THE WALL STREET JOURNAL
WEDNESDAY, FEBRUARY 24, 1999

Government to Grandpa: Rat Out Your Doctor

By NANCY W. DICKEY

Today the federal government and the American Association of Retired Persons are launching an aggressive national campaign to urge Medicare patients to contact a toll-free fraud hotline if they suspect any improper billing by their physicians, hospitals or other health-care providers. The effort is dangerously flawed, for the government doesn't know what the degree of Medicare fraud really is, nor does it acknowledge that government itself is a big part of the problem.

Instead, the Department of Health and Human Services and the Health Care Financing Administration, which administers Medicare, this week plan to deputize the older members of our families as junior G-men. Armed with T-shirts, baseball caps and magnifying glasses, Medicare patients will be asked to root out fraud in return for a $1,000-a-case bounty. To organize these posses, HCFA has enlisted AARP to hold training "rallies" at more than 100 locations across the country, complete with Hollywood-style videos and marching orders from FBI agents.

What is missing from this picture is a serious attempt by HCFA to distinguish between real fraud and honest differences of opinion on how to interpret the 100,000 pages of confusing and arcane Medicare regulations and red tape the government imposes on physicians. The problem is that the government has created a maze of rules not even Marcus Welby could navigate safely, because the government assumes, wrongly, that Dr. Welby and his colleagues must be up to no good.

I'm a family physician in Texas. When a patient who can't afford care comes to my family clinic, I cannot waive the copayment and provide free care. Nor can I tell Medicare I provided a less expensive level of care than I really did. In the bureaucrats' eyes, all of this is fraud, and I could go to jail.

The target

The American Medical Association has zero tolerance for real fraud, and we are committed to working vigorously to eliminate it so more public funds can be devoted to patient care. In fact, we repeatedly have offered to sit down with HHS Secretary Donna Shalala to assist in any way possible. But demonizing the entire medical community with the broad brush of "fraud, waste and abuse" trivializes real fraud and sets up an adversarial tension in every patient-physician encounter that is contrary to quality patient care.

There is no question that real fraud does occur. Last year the government reported 326 convictions for all types of Medicare fraud among all providers. The AMA—along with county, state and specialty medical societies—would agree that even this handful of bad apples is too many. For years, we have worked with federal agencies to address specific, documented, intentional acts of fraud and to develop strategies for combating fraudulent conduct.

We think the effort is working, because the level of payments HCFA estimates are "improper" has fallen 46% in the past two years, to $12.6 billion in 1998 from $23.2 billion in 1996. But no one knows if these numbers are real or not, because the government admits it cannot separate honest mistakes from fraud and abuse.

What the government relies on is an "estimate" of improper payments based on a review of claims that were filed for 600 Medicare patients. That's 0.0015% of Medicare's 39 million beneficiaries. It is from this sample that officials project that $12.6 billion is being ripped off the system. And rather than isolating and acting on documented cases of fraud, Washington's answer is to ask patients to solve the problem.

Such an approach is fitting for a fight against Mafia soldiers and neighborhood drug dealers, not your personal physician. The tactics remind us of how the "old" IRS hounded and abused honest citizens who happened to get on their "enemies list." And the government's strangely angry antiphysician rhetoric is certain to play to the very worst fears of many older and ill patients who are especially susceptible to emotionalism and manipulation.

This ill-conceived and reckless strategy drives a wedge between patient and physician, jeopardizing the special relationship of trust that is at the heart of American medicine. How can a patient and physician comfortably come together in this intimate relationship when the government is offering a reward for the patient to "drop a dime" on the doctor?

Our suggestion to the administration is simple: Cut out the foolishness. Sit down with us to work out a responsible and legitimate way to resolve the problems of real and documented improper Medicare payments. Correct a database that is faulty and frail. Simplify the complex thicket of rules and regulations that torment physicians and imperil the quality of care. Educate physicians and patients in ways that bring us together, not tear us apart.

Physicians are sworn to be professionally accountable. That's why we vow to "do no harm" and put our patients first. Our aim is to help physicians do exactly that. We continue to stand ready and committed to exposing and eliminating true fraud. We only ask that the government get serious and do the same thing.

Dr. Dickey is president of the American Medical Association.

See on CBS this morning

Why We Hail the Good War

By Samuel Hynes

It's not only the predominance of "Saving Private Ryan" and "The Thin Red Line" among this year's Academy Award nominees that suggests that World War II is now a national preoccupation. Consider also the popularity of Tom Brokaw's "The Greatest Generation," one of the fastest-selling nonfiction books of all time, and of Stephen Ambrose's histories of the war. Then there is the success in America of two British war novels, Sebastian Faulks's "Charlotte Gray" and Louis de Bernieres's "Captain Correlli's Mandolin." And look at the way memoirs of that war keep appearing, written by men now in their 70s and 80s, and read by people who weren't alive when the fighting took place.

What accounts for this trend? And why now?

Perhaps it has to do with the end of the century. Americans look back at the past 100 years and see that this whole stretch of our national past hangs on two pegs: World War II and the war in Vietnam. The story of the first of these crucial episodes supports our national belief that our country is big enough, strong enough and moral enough to weigh in on the side of virtue when it has to, and win; the second tells us that national good intentions can go terribly wrong, that it's possible to intervene on the wrong side, or for the wrong reasons, and lose. So for a while let's forget our Bad War. And while we're at it, forget all the inglorious little engagements that American troops have been involved in since then: the comic-opera Grenada affair, the adventure in Panama, the unfortunate business in Somalia, the no-fly zones over Iraq—all so fractious, so morally tangled, and so unsatisfactory as myths of national virtue. Let's just rerun our one Good War.

The notion of the Good War is a myth, of course. It reduces the war story to a black-and-white parable in which the world's right-minded people defeat the world's evil. It says nothing about all the unpleasantness of that war: the 60 million dead (most of them civilians), the horrors of Bataan and Stalingrad, the bodies washing in the surf at Tarawa and Salerno and Omaha Beach, what the Germans did at Lidice and Oradour and what the Japanese did at Nanking and Changi, the bombs at Hiroshima and Nagasaki and the death camps. But that's what such myths do: They simplify and tidy the mess of historical reality, and so give us a story we can comprehend, and a meaning we can endure.

That doesn't make our Good War myth a lie; the story it tells is selective, but it's based on truth. In those years the Ameri-

National Archives

It wasn't romantic

can people *did* come together to fight a war they believed was necessary and just. It was the most unified national effort in our entire history: Men fought, women worked in war factories, kids collected scrap, old ladies knitted—anyone who was alive then remembers that spirit.

The draft was at the heart of it all, and what a good idea it was! Everybody signed up, everybody who was able went; you couldn't buy your way out, you couldn't dodge it by staying in college. That's surely where the movie cliché of the all-American bomber crew came from—one Boston Brahmin, one Brooklyn Jew, one Navajo Indian, one Georgia cracker and one Swede from North Dakota, all bonded together in the good cause. There were no black airmen in those mythic crews, to be sure, and so it wasn't really all-American, and that was shameful; but in spite of that injustice the country came closer to fielding a truly democratic fighting force in World War II than it had ever done before, or has managed to do since.

If a united nation fights a Good War and wins, the myth that comes out of that war is bound to survive in the imaginations of later generations. And as it recedes into the past, it will come to seem as epic as the Iliad—a story of the olden days, when the bravest men fought the biggest battles for the greatest cause.

All those superlatives make me uneasy. I don't think the generation that fought the war was the "greatest" in any reasonable sense. It was the occasion history offered us that was great, and the nation rose to meet it. But actually the decision to fight was a morally easy one. If you have the muscle that America has, war is always an easy choice, and after Pearl Harbor and the fall of France and the Battle of Britain, how could we have acted differently than we did? The choices since then have been tougher, and the war stories more ambiguous. So of course we look back as a nation to the time when our might and the world's right came together, and we won the Last Big One.

This doesn't mean that we should all be triumphalist about our Good War, and most of the versions of it that are current now aren't. ("Saving Private Ryan" is the exception, and you can feel its hollowness beneath all the special effects.) On the contrary, these stories restore the unimaginable particulars that pull the myth down into reality, and tell us how it was on those battlefields half a century ago.

We need to know those truths, so that we will not allow ourselves to grow nostalgic for the Good War and the greatest generation, but will remember the pain, the waste, the cruelty and the dying. But it's also surely a good thing for Americans of whatever generation to live imaginatively in that wartime when for a while our national values really seemed to direct our actions. Perhaps such a time could come again, not in a war but in the alternative—not peace, God knows, but the state of nervous nonwar that we live in now.

Mr. Hynes, a Marine pilot in World War II, is author, most recently, of "The Soldier's Tale: Bearing Witness to Modern War" (Penguin, 1998). His World War II memoir, "Flights of Passage," was recently reissued by Pocket Books.

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Alissa Fox
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1/21

Chris,

We really appreciate you meeting with us on such short notice.

I've attached a copy of our testimony that reflects our agreement with most GAO/16 recommendations, as well as our own recommendations (beginning on page 12.

Thanks again,

Alissa

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TESTIMONY OF THE BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

MEDICARE CONTRACTORS

FOR THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON COMMERCE
U.S. HOUSE OF REPRESENTATIVES

PRESENTED BY:

HARRY CAIN
EXECUTIVE VICE PRESIDENT

SEPTEMBER 9, 1999

Mr. Chairman and members of the Subcommittee, I am Harry Cain, Executive Vice President of the Blue Cross and Blue Shield Association. We represent 51 independent Blue Cross and Blue Shield Plans throughout the nation. I appreciate the opportunity to testify before the Subcommittee on various issues related to Medicare contractors, with particular emphasis on fraud and abuse.

Medicare is administered through a long-standing partnership between the private health insurance industry and the Health Care Financing Administration (HCFA). Since 1965, Blue Cross and Blue Shield Plans have played a leading role in administering the program. They have contracted with the federal government to handle much of the day-to-day work of paying Medicare claims accurately and in a timely manner. Nationally, Blue Cross and Blue Shield Plans process over 85 percent of Medicare Part A claims and about 57 percent of all Part B claims.

Medicare contractors have three major areas of responsibility on behalf of the federal government:

1. **Paying Claims:** Medicare contractors process all the bills for the traditional Medicare fee-for-service program. In FY 1999, it is estimated that contractors will process over 900 million claims, more than 3.5 million every working day.
2. **Providing Beneficiary and Provider Customer Services:** Contractors are the main points of routine contact with the Medicare program for both beneficiaries and providers. Contractors educate beneficiaries and providers about Medicare and respond to about 40 million inquiries annually.
3. **Special Initiatives to Fight Medicare Fraud, Waste, and Abuse:** All contractors have separate fraud and abuse departments dedicated to assuring that Medicare payments are made properly. According to the Department of Health and Human Services (HHS), these activities saved the government $9 billion in 1998.

Medicare contractors have been extremely efficient and cost effective for the federal government. In 1999, contractors' administrative costs represent less than 1 percent of total

Medicare benefits. While workloads have soared over the last 25 years, operating costs -- on a unit cost basis -- have declined about two-thirds from 1975 to 1999. Few government expenditures produce the documented, tangible savings of taxpayers' dollars generated by Medicare anti-fraud and abuse activities. **For every $1 spent fighting fraud and abuse, Medicare contractors save the government $17.**

Medicare contractors proactively combat Medicare fraud, waste, and abuse through a multi-faceted program under HCFA's direction and review. Thanks to recent increases in funding, Medicare contractors are now able to expand their anti-fraud and abuse efforts, and we are seeing excellent results. We believe continued improvements are essential.

With this as background, I would like to focus on the following three areas in my testimony:

I. Contractor initiatives to combat fraud, waste, and abuse in the Medicare program;

II. BCBSA recommendations for contractor reform; and

III. BCBSA's response to the recent General Accounting Office (GAO) and 1998 HHS Office of Inspector General (OIG) reports.

I. COMBATTING MEDICARE FRAUD, WASTE, AND ABUSE

Contractors collectively employ over 22,000 workers across the country to process claims and prevent excessive, improper, or unnecessary spending in the Medicare program. Through their long-term relationship with Medicare, Blue Cross and Blue Shield Medicare contractors have acquired extensive experience and knowledge about this complex program. Our Plans have become experts in detecting ways in which some providers attempt to abuse or defraud Medicare. Blue Cross and Blue Shield companies also hire experienced investigators with diverse backgrounds to fight fraud, waste, and abuse. These professionals include law enforcement officials, physicians, nurses, attorneys, accountants, statisticians, and business managers.

Contractor Operations to Fight Fraud

The task of safeguarding Medicare funds is not limited to identifying instances where providers have intentionally sought overpayments. Instead, contractors rely on a multi-pronged approach. A successful program begins when a Medicare claim is submitted for payment. Once the claim enters a Medicare contractor's system, it is subjected to several layers of review to ensure its appropriateness. The following summarizes contractor anti-fraud and abuse activities:

Claims processing screens: Contractors' computer systems are programmed so that all Medicare claims are screened on the front-end. These initial computer checks seek to:

- identify duplicate bills;
- ensure the claim is from an enrolled provider;
- ensure the claim is for services rendered to an eligible beneficiary;
- determine the appropriate payment amount for a specific service;
- assure the bill is complete and consistent (for example, the screens would reject a bill for cataract surgery that listed the diagnosis as congestive heart failure); and
- screen out claims that appear suspicious and should be investigated before they are paid.

Provider registration screening: All providers must receive a Medicare registration number from a contractor before they can bill Medicare. Contractors review provider applications closely to prevent fraudulent providers from getting into the program by using false names or addresses.

Medical review: The purpose of medical review is to examine claims and supporting documentation to assure services are medically necessary and appropriate. Contractors' medical review staffs are assisted by physicians who obtain input from the local provider community in establishing each contractor's policies. Because of funding constraints, only a small percentage of Medicare claims and supporting documentation is actually reviewed. Recent increases in funding for anti-fraud and abuse activities have allowed contractors to review more claims; but the proportion of all claims reviewed by contractors remains limited.

Contractors conduct two types of medical reviews:

- **Prepayment review:** Contractors use a cost-effective, focused medical review process to determine which bills need to be reviewed further before payment is authorized. All contractors screen bills before payment to detect potential problems, such as unnecessarily intense or frequent care. Some screens are nationally set by HCFA, while others are developed locally to reflect regional problems. These screens are based on policies applicable to specific procedures, frequency of services, and provider-specific data accumulated from data analyses of previous services. Physicians are integral to the medical review process and lead reviews of complex cases.

- **Postpayment review:** After bills are paid, contractors monitor the Medicare claims experience of all providers and services in a region. Contractors typically focus on high-dollar and frequently performed services. Aggregated data are analyzed to identify providers whose utilization patterns differ substantially from their peers. Contractors use different statistical software packages to track data and identify patterns or trends that may reveal inappropriate levels or types of treatments provided to beneficiaries. Examples of this type of profiling are identifying providers performing an unusually high number of services on beneficiaries, or ordering an excessive number of tests. These in-depth reviews can last several months and can involve patient surveys, review of medical records and discussions with providers. Actions taken based on these findings include: provider education; payment recovery where investigations reveal inappropriate or fraudulent billings; referrals to the OIG; and development of prepayment screens to identify future problems before bills are paid.

Cost report audits: The Medicare audit function represents the most all-inclusive opportunity for Medicare Part A contractors to impact Medicare dollars. The audit function is similar to the role of the Internal Revenue Service. Cost reports are the vehicle through which Medicare Part A providers make a final, comprehensive claim against the federal government for reimbursement at the end of the year for providing services to Medicare beneficiaries.

Professional accountants review the reports to ensure that all costs are appropriate and that they match previously submitted claims. Specifically, these accountants check for areas that indicate excessive claims for reimbursement, violations of program law or regulation, mathematical errors, or fraud and abuse. Contractors will send professional accountants to the provider site to perform a limited financial audit of a selected number of the provider's books and records, if judged necessary and cost-effective within constraints of available funding.

Medicare Secondary Payer (MSP): Contractors constantly check claims to determine instances where a beneficiary has private insurance coverage that should pay the bill instead of Medicare. The other payers whose coverage should pay before Medicare coverage begins include: employer group health plans covering working beneficiaries, workers' compensation, and auto, liability, and no-fault insurance. The primary functions of MSP include:

- reviewing claims for indications of other coverage;
- developing claims with indications of other coverage to determine if other coverage actually exists;
- ensuring that appropriate Medicare payment is made on claims for which Medicare is the secondary payer;
- tracking auto, liability, and workers' compensation cases to assure Medicare payments are either not made or are recovered from any settlement awards; and
- conducting outreach activities to educate beneficiaries, providers, attorneys, and insurers about MSP.

Provider and beneficiary education: Contractors educate both beneficiaries and providers on payment integrity and quality assurance issues. For example, contractors send providers newsletters, hold seminars, and host conferences to explain the latest billing techniques or new Medicare coverage rules. These educational efforts save the Medicare Trust Funds money by having the sentinel effect of preventing future fraud.

Contractors Work with Other Entities

Equally important as contractors' own anti-fraud activities is the interaction of contractors with other agencies. Contractors work with HCFA's central and regional offices to detect fraud and develop medical policies to prevent unnecessary spending of Trust Fund dollars. Contractors have also established relationships with other contractors, states, and local anti-fraud task forces to detect and fight Medicare fraud. One Blue Cross and Blue Shield Plan has worked with its local Operation Restore Trust office in a special fraud task force designed specifically to proactively identify the top fraudulent providers billing Medicare.

Contractors also work closely with law enforcement agencies. When contractors have identified and substantiated a case of potential fraud, they forward it to the HHS OIG for further investigation. HCFA's instructions direct contractors to give the highest priority to those cases that have the greatest impact on the Medicare program. These include multi-state fraud, patient abuse, high dollar amounts of potential overpayment, and likelihood for an increase in the amount of fraud or enlargement of a pattern. However, contractors do not refer potential cases to law enforcement solely on the magnitude of the case; each is evaluated and referred based on its own merit. Contractors develop various criteria based on guidance issued by HCFA in the Medicare Carrier and Intermediary Manuals. In general, contractors refer cases to the OIG once they have knowledge that the provider has intentionally engaged in improper billing, submitted improper claims with actual knowledge of their falsity, or submitted claims with reckless disregard or deliberate ignorance of their inaccuracy.

Potential fraud cases can also be referred to the Department of Justice for prosecution. Contractors also hold training sessions for law enforcement agents to educate them on various aspects of the Medicare program, including proper billing procedures and how to read cost reports.

HCFA Review of Contractors

Medicare contractors operate under detailed instructions from HCFA. As government contractors, Medicare contractors must comply with numerous federal statutes, regulations, and Executive Orders. In addition, contractors must follow extensive HCFA issued program guidelines and manual instructions. To monitor compliance with these guidelines, contractors are visited annually by their local HCFA regional office staff for an assessment of their performance against HCFA's requirements. These reviews, termed Contractor Performance Evaluations, are conducted in various functional areas and culminate in a formal annual report called the Report of Contractor Performance. Also, several annual or special certifications are expected to be executed by contractors in support of the Chief Financial Officers Act, the Federal Managers Fiscal Integrity Act, the fiscal year budget proposal, and other areas of specific interest, such as Y2K readiness.

Challenges Facing Contractors

Medicare contractors face three key challenges to continued success in fighting fraud and abuse: (1) Inadequate funding levels; (2) Increased complexity of Medicare rules; and (3) Constant changes in direction. These challenges are described below:

Inadequate funding levels: Of utmost importance to attaining outstanding performance is an adequate budget.

However, Medicare contractors have been severely underfunded since the early 1990's and are facing poor prospects of receiving adequate funding next year. During the early to mid-1990's, reductions in funding relative to increases in workload seriously eroded contractors' ability to fight fraud and abuse. Between 1989 and 1996, the number of Medicare claims climbed almost 70 percent to over 800 million, while payment review resources grew less than 11 percent. As a result, the amount allocated to contractors to review claims shrank from 74 cents to 48 cents per claim. Because of the significant cost of reviewing claims, **this decline in funding resulted in HCFA's directions to contractors to reduce the percentage of claims that were scrutinized**

and investigated. Similarly, the percentage of cost reports audited declined: between 1991 and 1996, the chances that any institutional provider's cost report would be reviewed in detail fell from about 1 in 6 to about 1 in 13.

Throughout this period, contractors identified to HCFA additional anti-fraud efforts they could undertake if awarded additional resources. BCBSA and Blue Plans urged both Congress and the Administration to allocate significantly more funds for critical anti-fraud and abuse efforts. Finally, in 1996, Congress created the Medicare Integrity Program (MIP) in the Health Insurance Portability and Accountability Act. MIP provided a permanent, stable funding authority for the portion of the Medicare contractor budget that is explicitly designated as fraud and abuse detection activities. MIP funding was set at $500 million in 1998 and is authorized to rise to $720 million in 2002.

Thanks to this new funding mechanism, Medicare contractors have been able to improve their efforts to reduce the amount of fraud, waste, and abuse in the Medicare program. Earlier this year, the HHS OIG released its 1998 financial audit indicating that Medicare provider billing errors had fallen dramatically. Contractors' enhanced anti-fraud and abuse efforts due to MIP funding contributed to that significant decline in improper claims and documentation submission by providers. The OIG also found a greater number of providers submitting claims with proper documentation – a sign of contractors' enhanced education efforts to inform providers of proper documentation procedures. The Congressional Budget Office also has attributed the abrupt slowdown in Medicare spending between 1998-99, in part, to stepped-up policing of fraud and abuse, in which contractors have played a significant role.

But, the creation of MIP did not solve the budget problems for the remainder of the contractor budget. Even with increased MIP funding, total contractor funding (including MIP), on a per-claim basis was lower in 1998 than in every previous year back to 1989.

The largest portion of the contractor budget -- program management -- is subject to the annual appropriations process and continues to face severe funding pressures. Program management activities include claims processing activities, beneficiary and provider communications, and

hearings and appeals of claims initially denied. Under the appropriations process, contractors must compete for funding with high priority agencies such as the National Institutes of Health.

For example, between 1989 and 1998, funding for program management activities (adjusted for inflation) declined by 18 percent. During this period, the volume of Medicare claims increased by 84 percent; Medicare outlays (in real dollars), by 65 percent. Whenever possible, contractors responded to reduced funding by achieving significant efficiencies in claims processing, lowering program management costs per claim by 56 percent in real dollars over this period. But even these efficiencies have not been enough to keep pace with rising Medicare claims volume and diminishing funding levels: In 1998, for example, HCFA made up for funding short falls by instructing contractors to slow down payments to hospitals and doctors, make greater use of voice mail, and send fewer explanations of benefits notices to beneficiaries.

Inadequate budgets for program management also impacts Medicare's fight against fraud and abuse. While many think of program management activities as simply paying claims, these activities are Medicare's first line of defense and are critically linked to MIP anti-fraud and abuse activities. As an example, many of the front-end computer edits described earlier (e.g., preventing duplicate payments and detecting suspicious claims) are funded through program management. Inadequate funding impacts different functions at different times, but always disrupts the integration of all the functional components needed to "get things right the first time." It thus results in inefficiency and higher costs.

Moreover, increased anti-fraud initiatives have created increased workloads for program management activities. An expert study commissioned by BCBSA last year demonstrates that contractor program management funding will be significantly strained by the increased anti-fraud and abuse detection efforts under MIP. The report shows that every 10 percent increase in MIP funding will result in a $13 million increase in contractor costs due to increased appeals, inquiries, and hearings.

Increased complexity of Medicare rules: Another challenge faced by contractors is the significantly greater workload expected next year and in future years as the Medicare program grows more and more complex. The new payment mechanisms for outpatient departments, home health agencies, and skilled nursing facilities, to name a few, are very complicated and will require a great deal of resources to implement. Just as Members of Congress are hearing from these providers, so too are contractors who must answer their questions and concerns about new payment methodologies.

Furthermore, any Medicare reform legislation could have a profound impact on contractor activities. For example, the President's FY 2000 HCFA budget request included $60 million to implement various provisions of the 1997 Balanced Budget Act. Clearly, changes to Medicare coverage rules can have financial impacts on contractor budgets. Unfortunately, Congress does not generally provide the necessary administrative resources when enacting Medicare legislation. We urge Congress to assure that contractors are adequately funded when considering legislative changes.

Constant Changes in Direction: Medicare contractors are challenged by the very nature of the business. Medicare contractors must deal with hundreds of pages of instructions from HCFA. When last we counted (1993), the Medicare contractors had received, on average, a new instruction from HCFA every five hours of every day of every year. And the program has become even more complex since 1993. This constant state of change requires contractors to be extremely flexible — both in terms of its operations and its budget. It has not been uncommon in the past for contractors to be forced to abandon projects or reallocate staff midyear in order to adapt to HCFA's suddenly revised priorities or modified funding levels. HCFA and Congress seldom realize that these continuous changes in direction require time and money.

By law, Medicare contractors are not allowed any profit. Medicare contractors operate under cost contracts, and HCFA places budget caps, or limits, on the unit costs paid to contractors to process claims. Under these contracts, Medicare contractors essentially do whatever work HCFA requests, without "change orders." There is not a clear statement of work at the beginning of the year, and contractors generally must comply with constant change orders from

HCFA without additional reimbursement. These demands make the Medicare contractor business extremely challenging.

II. BCBSA RECOMMENDATIONS TO IMPROVE THE MEDICARE CONTRACTOR PROGRAM

Consistent with the views of the GAO and the HHS OIG, BCBSA agrees that revisions to the Medicare contractor program are necessary to strengthen contractors' abilities to effectively and efficiently handle day-to-day administration of the Medicare program. Blue Cross and Blue Shield Medicare contractors are committed to achieving outstanding performance levels. We want to work with the Congress and HCFA to attain this objective. We recommend consideration of the following recommendations:

1. **Competitive Contracting:** We believe that Congress should explore revising Medicare contracts to allow qualified companies to compete based on the Federal Acquisition Rules (FAR) – the federal government's rules on competitive contracting. The FAR would instill at least two disciplines now missing in the program: a clear scope of work, and a professional contracting officer for each contract, through whom contract changes are made. Conducting such a competition under the FAR – which now governs all other government contracts – would ensure that contracts are awarded on the basis of fair competition, and it would give all contractors appropriate appeal rights and due process.

   The FAR would also ensure that HCFA pays termination costs to contractors that leave the program. I would note that HCFA's reform proposal would deviate from the FAR by eliminating this requirement. This would be unprecedented. No other type of government contract, including defense contracts, lacks the requirement that the government pay contractors reasonable termination costs.

   It is essential that any move to competitive bidding of these contracts be based on a strategic plan that lays out the timetable for this change to minimize disruption to Medicare beneficiaries and providers. Moving to a competitive bidding process will require careful

planning, a sufficient transition, and additional HCFA staff to manage this major new contracting initiative. Congress may want to review a proposed strategic plan before granting HCFA this new authority.

2. **Alternatives to the current cost contracts:** Moving to the FAR would allow HCFA to contract with entities using other payment options, including fixed-price, cost-plus-fee, or cost-plus-incentive contracts. But before moving ahead too quickly, we urge that HCFA study the various contracting options available under the FAR to determine which method would be most appropriate. BCBSA would like to work with Congress and the Administration to develop the most promising proposals for improving the public-private partnership that administers the Medicare program.

3. **Voluntary Self-Disclosure Protocol:** Blue Cross and Blue Shield companies place the utmost importance on maintaining the highest possible levels of compliance and ethics – not only where Medicare is concerned, but in all aspects of their business. They are committed to assuring that there is a code of conduct, as well as effective compliance programs, within each Plan. However, it is critical that Medicare contractors have the appropriate incentives to report to the federal government when they detect probable wrongdoing in their own business. And most importantly, these incentives must be structured to allow these companies to take immediate corrective actions to remedy any identified problems. We believe HCFA should adopt a program similar to the Department of Defense's Voluntary Disclosure Program, which provides companies incentives to report problems and resolve them. Well-designed compliance programs should include the following seven elements considered necessary for a comprehensive program under the United States Sentencing Guidelines:

   - development of written policies and procedures;
   - designation of a compliance officer and/or other appropriate bodies;
   - development and implementation of effective training and education about compliance and ethics;

- development and maintenance of effective lines of communication, including a hotline where employees can report concerns outside the normal chain of command;
- enforcement of standards through well-publicized disciplinary guidelines;
- use of audits and other methods to monitor compliance; and
- development of procedures to respond to problems and to initiate corrective actions.

4. **Adequate and stable funding levels:** Congress should provide adequate funding levels to assure that contractors can perform the range of functions necessary to safeguard program funds. As highlighted earlier, funding has not kept pace with programmatic needs--important functions are not being funded. We urge Congress and the Administration to explore using a new methodology to develop Medicare contractor budgets. This method should assure that a set percentage of Medicare claims is reviewed annually and that each time a new Medicare law is passed, there are sufficient administrative resources to handle the new workload. While Blue Cross and Blue Shield Medicare contractors are committed to continually achieving greater efficiencies, it is simply not realistic to expect contractors to attain outstanding performance levels with greater workloads and tighter budgets.

   The prospects for adequate funding for program management activities, which are subject to the annual appropriations process, do not appear promising for FY 2000. The Administration is essentially proposing a **reduction in funding for the administration of the Medicare program of 7 percent.** This budget proposes $1,274 million, just $4 million above the FY 1999 level. However, the President's budget level is dependent on $93 million in new provider user fees, which Congress has consistently rejected in past years. Excluding these funds lowers the President's budget request to $1,181 million, 7 percent below FY 1999. Yet increased funding is critically needed next year to cover increased claims volume, implementation of provisions in BBA and HIPAA, and increased workload associated with expanded anti-fraud and abuse activities. It is imperative that Congress provide a stable and adequate funding stream for **all** contractor activities. As indicated earlier, underfunding program management activities can result in payment slowdowns to providers and beneficiaries, and deterioration in effective anti-fraud efforts given that program management and MIP functions are intertwined in the fight against fraud and abuse.

In the President's FY 2000 budget, HCFA indicated its interest in exploring alternative funding options for Medicare administrative activities. We support HCFA's efforts and would like to work with the Congress to move toward a stable and reliable funding source for the future.

5. **Coordinated Administration:** Finally, we recommend against awarding contracts in a way that would fragment and weaken Medicare administration, as proposed by HCFA in its contractor reform proposal. Competition does not have to mean fragmentation. Instead, competition should mean contractors compete on a level playing field to be the *single* manager of a contract, and be held responsible for subcontracting more specialized work to other entities, if appropriate. By breaking up contracting functions and spreading them among a large pool of new entities – many of whom would be inexperienced in Medicare – the claims payment process would be fragmented. This is likely to disrupt effective management of the program. Costs would invariably increase because claims processing, customer service, and fraud and abuse activities are interconnected; for example, claims processing and fraud control efforts would still require coordination and extensive data sharing after these responsibilities are divided. At the very least, a comprehensive plan to ensure efficient coordination among the functional contractors and an infrastructure to support the coordination must be developed and implemented prior to adopting HCFA's proposal.

Moreover, separating key functions to different contractors could hinder efforts to fight fraud and abuse for at least four reasons.

First, such fragmentation is likely to create competing, counterproductive incentives. BCBSA is very concerned with the unintended consequences of breaking up contractor functions. On the one hand, contractors are responsible for claims processing and paying claims based on a time schedule set by Congress. On the other hand, contractors are responsible for program safeguard activities – in essence, taking the time to review claims carefully to make sure they are paid properly. In a single organization, contractor management can balance these competing

priorities to reach a productive synergy. However, were HCFA to separate these functions among competing organizations, neither organization would have the incentive to work together. This problem would be exacerbated if claims processing activities were further fragmented.

Second, the staffing resources required to implement and manage this type of new contracting authority are so immense that they would undermine HCFA's efforts to administer its other initiatives effectively. Potentially, HCFA would have to manage numerous additional new contracts for claims processing services and beneficiary/provider communications centers with entities unfamiliar with Medicare. Contractors currently work without a scope of work and without individual contract officers. This new legislation would require that each contractor have a unique contract with a specific scope of work and a separate contracting officer. Most significantly, HCFA would have to directly manage each of these separate functional contracts to assure the entire claims administration process runs smoothly. These requirements – in and of themselves – could not be met without HCFA adding more people with greater contracting experience than they currently employ. HCFA is already burdened by many other new responsibilities. With these other large workloads, we believe the agency does not have the resources, staff, or expertise to implement this type of new procurement activity.

Third, contracts could be awarded to entities that have no experience working with the Medicare program (a current program requirement), or even entities that have no familiarity with health claims processing. Allowing HCFA to contract with organizations unfamiliar with Medicare's intricate payment methodologies for critical claims payment or fraud detection activities could reduce payment accuracy, delay payments to providers, and reduce the quality of service providers and beneficiaries expect. An expert study commissioned by BCBSA found that awarding Medicare fraud detection functions to inexperienced contractors would be "highly questionable and risky."

Fourth, functional contracts are likely to increase, not decrease costs. Having multiple functional contractors replace single contractors is likely to increase costs to the government.

There is likely to be significant duplication and overlap of efforts, including increased overhead costs, in addition to increased resource requirements for HCFA.

Above all else, fragmenting the claims payment process would destroy the current *single* point of accountability now available to HCFA, providers, and beneficiaries. I cannot emphasize enough the potential confusion and difficulty that may arise from managing a multitude of independent specialty contractors who share work but do not share accountability for the outcome (e.g., for a correctly and efficiently processed claim), and may even consider themselves competitors to each other. It is conceivable that under HCFA's proposal an individual claim could be handled by three or more individual contractors before it is finally processed. This fragmentation could increase claims payment timeframes, and such a proposal removes any accountability for processing a single claim properly – from beginning to end. GAO's previous statement to this Subcommittee sums up our concerns as well: "After 30 years of integration, contractor's functions may not be easy to separate, and having multiple companies doing different tasks could create coordination difficulties."

III. BCBSA RESPONSE TO GAO AND OIG REPORTS

In addition to recommending broad reform of the Medicare contractor program, GAO and the HHS OIG made several more specific recommendations to improve program management. We agree with many of these recommendations--some entirely, and some with certain qualifications.

1. **GAO recommended establishing an internal contractor management policy group to oversee contractor certifications.** We support this recommendation, but urge HCFA to ensure that the emphasis on certifications should be to look behind the existing contractor certifications and not to look for reasons to proliferate the number and type of required certifications.

2. **GAO recommended that HCFA establish annual core benchmarks for contractor performance and assess contractors based on those standards.** We support benchmarks for contractor performance that are well-defined, achievable, and in line with annual funding

levels. These standards should measure the key components of expected contractor performance and not be based on measurement of micro-level, transaction-oriented activities, as in the past.

3. **GAO recommended designating an internal HCFA unit to evaluate effectiveness of oversight policy and direction by headquarters to regional offices, as well as regional office oversight of contractors.** We support any efforts to improve the consistency of information disseminated from regional and central offices.

4. **GAO recommended that a strategic plan be developed on how HCFA would implement contractor reform if HCFA were granted such authority.** We agree that HCFA should establish a strategic plan – including an independent study of its proposal – before proceeding with any reforms. This study should determine whether these administrative changes improve the efficiency and effectiveness of Medicare program operations. Because of its potential impact on the Medicare program, Medicare expenditures, and Medicare beneficiaries and providers, contractor reform must be carefully planned and its impacts fully understood before proceeding. This plan must also analyze the cost implications of functional contracting, which we believe may be substantial.

   HCFA has just awarded 12 new MIP contractors. Despite the fact that MIP allows HCFA to contract with new entities to perform program safeguards activities, HCFA has decided that these new contractors will *supplement, not replace,* program integrity functions performed by current contractors at this point in time. We approve of HCFA's actions, and recommend that HCFA's strategic plan for further contractor reforms include an analysis of this recent MIP procurement.

   A strategic plan would also allow HCFA to understand the internal workload implications that contractor reform would impose on the agency. At a time when HCFA already has significant new responsibilities, including implementing the BBA and HIPAA, HCFA should have the resources necessary to properly and effectively carry out these new contractor changes before new authority is provided.

5. **GAO and OIG recommended improving contractor controls over Medicare accounts receivable, cash, financial reconciliations, and electronic data processing.** Contractors are continually working to improve their financial oversight functions. We would support moving to a dual entry accounting system once HCFA specifies the systems requirements and provides the funding to make the changes. Because of Y2K priorities, HCFA has indicated it will not allow any systems changes until 2001.

6. **OIG recommended establishing clear definitions of key words and terms (e.g. complaint, case, program vulnerability, and overpayment).** We would support having clear, consistent definitions and instructions regarding the operation of Medicare contractor fraud units.

7. **GAO recommended eliminating provider nomination** – the process by which providers can choose their intermediaries. Provider nomination was originally implemented to offer greater ease and simplicity of claims payment for institutional providers. This process is especially important for provider chains that are able to choose one contractor to handle claims from their providers on a nationwide basis. As Congress considers this recommendation, we urge you to obtain input from the provider community on the impact of such a change.

Response to Recent OIG Reports

Over the past year, OIG has issued two key reports related to Medicare contractor performance.

In November 1998, the OIG released a report that reviewed the effectiveness of Medicare contractors' fraud control units based on 1996 data. The OIG found that staff turnover, lack of proper training, and a lack of uniformity and understanding of key fraud terms and definitions have hampered the fraud units. In reviewing the results of this report, the Subcommittee must realize that effective anti-fraud and abuse efforts – especially the ability to retain trained staff – have been severely impeded by lack of adequate and, importantly, stable funding levels.

Unpredictable and insufficient funding patterns in the early and mid-1990's – when contractors were subjected to unpredictable cutbacks or additional funding late in the year – made it extremely difficult for contractors to recruit and retain well-trained staffs. This environment often made it necessary for contractors to reduce their fraud staffs (i.e., lay off experienced people), and later try to recruit new untrained staff as funding became available. It takes approximately one year to adequately train anti-fraud and abuse staff so that they become familiar with the complex Medicare rules. As mentioned earlier, the MIP funding which first became available in 1997 has eased this problem.

Congress should also be aware of another problem contractors faced in the early 1990's. Before 1997, contractors were often told by OIG to refer only "big dollar" cases to the agency, since it was ill-equipped to handle a large volume of smaller cases. OIG did not receive adequate anti-fraud and abuse funds to increase its own staff until 1997.

In February 1999, the OIG released its annual Chief Financial Officers report that demonstrated the new MIP funding had significantly reduced Medicare overpayments. While we are pleased that this study shows the outstanding job contractors performed in 1998 in reducing overpayments, this report indicated that additional efforts are needed. In assessing the performance of contractors, it is important to realize that the kind of errors identified by the OIG were associated with claims that, based on the information submitted, **were correctly processed by Medicare contractors**. However, the OIG in this audit had Medicare contractors look beyond the actual claim to the medical documentation (i.e., the patient's medical record in the physician's office) related to the service. By doing this, Medicare contractors found significant overpayments. However, Medicare contractors are not routinely instructed nor paid by HCFA to conduct this resource intensive type of review.

Medicare Contractor Compliance Efforts

Finally, allow me to address the serious compliance issues that were raised in the Subcommittee's July 14th hearing. The Blue Cross and Blue Shield Association deeply regrets any cloud over our Member Plans' role in the Medicare program due to actual or alleged misconduct of employees of certain Plans. For more than 30 years, the Blues have been committed to providing high-quality, cost-effective customer service to Medicare beneficiaries, providers, and our partners in the federal government. We are saddened that, in the eyes of some, the developments described in GAO's report may tarnish our long-standing track record as Medicare contractors.

Since the inception of Medicare, the Blues have been the undisputed leaders in private sector Medicare administration. Furthermore, Blue companies perform this public service at cost; they do not generate a profit on their Medicare claims processing work. Many health insurers believe that the legal risks and financial liabilities associated with being a Medicare fee-for-service contractor far outweigh the rewards or benefits. But many Blue companies remain committed to helping HCFA deliver timely, cost-effective services to beneficiaries who need them. Blue Plans also are committed to proactively rooting out provider fraud and abuse.

Medicare contractors collectively process more than 900 million claims involving more than $200 billion annually. The overwhelming majority of these transactions are handled without any adverse incident. In fact, HCFA has accepted and reimbursed more than 99 percent of the Medicare administrative costs submitted by Blue Plans over the life of the program.

With this said, all Blue Plans have, as part of the BCBSA licensing requirements, a code of conduct for all employees. In addition, all Blue Plans are committed to having a compliance plan and have taken significant actions to enhance their compliance plans and management controls to ensure that problems in the past do not occur in the future. Examples of Plan efforts include: appointing a compliance officer to oversee compliance efforts; routine training for employees on compliance; implementing an internal compliance committee; and implementing a 24-hour compliance hotline where employees can report concerns. Plans also use innovative

ways to update compliance awareness in the organization. One Plan distributes a compliance question to all employees once a week. Employees must answer a certain number during the year. Answers are then announced and discussed. It keeps everyone thinking about compliance all the time. The same Plan requires managers to talk to their staff monthly about compliance and makes random phone calls to employees to see if managers are in fact discussing compliance issues with them.

In addition to the activities Blue Plans take to promote compliance and ethics within their own company operations, Blue Medicare contractors each year certify their compliance with Medicare rules and regulations using the Medicare Management and Operations Review Program (MMORP). The MMORP was created in 1995 by BCBSA and is a comprehensive audit program developed to verify the accuracy and completeness of Plan data. It is a national compendium of the 25,000 pages of laws, regulations, general instructions, and contract requirements that Medicare contractors must meet condensed into one manual, including step-by-step tests to help plans ensure the accuracy of their data. Blue Plans use the MMORP as a management tool to assist them with compliance with their Medicare contracts. Blue Plans provide BCBSA with suggestions about new enhancements to the MMORP; each year, we update and expand the manual to provide new, detailed information at the request of our member companies.

Along with using the MMORP, Blue Cross and Blue Shield Plans take part in numerous compliance training programs and examinations offered by BCBSA. BCBSA holds an annual conference for Plan compliance officers, legal staff, and other Plan staff that provides the most up-to-date information on compliance and ethics issues in health care and government programs. A forum is provided at the conference where Plans can share best practices of their own compliance and ethics programs. Following the successful completion of an examination, participants in each conference receive a certification of their compliance and ethics training.

BCBSA also provides different levels of compliance training programs to Plans. BCBSA supplies video presentations, case studies, and extensive discussion materials to Plans to inform them of compliance and ethics issues affecting their organization's operations. These training

materials review such issues as conducting risk assessments, creating effective internal controls, and developing a conflict of interest avoidance plan. Plans can use these tools to conduct their own internal training or Plans can request that BCBSA staff run a training session for them. More advanced training is also available for Plan senior staff involved in compliance and ethics activities. BCBSA staff is also available to answer questions about compliance or help Plans with modifications to their compliance plans. Finally, BCBSA also makes compliance and ethics information available to Plans on the Association's Intranet.

CONCLUSION

Blue Cross and Blue Shield Medicare contractors are committed to achieving outstanding performance. We believe more can and should be done to improve contractor's and HCFA's ability to safeguard the Medicare Trust Funds. Thus, we support exploring reform proposals that would allow contractors to compete on a level playing field, contract competitively as typical FAR-based government contractors, and contract on other than a pure cost reimbursement basis.

Success in Medicare claims administration requires that HCFA and the contractors work together toward their mutual goal of accurate and timely claims payment. Fragmenting contracts, as HCFA has proposed, would take us in the wrong direction. The true path to strengthening Medicare administration lies in raising performance standards, aggressively enforcing them, and terminating the contracts of underperformers. To get there, Medicare contractors will need (1) adequate and stable funding levels; (2) clear and consistent guidance; and (3) specific performance expectations.

We look forward to working with this Subcommittee and HCFA to make these needed improvements.

John:

Per your request here are the figures on active FBI Investigations of Health Care Fraud broken down by fiscal year.

FY 92:	592
FY 93:	1,051
FY 94:	1,500
FY 95:	1,878
FY 96:	2,200
FY 97:	2,582
FY 98:	2,800
FY 99:	3,027

FYI: You can not assume that the difference between active investigations from one year to the next reflects the total number of cases opened during that fiscal year. Many cases are both opened and closed during one given year or a case may be under investigation for several years. For example, the difference between FY 96 and FY 97 is 382 cases. It should not be assumed that the FBI only opened 382 cases in FY 97 because many of the 2,200 cases investigated during FY 96 were presumably closed.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Chief of Staff

Washington, D.C. 20201

FACSIMILE

DATE: 1/21/00

TO: Deborah

FAX#: 456-5557

FROM: Liz Summy
Deputy Chief of Staff

Phone: 202/690-7431 Fax: 202/401-5783

COMMENTS:

Deborah,

I am sending the HCFAC Paper & MIP Paper as discussed.

30+ **Pages [including this cover]**

JAN 21 2000

The Honorable J. Dennis Hastert
Speaker of the House of
Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Pursuant to subsection 1817(k)(5) of the Social Security Act, 42 U.S.C. § 1395i, we are pleased to submit to the Congress this third Annual Report on the Health Care Fraud and Abuse Control Program for Fiscal Year 1999.

During the third year of operation of the Program, the Department of Justice and Department of Health and Human Services collected over $490 million as a result of our health care fraud enforcement activities. From the funds collected, nearly $369 million was transferred to the Health Care Financing Administration or deposited directly into the Medicare Hospital Insurance Trust Fund.

The creation of the Health Care Fraud and Abuse Control Program has enabled our respective Departments, and our many partners in health care fraud enforcement, to better detect, investigate, prosecute and prevent such fraud and abuse. We are fully committed to continuing this responsible enforcement of federal statutes relating to health care fraud and abuse in this country.

A similar letter has been sent to the President of the Senate. Thank you for your attention and consideration.

Sincerely,

Donna E. Shalala
Secretary

Janet Reno
Attorney General

Enclosure

JAN 21 2000

The Honorable Albert Gore, Jr.
President of the Senate
Washington, D.C. 20510

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Sincerely,

Donna E. Shalala
Secretary

Janet Reno
Attorney General

Enclosure

The Department of Health and Human Services
And
The Department of Justice
Health Care Fraud and Abuse Control Program
Annual Report For FY 1999

January 2000

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GENERAL NOTE
All years are fiscal years unless otherwise noted in the text.

EXECUTIVE SUMMARY

The detection and elimination of health care fraud and abuse is a top priority of federal law enforcement. Our efforts to combat fraud were consolidated and strengthened considerably by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA established a national Health Care Fraud and Abuse Control Program (the Program), under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS)[1], acting through the Department's Inspector General (HHS/OIG), designed to coordinate federal, state and local law enforcement activities with respect to health care fraud and abuse. HIPAA brought much needed and powerful new criminal and civil enforcement tools and financial resources that permitted the government to expand and intensify the fight against health care fraud.

The third year of operation under the Program saw a continuation of the collaborative efforts of Federal and state enforcement and oversight agencies to identify and prosecute the most egregious instances of health care fraud, to prevent future fraud or abuse, and to protect program beneficiaries.

Civil and Criminal Enforcement Actions

Federal prosecutors filed 371 criminal indictments in health care fraud cases in 1999 -- a 16 percent increase over the previous year. A total of 396 defendants were convicted for health care fraud-related crimes in 1999. There were also 2,278 civil matters pending, and 91 civil cases filed in 1999.

Monetary Results

In 1999, the federal government won or negotiated more than $524 million in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the federal government in 1999 collected $490 million. It should be noted that some of the judgments, settlements, and administrative impositions in 1999 will result in collections in future years, just as some of the collections in 1999 are attributable to actions from prior years.

Nearly $369 million of the funds collected and disbursed in 1999 were returned to the Medicare Trust Fund. An additional $4.7 million was recovered as the federal share of Medicaid restitution.

Exclusion from Federally Sponsored Programs

[1]Hereafter, referred to as the Secretary.

HIPAA expanded and strengthened the government's ability to prohibit companies or individuals who have been convicted of certain health care offenses, lost their licenses, or engaged in other professional misconduct from participating in Medicare, Medicaid or other federally sponsored health care programs. In 1999, HHS excluded 2,976 individuals and entities.

Collaboration

One of the fundamental principals of the Program is to maximize the effectiveness and efficiency of law enforcement efforts by promoting information sharing and collaboration among the many federal, state and local allies in the fight against health care fraud. Such collaboration has increased during 1999, through heightened data sharing, establishment of a National Health Care Fraud Task Force chaired by the Deputy Attorney General (bringing together federal, state, and local prosecutors and other enforcement officials) and joint training, to name a few. In addition to the many joint health care investigations undertaken daily across the country, collaborative efforts have also produced effective new beneficiary outreach initiatives, and fraud prevention efforts.

Preventing Health Care Fraud

Preventing health care fraud and abuse is a central component of the Program. The Program's prevention efforts include the promulgation of formal advisory opinions to industry on proposed business practices, industry-specific program compliance guidance, special fraud alerts, corporate integrity agreements with providers who settle allegations of fraud, and beneficiary and provider education and outreach. Fraud prevention and compliance efforts are reaping significant results; the most recent audit of the Medicare payment error rates showed a $10.6 billion or 45 percent drop in improper fee-for-service payments over the last two years.

Administrative Penalties for "Patient Dumping"

The government expanded its efforts under the Patient Anti-Dumping Statute, which requires hospitals' emergency departments to provide emergency medical screening and stabilizing treatment, entering settlement agreements with 60 hospitals and physicians, and received one default judgment for a total of 61 individuals and entities -- up from a previous high of 53 settlements in 1998. The Government collected $1.725 million in civil monetary penalties associated with these cases.

INTRODUCTION

ANNUAL REPORT OF THE ATTORNEY GENERAL AND THE SECRETARY DETAILING EXPENDITURES AND REVENUES UNDER THE HEALTH CARE FRAUD AND ABUSE CONTROL PROGRAM FOR FISCAL YEAR 1999

As Required by
Section 1817(k)(5) of the Social Security Act

STATUTORY BACKGROUND

The Social Security Act Section 1128C(a), as established by the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191, HIPAA or the Act), created the Health Care Fraud and Abuse Control Program (the Program), a far-reaching program to combat fraud and abuse in health care, including both public and private health plans.

The Act requires that an amount equaling recoveries from health care investigations -- including criminal fines, forfeitures, civil settlements and judgments, and administrative penalties, but excluding restitution, compensation to the victim agency, and relators' shares -- be deposited in the Medicare[2] Trust Fund. All funds deposited in the Trust Fund as a result of the Act are available for the operations of the Trust Fund.

As stated above, the Act appropriates monies from the Medicare Trust Fund to a newly created expenditure account, called the Health Care Fraud and Abuse Control Account (the Account), in amounts that the Secretary and Attorney General jointly certify are necessary to finance anti-fraud activities. The maximum amounts available for expenditure are specified in the Act. Certain of these sums are to be available only for activities of the HHS/OIG, with respect to Medicare and Medicaid programs. In 1999, the third year of the Program, the Secretary and the Attorney General certified $137.5 million for appropriation to the Account. A detailed breakdown of the allocation of these funds is set forth later in this report. These resources supplement the direct appropriations of HHS and DOJ that are devoted to health care fraud enforcement. (Separately, the Federal Bureau of Investigation (FBI) received $66 million from HIPAA which is discussed in the Appendix.)

Under the joint direction of the Attorney General and the Secretary, the Program's goals are:

[2]Also known as the Hospital Insurance (HI) Trust Fund. All further references to the Medicare Trust Fund refer to the HI Trust Fund.

(1) to coordinate federal, state and local law enforcement efforts relating to health care fraud and abuse;

(2) to conduct investigations, audits, and evaluations relating to the delivery of and payment for health care in the United States;

(3) to facilitate enforcement of all applicable remedies for such fraud;

(4) to provide guidance to the health care industry regarding fraudulent practices; and

(5) to establish a national data bank to receive and report final adverse actions against health care providers.

The Act requires the Attorney General and the Secretary to submit a joint annual report to the Congress which identifies:

(A) the amounts appropriated to the HI Trust Fund for the previous fiscal year under various categories and the source of such amounts; and

(B) the amounts appropriated from the Trust Fund for such year for use by the Attorney General and the Secretary and the justification for the expenditure of such amounts.

This annual report is submitted in fulfillment of the above statutory requirements.

MONETARY RESULTS

As required by the Act, HHS and DOJ must detail in this Annual Report the amounts deposited and appropriated to the Medicare Trust Fund, and the source of such deposits. In 1999, as a result of the combined anti-fraud actions of the federal and state governments and others, the federal government collected $490 million in connection with health care fraud cases and matters[3]. These funds were deposited with the Department of the Treasury and Health Care Financing Administration (HCFA), transferred to other federal agencies administering health care programs, or paid to private persons. The following chart provides a breakdown of the transfers/deposits:

Total Transfer/Deposits by Recipient 1999	
Department of the Treasury	
HIPAA Deposits to the Medicare Trust Fund	
Gifts and Bequests	$ 2,500
Amount Equal to Criminal Fines	36,006,432
Civil Monetary Penalties	4,797,073
Amount Equal to Asset Forfeiture *	0
Amount Equal to Penalties and Multiple Damages	73,559,143
Health Care Financing Administration	
OIG Audit Disallowances - Recovered	50,002,122
Restitution/Compensatory Damages	209,200,132
	373,567,402
Restitution/Compensatory Damages to Federal Agencies	
Office of Personnel Management	9,286,426
Other Agencies	5,408,372
Treasury Miscellaneous Receipts	14,793,185
Department of Health and Human Services - Other than HCFA	42,993,069
	72,481,052
Relators' Payments **	**44,418,028**
TOTAL ***	**$490,466,482**

*This includes only forfeitures under 18 United States Code (U.S.C.) 1347, a new federal health care fraud offense that became effective on August 21, 1996. Not included are forfeitures obtained in numerous health care fraud cases prosecuted under federal mail and wire fraud and other offenses.

**These are funds awarded to private persons who file suits on behalf of the federal government under the *qui tam* provisions of the False Claims Act, 31 U.S.C. sec 3730(b).

***Funds are also collected on behalf of state Medicaid programs and private insurance companies; these funds are not represented here.

[3]In 1999, DOJ collected, or continued to hold in suspense, an additional $96,480,614 in health care fraud cases and matters that was not disbursed to the affected agencies and/or the Account in 1999 due to: (i) on-going litigation regarding relator shares in *qui tam* cases that will affect the amount retained by the federal government; and (ii) receipt of funds late in the year that were then processed in FY 2000.

The above transfers include certain collections, or amounts equal to certain collections, required by HIPAA to be deposited directly into the Medicare Trust Fund. These amounts include:

(1) Gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Account or any activity financed through the Account;

(2) Criminal fines recovered in cases involving a federal health care offense, including collections under 1347 of title 18, U.S.C. (relating to health care fraud);

(3) Civil monetary penalties in cases involving a federal health care offense;

(4) Amounts resulting from the forfeiture of property by reason of a federal health care offense, including collections under section 982(a)(6) of title 18, U.S.C.;

(5) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 Title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

HIPAA requires an independent review of these deposits by the General Accounting Office (GAO).

PROGRAM ACCOMPLISHMENTS

Expenditures

In the third year of operation, the Secretary and the Attorney General certified $137.5 million as necessary for the Program. The following chart gives the allocation by recipient:

1999 ALLOCATION OF HCFAC APPROPRIATION (Dollars in thousands)	
Organization	**Allocation**
Department of Health and Human Services	
Office of Inspector General	$98,220
Office of the General Counsel	2,292
Administration on Aging	1,400
Health Resources Services Administration	4,443
Departmental Appeals Board	138
Total	106,493
Department of Justice	
United States Attorneys	21,580
Civil Division	8,119
Criminal Division	803
Justice Management Division	280
Total	30,740
Total	**137,233**[4]

These resources supplement the direct appropriations of HHS and DOJ that are devoted, in part, to health care fraud enforcement. Separately, the FBI received an additional $66 million in funding which is discussed in the Appendix to this Report.

Accomplishments

Collections

During this year, the federal government won or negotiated more than $524 million in judgments, settlements, and administrative impositions in health care fraud cases and proceedings. As a result of these activities, as well as prior year judgments, settlements, and administrative impositions, the federal government in 1999 collected $490 million in cases resulting from health care fraud and abuse, of which nearly $369 million was returned to the

[4]The original certification was for $137,540,000. However, during the fiscal year a $307,000 recission was taken against the account, leaving $137,223,000 available.

Medicare Trust Fund, and $4.7 million was recovered as the federal share of Medicaid restitution. It should be emphasized that some of the judgments, settlements, and administrative impositions in 1999 will result in collections in future years, just as some of the collections in 1999 are attributable to actions from prior years.

Judgments/Settlements

Working together, we have brought to successful conclusion the investigation and prosecution of numerous costly health care fraud schemes. Among them, are the following.

- A major provider of home health services and one of its subsidiaries entered into a global settlement totaling $61 million, including approximately $10 million in criminal fines, to resolve the corporation's criminal, civil, and administrative liability arising from Medicare fraud investigations in Georgia, Florida, and New York. In Georgia and Florida, the investigation examined a series of transactions in which the home health services corporation paid another large health care corporation for the right to provide Medicare-reimbursable management services to that corporation. These payments included large cash contributions to the other corporation, enabling it to purchase home health agencies of third parties. In consideration of these payments, and of an agreement by the defendant to sell its own home health agencies to the other corporation at a reduced price, the defendant received the right to manage the visits resulting from these transactions for a management fee which was fully reimbursed by Medicare. The effect of these transactions was to disguise non-reimbursable acquisition costs as management fees, which Medicare does not reimburse. As a result of this investigation, the subsidiary pled guilty to conspiracy, mail fraud, and violation of the Medicare anti-kickback statute in three districts. In New York, a separate investigation focused on allegations that the corporation submitted unallowable expenses on its Medicare cost reports, including personal expenses of executives, gifts and entertainment, and merger costs. In addition to paying $61 million, the corporation entered into a comprehensive corporate integrity agreement with the Government.

- In Pennsylvania, a company providing end-stage renal disease (ESRD) services through a network of subsidiary corporations it had acquired, agreed to pay the Government $16.5 million to resolve allegations of false Medicare claims submitted by one of the subsidiaries. The claims arose from the sale of Medicare-reimbursable noninvasive diagnostic tests between 1992 and 1995. The subsidiary companies provided financial inducements to primary care physicians and to renal dialysis facilities in exchange for the referral of patients for diagnostic testing. As a result, a percentage of the tests performed by the subsidiaries were medically unnecessary. The final settlement resolved three different *qui tam* lawsuits which had been brought against the subsidiaries and/or the parent company.

- A key component of the HCFAC effort to protect the integrity of the Medicare trust funds is the investigation of allegations of fraud by contractors enlisted by HCFA to process and pay Medicare claims. Stemming from a *qui tam* complaint filed in New

Mexico, two former Medicare contractors agreed to settle their False Claims Act, criminal, and administrative liability for misrepresenting their performance. In order to resolve allegations of manipulating certain computer files to obtain a better score on the Contractor Performance Evaluation Program, one of the corporations agreed to pay the Government $6.84 million. On or after May 1, 2001, the United States may, at its sole discretion, demand that the other corporation pay the Government $5.86 million, after considering the corporation's financial condition, for attempting to conceal evidence of poor performance on their audits of Medicare Part A providers. In addition, both corporations will forgo contract claims for overbudget and termination costs totaling $3.1 million. Both corporations also entered into a 5-year corporate integrity agreement with the OIG. In addition, as part of the global settlement, the former contractors pled guilty to obstruction of a Federal audit and conspiracy to obstruct a Federal audit. A third corporation, co-owned by the contractors to provide them with management services, pled guilty to conspiring to obstruct a Federal audit as well. The United States should ultimately receive $15.8 million in criminal fines, the civil settlement, and the contract claims.

- On October 15, 1998, the United States reached an agreement with a major metropolitan fire department and a local hospital corporation to resolve allegations in a *qui tam* complaint that the defendants routinely had submitted false claims to the United States to obtain reimbursement for medically unnecessary ambulance transportation. The city agreed to pay the Government $9.5 million. Among other things, the complaint alleged that the fire department misrepresented the diagnosis of patients in order to receive reimbursement from Medicare for ambulance transportation. As part of the settlement, the company entered into a comprehensive institutional compliance agreement which will be monitored and enforced by the HHS/OIG for the next 5 years.

These and other settlements reflect the culmination of investigations that have been ongoing for several years. Though settled in 1999, the fines and restitution generated by some of these cases will not be credited to the Medicare Trust Funds until 2000.

Collaboration

Effective health care fraud and abuse control requires close collaboration and regular exchanges of information among federal, state and local law enforcement entities. Shown here are a few of the many instances of collaborative effort between DOJ, HHS, and many other organizations involved in combating health care fraud.

National Health Care Fraud Task Force. In 1999, the Administration launched a new National Health Care Fraud Task Force, chaired by the Deputy Attorney General, in which HHS/OIG, HCFA, DOJ and State and local prosecutors will work together in formulating strategies to combat health care fraud and abuse and safeguard the well-being of Medicare and Medicaid beneficiaries. While the task force will focus on a wide range of health care fraud and abuse policy issues, particular attention will be devoted to fighting nursing home fraud and abuse and excluding dishonest and abusive providers from participation in Medicare, Medicaid and

other Government-funded health care programs.

Nursing Homes. The destructive impact of fraudulent billing is not measured in dollars only. During 1999, the Program continued to pursue investigations, prosecutions, audits and evaluations that directly affect not only financial losses, but also the *quality* of care provided to Medicare, Medicaid and other beneficiaries of government funded health care programs. Quality of care in nursing homes has been identified as a priority for both DOJ and HHS; and in October 1998, DOJ launched a major new initiative to crack down on fraud, abuse and neglect in nursing homes and other residential care facilities. The Nursing Home Initiative, coordinated by the Civil Division, focuses on enhanced enforcement; training; outreach to industry, resident advocates, medical professionals, academics and others; new legislation to address gaps in federal law; an analysis of the applicable state laws and improved inter-agency and governmental coordination, use of data, and services to victims.

DOJ began a series of regional training conferences in 1999 that brought together representatives of federal, state, and local law enforcement, regulatory, survey, oversight and advocacy entities. During the conferences, State Working Groups (SWG) were formed (or expanded where they existed), including representatives of the many entities that play a role in nursing home quality of care. These SWGs provide an on-going opportunity to promote quality of care by establishing a forum for key players to meet, share information and skills, identify problem facilities, best practices, and ways to address quality of care given the unique situations in the various states.

These and other investigative initiatives complement HCFA's ongoing Nursing Home Initiative, which has already resulted in significant improvements to nursing home oversight, enforcement and quality monitoring. Communication and coordination are facilitated by monthly Nursing Home Steering Committee meetings attended by the Civil Division, Criminal Division, Civil Rights Division, FBI, HHS/OIG, HCFA, HHS/OGC as well as in Senior Staff and Executive Level policy meetings during which nursing home fraud, abuse and neglect are among the health care issues addressed.

Examples of investigations of nursing homes for false claims relating to the quality of care provided to their residents that were brought to successful conclusion in 1999 include:

- A survey by the state Department of Health of a Pennsylvania nursing home disclosed inadequate wound care, incontinence care and nutrition. After investigation, the nursing home entered a settlement agreement with the government, agreeing to pay $195,000, to implement specific quality of care protocols, and to appoint a monitor to oversee the quality of patient care.

- In Kansas, a therapy service provider agreed to pay the Government $688,996 to settle allegations of impropriety in providing services to nursing home patients. It was alleged that the provider billed for therapy that was medically unnecessary and excessive, as well as billed for staff education inappropriately, and overbilled for applications of splints and positioning of patients. As part of the settlement, the provider agreed to adhere to a

3-year comprehensive corporate integrity agreement.

Beneficiary Outreach. On February 24, 1999, the HHS/OIG, DOJ, HCFA, and the Administration on Aging (AoA) joined with the American Association for Retired Persons (AARP) to launch an initiative against Medicare fraud, waste, and abuse. The educational campaign -- entitled "Who Pays? You Pay. Report Medicare Fraud" -- was held in 31 cities throughout the country, and was attended by approximately 10,000 Medicare beneficiaries. Outreach materials developed for the campaign include a brochure, entitled "What You Can Do To Stop Medicare Fraud" in English and Spanish, a drain-image poster entitled "Medicare Fraud is Money Down the Drain", and a 30-second public service announcement. The award-winning announcement was produced by AARP and is shown under the logos of AARP and HHS.

Since the campaign kick-off, the collaborative partnership between HHS/OIG, HCFA, AoA, DOJ, and AARP has continued. Monthly meetings are held to update partners on the activities of each respective partner and to plan for future collaborative activities. Since the event, the HHS/OIG Hotline 1-800-HHS-TIPS, has served as an educational and reporting resource to approximately 300,000 callers (up from 76,000 calls in 1998). The Hotline has also experienced a spike in calls from Puerto Rico and has established an active monitoring and evaluation system to ensure that concerns of the Hispanic community are addressed. To address this call increase, the Hotline has hired an additional Spanish-speaking representative and has increased the number of Spanish representatives at the contractor site in Chicago.

Data Sharing. In 1999, efforts continued to share information – both general data about trends in health care fraud and emerging investigative and prosecutorial techniques -- and to communicate and coordinate with respect to specific investigations. A general data sharing process was instituted between the FBI and the HHS/OIG to ensure that complete, accurate and current information on Federal health care fraud investigations is maintained and readily accessible by both agencies.

Preventing Health Care Fraud

The Program also continues to focus on *prevention* of health care fraud and abuse through inclusion of rigorous corporate integrity provisions in settlements with alleged offenders, industry-specific program compliance guidance, formal advisory opinions, special fraud alerts, beneficiary outreach, and exclusions from program participation. These activities, coupled with the overall sentinel effect of our heightened enforcement efforts have netted real results. Perhaps the most concrete evidence of the success of anti-fraud and oversight efforts is the significant reduction in the error rates in Medicare fee-for-service payments – an overall 45 percent reduction in improper payments in just 2 years. As part of the HHS/OIG audit of HHS's 1996 financial statements, HHS/OIG developed a statistically valid estimate of improper payments amounting to $23.2 billion, or about 14 percent of the total payments made in the fiscal year. Just 2 years later, improper payments dropped by $10.6 billion to $12.6 billion, or about 7 percent of the fiscal year total.

According to Treasury Department and Congressional Budget Office statistics, Medicare

spending rose at an average annual rate of about 9 percent from 1994 to 1997, then dropped to 1.5 percent in 1998 — the smallest increase in the history of the program. 1998 also marked the first year that Medicare spending grew more slowly than the Federal budget as a whole, which increased by 3 percent. This downward trend is continuing; during 1999, Medicare spending actually declined 0.7 percent. Even home health care expenditures, which experienced explosive growth during most of the 1990's, declined. The Medicare Trustees recently announced that the solvency of the Trust Fund had been extended 7 years to 2015, after also being extended 7 years the prior year.

A more detailed description of these and other accomplishments of the major federal participants in the coordinated effort established under HIPAA follows. While information in this report is presented in the context of a single agency, most of these accomplishments reflect the combined efforts of HHS, DOJ and other partners in the anti-fraud efforts. The continuing accomplishments of the DOJ and HHS and our partners in the coordinated anti-fraud effort, as well as prevention efforts, demonstrate that the increased funds to battle health care fraud and abuse continue to be sound investments, as well as good public policy.

FUNDING FOR DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Certain of the funds appropriated under HIPAA are, by statute, set aside for Medicare and Medicaid activities of the HHS/OIG. During the third year of the Program, the Act provides that between $90 and $100 million be devoted to these purposes. The Secretary and the Attorney General jointly allotted $98.2 million to the HHS/OIG in 1999, an increase of $12 million over 1998.

With these increased resources, HHS/OIG conducted or participated in 942 prosecutions or settlements in 1999. A total of 2,976 individuals and entities were also excluded, many as a result of criminal convictions for program-related crimes (550), criminal convictions for patient abuse or neglect (323), and others were excluded based on licensure revocations (1,416).

In addition to the HHS/OIG's role in bringing about the judgments and settlements described in the Overview of Accomplishments, the Department of Health and Human Services acted on HHS/OIG recommendations and disallowed $113.5 million in improperly paid health care funds in 1999. HHS/OIG continues to work with HCFA to develop and implement recommendations to correct systemic vulnerabilities detected during HHS/OIG evaluations and audits. These corrective actions often result in health care funds not expended (that is, funds put to better use as a result of implemented HHS/OIG initiatives). In 1999, such funds not expended on improper or unnecessary care amounted to approximately $11.8 billion – about $10.8 billion in Medicare savings, and nearly $1 billion in savings to the Medicaid program.

HHS/OIG moved closer to its goal of extending its investigative and audit staffs to cover *all* geographical areas in the country, particularly those that were previously underserved. During 1999, overall HHS/OIG staff levels increased from 1,258 to 1,363 by the end of the year, and HHS/OIG opened 2 new investigative offices. The HHS/OIG also significantly increased its staffing resources devoted to ensuring health care providers' compliance with Federal health care program rules.

Fraud and Abuse Prevention

The increased resources made available under HIPAA have enabled the HHS/OIG to expand activities designed not just to uncover existing fraud and abuse, but to *prevent* it. Vital prevention initiatives, such as those listed below, inform and assist the health care industry, and patients. Equally important, these prevention activities reduce the government's enforcement costs and program losses.

Compliance Guidance. A key element of HHS/OIG's prevention efforts has been the

development of compliance program guidance to encourage and assist the private health care industry to fight fraud and abuse. The guidance, developed in conjunction with the provider community, identifies steps that health providers may voluntarily take to improve adherence to Medicare and Medicaid rules. In 1999, the OIG developed and released final compliance program guidance for third party medical billing companies, hospices and the durable medical equipment, prosthetics, orthotics, and suppliers industry.

Corporate Integrity Agreements. Many health care providers that enter agreements with the government in settlement of potential liability for violations of the False Claims Act also agree to adhere to a separate "corporate integrity agreement." Under this agreement, the provider commits to establishing a compliance program or undertaking other specified steps to ensure its future compliance with Medicare and Medicaid rules. The duration of most corporate integrity agreements is 5 years, during which time the provider must submit periodic reports to HHS/OIG. These agreements require a substantial effort by the provider to ensure that the organization is operating in accordance with Federal health care programs rules and regulations and the parameters established by the corporate integrity agreement. Breach of the agreement may result in a variety of sanctions, including exclusion of the provider. At the close of 1999, HHS/OIG was monitoring more than 425 corporate integrity agreements.

Industry Guidance. The centerpiece of the HIPAA guidance initiatives is an advisory opinion process through which parties can obtain binding legal guidance as to whether their existing or proposed health care business transactions run afoul of the Federal anti-kickback statute, the civil money penalties laws, or the exclusion provisions. The advisory opinion process has become an integral part of the Inspector General's ongoing commitment to preventing health care fraud. During 1999, the HHS/OIG accepted 39 requests for advisory opinions and issued 15 opinions. Many requests are still being processed; others were withdrawn or rejected as outside the scope of the advisory opinion process.

The advisory opinion process also serves to enhance the HHS/OIG's understanding of new and emerging health care business arrangements and informed the development of new safe harbor regulations, fraud alerts, and special advisory bulletins. Topics so addressed in 1999 include hospital payments to physicians to reduce or limit services to beneficiaries (commonly known as "gainsharing" arrangements); the effect of exclusion from Federal health care programs on excluded providers and those who employ or contract with them; physician liability for certifications of medical necessity in the provision of medical equipment and home health services; and the effects of exclusion from Federal health care programs on current and prospective employees.

The HHS/OIG made significant strides toward resolving pending safe harbor regulations. Formal clearance was begun for a proposed anti-kickback safe harbor for ambulance restocking arrangements between hospitals and ambulance providers who transport patients to hospital emergency rooms and a proposed safe harbor under the civil money penalty law for inducements to beneficiaries to protect certain payments by ESRD facilities of insurance premiums for their patients. Two final anti-kickback statute safe harbor rules were finalized for issuance in early 2000 -- one promulgating eight new safe harbors and a series of clarifications to existing safe

harbors (originally proposed in 1993 and 1994), and another addressing the statutory exception for shared risk arrangements.

In addition, HHS/OIG has made frequent presentations to industry groups on areas of suspected fraud and abuse and measures they can take to avoid trouble.

Medicare Error Rate: The HHS/OIG's annual audit of the Department's financial statements included a statistically valid review of the error rate in Medicare fee-for-service payments. This year's estimate is $7.7 billion less than last year's estimate of $20.3 billion and $10.6 billion less than the previous year's estimate of $23.2 billion--a 45 percent drop. While there is no empirical evidence supporting a specific causal relationship between the error rate decline and particular corrective actions, we believe that among the important causes for the reduced error rate are the fraud and abuse prevention and detection initiatives, the Medicare Integrity Program administered by HCFA and the cooperative efforts of major provider groups.

Recommendations for Systemic Improvements: Frequently, investigations (and resulting civil settlements or criminal prosecutions), audits and evaluations reveal vulnerabilities or incentives for fraud in agency programs or administrative processes. As required by the Inspector General Act, the HHS/OIG makes recommendations to correct these vulnerabilities, and thereby promote economy and efficiency in HHS programs and operations. Relying on the independent factual information generated by HHS/OIG, agency managers fashion legislative proposals and other corrective actions that, when enacted or implemented, close loopholes and avoid ineffective expenditures or improper conduct. The net savings from these joint efforts toward program improvements can be substantial.

An example of an HHS/OIG study that provided evidence and ideas supporting proposals for significant cost savings issued during 1999 was the series of reports on the early effects of the prospective payment system (PPS) on access to skilled nursing facilities and the appropriateness of Medicare payments for physical and occupational therapy in skilled nursing facilities. The studies found that there are no serious problems in placing Medicare beneficiaries in nursing homes; however, nursing homes are changing their admission practices in response to the new PPS. One-fifth of the hospital discharge planners say that it has become more difficult to place patients who require extensive services while it has become easier to place patients who need rehabilitation services. Most nursing home patients were appropriate candidates for and benefitted from the physical and occupational therapy they received. However, 13 percent of the therapy was improperly billed to Medicare. In terms of dollar amounts, Medicare reimbursed skilled nursing facilities almost $1 billion for improperly billed physical and occupational therapy and almost $331 million for undocumented physical and occupational therapy.

The reports recommended that HCFA instruct Medicare fiscal intermediaries to provide more training to facility and therapy staff on Medicare coverage criteria and guidelines, local medical review policies, and monitoring procedures for therapy and adequately fund Medicare contractors to perform medical reviews of therapy.

Focus on Collaboration

Federal-State Audit Partnership. In 1994, the HHS/OIG initiated a partnership between federal and state auditors to enhance and provide broader audit coverage of the Medicaid

program. Collaboration among HHS/OIG, State auditors, inspectors general, Medicaid agencies and HCFA maximizes scarce resources at both the Federal and State levels. The focus of the partnership effort is not on the traditional identification and recovery of unallowable Medicaid costs; rather the program focuses on identifying program improvements and reducing the cost of providing necessary services to Medicaid recipients. HHS/OIG auditors provide computer support, audit programs and guides, training, information-sharing and other specialized assistance to State auditors, as well as direct audit support.

To date, active partnerships flourish in 22 states. This partnership effort has been a resounding success. State auditors have shown a great interest in creating partnerships and we continue to get inquiries on other potential joint projects. By the end of 1999, these State partnerships generated approximately $145 million in Federal and State savings since the partnership began. Many of these recommendations related to Medicaid prescription drugs.

Roundtable on Compliance. In conjunction with the health care industry, the HHS/OIG conducted a joint roundtable on health care compliance to gain new insights into the challenges of creating effective compliance programs. The event reflects HHS/OIG's commitment to engage in ongoing discussions with the health care compliance industry about practices and policies related to compliance programs, including the impact of compliance recommendations advanced by HHS/OIG. More than 125 compliance officers, government representatives and others attended the event.

Self-Disclosure Protocol. In October 1998, the HHS/OIG implemented a self-disclosure program, to assist providers and suppliers in investigating and reporting potential violations of Federal health care laws. The program offers providers an opportunity to police themselves, correct underlying problems and work cooperatively to resolve these matters. Since issuance of the protocol, 40 health care providers have submitted self-disclosures to the HHS/OIG. Two of these were successfully resolved through the return of overpayments to the Federal Government; the others are under investigation.

Data Sharing. With the increased focus on investigations that are national in scope, close collaboration among investigative and prosecutive agencies has become critical. To this end, the HHS/OIG Office of Investigations and the FBI have initiated an efficient information sharing system. Copies of all healthcare fraud referrals and allegations received by HHS/OIG are sent to the FBI Health Care Fraud Unit at FBI Headquarters. The FBI then serves as an informational contact and dissemination point for DOJ and its prosecutors nationwide. In turn, the FBI provides information on their health care investigative matters to HHS/OIG. All such cases, wherever generated, are entered into the HHS/OIG Case Information Management System, which serves as a comprehensive data base for Federal health care investigations. This prompt information sharing system fosters efficient investigative teamwork, supports criminal prosecutions and deters health care fraud.

Beneficiary Outreach. The HHS/OIG's outreach efforts are not limited to industry; equally important is enlisting the beneficiary population in the fight against fraud and abuse. The HHS/OIG continues to distribute hundreds of its Medicare fraud educational materials to beneficiaries through AoA grantees, the AoA network, AARP regional offices, and to public libraries in each State. HHS/OIG has developed a working relationship with national Asian American and Hispanic organizations to seek advice on translating and printing HHS/OIG

Medicare fraud materials into Chinese, and to distribute these materials and those already printed in Spanish, respectively, to Chinese Americans and a wider Spanish-speaking population.

Focus on Quality of Care

Some of the HHS/OIG's most important investigations, audits and evaluations focused on the *quality* of care furnished to program beneficiaries. These include the investigations described in the Overview section of this report, as well as the following activities:

Patient Anti-Dumping Enforcement. Both HCFA and the HHS/OIG continue to vigorously pursue potential violations under the patient anti-dumping statute. Federal law requires that an emergency medical screening examination and stabilizing treatment be provided by the emergency department of a Medicare participating hospital. In 1999, HHS/OIG entered 61 settlement agreements with hospitals and physicians and collected civil monetary penalties of $1.7 million. This is an increase from the previous high of 53 settlements in 1998, and reflects the commitment of both HCFA and HHS/OIG to ensure patient access to appropriate emergency medical services.

Quality of Care in Nursing Homes. The HHS/OIG released a series of inspection reports concluding that serious problems with quality of care continue to exist in nursing homes. This is demonstrated by an increase in survey and certification "quality of care" deficiencies as well as an increase in ombudsman complaints, especially about resident care. Other findings include inadequate nursing home staffing levels; weaknesses in the survey system; inadequate resources in the ombudsman program; and inconsistent and unreliable State systems to safeguard nursing home residents. The problems described in this inspection will require continuing attention. An effective strategy would include actions to enhance the survey and certification process; strengthen the ombudsman program with increased resources; improve nursing home staffing levels; and improve coordination between State survey agencies and ombudsmen. Additionally, further evaluation and performance measurement of the Omnibus Budget Reconciliation Act 1987 and the conditions in nursing homes would make an important contribution to efforts to advance nursing home care.

Hospital Quality Oversight. A two-year study by the HHS/OIG found major deficiencies in the external oversight system intended to make sure the nation's hospitals are safe and recommended how those agencies responsible for oversight can provide leadership in improving quality and accountability. The study received significant national media attention when it was released. Four evaluation reports assessed the key roles in hospital quality oversight played by the Joint Commission for Accreditation of Healthcare Organizations, the State survey and certification agencies, and HCFA, which oversees Medicare. Overall, the reports concluded that while the system of oversight that HCFA relies upon has some strengths, it also has deficiencies that warrant serious attention. The HCFA does little at present to hold either the Joint Commission or the State survey agencies accountable for their performance.

The reports called for HCFA to exert leadership in addressing the shortcomings. The HHS/OIG urged HCFA to steer the external review process so that it represented a balance between the

educationally oriented approaches of the Joint Commission and the enforcement-oriented approaches of the State agencies. In recommendations, the HHS/OIG presented a number of steps HCFA should take to hold both the Joint Commission and the States more fully accountable for their performance in reviewing hospitals. In addition, the HHS/OIG called for HCFA to determine the appropriate minimum cycle for conducting certification surveys of non-accredited hospitals. Since the publication of the final report, the Joint Commission has made several changes to its review and accreditation process, based on HHS/OIG recommendations, that have made the process more meaningful and more accountable.

Mental Health Services. A settlement agreement was reached with a university to resolve its civil liability for the submission of false claims to Medicare, Medicaid and other Federal health care programs from 1992 through 1997. At issue were claims for mental health services rendered at its clinics by non-paid, unsupervised students. The university submitted the claims and was reimbursed as if qualified mental health providers (psychologists or psychiatrists) had provided the services. The university agreed to enter a 5-year comprehensive corporate integrity agreement with the HHS/OIG. It also agreed to pay the government a total of over $4 million. Monetary payment will be made to the federal government for both the Medicare damages and the federal portion of Medicaid damages. However, the State agreed that the university could satisfy its liability for the state share of the Medicaid damages through the provision of services rather than through a cash payment.

The HHS/OIG also completed a five-State study of partial hospitalization program services provided in community mental health centers. This program is an intensive outpatient psychiatric program which provides services to acutely ill individuals in order to prevent their hospitalization. Medical reviewers found that over 90 percent of the Medicare payments ($229 million of $252 million) were for unallowable or highly questionable services. Cost reports at selected centers contained significant unallowable and nonreimbursable items. Further, HCFA's enrollment initiative in nine States found that a high percentage of the nearly 700 centers covered did not meet certification requirements to qualify for Medicare payments. To address these problems, HCFA developed a 10-point plan under which approximately 150 centers have already been terminated (this includes voluntary terminations and cessation of business). Instructions were issued to fiscal intermediaries on intensified medical review and provider education. HCFA is also implementing a prospective payment system for partial hospitalization program services, and has started the process of deactivating billing numbers for centers that have not billed Medicare within 6 months.

Health Resources and Services Administration

The Act mandates that the HHS/OIG and DOJ establish a national health care fraud and abuse data collection program for the reporting and disclosure of certain final adverse actions (excluding settlements in which no findings of liability have been made) taken against health care providers, suppliers, and practitioners. The Health Resources and Services Administration (HRSA) has been authorized to design, implement and operate this program, currently named the Healthcare Integrity and Protection Data Bank (HIPDB). In 1999, HRSA received $4.4 million

from the Account to continue development of the HIPDB as an all electronic system that will collect, store and disseminate reports to the law enforcement community and health plans upon request.

The Act requires Secretarial rulemaking for certain features of the HIPDB, including access, information dissemination, disclosures to the subjects of reported information and report corrections, and any other optional reporting elements that the Secretary chooses to request. Decisions were made jointly by HHS and DOJ to continue the development of the data base in 1999 in anticipation of the publication of the Final Rule. Final regulations were published in the Federal Register in October 1999 and plans are underway to open the data bank in early 2000.

Development of the HIPDB has included activities related to data base design specifications, reviews of required hardware and software, modification of physical facilities, and the procurement and installation of equipment. The forms and methods of information to be collected to populate the data base has also been part of the HIPDB development process. Most of the information reported to the HIPDB will come from Federal agencies and State licensing authorities. Data acquisition activities have included working with: DOJ, HCFA, HHS/OIG, the Departments of Defense and Veterans Affairs, and various health care related and health professional organizations, including those representing Nursing and Chiropractic Licensing Boards.

Operations will be supported by charging a fee for searching the data base. When the HIPDB becomes operational, the query fee payment will be collected via an interface with Mellon Bank. To date, more than 2,300 entities have registered to query the HIPDB in anticipation of its opening for operation.

Office of the General Counsel

The Office of the General Counsel's (OGC) headquarters divisions (the Health Care Financing Division and the Business and Administrative Law Division) as well as its 10 regional offices provide legal support consistent with the statutory authority of the HCFAC Program. These OGC components, in partnership with other HHS components — including HCFA, HHS/OIG and DOJ, work jointly to combat health care fraud and abuse.

OGC was allocated $2.3 million in HCFAC funding for 1999. These funds were used primarily for litigation activity, both administrative and judicial. OGC continues to experience an increase in the number of new Program Integrity Litigation items: an approximate increase in new cases for fiscal years 1998 and 1999 of 17 and 18 percent, respectively. Pending cases for those fiscal years increased 34 and 14 percent respectively. It is our anticipated new litigation and pending litigation that drives OGC's activities. The bulk of the administrative (non-court) litigation involved: (1) Civil Money Penalties (CMPs) and other sanctions imposed on nursing facilities; (2) revocations, terminations or denials of provider status (especially nursing facilities, home health agencies, as well as Community Mental Health Centers (CMHCs) under the Operation Restore Trust CMHC Initiative); (3) Medicare Secondary Payor (MSP) cases; and,

(4) suspensions of Medicare payments to providers and suppliers. The bulk of the court litigation involved MSPs or bankruptcies. The dollars reflected here are not included in the Monetary Results section of this report.

Accomplishments

Within this year's framework of prominent HCFAC themes such as civil and criminal enforcement actions; exclusions from federally sponsored programs; initiatives for preventing health care fraud; administrative penalties for Emergency Medical Treatment and Active Labor Act (EMTALA) violations; and collaborative and outreach efforts, OGC had the following HCFAC accomplishments:

- OGC's HCFA Division worked with OIG to draft a Special Advisory Bulletin to clarify the applicability of the EMTALA to managed care organizations. That Division also assisted HCFA in its efforts to draft a regulation to clarify the scope of EMTALA so that hospitals will know when their obligations under EMTALA begin and end and whether the obligations under EMTALA apply to hospital inpatients. Other EMTALA efforts included a presentation by Region X staff to the Washington State Bar Association on EMTALA requirements.

- Region V staff assisted in successfully defending against federal district court and bankruptcy court suits seeking to enjoin recoupment of overpayments from a home health agency in Indiana ($5 million) and from a nursing facility ($1 million).

- Region VI's collaborative and outreach efforts are plentiful and significant: for example, in ongoing collaborative efforts with HCFA, the Texas Department of Human Services and the Texas Attorney General's Office, an action plan to preserve patient health and safety when nursing home chains become insolvent or file for bankruptcy was coordinated. These efforts arose out of the bankruptcy of a Texas nursing home chain where issues of fraud, suspension of payments, patient safety and bankruptcy were all present. As a result, this model will be used in similar OGC efforts in the future.

- Region VI also was successful in protecting HCFA's interests when a nursing home chain in Texas (90 facilities) filed for bankruptcy. Through the efforts of Region VI's staff, HCFA was able to recoup a $3 million cost report overpayment over a 12-month period. Additionally, they were able to arrange for continued repayment of a $885.9 thousand settlement of 29 civil monetary penalty cases.

- OGC's Region III and Region X offices collaborated with efforts to sustain denial of $4.8 million in payments to a Medicare supplier, headquartered in Pennsylvania, of orthotics and lymphedema pumps. The supplier filed for bankruptcy protection which most likely would have resulted in HCFA (as an unsecured creditor) receiving pennies on the dollars for its claims. However, OGC was able to convince the unsecured creditors' committee that the debtor's claims were fraudulent, and that the appeal of the denial of claims would be fruitless. Medicare was able to retain the $4.8 million as a result of

these offices' efforts.

Administration on Aging

In 1999, the Administration on Aging (AoA) was allocated $1.4 million in HCFAC funds to train and educate both paid and volunteer aging network staff to recognize and report potential practices and patterns of fraud, waste, and abuse in the Medicare and Medicaid programs. These activities were focused on training nursing home ombudsmen, health insurance counselors, state and area agency on aging staff, senior center directors, social workers, eldercare information specialists, and other professionals in 18 states how to identify and report potentially fraudulent practices.

This funding also helped to support the technical assistance and nationwide infrastructure for educating beneficiaries to be the "eyes and ears" of the Medicare system. The AoA and its network agencies engaged in coordinated outreach and educational activities designed to assist older persons and their families to recognize and report fraudulent and abusive situations and to prevent or minimize victimization of such behavior.

Accomplishments

- The 18 grantees trained more than 10,000 staff and volunteers to be Medicare resources and educators in their communities.

- With the collaboration and assistance of HCFA, the HHS/OIG, health care providers, and other professionals from around the country, the projects developed more than 150 community-based training manuals, educational brochures, and public information documents designed to recruit volunteers, involve providers in the campaign, and inform beneficiaries of what they should do if they have questions regarding their Explanation of Medicare Benefits Statement or Medicare Summary Notice. Educational materials were developed in a variety of languages, and outreach initiatives were targeted to high-risk populations. The AoA entered into a contract to develop culturally sensitive videos and brochures targeted to the African American, Hispanic, and Chinese communities.

- The AoA grantees convened more than 1,500 community education events which educated and informed over 200,000 individuals through public forums and education and training sessions to identify and report health care waste, fraud, and abuse. Special initiatives were undertaken to include local health care providers in these activities. Two examples of these efforts include the assistance of physicians in developing a personal health care journal that beneficiaries can use to record the services they receive during a doctor or hospital visit, and a collaboration with hospitals in developing and distributing an informational brochure on waste, fraud, and abuse that individuals receive when they are discharged from the hospital.

- With the assistance of the HHS/OIG and HCFA, the grantees developed and tested

telephone screening systems and tracking mechanisms designed to trace the outcomes of inquiries made by beneficiaries. Of the more than 9,800 calls concerning potential cases of health care fraud, waste, and abuse which were screened by the projects, approximately half were referred to Medicare carriers, intermediaries, or regional durable medical equipment carriers for follow-up, thirty percent were referred to providers, and one-fifth were referred to the HHS/OIG Hotline, State Medicaid Fraud Control Units, State Attorney General's Offices, or other fraud and abuse agencies.

HCFAC funding also provided vital technical assistance to support AoA's Senior Medicare Patrol Projects which have been highly successful in recruiting and training retired professionals to report waste, fraud, and abuse.

Departmental Appeals Board

The Secretary delegated to the Departmental Appeals Board (DAB) responsibility for conducting hearings and reviewing appeals in administrative sanction cases initiated by the HHS/OIG. The HHS/OIG administrative sanction cases may result in exclusion from participation in Medicare and State health care programs imposed under sections 1128 and 1156 of the Social Security Act, and imposition of CMP pursuant to section 1128A of the Act. Another substantial category of HHS/OIG administrative sanction cases involve violation of the Patient Anti-Dumping Statute, section 1867 of the Social Security Act. With enhanced HHS/OIG resources resulting from HIPAA, the HHS/OIG has processed an ever-increasing number of administrative sanction cases.

The DAB Civil Remedies Division received $138,000 in 1999 in HCFAC funds. These funds supported the work involved in issuing 33 decisions, dismissing 73 cases, and closing 106 cases in 1999. All of these cases were generated by the HHS/OIG.

FUNDING FOR DEPARTMENT OF JUSTICE

United States Attorneys

Health care fraud involves a variety of schemes that defraud public and private insurers and providers nationwide. In addition to Medicare and Medicaid, a number of federally funded health benefit programs have been the targets of these schemes. The fraudulent activity may include double billing schemes, kickbacks, billing for unnecessary or unperformed tests, or may be related to the quality of care provided to patients. In addition to monetary losses, in some instances these improper activities endanger patient safety. United States Attorneys' offices (USAOs) are responsible for civilly and criminally prosecuting health care professionals, providers, and other specialized business entities who engage in health care fraud and abuse.

USAOs continue to strengthen cooperative efforts with federal, state and local law enforcement agencies involved in the prevention, evaluation, detection, and investigation of health care fraud and abuse. In addition to the FBI, HHS/OIG and HCFA, USAOs offices work with State Medicaid Fraud Control Units, Offices of Inspectors General for a number of federal agencies, the Drug Enforcement Administration, and the Department of Defense Criminal Investigative Service and TRICARE Support Office. Each USAO has appointed both a civil and criminal health care fraud coordinator to assist in coordination and facilitate communication between federal, state and local law enforcement groups.

Over the past year, USAOs have diligently worked to enhance provider understanding of the Department's enforcement responsibilities and efforts. A number of outreach presentations have been made to health care professionals, provider organizations, and beneficiary groups around the country in this regard.

Prior to the enactment of HIPAA, USAOs dedicated substantial resources to combating health care fraud and abuse. HIPAA allocations have supplemented these efforts.

Training

The Executive Office for the United States Attorneys' Office of Legal Education (OLE) is tasked with the responsibility for providing health care fraud training for USAO and DOJ attorneys, investigators, and auditors. During 1999, OLE conducted a number of courses and presentations on health care fraud, including:

- Affirmative Enforcement for Investigators (including a health care fraud training component)
- Civil Health Care Fraud for Attorneys
- Criminal Health Care Fraud for Attorneys

- Basic Health Care Fraud for Attorneys - Criminal and Civil
- Basic Affirmative Civil Enforcement for Attorneys (includes a health care fraud component)

While the primary participants in OLE sponsored courses were DOJ employees, agency counsel and investigative personnel were also invited to participate as presenters and students. In addition to OLE sponsored training a number of USAO attorneys, auditors and investigators participated in multi-agency health care fraud training courses over the last year.

Accomplishments - Criminal Prosecutions

The primary objective of criminal prosecution efforts is to ensure the integrity of our nation's health care programs and to punish and deter those who, through their improper activities, adversely affect the health care system and the taxpayers.

Each time a criminal case is referred to a USAO from the FBI, HHS/OIG, or other law enforcement agency, it is opened as a matter pending in the district. A referral remains a matter until an indictment or information is filed or the case is declined for prosecution. In 1999, the USAOs had 1,994 criminal matters pending involving 3,158 defendants, a 6.9 percent increase in the number of criminal matters over 1998. During 1999, 371 cases were filed involving 506 defendants. This represents a 16.3 percent increase over cases filed in 1998. A total of 396 defendants were convicted for health care fraud-related crimes in 1999. Health care fraud convictions include both guilty pleas and guilty verdicts.

In one case, 20 individuals were convicted for their involvement in a massive and sophisticated scheme to defraud Medicare. The convictions arose from an almost five-year investigation (conducted by HHS/OIG, FBI, the Internal Revenue Service, and the Department of Labor) of a home health agency, which from 1991 to 1994 was the largest Medicare-certified home health agency in Miami. During that time, the home health agency was paid approximately $120 million by Medicare for reimbursement of services, including nursing and home health aide visits, which either had not been provided, were not necessary, or were provided to persons who were not eligible. In some cases, Medicare was billed for services provided to persons who were already deceased when the billed services were supposedly rendered. The two highest level home health agency administrators admitted to illegal hidden partnerships in literally hundreds of subcontractor groups and the conspirators' involvement in hundreds of thousands of dollars in illegal payoffs to everyone from "professional beneficiaries" to home health aids, nurses and doctors. The convicted defendants, in what eventually became two separate federal court cases, arising from two separate series of indictments, received sentences ranging from 18 months imprisonment to, in the case of the highest level administrator, 12 years imprisonment. A single defendant returned $1.1 million in fraudulently obtained assets.

Accomplishments - Civil Cases

Civil health care fraud efforts constitute a major focus of Affirmative Civil Enforcement (ACE) activities. The ACE Program helps ensure that federal laws are obeyed and that violators provide compensation to the government for losses and damages they cause. Civil health care fraud matters ordinarily involve the United States utilizing the False Claims Act, as well as common law fraud remedies, payment by mistake, unjust enrichment and conversion to recover damages from those who have submitted false or improper claims to the United States.

Each time a civil referral is made to a USAO it is opened as a matter pending in the district. Civil health care fraud matters are referred directly from federal or state investigative agencies, or result from filings by private persons known as "relators," who file suits on behalf of the Federal Government under the 1986 *qui tam* amendments to the False Claims Act. Relators may be entitled to share in the recoveries resulting from these lawsuits. At the end of 1999, the USAOs had 2,278 civil health care fraud matters pending. A matter becomes a case when the United States files a civil complaint, or intervenes in a *qui tam* action, in United States District Court. The vast majority of civil health care fraud cases and matters are settled without a complaint ever being filed. In 1999, 91 civil health care fraud cases were filed.

A multimillion dollar settlement was reached with one of the largest home health care companies in Texas, which agreed to pay the Government $10 million to resolve allegations involving its subsidiary, a provider of home health care and infusion therapy services. Allegedly, the subsidiary improperly charged Medicare for unallowable costs including salaries, travel, and legal fees. In addition, the subsidiary allegedly conspired with and caused skilled nursing facilities to overcharge Medicare for infusion therapy drugs, supplies, and nursing services. As part of the settlement, the subsidiary also entered into a comprehensive corporate integrity agreement with HHS/OIG.

Civil Division

Civil Division attorneys vigorously pursue civil remedies in health care fraud matters, working closely with the USAOs, the FBI, the Inspectors General of HHS and Defense, as well as other federal and state law enforcement agencies. Cases involve health care providers, carriers and fiscal intermediaries that defraud Medicare, Medicaid and other federal health care programs.

The Department's Nursing Home Initiative, launched in October 1998 to crack down on fraud, abuse and neglect in nursing homes and other residential care facilities, is coordinated by a Civil Division attorney, and focuses on eight key areas: (1) stepped up enforcement; (2) improved coordination among federal agencies and among federal, state and local law enforcement, regulatory agencies and resident advocates; (3) development and use of data systems to target facilities that provide inadequate care; (4) focused training, particularly training that brings together prosecutors, investigators, regulators, surveyors, advocates and others;(5) outreach efforts to industry to promote compliance and to patient advocates, medical professionals and academics; (6) new legislation to address gaps in federal law; (7) improved services to victims of fraud, abuse and neglect; and (8) analysis of state laws to identify effective or promising state abuse and neglect statutes and enforcement practices. This Initiative complements the efforts

being undertaken at HCFA and HHS/OIG, communication and coordination are facilitated by monthly Steering Committee meetings attended by the Criminal Division, FBI, HHS/OIG, and HCFA.

The financial crisis in the nursing home industry has to date resulted in bankruptcy filings by two of the ten largest nursing home chains and several smaller chains. These bankruptcy cases, the largest ever involving health care providers, raise both financial and quality of care issues, and require significant on-going coordination between the Civil Division's Corporate Finance (bankruptcy experts) and Civil Fraud sections, the Criminal Division, HCFA, and HHS/OIG.

The Civil Division continues to chair the Managed Care Fraud Working Group, which meets quarterly and coordinates the managed care enforcement activities of DOJ, FBI, HHS/OIG, HCFA, TRICARE Management activity of the Department of Defense, Office of Personnel Management Office of Inspector General, The National Association of Attorneys General, the National Association of Medicaid Fraud Control Units, and the Internal Revenue Service.

Accomplishments

In 1999, 182 new health care fraud matters were initiated. In addition to pursuing more health care fraud allegations, the Civil Division is pursuing an increasing number of health care fraud cases in which the apparent single damages are particularly high. Following is a discussion of some of the significant cases the Division has been involved in during 1999.

A $32 million payment was received from a university — the largest recovery ever in a case involving either the Food and Drug Administration or the National Institutes of Health (NIH). The case established favorable new case law and its settlement resolved allegations that, for more than two decades, the University had illegally profited from selling an unlicensed drug, failed to report the sales income to NIH, improperly tested the drug on patients and improperly used grant funds.

The Civil Division, in conjunction with 39 USAOs, is handling a *qui tam* action alleging that 100 hospitals located nationwide upcoded pneumonia diagnosis codes to falsely obtain higher Medicare reimbursements. Thus far, settlements have been reached with eight defendants for a total recovery of $15.4 million.

A $15 million settlement resolved a case against a billing service and its physician founder, for submitting false claims on behalf of emergency physicians around the country. The settlement with the United States and twenty-eight states was reached after a trial on liability in which the court found both the company and the owner liable for violating the False Claims Act. In addition to the civil settlement, the owner was excluded from participation in all federal health care programs for fifteen years.

A drugstore chain paid nearly $8 million to settle allegations of submitting false prescription claims to state Medicaid and other federally-funded health programs. The case was the first to address a common practice of billing insurance programs for the full amount of prescriptions which were only partially filled.

Vital resources were made available from the Account to provide the Civil Division with Automated Litigation Support (ALS), auditors and consultants. These resources supplemented other Civil Division funds. During 1999, ALS was provided to 14 cases while auditor/consultant support was provided to 21 cases. Four of the supported cases have settled, yielding more than $44 million. Recoveries in the remaining cases are expected to reach hundreds of millions of dollars.

Criminal Division

The Fraud Section of the Criminal Division develops and implements white collar crime policy and provides support to the Criminal Division, DOJ and other federal agencies on white collar crime issues. The Fraud Section supports the USAOs with legal and investigative guidance and, in certain instances, provides trial attorneys to prosecute criminal fraud cases. For several years, a major focus of Fraud Section personnel and resources has been to investigate and prosecute fraud involving federal health care programs.

The Fraud Section has provided guidance to FBI agents, AUSAs and Criminal Division attorneys on criminal, civil and administrative tools to combat health care fraud, and worked on an inter-agency level through:

- providing frequent advice and written materials on confidentiality and disclosure issues arising in the course of investigations and legal proceedings regarding medical records.

- reviewing and commenting on numerous requests for advisory opinions submitted by health care providers to the HHS/OIG and consulting with the HHS/OIG on draft advisory opinions per the requirements of HIPAA.

- sponsoring a national Nursing Home Fraud and Abuse conference to address the problems of financial fraud and resident abuse and neglect. The conference brought together key officials from DOJ, USAOs, HHS/OIG, HCFA, and other federal, state, and local agencies, to develop a plan of action for combating fraud, abuse, and neglect in nursing homes across the nation. The national conference helped lead to the development of DOJ's Nursing Home Initiative and the development of regional nursing home training conferences that will be held in Los Angeles, Philadelphia, and Des Moines.

- preparing and distributing to all USAOs and FBI field offices a quarterly electronic newsletter summarizing recent developments on major issues, interagency initiatives, and significant activities of DOJ's health care fraud component organizations as well as periodic electronic newsletters summarizing recent cases.

- participating on interagency working groups and task forces formed to address fraud in health care and managed care as well as newly emerging problem areas involving illicit online sales of drugs and medical products and nursing home fraud and resident abuse.

Justice Management Division

The Justice Management Division, Debt Collection Management Staff continues to perform for the program various administrative and coordination duties. The duties of this office include: budget formulation, oversight and coordinating with the Office of Management and Budget and HCFA; development and data collection for the internal program evaluation; coordinating with HHS/OIG and the Department of the Treasury on the tracking of collections; coordinating with the GAO on required audits; and preparation and coordination of the annual report.

APPENDIX

Federal Bureau of Investigation Mandatory Funding

"There are hereby appropriated from the general fund of the United States Treasury, and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation-- (I) for fiscal year 1999, $66,000,000".

Successful health care fraud enforcement cannot be achieved by any one agency alone. Investigations must be a cooperative effort if they are to be successful in combating the increasing problems of health care fraud. The FBI is involved in this cooperative effort. The FBI works many health care fraud cases on a joint basis with other federal agencies, including the HHS/OIG. These two federal agencies collaborate through attendance at health care fraud working groups, attend each other's training conferences, and have a liaison program between the two organizations. In addition, the Health Care Fraud task forces represent the coordinated efforts of the FBI, state and local law enforcement, investigative agencies such as Inspectors General, and private industry. The FBI and HHS/OIG share a common commitment to ending fragmented health care fraud enforcement.

In addition to providing new statutory tools to combat health care fraud, HIPAA specified mandatory funding to the FBI for health care fraud enforcement. In 1999, $66 million was provided by HIPAA for 651 positions (380 agents). The FBI used this funding, in large part, to fund an additional 40 agents and 42 support positions for health care fraud and to create several new dedicated Health Care Fraud Squads. This increase in personnel resources along with the direct FBI funding increased the number of FBI agents addressing health care fraud in the fourth quarter of 1999 to approximately 493 agents as compared to 112 in 1992.

As the FBI has increased the number of agents assigned to health care fraud investigations, the caseload has increased dramatically from 591 cases in 1992, to 3,027 cases through 1999. The FBI caseload is divided between those health plans receiving government funds and those that are privately funded. Criminal health care fraud convictions resulting from FBI investigations have risen from 116 in 1992, to 548 in 1999.

Health care fraud investigations are among those investigations having the highest priority within the FBI. The investigations are generally complex and require specific knowledge, skills and abilities to successfully investigate. Often sophisticated, innovative and creative ideas are needed to combat and eventually prosecute the perpetrators of these crimes. As the complexity

and long-term nature of health care fraud investigations increase, the FBI anticipates that the number of FBI investigations and convictions will begin to level off.

As part of the FBI's national strategy to address health care fraud, the Bureau utilizes proactive investigative techniques, to include the use of undercover operations. A major FBI led undercover investigation culminated in 1999 with the last of over 40 subjects either entering guilty pleas or being found guilty at trial as a result of their participation in a fraud scheme that robbed the Medicare Program of millions of dollars. During this investigation the FBI actually purchased a bogus home health agency and through various business dealings with the subjects uncovered a system rampant with fraud from top to bottom.

A considerable portion of the increased funding was utilized to support major health care fraud investigations. In addition, operational support has been provided for FBI national initiatives focusing on pharmaceutical diversion, chiropractic fraud, and medical clinics. Further, the Health Care Fraud Unit, FBI Headquarters, supported individual field offices with equipment and supplies to assist in numerous individual investigations.

The funding made available through HIPAA also made possible two Basic Health Care Fraud training conferences which provided the expertise necessary for an additional 200 FBI agents to address the health care fraud crime problem. A total of 82 additional FBI agents received specialized training on fraud schemes plaguing a particular provider service that has been historically vulnerable to fraud. The HIPAA funding also allowed FBI headquarters staff to conduct specialized training sessions in a number of FBI field offices and to make numerous presentations to various industry groups.

GLOSSARY

The Account - The Health Care Fraud and Abuse Control Account

ACE - Affirmative Civil Enforcement

ALS - Automated Litigation Support

AoA - Administration on Aging

AUSA - Assistant United States Attorney

CMHC - Community Mental Health Centers

CMP - Civil Monetary Penalty

DOJ - The Department of Justice

EMTALA - Emergency Medical Treatment and Active Labor Act

ESRD - End-stage Renal Disease

FBI - Federal Bureau of Investigation

GAO - General Accounting Office

HCFA - Health Care Financing Administration

HHS - The Department of Health and Human Services

HIPAA, or the Act - The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191

HIPDB - Healthcare Integrity and Protection Data Bank

HRSA - Health Resources and Services Administration

MSP - Medicare Secondary Payer

NIH - National Institutes of Health

OGC - The Department of Health and Human Services, Office of the General Counsel

OIG - The Department of Health and Human Services, Office of Inspector General

OLE - Office of Legal Education, located within the Executive Office for the United States Attorneys

PPS - Prospective Payment System

The Program - The Health Care Fraud and Abuse Control Program

Secretary - The Secretary of the Department of Health and Human Services

USAO - United States Attorney's Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of the Secretary
Washington, D.C. 20201

JAN 21 2000

The Honorable John E. Porter
Chairman
Subcommitttee on Labor, Health and
Human Services and Education
Committee on Appropriations
House of Representative
Washington, D.C. 20515

Dear Mr. Chairman:

I am pleased to transmit a report as requested in House Report 104-659, page 102 and House Report 105-635, page 115. This report is entitled "Medicare Integrity Program."

Sincerely,

John J. Callahan
Assistant Secretary for
Management and Budget

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Admi

Office of the Administrator
Washington, D.C. 20201

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Medicare Integrity Program

Nancy-Ann Min DeParle
Administrator, HCFA

January 2000

Introduction

In House Report 104-659, page 102, the Committee requested that the Health Care Financing Administration (HCFA) submit semiannual reports on the deficit reduction impact of the Medicare Integrity Program (MIP) of HR 3103, later enacted as Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The Committee requested the Health Care Financing Administration (HCFA) to provide separate information on the savings achieved under the assumed funding base. The committee is particularly interested in:

1. The actual revenues to the Federal Government as a result of recoveries, increased secondary payer collections, and audit reviews of providers (postpayment safeguard activities); and

2. The actual value of claims paid during the previous 6-month period and the estimated value of claims denied during the reporting period as a result of prepayment safeguard activities.

The requirement for this report was again included in House Report 105-635, page 115.

Current Activities

This semiannual report reflects the results of HCFA's Medicare activities under HIPAA for the 6-month period ending March 31, 1999. It does not include savings to the Medicaid program. Overall MIP savings totaled $4 billion for the first 6 months of FY 1999. This is an increase of $0.8 billion or 25% from savings reported for the first 6 months of FY 1998. A summary of the savings information contained in this report is shown below.

Dollars in Billions*

	6-mo FY96	FY 1997		FY 1998		6-mo FY99
ACTIVITY	**4/1/96 - 9/30/96**	**10/1/96 – 3/31/97**	**4/1/97 - 9/30/97**	**10/1/97 - 3/31/98**	**4/1/98 - 09/30/98**	**10/1/98 - 3/31/99**
Postpayment	$2.2	$1.3	$2.3	$ 0.9	$2.6	$1.4
Prepayment	$1.7	$1.9	$2.3	$ 2.3	$2.7	$2.6
Total Savings	$3.9	$3.2	$4.6	$3.2	$5.3	$4.0
Value of Paid Claims	$88.2	$89.3	$92.2	$ 89.9	$88.2	$ 84.6

Postpayment Activities - Recoveries for the 6-month period ending March 31, 1999, equaled $1.4 billion. This is an increase of approximately $0.5 billion when compared to savings from the first 6 months of FY 1998, but a decrease of $1.2 billion when compared to savings from the last 6 months of FY 1998. This fluctuation in postpayment savings is almost entirely attributable to changes in provider audit savings. As mentioned in our previous semiannual reports, savings from provider audits are not evenly distributed throughout the fiscal year. In fact, the majority of provider audit savings are generated during the second half of each fiscal year.

Postpayment audit activities recorded $0.5 billion in savings for the first half of FY 1999. In addition to these fee-for service audit savings, during the first half of FY 1999 HMO audit reported savings of $47 million, medical review reported savings of $17 million, and MSP reported savings of $866 million.

Prepayment Activities - The value of claims paid during the reporting period ending March 31, 1999, equaled $84.6 billion. The $84.6 billion figure represents the actual outlays, as confirmed by the Office of the Actuary and the Treasury Department income statement, for the first 6 months of fiscal year 1999. The value of claims denied during the reporting period as a result of prepayment safeguard activities were $2.6 billion. This figure reflects adjustment for any claims reversed on appeal during the period in which savings are calculated.

HCFA continues to pursue strategies that shift emphasis from postpayment recoveries to prepayment activities designed to ensure claims are paid correctly. The $2.6 billion savings is an increase of approximately $0.3 billion when compared to savings from the first 6 months of FY 1998, but a decrease of $0.1 billion when compared to savings from the last 6 months of FY 1998.

We hope the above information is useful. If we may be of further assistance, please contact me or have your staff contact Penny Thompson, Director, Program Integrity Group. Ms. Thompson may be reached on (410) 786-5704.

* These data were generated by HCFA's Medicare claims processing contractors. In a recent report, the GAO was critical of Medicare contractors. The FY2001 President's Budget will, therefore, include a contractor oversight initiative to address these concerns.