fighting fraud at the state level. Texas has also suited up to join whistleblower lawsuits.

From 2006 through fiscal year 2012, Texas recovered over $821 million for state and federal taxpayers after subtracting for relators' shares and Texas State attorney fees and costs. Over $348 million of this amount was allocated to Texas taxpayers and over $473 million was allocated to federal taxpayers under the Medicaid state and federal costing sharing system. It should be noted that nearly half of these recoveries – over $394 million – resulted from fraud cases in which Texas led the investigation and prosecution of the case under the Texas Medicaid Fraud Prevention Act.

New York is also moving aggressively to fight fraud using its state False Claims Act. New York Attorney General Eric Schneiderman has created a special "Taxpayer Protection Bureau" in his state to encourage and work with whistleblowers to expose corruption and to target firms that rip-off government pension funds and contractors that over-bill on taxpayer-funded construction.

Florida and California have likewise moved to recover hundreds of millions of dollars of taxpayer money stolen in Medicaid scams, pension scams, and construction scams. Florida's Attorney General, for example, just announced a $28 million recovery from Bank of New York Mellon in a False Claims Act case dealing with Florida's pension fund, which was short-changed on international currency transactions.

**Myth Busting**

In reviewing the rather loose discussion that has been voiced about the proposed West Virginia bill in the press, let me correct a few basic inaccuracies:

- Less than 200 cases a year are settled or adjudicated to conclusion at either the federal or state level. In recent years, however, this small number of cases has returned between $3 and $9 billion a year back to federal and state governments. Clearly, federal and state false claims acts are not being used recklessly.

- The FCA offers reduced punishments to violators who self-disclose their misconduct.

- Whistleblower cases cannot be based on publicly disclosed information.

- Companies typically settle False Claims Act cases and pay millions or even billions of dollars, not because they are innocent, but because they believe that if they took their case before a jury, they would lose and their civil liabilities would be greater.

- The proposed West Virginia False Claims Act does not allow whistleblowers to sue the state. The law is a tool used by the state to sue cheating corporations and individuals on behalf of West Virginia taxpayers.

- This is not controversial legislation, but legislation that is a proven success at the federal level and in 29 states and the District of Columbia. Over the course of the last 25 years, over $55 billion has been recovered using false claims act laws, and over 80% of this money has been returned thanks to whistleblower-initiated cases.

- President Bush signed into law legislation that will now give West Virginia a 35% increase in federal Medicaid settlement awards, provided West Virginia has a state False Claims Act at least as strong as the federal law. West Virginia will lose scores of millions of dollars if it embraces a law that is weaker, in any way, than the federal law.

- Whistleblower awards do not cost taxpayers a dime; they are paid for by the fraudsters who are often hit with treble damages which are levied in order to recover the cost of the government's investigations and prosecution (including whistleblower awards) and lost interest.

- Simple mistakes are not actionable. False Claims Act laws require a company to knowingly commit fraud.

- False Claims Act cases are not made on rumor, and cases are always evidence-based. Whistleblower complaints based on mere suspicions of fraud will be dismissed under heightened pleading rules that apply to FCA cases. To win a False Claims Act case, the evidence of fraud has to be specific, identifying the "who, what, when, and where" of the fraud.

- Whistleblower awards flow to those who are first to file, so there is never an incentive to wait for a fraud to grow before a whistleblower files a case. On the other hand, whistleblower cases demand evidence and without that evidence, they will be dismissed.

**Conclusion:**

Taxpayers Against Fraud Education Fund applauds this body for taking a step in the right direction to recapture West Virginia's stolen billions.

If only 3 percent of the state's $11.2 billion budget is lost to fraud every year, that sum totals to over $330 million dollars – or more than $600 per person per year.

While we will never get rid of all fraud against the government, state or federal, the West Virginia False Claims Act is clearly a strong step in the right direction.

In moving this legislation forward, however, it is critical that weakening amendments be rejected in order to preserve the Deficit Reduction Act of 2005 incentives from the federal government, which will bring scores of millions of dollars back to the people of West Virginia.

# Appendix A

Recent press releases about recoveries made under the Virginia Fraud Against Taxpayers Act.

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*Commonwealth of Virginia*
*Office of the Attorney General*

*Mark Herring*
*Attorney General*

*900 East Main Street*
*Richmond, Virginia 23219*

**For media inquiries only, contact:** Brian J. Gottstein
**Email:** bgottstein@oag.state.va.us (best contact method)
**Phone:** 804-786-5874

## Feds agree to release $115 million due Virginia from Medicaid fraud settlement

**RICHMOND** (June 5, 2013) - This afternoon, the U.S. Treasury Department alerted Attorney General Ken Cuccinelli that it would release $115 million due to Virginia for his office's role as the lead investigator in a 2012 Abbott Laboratories Medicaid fraud settlement.

The attorney general's office received a letter from Treasury's Executive Office for Asset Forfeiture (TEOAF) that a decision had been made on the disbursement. Subsequent phone calls with TEOAF confirmed the $115 million figure.

"I am grateful to Treasury's Executive Office for Asset Forfeiture for agreeing to work with us to get this money to Virginia law enforcement," said Cuccinelli. "We have been planning for more than a year to use this money for equipment and training to benefit law enforcement and communities throughout Virginia.

"This money is coming to Virginia because of the hard work and dedicated service of the staff of the Virginia Medicaid Fraud Control Unit. I want to thank them for their distinguished service to the people of the commonwealth," he said.

In a news conference earlier today, Cuccinelli detailed how he wanted the money to be spent on law enforcement. He also gave an accounting of the struggle to get the money to Virginia.

The Office of the Attorney General has no indication of when the money will be disbursed.

Additionally, some reporters have asked for clarification about what part of the Abbott settlement went to help Medicaid recipients. That money has already been disbursed.

The May 2012 $1.5 billion Abbott settlement was divided into (1) $800 million in civil settlements with the federal government and the states and (2) $700 million in criminal fines and forfeitures.

Under the civil settlement, Abbott paid $800 million to the federal government and the states to settle claims for defrauding Medicaid and other government health care programs. That part of the settlement has already happened and the money went to reimburse Medicaid and other programs to help beneficiaries.

Under the criminal portion, Abbott paid the federal government a criminal fine of $500 million, it paid $1.5 million to the Virginia Medicaid Fraud Control Unit for investigative costs, and it forfeited assets of $198.5 million to go to the investigative agencies for law enforcement purposes. Virginia's $115 million today comes from that asset forfeiture money, which is required by federal regulations to be used for law enforcement purposes.

*Commonwealth of Virginia*
*Office of the Attorney General*

*Mark Herring*
*Attorney General*

*900 East Main Street*
*Richmond, Virginia 23219*

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**Phone:** 804-786-5874

# Cuccinelli gives $30 million taken from criminals to help shore up state law enforcement retirement accounts

***- Money from Abbott Labs settlement to help preserve critically underfunded retirement accounts -***

RICHMOND (October 25, 2013) - In a Richmond news conference today, Attorney General Ken Cuccinelli gave $30 million to the Virginia Retirement System (VRS) to help shore up two underfunded retirement accounts for state law enforcement officers. The $30 million is part of a criminal settlement stemming from a fraud investigation by Cuccinelli's office; the funds are not taxpayer money.

Cuccinelli said that in addition to helping Virginia keep its retirement funding promise to law enforcement, the retirement accounts need to be shored up to prevent problems with recruitment, morale, and retention.

"It's critical that these retirement funds be preserved so that they can continue to provide the retirement benefits that were promised to public safety officers who have faithfully served their fellow Virginians," said Cuccinelli.

"If Virginia's retirement systems for state law enforcement officers are not on secure financial footing, it could lead to problems in recruitment, morale, and retention that would ultimately have a profoundly negative impact on public safety. These contributions are one way to help," the attorney general said.

VRS maintains two funds for state law enforcement. The State Police Officers' Retirement System (SPORS) is for retired Virginia State Police officers. The Virginia Law Officers' Retirement System (VaLORS) is for Capitol police officers, campus police officers, conservation officers of the Department of Game and Inland Fisheries, ABC special agents, marine resources officers, state correctional officers, state juvenile correctional officers, state parole officers, and commercial vehicle enforcement officers of the State Police.

The funds are two of the most underfunded of the VRS accounts. Cuccinelli presented checks for $15 million to VRS for each account.

Cuccinelli presented the two $15 million checks to Robert "Bob" Schultze, director of VRS, and Diana Cantor, chairman of the VRS board of trustees, along with members of the Virginia Capitol Police, Virginia Commonwealth University Police Department, Virginia Department of Juvenile Justice, Marine Resources Commission, Department of Game & Inland Fisheries, Department of Corrections, Alcoholic Beverage Control, J. Sargeant Reynolds Community College Police Department, and Virginia State University Police Department.

Download the photo here.

The $30 million is part of the attorney general's $115 million in asset forfeiture proceeds earned from a national Medicaid fraud investigation his office led against Abbott Laboratories, Inc. Besides restitution to the state's Medicaid program and penalties, Abbott paid the forfeiture as part of a 2012 settlement.

While the Abbott asset forfeiture money is the attorney general's office's to keep, Cuccinelli has been making plans for more than a year to use $105 million of the $115 million for grants to state and local police and sheriffs' departments to buy needed equipment such as bulletproof vests, tactical vehicles, and police cars. He is also earmarking money for continuing training for law enforcement and local prosecutors.

The Virginia-led Medicaid fraud investigation led to the second largest Medicaid fraud settlement in U.S. history at the time. In May 2012, Abbott Laboratories Inc. pled guilty and agreed to pay $1.5 billion to the federal government and the states to resolve criminal and civil liability arising from the company's unlawful promotion of the prescription drug Depakote for uses not approved as safe and effective by the Food and Drug Administration.

While SPORS and VaLORS are for state law enforcement officers, local sheriffs and police are employed by their local jurisdictions and are under separate retirement systems. Their jurisdictions may be members of VRS or the jurisdictions may manage their own retirement accounts. Local law enforcement retirement funds are generally not segregated from the rest of their fellow public employees' funds like they are for state law enforcement.

*Commonwealth of Virginia*
*Office of the Attorney General*

*Mark Herring*
*Attorney General*

*900 East Main Street*
*Richmond, Virginia 23219*

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**Email:** bgottstein@oag.state.va.us (best contact method)
**Phone:** 804-786-5874

# Cuccinelli announces $37 million Virginia Medicaid fraud settlement with McKesson Corp. for inflating prices of 400+ drugs

**RICHMOND (October 18, 2013) -** Attorney General Ken Cuccinelli announced today that Virginia will receive $37 million as part of a settlement his office negotiated with McKesson Corporation, one of the largest pharmaceutical wholesalers in the country, over allegations the company violated the Virginia Fraud Against Taxpayers Act by conspiring to inflate prices for more than 400 brand-named prescription drugs.

The attorney general alleged that McKesson conspired to inflate published Average Wholesale Price (AWP) information, causing Virginia's Medicaid program to overpay for those drugs. The Virginia Department of Medical Assistance Services (DMAS) uses the published AWP data to set Medicaid reimbursement rates for pharmaceuticals.

Virginia's $37 million settlement represents the largest recovery by any state Medicaid Fraud Control Unit (MFCU) against McKesson in this AWP case. In a previous settlement, which Virginia refused to join, 29 states, including California and New York, shared a total recovery of $151 million.

"This $37 million recovery shows that we will not tolerate Medicaid fraud in Virginia," said Cuccinelli. "It robs the taxpayers and it robs money needed for medical services for the poor. Our office refused to participate in a national settlement led by the Department of Justice because we needed to send a message that Virginia will fight to protect its Medicaid program from fraud and because the original settlement didn't cover the total loss to our Medicaid program.

"Our Medicaid Fraud Control Unit, working with the Virginia Department of Medical Assistance Services, was willing to go to trial in McKesson's hometown of San Francisco to get the maximum possible recovery we could in this case. Due to these efforts, we estimate that this $37 million recovery represents approximately ten times what other states that had a comparable impact to their Medicaid programs received from the previous, multistate settlement."

The settlement will return in excess of $30 million to the commonwealth's General Fund Health Care account within the next two weeks. $16.8 million is for compensatory damages for the state's Medicaid program, while $13.5 million is for penalties. This agreement resolves the case as to the Virginia state portion of Medicaid and imposes significant penalties upon McKesson Corporation for the alleged conduct.

"Combating Medicaid fraud has been a focus of my administration for the past three and a half years," Cuccinelli said. "When I took office, I made expanding our Medicaid fraud unit a priority precisely to achieve this type of result."

With this recovery, the office has returned more money to the General Fund during Cuccinelli 's tenure than has been allocated by the General Assembly to fund the office. From 2010-2013, the General Fund budget for the office was approximately $78 million. The Medicaid fraud unit alone has returned $67.7 million to the General Fund during that same time. Additionally, the Consumer Protection Section, which handles fraud not related to Medicaid, has returned $73 million to the General Fund. And through annual budget savings, Cuccinelli has returned $3.2 million from his budget to the General Fund over the last four years.

Virginia MFCU's recoveries in last three and a half years now total $1.6 billion - more than all other recoveries combined since MFCU began 30 years ago. This amount includes money recovered not only for Virginia, but for the federal Medicaid program and other states.

The  case was brought by Virginia's MFCU in the U.S. District Court for the Northern District of California, McKesson Corporation's home district. Assistant attorneys general William Clay Garrett, Patrick A. McDade, Adele M. Neiburg, Joseph S. Hall, Lisa H. Shin, Jessica M. Smith, Kimberly M. Bolton, and Pierce C. Acuff represented the commonwealth. The attorney general would also like to recognize many of his MFCU investigators and paralegals who worked on various aspects of the case.  The entire team reviewed more than three million pages of documents in the discovery phase of the litigation.

The commonwealth also retained the services of Hagens Berman Sobol Shapiro LLP to assist as local counsel in the matter. The Virginia Department of Medical Assistance Services assisted in the development of the case, especially helping with evidence discovery.

*Commonwealth of Virginia*
*Office of the Attorney General*

*Mark Herring*
*Attorney General*

*900 East Main Street*
*Richmond, Virginia 23219*

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# Cuccinelli recovers $21 million in health care fraud settlements with Johnson & Johnson

*- J&J and its subsidiary marketed antipsychotic drugs Risperdal and Invega for unapproved uses in vulnerable patient populations -*

RICHMOND (November 4, 2013) - Late today, Attorney General Ken Cuccinelli announced that his office has recovered $21 million in two settlements with pharmaceutical companies that allegedly defrauded Virginia's Medicaid program by - among other things - marketing the antipsychotic drugs Risperdal and Invega for uses not approved by the Food and Drug Administration. Johnson & Johnson and subsidiary Janssen Pharmaceuticals, Inc., also promoted that Risperdal be prescribed to children, the elderly, and those with mental disabilities despite warnings of significant health risks and despite no FDA approval for use in these patient populations. The two settlements agreed to today will result in nearly $10 million in restitution to Virginia's Medicaid program in addition to civil and criminal penalties for the companies.

"J&J put profits over patients when it promoted Risperdal and Invega for unapproved uses that threatened the most vulnerable in our commonwealth - our children, the elderly, and those with mental disabilities," said Cuccinelli.

Virginia joined with other states and the federal government in a $1.6 billion total global settlement with New Jersey-based pharmaceutical manufacturer Johnson & Johnson (J&J) and its subsidiary, Janssen Pharmaceuticals, Inc. Once the FDA approves a drug as safe and effective, a manufacturer cannot market or promote the drug for another unapproved off-label use.

The states and the federal government contend that the companies promoted Risperdal for unapproved uses, made false and misleading statements about the safety and efficacy of the drug, and paid illegal kickbacks to health care professionals and long-term care pharmacy providers to induce them to prescribe Risperdal to children, the elderly, and those with mental disabilities.

The states and the federal government further contend that the companies promoted Invega for off-label uses and made false and misleading statements about the safety and efficacy of the drug. The manufacturers' alleged unlawful conduct caused false claims to be submitted to government-funded health care programs, including state Medicaid programs. (More information on what the companies did is in the "Details of off-label allegations" section below.)

Virginia will receive approximately $17,445,682 as part of this settlement. Cuccinelli will be returning approximately $8,105,539 of that to the commonwealth's General Fund Health Care account, which funds the state part of Virginia's Medicaid program. Because Medicaid is a joint federal-state program, J&J's conduct caused losses to both the federal and state governments. The remaining part of the $17 million will reimburse the federal government for its portion of the losses in Virginia's Medicaid program, and a percentage will also go to the whistleblowers who helped bring the case.

Under the civil portion of the settlement, the companies will pay more than $1.2 billion total to the states and the federal government for allegedly violating the federal False Claims Act and state false claims laws. In addition, Janssen will plead guilty to a criminal misdemeanor charge of misbranding Risperdal in violation of the federal Food, Drug, and Cosmetic Act. As part of the criminal plea, Janssen has agreed to pay an additional $400 million in criminal fines and forfeitures, for a total settlement of $1.6 billion from the two companies. The companies will also enter into a Corporate Integrity Agreement with the U.S. Department of Health and Human Services' Office of the Inspector General, which will monitor the companies' future marketing practices.

**Details of off-label allegations**

The states and federal government alleged that Janssen marketed Risperdal to control the behaviors of elderly nursing home residents, children, and individuals with mental disabilities.

The complaint alleged that J&J and Janssen were aware that Risperdal posed serious health risks for the elderly, including an increased risk of strokes, but that the companies downplayed these risks. For example, when a J&J study of Risperdal showed a significant risk of strokes and other adverse effects in elderly dementia patients, the complaint alleged that Janssen combined the study data with other studies to make it appear that there was a lower overall risk of adverse effects.

The complaint also alleged that Janssen knew that patients taking Risperdal had an increased risk of developing diabetes, but promoted that Risperdal did not cause diabetes.

The complaint alleged that, despite the FDA warnings and increased health risks, from 1999 through 2005, Janssen aggressively marketed Risperdal to control behavioral disturbances in dementia patients through an "ElderCare sales force" designed to target nursing homes and doctors who treated the elderly. In business plans, Janssen's goal was to "[m]aximize and grow RISPERDAL's market leadership in geriatrics and long term care."

In addition to promoting Risperdal for elderly dementia patients, from 1999 through 2005, Janssen allegedly promoted the antipsychotic drug for use in children and individuals with mental disabilities. The complaint alleged that J&J and Janssen knew that Risperdal posed certain health risks to children, including the risk of elevated levels of prolactin, a hormone that can stimulate breast development and milk production.

In addition to allegations relating to Risperdal, today's settlement also resolves allegations relating to Invega, a newer antipsychotic drug also sold by Janssen. Although Invega was approved only for the treatment of schizophrenia and schizoaffective disorder, the government alleged that, from 2006 through 2009, J&J and Janssen marketed the drug for off-label indications and made false and misleading statements about its safety and efficacy.

**A second settlement over kickbacks**

In a separate but related case, in 2010, the United States, Virginia, California, Indiana, Kentucky, and Massachusetts issued complaints in the U.S. District Court for the District of Massachusetts alleging Johnson & Johnson paid the kickbacks to Omnicare, the nation's largest pharmacy specializing in dispensing drugs to nursing home patients. The alleged kickbacks were to switch nursing home patients to Johnson & Johnson drugs, including Duragesic, Aciphex, Propulsid, Levaquin, Ultram, Procrit and, most notably, Risperdal. Such kickbacks violated the Virginia Fraud Against Taxpayers Act.

Omnicare settled these allegations with the United States and the five plaintiff states in 2009 for $98 million. J&J settled today for $149 million, with $132 million going to the federal government, and $17 million going to the five participating states.

Virginia will receive an additional $3,574,970 as a result of this separate kickback settlement. $1,775,497 will go to the commonwealth's General Fund Health Care account. The remainder of the $3.5 million will reimburse the federal government for its portion of the losses in Virginia's Medicaid program, and a percentage will also go to the whistleblowers who helped bring the case.

Assistant attorneys general Candice Deisher, Kimberly Bolton, and former assistant attorney general Lelia Winget-Hernandez represented the commonwealth in the kickback case. The Virginia Department of Medical Assistance Services assisted in the development of the case, especially with evidence discovery.

**AG's fraud recoveries have paid the General Fund double the office's budget allocation**

On October 18, Cuccinelli announced a $37 million settlement his office negotiated with McKesson Corporation over allegations the company violated the Virginia Fraud Against Taxpayers Act by conspiring to inflate prices for more than 400 brand-named prescription drugs.

With McKesson's recovery and today's two recoveries, the office has returned almost twice as much money to the General Fund during Cuccinelli's tenure than the General Assembly appropriated to fund the office. From 2010-2013, the General Fund budget for the office was approximately $78 million. The Medicaid fraud unit alone has returned almost $78 million to the General Fund during that same time. Additionally, the Consumer Protection Section, which handles fraud not related to Medicaid, has returned $73 million to the

General Fund. And Cuccinelli has returned an additional $3.2 million to the General Fund through annual savings in his budget over the last four years.

Virginia MFCU's recoveries in last four years now total more than $1.6 billion - more than all other recoveries combined since MFCU began 30 years ago. This amount includes money recovered not only for Virginia, but for the federal Medicaid program and other states.

*Commonwealth of Virginia*
*Office of the Attorney General*

*Mark Herring*
*Attorney General*

*900 East Main Street*
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**Phone:** 804-786-5874

# Local sheriffs, police chiefs get $33 million from AG for new crime-fighting equipment and training

*- Cuccinelli uses money taken from criminals to provide new cruisers, School Resource Officer training, shooter response training, bulletproof vests, and more for Virginia law enforcement -*

RICHMOND (December 18, 2013) - Sheriffs, police chiefs, the State Police, and other law enforcers from around Virginia joined Attorney General Ken Cuccinelli in Richmond today as he distributed $33 million he took from criminals and is now using to fund requests from law enforcement for new equipment and training.

The funds will be used to provide training to School Resource Officers and SWAT teams; to provide new police cruisers, new computers and portable radios, bulletproof vests, training shooting ranges, night vision for finding missing people, money for gang reduction programs, and more. A link to the complete list of grants and localities receiving them is below.

The money is part of the attorney general's $115 million his Medicaid Fraud Control Unit received from its **2012 Abbott Labs fraud settlement**. Cuccinelli's Medicaid fraud unit was the lead investigator in the second largest Medicaid fraud settlement in U.S. history - $1.5 billion. Abbott Laboratories illegally marketed its drug Depakote for uses not approved as safe and effective by the Food and Drug Administration. On top of the restitution to the state's Medicaid program, the office earned the $115 million in asset forfeiture funds for its work as lead investigator.

The attorney general stressed that this money was coming from criminals, not the taxpayers. Ultimately, when all law enforcement requests are approved, Cuccinelli will be sharing $105 million of the $115 million with state and local law enforcement and keeping $10 million for equipment and programs within his own agency.

**Click here for localities receiving funds today, and the amounts and uses for the money.** The list also contains media contacts for the agencies. Grant amounts for each locality were based on proposals submitted by the agencies. They were reviewed by career employees at the attorney general's office who regularly work with local law enforcement.

**Click here for photos of departments receiving checks today.** The pictures are captioned, identifying the departments and the people in the photos. You are free to use the photos online, in print, or on air in articles related to this story. To download from Flickr, click on a thumbnail of a photo, then right click on the photo to bring up a menu. In the menu, click on a size you want to view, and a download link will appear.

"Public safety is a chief concern of mine as attorney general. My attorneys, investigators, and I work side-by-side with police and sheriffs' departments on gang prevention, rooting out Internet predators, and stopping human trafficking. That partnership only strengthens the tremendous respect we have for the work they do," said Cuccinelli.

He continued, "Because of the great work of our Medicaid Fraud Control Unit led by Randy Clouse, the office earned $115 million in asset forfeiture funds on top of our actual fraud recoveries. We wanted to share that money with state and local law enforcement to help provide needed equipment and training that will be paid for at the expense of criminals, not the taxpayers. We realize that local budgets are tight, and we also realize the risks that Virginia's law enforcers take and the daily sacrifices they make to keep their communities safe. I'm proud that today we could help them get some of the additional equipment and training they asked for."

**Examples of how the money will be used:**

- Hundreds of in-car computers, cameras, and radio systems will be upgraded around the commonwealth - many are outdated, out of warranty, and no longer supported by their manufacturers.
- The Bedford County Sheriff's Office will purchase a rapid response vehicle for the Southern Virginia Internet Crimes Against Children Task Force to use in searches during child exploitation and abduction cases throughout Southwest Virginia.
- The State Police will use $1.5 million to construct a simulations facility to train officers in the entry and clearing of different building layouts. The facility will be equipped with moveable walls on tracks that can be rapidly changed to represent different interiors, such as an office complex, a school, an apartment, a hotel, and more.
- The Department of Criminal Justice Services will use some of its money to implement a statewide online and classroom School Resource Officer training program.
- The Department of Criminal Justice Services will also use $500,000 to implement a statewide gang reduction program and $1.4 million to implement a statewide Active Shooter Response training program for more than 19,000 local and state law enforcement officers, so they can effectively and safely respond to criminal or terrorist acts.

- The Buckingham County Sheriff's Office, the Capitol Police, the Chesterfield County Sheriff's Office, and several other local police and sheriffs' departments will get bulletproof vests for patrol use and active shooter situations.
- The Hopewell Police Department and several other departments will be purchasing tactical supplies for their SWAT teams to better protect themselves and the public, and to bring crisis situations to safer and faster conclusions.
- Several departments will be buying more up-to-date automated fingerprint systems and equipment for their forensic labs to help them better gather and analyze evidence.
- The Northern Virginia Regional Gang Task Force will use its proceeds to help fund uniformed officers for gang suppression initiatives in neighborhoods with high levels of gang crimes.
- The Pulaski Police Department will buy 10 new patrol vehicles to replace aging vehicles. Several other departments will be doing the same.
- The Albemarle County, Charlottesville, and UVA police departments are jointly building an indoor regional firearms training facility that will serve more than 400 officers in Central Virginia.
- The Appomattox County Sheriff's Office will be getting night vision units to help capture suspects and locate lost or missing children and adults.
- The Tazewell County Sheriff's Office will be purchasing ATVs and four-wheel drive SUVs, which will allow them quick access to rural areas in emergency situations.
- The Hampton Police Department will be buying a dive team truck for underwater searches.
- The Alexandria Police Department will get new electronic surveillance equipment, as well as additional computer forensics training for its officers.

Today's event was held at the Virginia Capitol.

*Commonwealth of Virginia*
*Office of the Attorney General*

*Mark Herring*
*Attorney General*

*900 East Main Street*
*Richmond, Virginia 23219*

**For media inquiries only, contact:** Brian J. Gottstein
**Email:** bgottstein@oag.state.va.us (best contact method)
**Phone:** 804-786-5874

# Attorney general returns another $8.6 million in Medicaid fraud recovery to General Fund

**RICHMOND** (August 28, 2012) -- Attorney General Ken Cuccinelli announced to state legislators today that Virginia's Medicaid Fraud Control Unit will turn over a check to the General Fund later this month for $8.6 million, which represents Virginia's share of proceeds from a global settlement between pharmaceutical company GlaxoSmithKline (GSK) and Virginia, the United States, and other state governments to settle allegations of Medicaid fraud.

The investigation conducted by Virginia, the federal government, and the other states alleged that GSK violated federal and state laws by

- making false and misleading representations to health care providers about the drug Avandia's overall safety for diabetic patients;
- conducting illegal off-label marketing schemes to promote the sales of Paxil, Wellbutrin, Advair, Lamictal, and Zofran (off-label marketing promotes the use of a drug where that use is not approved by the U.S. Food and Drug Administration);
- conducting kickback schemes for these five drugs plus four additional drugs (Imitrex, Lotronex, Flovent, and Valtrex); and
- submitting false and inflated "Best Price" data to the federal Centers for Medicare & Medicaid Services, resulting in underpayment of rebates owed on certain products to the state Medicaid programs.

Virginia, the states, and the federal government alleged that these actions caused false claims for reimbursement to be submitted to government health care programs, including Medicaid.

"When companies defraud Medicaid to enrich their own pockets, they are not only defrauding Virginia's taxpayers, but because annual Medicaid dollars are limited, they are potentially depriving health care from the poorest citizens of the commonwealth," said Cuccinelli.

The global settlement with GSK resolves civil fraud claims arising from four qui tam ("whistleblower") cases filed under the federal False Claims Act and the Virginia Fraud Against Taxpayers Act.

The settlement agreement was reached in June 2012 and made public in July. The settlement check in the amount of $8,600,723.17 will be deposited into the General Fund's Healthcare Account for use by the Virginia Department of Medical Assistance Services for Virginia's Medicaid program.

*Commonwealth of Virginia*
*Office of the Attorney General*

*Mark Herring*
*Attorney General*

*900 East Main Street*
*Richmond, Virginia 23219*

**For media inquiries only, contact:** Brian J. Gottstein
**Email:** bgottstein@oag.state.va.us (best contact method)
**Phone:** 804-786-5874

# Attorney general returns another $3.3 million in Medicaid fraud recovery to General Fund

**RICHMOND** (October 23, 2012) -- Attorney General Ken Cuccinelli announced today that, as a result of an investigation by his Medicaid Fraud Control Unit, he will turn over a check to the General Fund later this month for nearly $3.3 million, which represents Virginia's share of proceeds from a settlement between Marion, Va.-based Medicaid provider Universal Health Services Inc. (UHS) and Virginia and the United States to settle allegations of Medicaid fraud.

UHS received Medicaid funds to provide psychiatric counseling and treatment for boys aged 11 to 17 years old. This settlement resolves a whistleblower lawsuit filed by former therapists at the closed facility. The lawsuit alleged that the defendants provided sub-standard care to adolescents in violation of federal and state Medicaid requirements, falsified records to cover up their serious violations and filed false Medicaid claims. Under the federal False Claims Act, a health care provider that submits false or fraudulent claims to a federal health care program is liable for three times the government's damages, plus a civil penalty for each false claim. The penalty is the same under the state False Claims Act.

This is the third largest Medicaid fraud recovery returned to the commonwealth's General Fund since August. On August 28, the attorney general announced to state legislators that Virginia's MFCU would turn over a check to the General Fund for $8.6 million, which represented Virginia's share of proceeds from a global settlement between pharmaceutical company GlaxoSmithKline (GSK), the Commonwealth of Virginia, the United States, and other state governments to settle allegations of Medicaid fraud. On October 5, the attorney general announced that he would turn over a check to the General Fund for nearly $4 million, which represented Virginia's share of proceeds from the civil recovery portion of a

settlement with pharmaceutical company Abbott Laboratories to settle allegations of off-label marketing of its drug, Depakote.

The attorney general acknowledged the efforts made by his office's Medicaid Fraud Control Unit, the U.S. Attorney's Office for the Western District of Virginia, the Civil Division of the Justice Department, and the Department of Health and Human Services' Office of the Inspector General.

"This settlement returns a substantial sum to the General Fund; money which was defrauded from the taxpayers and those truly in need of medical care," said Cuccinelli. "My office will continue its commitment to protecting Virginia's most vulnerable citizens"

*Commonwealth of Virginia*
*Office of the Attorney General*

*Mark Herring*
*Attorney General*

*900 East Main Street*
*Richmond, Virginia 23219*

**For media inquiries only, contact:** Brian J. Gottstein
**Email:** bgottstein@oag.state.va.us (best contact method)
**Phone:** 804-786-5874

# Attorney General Cuccinelli announces settlement with Texas-based pharmaceutical manufacturer for illegal marketing of Xenaderm

***~Virginia's Medicaid program to receive more than $223,000 in settlement~***

**RICHMOND** (February 27, 2013) - Today, Attorney General Ken Cuccinelli announced that his office has reached a settlement with Texas-based pharmaceutical manufacturer Healthpoint, Ltd. and its general partner, DFB Pharmaceuticals, for the illegal marketing of Xenaderm, a topical treatment for skin ulcers. The attorney general said that the agreement will resolve allegations that Healthpoint submitted false claims to Virginia's Medicaid program for the unapproved drug.

The settlement resolves federal and state False Claims Act cases brought against Healthpoint in the U.S. Federal District Court in Massachusetts. The cases were brought by the U.S. Department of Justice and fifteen plaintiff states. As part of a $48 million settlement announced by the Department of Justice on December 6, 2012, Healthpoint and DFB will pay approximately $33 million total to settle Medicaid-based claims nationally. The settlement will return $223,283.17 to the commonwealth's Medicaid program.

The federal and state complaints alleged Healthpoint marketed Xenaderm without FDA approval by modeling it on a pre-1962 drug that the FDA had never reviewed. Additionally, Healthpoint marketed the drug in spite of the FDA's determination in the 1970s that Xenaderm's principal ingredient was "less-than-effective" for its intended use. Since 1981, federal health care programs, including Medicaid, have not paid for "less-than-effective" drugs or drugs "identical, related, or similar" to "less-than-effective" drugs. According to the federal and state complaints, Healthpoint still misrepresented the regulatory status of

Xenaderm when it submitted quarterly reports to the government and, as a result, knowingly submitted false Xenaderm claims to Medicaid programs.

A National Association of Medicaid Fraud Control Units (NAMFCU) team participated in the settlement negotiations with Healthpoint on behalf of the settling states. Team members included representatives from attorney general's offices of Virginia, Florida, North Carolina, Ohio, and Massachusetts. Assistant Attorney General Megan L. F. Holt served on the NAMFCU Settlement Team.

# Appendix B

Summary of a 2012 report from Taxpayers Against Fraud Education entitled "Fighting Medicaid Fraud in Texas."

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## Fighting Medicaid Fraud in Texas

Fighting Medicaid Fraud in Texas, a new report from Taxpayers Against Fraud Education Fund, authored by Jack Meyer and Chris Wolff of Health Management Associates, looks at money recovered under the Texas False Claims Act (formally titled the Texas Medicaid Fraud Prevention Act) and its federal analog, the federal False Claims Act.

### The study's key findings:

- Texas has recovered a tremendous amount of money through enforcement of the Texas Medicaid Fraud Prevention Act (TMPFA) and the federal FCA. From 2006 through 2012, Texas recovered over $821 million for state and federal taxpayers after subtracting for relators' shares and Texas State attorney fees and costs.

- Over $348 million of this amount was allocated to Texas taxpayers and over $473 million was allocated to federal taxpayers under the Medicaid state/federal share system
  Nearly half of these recoveries – over $394 million – resulted from fraud cases in which Texas led the investigation and prosecution of the case under TMFPA.

- Whistleblowers have played a critical role in these recoveries, with over $800 million of the $821 million in total state recoveries stemming from whistleblower-initiated cases.
  The total budget for the Texas Attorney General's anti-fraud staff – which in the time frame reviewed has varied between $4.75 million and $8.45 million per year – is dwarfed by recoveries to the State generated by the work of this office.

- Provisions in TMPFA requiring defendant compensation of the State attorneys' fees and costs have brought back over $75 million to the State between 2006 and 2012.

**The full report** can be read here >> http://www.taf.org/Texas-Report-3-18-13.pdf