Date: _____

FAX

Health Division

Office of Management and Budget
Executive Office of the President
Washington, DC 20503

To: DEBORAH
Fax:

From: YVETTE

Number of Pages (excluding cover): 3

Subject: FINAL MIP REPORT

Voice Numbers:

Health Division (Front Office)	202/395-4922
Health & Human Services Branch	202/395-4925
Health Programs & Services Branch	202/395-4926
Health Financing Branch	202/395-4930

Fax Numbers:

Health Division (Front Office)	202/395-3910
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Health Division (Room 7002)	202/395-5648

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

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.

Client Notes

11 / #303m

CRIMINAL AND CIVIL CASES INVOLVING MEDICARE CONTRACTORS

NAME	CHARGE	ADJUDICATION
BC/BS of Florida	Created Physician Orders. Bypassed Computer Edits.	Civil Settlement of $10,000,000 8/4/93
BC/BS of Massachusetts	CPEP Fraud. Inflated number of claims processed.	Civil Settlement of $2,750,000 9/28/94
BC/BS of Michigan	Falsified documents to support its audits.	Civil Settlement of $27,600,000 1/10/95
BC/BS of Michigan	Used Medicare Trust Fund to pay private claims. Medicare as secondary payer issue.	Civil settlement of $24,000,000 1/10/95
BCBS Association on behalf of 66 subcontractors	MSP violations	Civil Settlement of $27 million 1/10/95
BS of California	Falsified documents. Hid ongoing processing errors. Failed to process claims timely Destroyed claims.	Criminal Conviction of corp. and Civil settlement of $12,000,000 4/30/97
BC/BS of Massachusetts (HMO)	Falsified statements on HMO applications.	Civil Settlement $700,000 settlement 9/18/97
Health Care Services Corp. (BC/BS of Illinois)	Altered documents to increase evaluation score. Bypassed computer edits. Destroyed claims. MSP violations	Civil settlement $140,000,000 Criminal convictions - corp. and individuals. 7/16/98 Additional criminal trials pending. Criminal fine for corp. of $4 mil.
Pennsylvania BS (Highmark)	MSP and CPEP fraud issues	Civil Settlement of $38,500,000 8/14/98

BC/BS of Mass.	**MSP violations**	**Civil Settlement of $4.75 million 1/18/99**
Rocky Mountain Hospital and Medical Services	**falsifying CPEP data and audit findings**	**Criminal plea to four felony counts Of obstructing a federal audit; Civil Settlement of $12 million; 7/28/99**

The President's Plan to Preserve Medicare

and

An Analysis of the Alternatives

Report Prepared by
U.S. Senate Budget Committee Democratic Staff
Frank R. Lautenberg, Ranking Member

February 25, 1999

Introduction

As our population ages, financing retirement and health care expenses for older Americans is among our greatest challenges. The rising costs of Social Security and Medicare in the next century is perhaps the greatest threat to our long-term fiscal solvency. The President has proposal a plan to meet those challenges.

The President's plan would reserve 77 percent of the budget surplus to preserve Social Security and strengthen Medicare. Over the next 15 years, 62 percent of the projected budget surplus — more than $2.7 trillion — would be transferred to the Social Security Trust Fund, and 15 percent of the surplus — $686 billion — would be reserved for Medicare's Hospital Insurance (HI) Trust Fund. *These transfers would extend the solvency of the Social Security trust fund through 2049, and the solvency of the Medicare Trust Fund through 2020.* The President expressed his willingness to work with the Congress to identify further changes that would extend the life of both Trust Funds through the retirement of the babyboom generation..

Republicans proposals reserve a portion of the surplus for Social Security but use all remaining amounts for tax cuts. Not a single penny of the projected $4.9 trillion surplus is reserved for the Medicare program. The $686 billion allocated to Medicare in the President's plan would be used instead to pay for an across-the-board tax cut, totaling $1.5 trillion over 15 years. These Republican tax cuts would benefit the highest-income taxpayers while providing little or no tax relief to seniors and other moderate-income Americans. The average tax cut for the lowest-income taxpayers — those with incomes below $38,000 — would be just $99. By contrast, taxpayers in the top 10 percent of income distribution would enjoy an average tax cut of nearly $4,000 a year.

By choosing tax cuts over Medicare (again), Republicans will be forced to rely on sharp cuts in spending or painful revenue increases to sustain the HI Trust Fund through 2020. Over ten years, the Republicans will be forced to save at least $349 billion through these reforms — on top of the $394 billion in savings enacted for a similar period in the Balanced Budget Act for 1997. Savings of this magnitude could result in the following:

- Beneficiary contributions that double by 2009;
- Provider payments reduced across-the-board by 18 percent beginning in 2000;
- A payroll tax increases of 38 percent, beginning in 2000.

This report will describe the President's plan to preserve Medicare and explain the spending cuts and revenue increases that would be required to extend Trust Fund solvency in the Republican's plan. In the coming months, the American people will have an opportunity to choose between the President's budget and the Republican proposals. We hope that this report will help Congress and the public make informed judgements about these competing approaches.

The President's Proposal to Strengthen Medicare

The President wants to ensure that the projected budget surplus is preserved for the benefit of all Americans. To help accomplish this goal, he has proposed to reserve 15 percent of the surplus, or $686 billion, to extend the life of Medicare's Hospital Insurance (HI) Trust Fund from 2008 to 2020. The transferred funds cannot be used for any other purpose, guaranteeing that the money will reduce debt in the short term and will help older and disabled Americans meet their long-term health needs. Table 1 shows the amounts of the transfer over the next 15 years.

Table 1: The President's Transfer to the Medicare Trust Fund ($ billions)

	2000	2001	2002	2003	2004	2005-09	2000-09	2000-14
Transfer	18	20	28	27	30	226	349	686

- *This proposal is necessary because like Social Security, Medicare will be impacted by the retirement of the baby boom generation.* Total enrollment is expected to double from 39 million in 1999 to 78 million in 2032. Compounding these demographic changes, are escalating health care costs due to changing disease patterns, technological advances, and a high value placed on health. As a result, the HI trust fund is projected to become insolvent in 2008, just as the baby boom generation begins to retire.

- *The surplus is the fairest and most appropriate source of new revenue for Medicare*, since it was created largely by the people who soon will become Medicare beneficiaries — the baby boom generation, and those nearing retirement

- *These budget surplus dollars do not preclude larger-scale changes to the program.* However, proposals aimed at restructuring the Medicare program generally take many years to fully implement. Since these reforms are largely untested, they offer no real guarantee that they will slow the growth of Medicare spending and in the short term, none of the current proposals address the nearer term insolvency issue. The staff of the Bi-partisan Commission on the Future of Medicare found that a proposal to transfer Medicare to a premium support program "would not significantly extend the insolvency date of the Part A trust fund."

- The President's plan buys time to evaluate the implications of restructuring proposals on beneficiaries and providers and to phase in reform gradually, reducing the need for arbitrary cuts in providers, higher premium costs, or a payroll tax increase.

What are the Alternatives to the President's Plan?

If the President' plan is rejected in exchange for a tax cut that consumes the entire on-budget surplus, extending Trust Fund solvency through 2020 would require sharp reductions in HI spending or increased revenues. These options are described in more detail in this report, using data from the Office of the Actuary of the Health Care Financing Administration (HCFA), and estimates from the Congressional Budget Office (CBO). The analysis considers the potential impact of these alternatives on health care providers, beneficiaries, and working Americans.

Table 2: Extending HI Trust Fund Solvency through 2020: The Alternatives

The President's Plan	Alternatives
▸ Transfer $686 billion of surplus to HI trust fund over next 15 years	▸ Increase beneficiary contributions by $686 billion over 15 years, or ▸ Cut Medicare provider payments and services by $686 billion, or ▸ Increase Medicare payroll tax to 3.46 percent beginning in FY 2000

Methodology

There are a number of ways to estimate the size and nature of spending reductions and revenue increases that would required to achieve HI Trust Fund solvency through 2020. The analysis in this report relies on the following assumptions and estimates.

- *Beneficiary contributions.* The beneficiary contributions were derived by dividing the Medicare transfer in each year by the projected number of Medicare beneficiaries.

- *Reductions in spending growth:* The HCFA actuaries produced an estimate of the reduction in per beneficiary HI spending growth necessary to extend the solvency of Medicare's Hospital Insurance Trust Fund through 2020. Based on their estimates, per beneficiary growth is frozen at 2.8 percent a year, starting in 2000. Aggregate HI spending growth would decline by 1.3 percent each year from current law levels.

- *Reductions in provider payments.* Cuts in provider payments were derived by simply allocating the transfer in each year to Part A providers in the form of spending reductions on a pro-rata basis.

- *Payroll tax increase.* Estimates of the payroll tax increase required to extend Trust Fund solvency through 2020 were provided by the HCFA actuaries.

Beneficiary Contributions Required to Extend Solvency to 2020

One option for increasing revenues into the HI Trust Fund is to require every beneficiary to contribute an amount, that in the aggregate, are equivalent to the President's $686 billion general fund transfer. Table 3 shows the additional amounts beneficiaries would have to pay under this scenario in 2000, 2009, and over the next 10 years.

Table 3: Medicare Premium Increase Required for Solvency through 2020 (in dollars)

	2000 Monthly	2000 Annual	2009 Annual	2000-09 Annual
New contributions	38.07	456.85	1,236.20	8,206.26
Current SMI premium	50.60	607.20	1,262.40	9,219.40
Total	**88.67**	**1064.05**	**2,498.60**	**17,425.86**

- In order to extend the fund to 2020, each beneficiary would be required to pay an additional $38 per month in the year 2000.
- On an annual basis, these contributions would rise from $457 in 2000 to $1,236 in 2009.
- The estimates on the table include current Part B premiums, but do not include other out-of-pocket expenses incurred for the Part A deductible, various co payments and other services not covered by Medicare.
- The Republican alternative, which would give each taxpayer a 10 percent cut, does little to offset the impact of these premium increases on Medicare beneficiaries. The median taxable income of Medicare beneficiaries aged 65 was $14,834 in 1996.[1] Most of the elderly in this income category do not pay taxes, but if they did, their tax cut would be $49 a year compared to an increased contribution of $456.
- Low-income beneficiaries would be [Add section]

[1]Source: Income of the Population 55 or older, 1996, Social Security Adminsitration, Office of Research and Evaluation, and Statistics, April 1998.

Spending Reductions, Provider Cuts, and Program Terminations Required to Extend Solvency to 2020

The HI Trust Fund provides direct funding to providers of inpatient hospital care, skilled nursing facility care (SNF) , home health services, and hospice care. The Trust Fund also provides direct funding to Medicare managed care organizations for the provision of Part A services to their enrollees. This section describes the reductions in spending based on estimates by HCFA actuaries, along with estimates of provider cuts and program changes that would be required to extend Trust Fund solvency through 2020.

Spending Reductions

Medicare payments to Part A providers are projected to grow at an average annual rate of 6.7 percent between 1999 and 2020. By reducing per capital spending to 2.8 percent a year, beginning in 2000 results in an annual decline in overall spending equivalent to 1.3 percent a year. The growth reductions under the scenario are clearly unsustainable:

- Medicare spending growth per-beneficiary would be 60 percent below projected private health insurance spending per-person, now estimated to be 7.3 percent.

- By 2020, per-beneficiary spending would be 40 percent below current law levels for that year and 10 percent below today's level

- Aggregate HI expenditures, now projected to grwoth at an average annual rate of 6.7 percent, would grow at 5.3 percent. By 2020, Part A spending would be nearly 25 percent below current law levels resulting in cuts totaling $163 billion over the first ten years, $417 billion by 2014, and more than $1 trillion over the period, 2000-2020.

Provider Cuts

Provider cuts total $394 over the next ten years, the same dollar amount as the President's transfer. These cuts are just slightly below the levels contained in the in the Balance budget Act (BBA) for all Medicare spending ($394 billion) for an overlapping period (1998-2007).

Applying this cut on a pro-rata basis reduces Part A provider payments by 18 percent over the next 10 years.

- ***Hospital payments*** decline by $188 billion. These cuts would be in addition to the $83 billion in hospital-related savings contained in the BBA of 1997 that the hospitals are just now beginning to absorb. This category includes funding for teaching hospitals for the costs of graduate medical education (GME) and makes disproportionate share payments (DSH)

to hospitals that serve a high percentage of low-income individuals. These programs would also have to be reduced, significantly diminishing the Federal Government's ability to support physician training and to preserve access to medical services for low-income individuals

- ***Payments to Group Plans*** would be cut by $105 billion over 10 years.
- ***Skilled nursing facilities*** would receive $31 billion less over the 10 years. These programs were also reduced in the BBA of 1997 by more than $32 billion over the period 1998-2007.
- ***Home health and hospice expenditures*** would decline by $25 billion over the first 10 years. These programs were cut by nearly $50 billion in the BBA.

The major HI expenditure cuts are shown in Table 4, below.

Table 4: HI Expenditure Cuts Required to Extend Solvency to 2020
(Outlays in $ billions; 2000-2009)

Program	Baseline	Alternative	Reduction	% Change
Hospital inpatient care	1,025	838	-188	18.3%
Group Plans	572	467	-105	18.3%
Skilled Nursing Facilities	170	139	-31	18.3%
Home Health (Part A)	112	91	-20	18.3%
Hospice	29	24	-5	18.3%
TOTAL	**1,908**	**1,559**	**-349**	**18.3%**

Source: CBO program estimates from January, 1998. Estimates for this fiscal year not yet available.

Another way to illustrate the magnitude of the cuts required to achieve solvency is by eliminating certain Part A benefits and services. For example, removing any one of the following services from the Medicare Trust Fund would still not be sufficient to extend the life of the Trust Fund through 2020:

- *All* skilled nursing facilities plus hospice spending, or
- *All* Part A home health spending, or
- *All* indirect medical education, graduate medical education, and disproportionate share hospital spending.

The difficult task of reducing Part A spending in the amounts required to extend solvency to 2020 is illustrated in Table 5, below. The table contains a fairly comprehensive list of the savings options that could be considered for reducing Part A spending. Even this list sums to just $79 billion over 10 years, far below the President's $349 billion transfer for that same time period.

Table 5. Menu of Savings Options for Part A Programs
(Outlay savings for 2000-2009; $ billions)

Budget Options to Reduce Hospital Insurance expenditures	2000-09
1. Reduce Medicare's payments for IME costs	-15.9
2. Reduce Medicare's direct payments for medical education	-10.9
3. Eliminate payments to sole community hospitals	-0.6
4. Increase and extend the reductions in the Medicare PPS market basket	-42.7
5. Reduce Medicare's payments for hospital's inpatient capital-related costs	-3.2
6. Eliminate Medicare's payments to hospitals for enrollees' bad debts	-5.8
Subtotal, options 1/	-79.1
President's Medicare Transfer for 2000-2009	-349.0

1/ These options are not necessarily additive.

Payroll Tax Increase Required to Extend Trust Fund to 2020

The HI Trust fund can be extended through 2020 by increasing the Medicare payroll tax. At present, the tax is 2.9 percent, evenly split between employees and employers (self-employed individuals pay the full 2.9 percent). Without the transfer of the surplus, the Part A payroll tax would have to be increased by 18 percent to 3.46 percent — starting in 2000 — to extend solvency until 2020.

Transferring 15 percent of the surplus into the Part A trust fund protects working Americans and their employers from higher payroll taxes, which is a more regressive form of taxation than other taxes. This point is illustrated on Table 6, which compares the average tax cut under the Republican proposal, with the average payroll tax increase by income category.

- Individuals making less than $10,000 a year would get an average tax cut of $1 and pay $217 in higher payroll taxes.
- The payroll tax increase exceeds the Republican tax cut for all income categories below $100,000.

Table 6: Payroll Tax Increase Compared to Republican Tax Cut (in dollars)

Income Group	Average Tax Cut	Average Payroll Tax Increase	Difference
Less than $10,000	$1	$217	-$216
$10,000 to $19,999	$35	$761	-$726
$20,000 to $29,999	$130	$1,083	-$953
$30,000 to $39,999	$244	$1,192	-$948
$40,000 to $49,999	$383	$1,095	-$712
$50,000 to $75,999	$614	$2,594	-$1,980
$75,000 to $99,999	$994	$1,697	-$703
$100,000 and over	??	$3,629	??

U.S. Department of Justice

Washington, D.C. 20530

Deputy Attorney General Eric Holder Remarks
"Who Pays? You Pay" News Conference
AARP, HHS and DOJ
February 24, 1999

Thank you very much. As the Attorney General said in Washington today, the Department of Justice is pleased to be here with the AARP and our other partners to stress the importance of the involvement of beneficiaries in detecting and punishing fraud in our health care system.

We realize that most providers are honest and are committed to protecting the integrity of the health care system and the patients it serves. But, as you have heard today, the few that are cheating the system are costing us billions.

At the Department of Justice, we will use every available tool to prosecute health care cheats and recover funds that are stolen from the system. Under a law passed by Congress and signed by the President in 1996, the vast majority of the money we recover from health care fraud scams is returned to the Medicare Trust Fund, ensuring that these funds are used for their original purpose – providing essential health services to our nation's elderly and disabled citizens.

The schemes that we prosecute range from blatant ripoffs – like charging for services that are never provided – to sophisticated schemes – such as creating sham medical clinics that, to the untrained eye, may appear to be legitimate businesses. We are even seeing signs that career criminals are getting into the health care fraud business.

How can beneficiaries help us in our fight against fraud and abuse? The first step is looking for fraud, waste and abuse in their bills. Schemes like billing for services never provided or billing for a more expensive service than actually provided are just two examples of things that might alert you to a problem.

By making the phone call to the hotline, you will be taking the first step in the process. From there, the report will be reviewed and, when appropriate, the matter will be referred for prosecution to Justice Department headquarters in Washington, D.C., or to one of our U.S. Attorneys offices around the country.

We are committed to following through when a complaint results in the discovery of wrongdoing-and we are counting on beneficiaries to start the process when they notice something is wrong.

Thank you to everyone who is committed to protecting the Medicare system that 39 million Americans rely upon today and the health care system that all of us deserve to be strong in the future.

WHO PAYS? YOU PAY.
REPORT MEDICARE FRAUD.

Call 1-800-447-8477 to report questionable Medicare charges

News Release

FOR IMMEDIATE RELEASE:
February 24, 1999

CONTACT:
Steve Hahn/AARP
(202) 434-2560
Campbell Gardett/HHS
(202) 690-6343
Chris Watney/DOJ
(202) 514-2007

MEDICARE FRAUD: "WHO PAYS? YOU PAY."
New Campaign Takes Direct Aim at Medicare Fraud, Waste and Abuse

WASHINGTON – In one of the largest public outreach campaigns in the history of Medicare, with the program's largest single-day training event, a new campaign was announced today to help eliminate Medicare fraud, waste and abuse. The "**Who Pays? You Pay.**" campaign involves a unique partnership between AARP, the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Justice (DOJ). It will establish a greater line of defense against a problem that costs taxpayers billions of dollars each year, and change the way people think about and respond to misspent Medicare dollars.

With 39 million beneficiaries and about 900 million claims processed each year, the Medicare program has been vulnerable to unscrupulous individuals and companies. A new AARP survey found that many Americans believe fraud, waste and abuse directly contribute to the rising cost of health care and a lower quality of care.

AARP President Joe Perkins called on beneficiaries to become the front line of defense. "A recent HHS Inspector General's audit shows the government's efforts to crack down against improper Medicare payments is getting results. To do more requires the help of Medicare beneficiaries. The people who use the system are often in the best position to spot problems – and according to new AARP research, are also willing to help."

Almost 90 percent of those who participated in the new AARP consumer survey on health care fraud said they would stand ready to assist, if they only knew how. The partners' campaign will make that easier with a new "Three-Step Plan to Fight Medicare Fraud" brochure, a widely publicized 800 number operated by the HHS Office of the Inspector General (OIG), an award-winning public service announcement, an aggressive information campaign, partnerships

- more -

with the provider community and special training for beneficiaries nationwide. HHS Secretary Donna Shalala, who helped kick off the campaign with a teleconference viewed by thousands of beneficiaries in 31 cities said, "Today we're launching a new kind of partnership – a partnership with millions of beneficiaries. We're asking beneficiaries to be the eyes and ears of the Medicare program."

The campaign asks beneficiaries to regularly review their Medicare statements. A new information brochure published by AARP explains how. "Did I receive the services or products for which Medicare is being billed? Did my doctor order the service or product for me? And, to the best of my judgment, is the service or product necessary given my health condition?"

If the answer to any of these questions is no, the partners emphasized working first with the health care provider or Medicare insurance company. "Oftentimes questionable charges are the result of a clerical error and can be easily resolved," said HHS Inspector General June Gibbs Brown who also helped launch the campaign. "But if there is still some doubt, don't hesitate to call the HHS Inspector General's hotline at **1-800-HHS-TIPS, (1-800-447-8477)**," she said.

The DOJ, FBI and Office of the Inspector General have stepped up efforts to catch and prosecute wrongdoers. The FBI has increased the number of agents working on health-care fraud to 400 this year and will further increase that number in years to come. Attorney General Janet Reno said, "The majority of health-care providers are honest and dedicated to maintaining the integrity of the Medicare system, but there is work to do. The Department of Justice is committed to prosecuting those who abuse the system as well as preventing fraud before it occurs."

The partners advise beneficiaries to protect themselves from fraud by treating their Medicare card like any other credit card and not giving away Medicare numbers in exchange for free goods or services. "You should keep your guard up if people say they can get Medicare to pay for things that aren't covered. Such promises can be scams. You should report them right away," said Nancy Ann DeParle, administrator of the Health Care Financing Administration.

The partners also encouraged beneficiaries to look for common types of errors that may indicate problems such as charges for services never performed, double billing, inappropriate services, low-cost or used equipment billed to Medicare as new equipment and routinely waiving patient coinsurance to name a few.

Also joining the campaign announcement were HHS Assistant Secretary for Aging Jeanette C. Takamura, FBI Assistant Director in Charge of the New York Office Lewis Schiliro and Assistant Attorney General Eric Holder. (see attached quote page).

The **"Who Pays? You Pay."** campaign will be an ongoing effort involving government agencies, beneficiaries, providers and citizens concerned about Medicare fraud, waste and abuse. In addition to today's training, throughout the year, AARP and the Administration on Aging will educate thousands of volunteers across the nation on how to become Medicare fraud fighters.

# # # #

Feb 24 AARP/HHS/DoJ EVENT

Press Conference sites:

Washington, DC
New York
Atlanta
Miami
Chicago

Follow-up training sites:

(All above except Washington DC)
Buffalo
Boston
Philadelphia
Memphis
San Juan, PR
Cleveland
Des Moines
Detroit
Minneapolis
Dallas
New Orleans
Kansas City
Denver
Phoenix
Boise
Medford, OR
Pendleton, OR
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Seattle
Spokane
Los Angeles
Bakersfield
San Diego
Sacramento
Honolulu

TO: DEBORAH

65557

To Deborah

From Melissa

Brand stuff - 4 pages —

note it's 900 million claims a year.

MS

Washington, D.C. 20530

Attorney General Janet Reno Remarks
"Who Pays? You Pay" News Conference
AARP, HHS, DOJ
February 24, 1999

The theme of this campaign -- "Who Pays? You Pay" – captures in a few words the serious problem of health care fraud, particularly in Medicare. Each year, we lose billions of dollars to fraudulent and abusive practices in the health care system. For Medicare, these are dollars that could be better spent on improving and expanding Medicare benefits. And on the private side, it means higher premiums and fewer services. So in a very real sense, when it comes to Medicare fraud, it's beneficiaries and taxpayers who are paying the price.

That's why I have made combating health care fraud one of the top priorities of the Justice Department. Through the 94 U.S. Attorneys' Offices, the Federal Bureau of Investigation, and our law enforcement partners in the Department of Health and Human Services, we are doing more today to crack down on health care fraud than ever before.

Health care cheats should be on notice that we will use every appropriate tool to combat Medicare fraud and abuse. In the past several years, we have doubled the number of criminal convictions against health care cheats and collected more than $1.2 billion in criminal fines and civil cases. This should send a real clear message

that when it comes to health care fraud, it's the criminals who end up paying.

While enforcement and prosecution are important, preventing health care fraud is just as important – and when it comes to prevention, Medicare beneficiaries are the first line of defense. When you visit a doctor, receive a prescription, or stay in the hospital, you know what services you have been provided and, in many cases, are in the best position to identify fraudulent health care scams.

It's also important to realize that a tip you provide may be just the "tip" of the iceberg. When you scrutinize your "explanation of benefits" form, you may discover an error of ten dollars or hundreds of dollars and think it's not worth reporting. But this may be just one example of a widespread pattern of fraud that covers hundreds of patients and costs the Medicare program hundreds of thousands or even millions of dollars each year.

So I want to congratulate the AARP for sponsoring this important campaign to fight health care fraud. And I want to thank the tens of thousands of beneficiaries who are participating in today's fraud-fighting training program.

You are the first line of defense in combating health care fraud, and we are truly grateful for your commitment and dedication to this important task.

U.S. Department of Justice

Associate Deputy Attorney General *Washington, D.C. 20530*

Fax Transmission Cover Sheet

To: **Chris Jennings, Deputy Asst. to the President**

Phone: (202) 456-5560 **Fax: (202) 456-5557**

From: **John T. Bentivoglio**

Phone: **(202) 514-2707**
Fax: **(202) 616-1239**

Date: **January 7,2000**

Number of Pages (including Cover Sheet): **22**

Message:

Per the attached memo.

Note: The information contained in this facsimile should be considered confidential.

U.S. Department of Justice

Office of the Deputy Attorney General

Associate Deputy Attorney General

Washington, D.C. 20530

January 7, 2000

To: Chris Jennings
Deputy Assistant to the President

From: John T. Bentivoglio

Subject: Statistics/Background for Possible Health Care Fraud Event

Per your request, attached are the preliminary statistics on the Department's enforcement efforts in FY 1999. We should have final numbers early next week, although I do not anticipate they will change substantially between now and then. I have also attached excerpts from the FY1998 joint DOJ-HHS report, which provides helpful comparisons.

Summary of Statistics:

- Collections are up 57% - from $296 million in FY 1998 to $466 million in FY 1999.
- Criminal health care fraud matters and defendants are up 4% and 6% respectively between FY 1998 and FY 1999.
- Criminal health care fraud cases filed and defendants charged both are up 15% between FY 1998 and FY 1999.
- The number of defendants convicted of health care fraud crimes increased 21% between FY 1998 and FY 1999.
- **However, the number of civil health care fraud matters decreased significantly** (from 3,471 matters in FY 1998 to 2,278 matters in FY 1999), as did the number of civil health care fraud cases filed (from 107 in FY 1998 to 91 in FY 1999). The decrease in the number of matters is the result of less emphasis on small-dollar cases in the so-called "national initiatives" (the projects that generated the most controversy from hospitals and other health care groups).

Legislative Agenda

If there is an event on these statistics in the near future, I would urge you to include a pitch for the legislative proposals that we submitted last year -- but were never acted upon by the Republican Congress. The message would be that while we have made substantial progress, we are still loosing too many tax dollars to health care fraud and now is not the time to let up on our successful efforts. The proposals include:

- New tools to help investigate and prosecute health care fraud.
- The new statute to providing civil and criminal penalties for egregious cases of abuse and neglect in nursing homes.
- Closing the loophole that allows health care fraud artists to discharge their debts in bankruptcy.

I have enclosed some background material on these legislative proposals (all of these proposals have previously cleared as part of the crime bill).

* * * * *

Please let me know if you need additional information. I will be out of the office on travel with the Attorney General from Saturday, January 8, through Monday, January 10, and returning on Tuesday, January 11. (The Attorney General will not be back until Wednesday, January 12). I will be checking voice mail regularly. If you need to reach me urgently, please page me through the DOJ Command Center at (202) 514-5000.

cc: Mike Hash, HCFA

FISCAL YEAR	MATTERS	DEFENDANTS
1999	1,944	3,158
1998	1,866	2,986
1997	1,517	2,479
1996	1,346	2,151

FISCAL YEAR	CASES	DEFENDANTS
1999	371	506
1998	322	439
1997	282	531
1996	246	450

FISCAL YEAR	CASES	DEFENDANTS
1999	NA	396
1998	219	326
1997	217	363
1996	177	307

FISCAL YEAR	MATTERS
1999	2,278
1998	3,471
1997	4,010
1996	2,488

FISCAL YEAR	CASES
1999	91
1998	107
1997	89
1996	90

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 $466 million in connection with health care fraud cases and matters[1]. 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	0
Civil Monetary Penalties	36,006,432
Amount Equal to Asset Forfeiture *	4,797,073
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 Other Federal Agencies	
Office of Personnel Management	9,286,426
Other	20,201,557
Department of Health and Human Services - Other than HCFA	42,993,069
	72,481,052
Relators' Payments **	**20,463,618**
TOTAL ***	**$466,512,072**

*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.

[1]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.

FY 1998

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 1998, as a result of the combined anti-fraud actions of the federal and state governments and others, the Federal Government collected $296 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 1998	
Department of the Treasury	
HIPAA Deposits to the Medicare Trust Fund	
Gifts and Bequests	$ 3,000
Amount Equal to Criminal Fines	2,503,298
Civil Monetary Penalties	1,855,277
Amount Equal to Asset Forfeiture *	0
Amount Equal to Penalties and Multiple Damages	103,025,990
Health Care Financing Administration	
OIG Audit Disallowances - Recovered	27,998,956
Restitution/Compensatory Damages	144,741,634
	280,128,155
Restitution/Compensatory Damages to Other Federal Agencies	
Department of Defense	7,488,888
Office of Personnel Management	173,866
Other	3,125,418
Department of Health and Human Services - Other than HCFA	1,270,196
	12,058,368
Relators' Payments **	**4,344,610**
TOTAL ***	**$296,531,133**

*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 1998, 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 1998 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 1999.

SUBTITLE D – HEALTH CARE FRAUD AND ABUSE.

SEC. 5031. ATTORNEY GENERAL'S INJUNCTION AUTHORITY.

Section 1128B of the Social Security Act (42 U.S.C. 1320a-7b) is amended by adding at the end the following new subsection:

"(h) If the Attorney General has reason to believe that a person is engaging about to engage in conduct constituting an offense under this section, the Attorney General may petition an appropriate United States District Court for an order prohibiting that person from engaging in such conduct. The court may issue an order prohibiting that person from engaging in such conduct if the court finds that the conduct constitutes such an offense. The filing of a petition under this section does not preclude any other remedy that is available by law to the United States or any other person.".

SEC. 5032. ATTORNEY GENERAL'S AUTHORITY TO SEEK CIVIL PENALTIES.

Section 1128B of the Social Security Act (42 U.S.C. § 1320a-7b), as amended by section 5031 of this Act, is further amended by inserting after subsection (f) the following new subsection:

"(g)(1) The Attorney General may bring an action in the district courts to impose upon any person who carries out any activity in violation of this section with respect to a Federal health care program a civil penalty of $25,000 to $50,000 for each such violation, and damages of three times the total remuneration offered, paid, solicited, or received.

"(2) A violation exists under paragraph (1) if one or more purposes of the remuneration is unlawful, and the damages shall be the full amount of such remuneration.

"(3) The procedures for actions under paragraph (1) with regard to subpoenas, statutes of limitation, standards of proof, and collateral estoppel shall be governed by section 3731 of title 31, United States Code, and the Federal Rules of Civil Procedure shall apply to actions brought under this section.

"(4) This section does not affect the availability of other criminal and civil remedies that may be available for such violations.".

SEC. 5033. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended –

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following new subsection:

"(c) A person who is privy to grand jury information concerning a Federal health care offense, as defined in section 24 of this title –

"(1) received in the course of duty as an attorney for the government; or

"(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the government to use in any investigation or civil proceeding relating to health care fraud or false claims.".

SEC. 5034. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

Subsection (a) of section 3486 of title 18, United States Code, is amended by inserting after "Federal health care offense", ", or any allegation of health care fraud or false claims (whether criminal or civil),".

SEC. 5035. STUDY AND REPORT ON HEALTH CARE FRAUD SENTENCES.

(a) DIRECTIVE TO THE UNITED STATES SENTENCING COMMISSION.----Pursuant to its authority under section 994(p) of title 28, United States Code, and in accordance with this section, the United States Sentencing Commission shall review and, if appropriate, amend its guidelines and its policy statements applicable to persons convicted of health care fraud offenses.

(b) REQUIREMENTS.—In carrying out this section, the Sentencing Commission shall:

(1) ensure that the sentencing guidelines and policy statements reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud;

(2) consider providing increased penalties for persons convicted of health care fraud offenses in appropriate circumstances;

(3) consult with individuals or groups representing health care fraud victims, law enforcement officials, the health care industry, and the Federal judiciary as part of the review described in subsection (a);

(4) assure reasonable consistency with other relevant directives and with other guidelines;

(5) account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the sentencing guidelines currently provide sentencing enhancements;

(6) make any necessary conforming changes to the sentencing guidelines; and

(7) assure that the guidelines adequately meet the purposes of sentencing as set forth in section 3553(a)(2) of title 18, United States Code.

(c) REPORT.—Not later than December 31, 2000, the United States Sentencing Commission shall submit a report to Congress on issues relating to health care fraud. The report shall explain the changes, if any, to sentencing policy made by the Sentencing Commission in response to this section and include any recommendations that the Commission may have for retention or modification of current penalty levels, including statutory penalty levels, for health care fraud offenses.

SEC. 5036. PROVISIONS PROTECTING THE INTERESTS OF FALSE CLAIMS ACT MATTERS IN BANKRUPTCY PROCEEDINGS.

(a) CERTAIN ACTIONS NOT STAYED BY BANKRUPTCY PROCEEDINGS. – The commencement or continuation of an action under sections 3729 through 3733 of title 31, United States Code, shall not be stayed by section 362(a)(1), (a)(2), (a)(3) or (a)(6) or under section 105(a) of title 11, United States Code.

(b) CERTAIN DEBTS NOT DISCHARGEABLE IN BANKRUPTCY. – No debt owed to the United States for violating sections 3729 through 3733 of title 31, United States Code, or under a compromise or other agreement resolving such a debt shall be discharged under title 11, United States Code.

(c) REPAYMENT OF CERTAIN DEBTS CONSIDERED FINAL. – No transfer on account of a debt owed to the United States for violating sections 3729 through 3733 of title 31, United States Code, or under a compromise or other agreement resolving such a debt shall be avoided under section 544, 545, 547, 548, 549, 553(b) or 724(a) of title 11, United States Code.

SEC. 5037. EXTENDING ANTI-FRAUD SAFEGUARDS TO THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.

(a) Section 1128B(f)(1) of the Social Security Act (42 U.S.C. § 1320a-7b(f)(1)) is amended by striking "(other than the health insurance program under chapter 89 of title 5, United States Code)".

SEC. 5038. PREVENTING AND PUNISHING ABUSE AND NEGLECT OF ELDERLY AND OTHER RESIDENTS IN NURSING HOMES AND RESIDENTIAL HEALTH CARE FACILITIES.

(a) SHORT TITLE. – This section may be cited as the "Nursing Home Abuse and Neglect Prevention and Punishment Act of 1999".

(b) PROTECTION OF RESIDENTS IN NURSING HOMES AND OTHER RESIDENTIAL HEALTH CARE FACILITIES. – Chapter 63 of title 18, United States Code, is amended by adding at the end the following new section:

"§ 1348. **Pattern of violations resulting in harm to residents of nursing homes and related facilities.**

"(a) **Offense.**--Whoever engages in a pattern of knowing and willful violations of Federal laws, regulations, or rules, or State laws governing the health, safety, or care of individuals residing in a residential health care facility or facilities that results in significant physical or mental harm to one or more such residents, shall be punished as provided in section 1347, except that any organization shall be fined not more than $2,000,000 per residential health care facility.

"(b) **Civil provisions.**--

"(1) **Civil Penalties.**-- The Attorney General may bring an action in a United States district court to impose on any individual or entity that engages in a pattern of violations of Federal laws, regulations, or rules, or State laws, which violations affect the health, safety, or care of individuals residing in a residential health care facility and where such pattern results in physical or mental harm to one or more such residents, a civil penalty of --

"(A) in the case of an individual (other than an owner, operator, officer or manager of such a residential health care facility) up to $10,000;

"(B) in the case of an individual who is an owner, operator, officer or manager of such a residential health care facility up to $100,000 for each separate facility involved in the pattern of violations under this section; or

"(C) in the case of a residential health care facility up to $1,000,000 for each pattern of violations, and in the case of an entity up to $1,000,000 for each separate

residential health care facility involved in the pattern of violations owned or managed by that entity.

"(2) **Other appropriate relief.**-- If the Attorney General has reason to believe that an individual or entity is engaging in or is about to engage in a pattern of violations of Federal laws, regulations, or rules, or State laws, which violations affect the health, safety, or care of individuals residing in a residential health care facility, and where such pattern results in or has the potential for resulting in physical or mental harm to one or more such residents, the Attorney General may petition an appropriate United States district court for appropriate equitable and declaratory relief to eliminate the pattern.

"(3) **Procedures for this subsection.** —

"(A) A subpoena requiring the attendance of a witness at a trial or hearing conducted under this subsection may be served at any place in the United States.

"(B) An action brought under paragraph (1) of this subsection may not be brought more than 6 years after the date on which the violation of this subsection occurred.

"(C) The United States shall be required to prove all actions under this subsection by a preponderance of the evidence.

"(D) The Civil Investigative Demand procedures set forth in the Antitrust Civil Process Act (15 U.S.C. 1311-14) and regulations promulgated pursuant thereto shall apply to investigations and actions pursued under this subsection.

"(E) The filing or resolution of a matter under this subsection does not preclude any other remedy that is available to the United States or any other person.

"(c) **Prohibition against retaliation.**-- Any person who is the subject of retaliation, either directly or indirectly, for reporting conditions that may constitute a violation of this section shall be authorized to bring an action in an appropriate United States district court for damages, attorneys' fees and other relief.

"(d) **Definitions.**-- For purposes of this section, the following definitions apply:

"(1) 'Residential health care facility' means any facility (including any facility that does not exclusively provide residential health care services) including but not limited to skilled and unskilled nursing facilities and mental health and mental retardation facilities, that receives Federal funds, directly from the Federal government or indirectly from a third party on contract with or receiving a grant or other monies from the Federal government, to provide health care, or that provides health care services in a residential setting and that, in any calendar year in which a violation occurs, is the recipient of benefits or payments in excess of $10,000 from a Federal Health Care Program.

"(2) 'Entity' means any residential health care facility (including facilities that do not exclusively provide residential health care services), any entity that manages a residential health care facility, or any entity that owns, directly or indirectly, a controlling interest or a 50% or greater interest in one or more residential health care facilities, including States, localities and political subdivisions thereof.

"(3) 'Federal Health Care Program' means –

(A) any plan or program that provides health benefits,

whether directly, through insurance, or otherwise, which is funded

directly, in whole or in part, by the United States Government; or

(B) any State health care program, as defined in Section 1128(h) of the Social

Security Act (42 U.S.C. 1320a-7(h)).

"(4) 'Pattern of violations' means multiple violations of a single law, regulation, or rule, or single violations of multiple laws, regulations, or rules, that are widespread, systemic, repeated, similar in nature, or result from a policy or practice.

"(5) 'State' means a state of the United States, the District of Columbia, and any commonwealth, territory, or possession of the United States.".

(c) AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES. -- Section 3486(a)(1) of title 18, United States Code, is amended by inserting after "Federal health care offense", "or act or activity involving section 1350 of this title".

(d) The table of sections for chapter 63 of title 18, United States Code, is amended by adding at the end:

"1348. Pattern of violations resulting in harm to residents of nursing homes and related facilities.".

SUBTITLE D – HEALTH CARE FRAUD AND ABUSE.

SEC. 5031. ATTORNEY GENERAL INJUNCTION AUTHORITY.

Under existing law (18 U.S.C. § 1345(a)(1)(C)), Federal prosecutors are able to obtain injunctive relief in connection with a wide variety of Federal health care offenses. This authority has proven to be extremely valuable in putting a halt to fraudulent behavior. Unfortunately, however, such relief is not available in connection with kickback offenses under section 1128B of the Social Security Act (42 U.S.C. § 1320a-7b) ("Criminal penalties for acts involving Medicare or State health care programs"). This is a serious omission. Because of the large amounts of money involved in these kinds of cases, it is essential that the Attorney General have the authority to enjoin kickback schemes while they are in progress. The draft bill would permit the Attorney General to do so.

SEC. 5032. ATTORNEY GENERAL AUTHORITY TO SEEK CIVIL PENALTIES.

Section 1128B of the Social Security Act (42 U.S.C. § 1320a-7b) establishes criminal penalties for kickback offenses committed against federal health care programs, such as Medicare and CHAMPUS. There is, however, no direct civil penalty applicable to such offenses. As a consequence, an attorney for the government is forced in cases of this nature to do nothing or pursue criminal charges – quite possibly in a case that, while meriting government action, might not be appropriate for criminal prosecution. The proposal would permit the Attorney General to bring civil actions against wrongdoers under the anti-kickback provisions of the Social Security Act. Civil penalties are, particularly important to successful prosecution of health care fraud cases, since the complex business arrangements that are often employed in connection with kickback schemes often make it difficult – or impossible – to demonstrate the necessary scienter needed to sustain a crime.

SEC. 5033. GRAND JURY DISCLOSURE.

Under existing law, an attorney for the government may not, as a general matter, disclose matters that occur before a Federal grand jury. A violation of this non-disclosure requirement (set forth in Rules 6(e) of the Federal Rules of Criminal Procedure) is punishable as contempt of court. An overriding objective of this prohibition is to protect the integrity of criminal investigations by limiting opportunities to intimidate witnesses, destroy documents or otherwise obstruct justice. The prohibition is also important in protecting the rights and reputations of persons who appear before grand juries.

In 1989, Congress created an exception to Rule 6(e) when it enacted 18 U.S.C. § 3322 ("Disclosure of Certain Matters Occurring Before Grand Jury") (enacted as section 964 of the "Financial Institutions Reform, Recovery, and Enforcement Act of 1989," (Pub. L. 101-73). Under 18 U.S.C. § 3322(a), an attorney for the government who is privy to grand jury information involving a criminal violation of the Federal banking laws may disclose that information to another attorney for the government for use in connection with civil actions commenced to enforce the banking laws. In enacting this provision, Congress recognized that, in this important class of cases, in which both criminal and civil actions are routinely brought against wrongdoers, and in which large amounts of money are at stake, the Rule 6(e) restriction on disclosure needlessly complicated investigations in complex financial institution fraud cases.

The draft bill would merely extend the existing Rule 6(e) exception to Federal health care offenses, as defined in 18 U.S.C. § 24. Enactment of this provision would not make available information to civil prosecutors that is not already available to them. Rather, it would simplify information sharing and would enhance the government's ability to investigate wrongdoing. Such a provision would be very important for the effectiveness of our overall health care anti-fraud effort. In particular, by facilitating the sharing of information between criminal investigators and civil prosecutors, this proposal would enable prosecutors to proceed more quickly and efficiently to recover losses to Federal health care programs, such as Medicare, Medicaid, CHAMPUS, and the Federal Employees

Health Benefits Program and to prevent wrongdoers from dissipating illegally obtained assets before appropriate action to recover the government's losses can be taken.

SEC. 5034. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

Under section 248 of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (enacting new 18 U.S.C. § 3486), the Attorney General or her designee is authorized to issue an administrative subpoena in connection with an investigation relating to a "Federal health care offense." Under 18 U.S.C. § 24, a "Federal health care offense" is defined to include only criminal offenses. In civil cases, however, the Department's attorneys must rely on subpoenas issued by the Office of the Inspector General (OIG) of the Department of Health and Human Services (which are issued only to OIG agents assigned to a particular case) or upon civil investigative demands (which must be signed personally by the Attorney General). This constitutes a serious limitation on our ability to investigate civil health care fraud cases in an effective and efficient manner. As a consequence, this provision would make it clear that the Attorney General or her designee (e.g., a duly authorized Assistant United States Attorney) would be permitted to issue an administrative subpoena in connection with any health care fraud case, criminal or civil, thus greatly facilitating our ability to pursue wrongdoers.

SEC. 5035. STUDY AND REPORT ON HEALTH CARE FRAUD SENTENCES.

Section 5035 directs the United States Sentencing Commission to review and possibly amend the sentencing guidelines with respect to health care fraud offenses. The provision requires the Commission to ensure that the guidelines reflect the serious harms associated with such fraud and to consider providing for increased penalties in appropriate circumstances. The Commission's review also must assure that the guidelines assure reasonable consistency and account for any circumstances that might justify departures from the guidelines. The provision also directs the Commission, by December 31, 2000, to submit a report to Congress on any changes to sentencing policy it has made relating to health care fraud, and to include any recommendations with respect to retention or modification of current statutory penalty levels.

SEC. 5036. PROVISIONS PROTECTING THE INTERESTS OF FALSE CLAIMS ACT MATTERS IN BANKRUPTCY PROCEEDINGS.

Certain actions not stayed by bankruptcy proceedings. The commencement or continuation of an action under 31 U.S.C. §§ 3729-3733 shall not be stayed by section 362(a)(1), (a)(2), (a)(3) and (a)(6) or under section 105(a) of Title 11, United States Code.

This subsection serves to codify judicial interpretation of the "police power" exception to the automatic stay provision in the Bankruptcy Code. The Bankruptcy Code's automatic stay provision prevents the commencement, continuation, enforcement or collection of a judicial, administrative, or

other claim against the debtor or the recovery of a prepetition claim against a debtor, regardless of whether the assets involved are property of the debtor's estate. 11 U.S.C. § 362(a). Section 105(a) of Title 11 authorizes a bankruptcy court to fashion orders necessary to further the substantive provisions of the Bankruptcy Code. Those accused of defrauding the government sometimes threaten or commence bankruptcy proceedings in an effort to deter the government from pursuing them further under the False Claims Act, in hopes that the bankruptcy proceeding will somehow derail the government's efforts to recover money taken from it through fraud. However, the Bankruptcy Code exempts from the automatic stay actions by the government that are exercises of the "police" or "regulatory" powers. 11 U.S.C. § 362(b)(4). Although actions under the civil False Claims Act, 31 U.S.C. § 3729 et seq., are not expressly exempted by this provision, it has been held that since the False Claims Act and other fraud-based statutes have a police and regulatory function to deter fraud, actions by the United States under such statutes come within the intended scope of the exemption. See, e.g., In re Commonwealth Companies, Inc., 913 F.2d 518 (8th Cir. 1990). To deter future litigation over this issue, this provision would amend the Bankruptcy Code so that it expressly exempts False Claims Act actions from the automatic stay provision.

Certain Debts not Dischargeable in Bankruptcy. No debt owed to the United States for violating 31 U.S.C. § 3729 et seq. or under a compromise or other agreement resolving such a debt shall be discharged under Title 11, United States Code.

The general rule is that all monetary claims against an individual are "discharged" after the bankruptcy court confirms a plan of reorganization in a Chapter 7 or Chapter 11 bankruptcy proceeding. However, there are exceptions to this rule, and if a claim is not discharged, the claimant may continue to pursue collection of the debt after bankruptcy. See 11 U.S.C. § 524 (describing the effects of discharge.) At present, False Claims Act debts, which are not based on a showing of intent to defraud, ca n be treated inconsistently under the exceptions to the dischargeability provisions. For example, several courts have held that debts will be held nondischargeable under 11 U.S.C § 523(a)(2)(A), a provision that concerns debts arising from fraud, only if the debtor had an "intent" to defraud. See, e.g., Mayer v. Spanel Int'l., Ltd., 51 F.3d 670 (7th Cir.), cert. denied, 516 U.S. 1008 (1995). Likewise, some courts have held that 11 U.S.C. § 523(a)(6), which provides an exception for debts arising from "willful and malicious injury," requires proof that the debtor knew his conduct would automatically or necessarily cause the creditor's injury, see, e.g., In re Scarlata, 979 F.2d 521, 526 (7th Cir. 1992), a standard which is similar to an "intent" standard. And, while 11 U.S.C. § 523(a)(7) render fines and penalties nondischargeable, that provision likely would not render the single damages portion of a False Claims Act debt nondischargeable. Indeed, one court has held that no portion of a False Claims Act debt is nondischargeable under 11 U.S.C. § 523(a)(7) since the treble damage remedy is compensatory in nature. See In re Stelweck, 86 B.R. 833 (Bankr. E.D. Pa. 1988), aff'd on other grounds, 108 B.R. 488 (E.D. Pa. 1989).

The proposed provision would provide for consistent treatment of False Claims Act debts against individuals as nondischargeable in bankruptcy proceedings..

Repayment of Certain Debts Considered Final. No transfer on account of a debt owed to the United States for violating 31 U.S.C. § 3729 et seq. or under a compromise or other agreement resolving such a debt shall be avoided under sections 544, 545, 547, 548, 549, 553(b) or 724(a) of Title 11, United States Code.

As a general matter, a debtor that was "insolvent" at the time it settled a False Claims Act case under current law may recoup or "avoid" the settlement payment if the transfer was made within the 90 day period before the debtor petitioned for bankruptcy, unless the transfer was intended to be and was a contemporaneous exchange for new value given to the debtor. The courts have adopted different views on the issue of whether a release of claims is considered "new value" given to the debtor. By providing that False Claims Act debts may not be avoided in bankruptcy proceedings, this provision would in effect make clear that a release of False Claims Act liability is "new value" given to a debtor.

SEC. 5037. EXTENDING ANTI-FRAUD SAFEGUARDS TO THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.

This section would extend important anti-fraud safeguards to the Federal Employees Health Benefit Program (FEHBP). The FEHBP is the largest employer-sponsored health care program in the United States, spending more than $17 billion in taxpayer funds on health care benefits for federal employees. Unfortunately, when Congress extended powerful anti-fraud safeguards to the Medicare and Medicaid programs -- including strong anti-kickback provisions, enhanced civil money penalty provisions, and new tools to exclude dishonest providers from certain federal health care programs -- in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress explicitly excluded the FEHBP from these safeguards. There is no sound policy justification for such an exclusion, and this section would remove this unwarranted exclusion

SEC. 5038. PREVENTING AND PUNISHING ABUSE AND NEGLECT OF ELDERLY AND OTHER RESIDENTS IN NURSING HOMES AND RESIDENTIAL HEALTH CARE FACILITIES.

Protecting elderly and disabled Americans from abuse and neglect is one of the Administration's highest priorities. While most nursing home operators and employees are honest and law abiding, too many vulnerable nursing home residents are subjected to serious abuse and neglect. Moreover, federal law currently provides inadequate remedies to deter, prevent, and punish widespread abuse and neglect in federally funded nursing homes and other residential health care facilities.

This section would create new federal criminal and civil penalties against any individual or organization that engages in a pattern of violations of federal laws, regulations or rules or state laws

governing the health, safety or care of patients in residential health care facilities where at least one such violation results in physical or mental harm to a resident. For criminal penalties to attach, the violations constituting the pattern must be committed knowingly and willfully. Significantly, the scienter attaches to the violations that constitute the pattern rather than to the pattern itself. This section would also authorize the Attorney General to impose civil money penalties for patterns of violations resulting in harm, and to obtain injunctive and other equitable relief to prevent or enjoin violations of the new statute.

A number of important terms are defined in the new 18 U.S.C. 1348. Residents of residential health care programs, who frequently are totally dependent on the program's staff for basic health and safety needs, are particularly vulnerable to abuse and neglect. Therefore, the term "residential health care facility" is defined broadly to include skilled and unskilled nursing facilities, mental health and mental retardation facilities, and other facilities or programs that provides health care services in a residential setting and that receives more than $10,000 in any calendar year from a federal health care program., including Medicaid.

The statute also defines "pattern of violations" or "pattern of knowing and willful violations" to mean multiple violations of a single law, regulation or rule or single violations of multiple laws, regulations or rules, that are widespread, systemic, repeated, similar in nature, or result from a policy or practice. For example, a widespread group of violations, even if not the result of a common policy or practice or not involving the same or similar law, regulation, or rule, would be covered by the new statute. On the other hand, one or more isolated violations that do not rise to the level of a "pattern" would not be covered. The terms "pattern of violations" and "pattern of knowing and willful violations" are meant to incorporate an element of proportionality so that the number of violations required to establish a pattern within an entity operating numerous facilities across the country would be greater than the number of violations required for a single facility. The terms also are meant to incorporate an element of severity so that a lesser number of violations would be required if the harm was severe.

CONTRACTOR OVERSIGHT INITIATIVE

HCFA has been criticized by the General Accounting Office (GAO) and the Office of Inspector General (OIG) for ineffective and inefficient management of the Medicare program. Assessments have shown that Medicare contractors are not effectively carrying out their responsibilities and HCFA is not performing effective oversight of these contractors. HCFA believes it knows how to improve this situation, but the improvement cannot be accomplished without a stable source of additional financing for both contractor operations and HCFA oversight activities. Our FY 2001 budget request addressed this.

A part of this vision is a joint venture between HCFA and OIG which includes implementing a sound financial management and Electronic Data Processing (EDP) internal control structure at the Medicare contractors and data centers with testing and validation by OIG. Using the GAO Standards for Internal Control in the Federal Government, we will develop an internal control model that will be consistent with good business practice. We will define the minimum level of quality acceptable for internal controls in operation and clarify the criteria against which internal controls will be evaluated. These internal controls will include areas such as accounts receivable, the Debt Collection Improvement Act, cash management, and systems security.

HCFA's actuaries have provided preliminary estimates that increased contractor oversight of this type across all contractors would result in savings of at least $50 million annually as a result of improvement in the quality of claims processing performance by those contractors currently experiencing the biggest quality problems. These savings would grow as benefits grow, thus should equal $100 million in 10 years. The actuaries also believe that there would be additional savings in areas such as accounts receivable and fraud detection, but they are unable to make specific estimates at this time.

Although we believe our vision is appropriate, we understand that we need to demonstrate the effectiveness of this approach in order to secure adequate, stable funding on an ongoing basis. Therefore, for FY 2001, we are modifying our initial request and proposing a demonstration to be funded directly from the Hospital Insurance and Supplementary Medical Insurance Trust Funds. This demonstration would focus on eight major contractors:

- We would add four staff to each of these contractors (32 staff in total). That staff would establish the internal control environment, identify control objectives and determine the relevant risks in achieving those objectives, and report reliable information to management.

- We would increase HCFA staff by 30. That staff would initially focus on work with the Medicare fee-for-service contractors and data centers in establishing the internal control structure surrounding the financial management and EDP operations. Once the control structure is in place, the staff would focus on continual monitoring and oversight of the contractors' internal control structure.

- We would increase the OIG staff by 30. That staff would evaluate and test the effectiveness of the Medicare fee-for-service contractors' internal control structure surrounding the financial management and EDP operations and reporting findings and recommendations for improvement to internal parties. In addition, the OIG staff would help identify control objectives and determine the risks associated with achieving those objectives.

We estimate that the demonstration will cost $9.2 million.

This demonstration will build on activities already underway. HCFA has contracted with a CPA firm to conduct financial management reviews at approximately 25 Medicare fee-for-service contractors. As a result of these reviews, we will know which internal controls should be the focus of the demonstration. We will evaluate the success of this demonstration by assessing the progress the contractors have made in implementing the needed controls in the spring of FY 2001.

HHS feels so strongly about the need for this demonstration that the Office of Inspector General has agreed to pick up $1 million of the cost from its appropriated funds and the Secretary has agreed to provide 25% of the needed funding from her 1% transfer authority. We are requesting OMB approval to take the remaining $6.2 million directly from the Trust Funds under our research authority. We have been advised by our General Counsel that research authorities under the Social Security Act permit payment for Federal FTEs directly from the Trust Funds. Therefore, we do not believe that any statutory changes are needed.

We believe that this demonstration will clearly establish the soundness of our approach to contractor oversight. The FY 2001 demonstration is a precursor to our longer term establishment of a HCFA contractor oversight program. Oversight of our fiscal intermediaries and carriers, we believe, is an inherent governmental function that needs to be improved and sustained. Therefore, our FY 2002 budget submission will include a contractor oversight plan that will cover the period 2002 through 2007. Essentially, HCFA will be seeking stable and reliable funding for Federal administrative FTEs and travel associated with contractor oversight which is crucial to the effective and efficient administration of the program.

Our long term proposal will address two things. The first is a gradual expansion of the FY 2001 demonstration such that by 2007, 100% or all contractors will be evaluated for financial management and EDP internal controls, verifying that the internal controls for each is documented and verifying they are operational. Second, we would fund, by 2007 approximately

500 HCFA CO and RO staff responsible for oversight of a multitude of contractor business functions including financial management, EDP, provider enrollment, overpayment collection, and customer service. With the additional HCFA staffing for contractor oversight, we also will be able to conduct performance reviews of functional areas at intermediaries and carriers multiple times per year versus only annually. The added advantage is the sentinel effect on the Medicare fee-for-service contractor community of having HCFA staff frequently reviewing their daily operations. In addition, 300 OIG staff will be funded under this initiative. At that time we will seek approval of a separate mandatory funding source, with built-in growth rates, much like HCFAC, which we believe is critical to the successful operation of a comprehensive contractor oversight program. The total staffing numbers for HCFA and OIG are a combination of new and existing staff. Under that proposal, the funding needed by Medicare contractors would be placed in the Medicare contractor line of the Program Management budget. We strongly believe that without this type of approach our ability to effectively manage the Medicare contractors is severely compromised.

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 7, 2000 - DRAFT

January 2000

TABLE OF CONTENTS

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 (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 lead with

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 $466 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. what happens to $ not → trust fund

More than 79 percent ($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

[1]Hereafter, referred to as the Secretary.

Medicaid restitution.

Exclusion from Federally Sponsored Programs

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 Health Care Fraud and Abuse Control 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 1999. 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.)

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

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

(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 $466 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 **	**20,463,618**
TOTAL ***	**$466,512,072**

*This includes only forfeitures under 18 United States Code (U.S.C.) 1347, a new federal health care fraud offense

[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.

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.

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	2,300
Administration on Aging	1,400
Health Resources Services Administration	4,443
Departmental Appeals Board	138
Total	106,501
Department of Justice	
United States Attorneys	21,580
Civil Division	8,119
Criminal Division	803
Justice Management Division	280
Total	30,740
Total	**137,241**[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

[4]The original certification was for $137,540,000. However, during the fiscal year a $299,000 recission was taken against the account, leaving $137,241,000 available.

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 $466 million in cases resulting from health care fraud and abuse, of which $369 million was returned to the 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 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 the Departments of Justice and HHS. 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.

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. Coordination between organizations is handled through monthly meetings of the Nursing Home Steering Committee.

DOJ began a series of regional training conferences bringing together federal, state and local law enforcement personnel and regulators with responsibility for enforcing laws designed to prevent

nursing home fraud, abuse and neglect with representatives of state survey offices, state and local ombudsman, Adult Protective Services and others who work in this area. The goal of the conferences is to promote adequate quality of care for residents, and coordinate federal, state and local law enforcement and regulatory efforts.

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. As another indicator of the impact of anti-fraud and abuse efforts, 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 underserved during lean budget years. 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.

Model 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 HCFA 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.

Voluntary Self-Disclosure Protocol. In October 1999, 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 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 $4,149,555 (an amount representing more than double damages). 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 was 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 defended 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, a model for use 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 efforts to sustain denial of $4.8 million in payments to a Medicare supplier of orthotics and lymphedema pumps, headquartered in Pennsylvania. 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 how 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 how 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 what they should 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, Chinese, Russian, and Korean communities.

- The AoA's grantees convened 1,700 community education events which educated and informed nearly 30,000 individuals how 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 2,500 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 entail 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 care provided to patients. In addition to monetary losses, in some instances these improper activities endanger patient 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 our 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 presentations and complete courses on health care fraud, including:

- Affirmative Enforcement for Investigators (including a health care fraud training component
- Advanced Civil Health Care Fraud for Attorneys
- Advanced 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 a number of USAO attorneys, auditors and investigators participated in non-OLE sponsored, 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 fraudulent activities, abuse 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 case 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 over 1998. 371 cases were filed with 506 defendants. This represents a 16.3 percent increase over cases filed in 1998. Health care fraud convictions include both guilty pleas and guilty verdicts. A total of 396 defendants were convicted for health care fraud-related crimes in 1999.

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, 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, were provided to persons who were not eligible and in some cases, were provided to persons who were already deceased when the billed services were supposedly rendered. The two highest level 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 is a powerful legal tool used to help ensure that federal laws are obeyed, and that violators provide compensation to the government for losses and damages they cause as a result of fraud, waste, and abuse. Civil health care fraud matters ordinarily involve the United States utilizing the False Claims Act, as well as the common law of fraud, payment by mistake, unjust enrichment and conversion, to recover damages from those who have knowingly submitted false or fraudulent claims. Additionally, in conjunction with a defendant committing a criminal health care fraud offense, the United States may file a civil proceeding using the Fraud Injunction Statute, to ensure assets traceable to such violation are available to repay those victims the defendant has defrauded.

Each time a civil matter is referred 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 and 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* complaint, in United States District Court. A large majority of civil health care fraud cases and matters are settled without a complaint ever being filed. In 1999, civil health care fraud cases filed decreased 15 percent over 1998, from 107 to 91.

A multimillion dollar settlement was reached with one a 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 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.

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 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 significant 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.

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 the Food and Drug Administration and the National Institutes of Health (NIH). The settlement resolved allegations that, for more than two decades, the University had illegally profited from selling an unlicensed biologic, 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 were supplemented with 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 regarding medical records arising in the course of investigations and legal proceedings.

- 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 follow-up regional nursing home conferences 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

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